

EXECUTIVE (EX) COMMITTEE AND PLENARY

Executive (EX) Committee and Plenary, Dec. 4, 2023, Minutes

Adopted the NAIC 2024 Proposed Budget (Attachment One)

Adopted the NAIC 2024 Proposed Committee Charges (Attachment Two)

Adopted the 2024 Generally Recognized Expense Table (GRET) (Attachment Three)

Adopted the Voluntary Market Regulation Certification Program, Implementation Plan, and Certification Scoring Definitions (Attachment Four)

Adopted the Pet Insurance Market Conduct Annual Statement (MCAS) (Attachment Five)

Adopted Amendments to the *Property and Casualty Insurance Guaranty Association Model Act (#540)* (Attachment Six)

Adopted Revisions to the Part A Insurance Holding Company Systems Accreditation Standard (Attachment Seven)

Adopted the *Model Bulletin on the Use of Algorithms, Predictive Models, and Artificial Intelligence (AI) Systems by Insurers* (Attachment Eight)

Report on States' Implementation of NAIC-Adopted Model Laws and Regulations (Attachment Nine)

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Draft: 12/19/23

Executive (EX) Committee and Plenary
Orlando, Florida
December 4, 2023

The Executive (EX) Committee and Plenary met in Orlando, FL, Dec. 4, 2023. The following Committee and Plenary members participated: Chlora Lindley-Myers, Chair (MO); Andrew N. Mais, Vice Chair (CT); Jon Godfread, Vice President (ND); Scott A. White, Secretary-Treasurer (VA); Dean L. Cameron, Most Recent Past President (ID); Lori K. Wing-Heier (AK); Mark Fowler (AL); Alan McClain (AR); Barbara D. Richardson (AZ); Ricardo Lara represented by Lucy Wang (CA); Michael Conway (CO); Karima M. Woods (DC); Trinidad Navarro (DE); Michael Yaworsky (FL); John F. King represented by Martin Sullivan (GA); Michelle B. Santos (GU); Gordon I. Ito (HI); Doug Ommen (IA); Dana Popish Severinghaus (IL); Amy L. Beard (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Timothy N. Schott (ME); Anita G. Fox (MI); Grace Arnold (MN); Mike Chaney (MS); Troy Downing (MT); Mike Causey (NC); Eric Dunning (NE); D.J. Bettencourt (NH); Justin Zimmerman (NJ); Alice T. Kane (NM); Scott Kipper (NV); Adrienne A. Harris represented by John Finston (NY); Judith L. French (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Michael Humphreys represented by Diana Sherman (PA); Alexander S. Adams Vega (PR); Elizabeth Kelleher Dwyer (RI); Michael Wise (SC); Larry D. Deiter (SD); Carter Lawrence (TN); Cassie Brown (TX); Jon Pike represented by Tanji Northrup (UT); Kevin Gaffney (VT); Mike Kreidler (WA); Allan L. McVey (WV); Nathan Houdek (WI); and Jeff Rude (WY).

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

Director Lindley-Myers reported that the Executive (EX) Committee met Dec. 2 and adopted the Dec. 1 report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.

The Committee also adopted its Oct. 13 minutes, which included the following action: 1) approved the filing of an amicus brief in *Delaware Department of Insurance v. United States of America (IRS)*.

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

The Committee also: 1) adopted its 2024 proposed charges; 2) received a status report on the *State Connected* strategic plan; and 3) received a status report on model law development efforts for amendments.

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

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

Commissioner Godfread made a motion, seconded by Ms. Wang, to adopt by consent the committee, subcommittee, and task force minutes of the Summer National Meeting. The motion passed unanimously.

3. Adopted the NAIC 2024 Proposed Budget

Commissioner Mais presented the NAIC 2024 proposed budget for approval by the Membership.

Commissioner Mais reported that the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee approved the 2024 proposed budget on Nov. 28. The proposed budget includes \$154.0 million in

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operating revenues and operating expenses of \$158.4 million, resulting in an operating margin loss of \$4.4 million. After the inclusion of \$3.3 million in investment income, the NAIC's proposed 2024 budget reflects a reduction in net assets of \$1.1 million. In addition, a total of \$10.6 million is requested for capital spending for important projects, such as the System for Electronic Rates & Forms Filing (SERFF) modernization project, Uniform Certificate of Authority Application (UCAA), and IT VISION system enhancements.

The proposed budget includes six fiscal impact statements. Four of the fiscals are solely technology-based, and the remaining two fiscals will improve the regulatory training platform and provide other specialized support services. The proposed fiscals are in alignment with the Members' priorities as outlined in the NAIC's strategic plan, *State Connected*, and continue to enhance the important regulatory support the NAIC provides to the members.

After the public hearing, an additional fiscal was added and approved for consideration at the joint meeting of the Executive (EX) Committee and Internal Administration (EX1) Subcommittee held on Dec. 1. This fiscal requested a total of \$525,000 for variable annuity and life insurance model office testing as part of the generator of economic scenarios (GOES) project, which began several years ago. Adding this fiscal to the 2024 base budget will increase operating expenses by \$475,000 to \$158.8 million, increasing the NAIC's budgeted net asset loss to \$1.5 million.

Based on projected 2023 financial results and with approval of the proposed 2024 budget, the NAIC's net asset balance at the end of 2023 is expected to be \$177.4 million, slightly below the target reserve of \$179.8 million.

During the public exposure period, the NAIC received two comment letters, one from the National Association of Mutual Insurance Companies (NAMIC) and one from members of the Consumer Board of Trustees. Both entities were given an opportunity to expand upon their comments during the public hearing. Overall, both letters were supportive of the NAIC's proposed 2024 budget.

Commissioner Mais made a motion, seconded by Director Cameron, to adopt the NAIC 2024 proposed budget (Attachment One). The motion passed unanimously.

4. Adopted the NAIC 2024 Proposed Committee Charges

Commissioner Mais reported that the proposed NAIC 2024 committee charges reflect the continued work of the NAIC committee system. The charges were exposed for public comment, discussed in open forum, and adopted by each letter committee. The charges include work on important financial solvency and market conduct regulatory topics; continued engagement with consumer representatives, the insurance industry, and federal and international colleagues; and continued discussions of challenging public policy issues that affect insurance regulation in all member jurisdictions.

Commissioner Mais made a motion, seconded by Director Cameron, to adopt the NAIC 2024 proposed committee charges (Attachment Two). The motion passed unanimously.

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

Director French reported that the Life Insurance and Annuities (A) Committee met Dec. 3. During this meeting, the Committee adopted its Nov. 21 meeting minutes, which included the following action: 1) adopted its Summer National Meeting minutes; 2) adopted the 2024 Generally Recognized Expense Table (GRET); 3) adopted the Life Actuarial (A) Task Force's 2024 proposed charges; and 4) adopted its 2024 proposed charges.

The Committee also: 1) adopted the report of the Life Actuarial (A) Task Force; 2) heard a federal update on the "Proposed Retirement Security Rule: Definition of an Investment Advice Fiduciary;" and 3) heard a presentation

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from the Center for Economic Justice (CEJ) and the University of Georgia on consumer financial literacy versus life insurance and annuities illustrations.

Commissioner Ommen reported that the North American Securities Administrators Association (NASAA) is working on revisions to its model rules in light of the SEC's 2019 Regulation Best Interest. Commissioner Ommen raised concerns that the proposed revisions could go beyond Regulation Best Interest and the revised NAIC *Suitability in Annuity Transactions Model Regulation* (#275). Commissioner Ommen encouraged the entire NAIC Membership, not just departments of insurance (DOIs) that regulate securities, to engage with the rule.

6. Adopted the 2024 Generally Recognized Expense Table (GRET)

Director French reported that the Society of Actuaries (SOA) committee on life insurance company expenses submitted its GRET analysis to the Life Actuarial (A) Task Force for 2024. The SOA followed the same methodology in developing the 2024 GRET that it used for the 2023 GRET.

The 2024 GRET was adopted by the Life Insurance and Annuities (A) Committee during its Nov. 21 meeting.

Director French made a motion, seconded by Commissioner Lawrence, to adopt the 2024 GRET (Attachment Three). The motion passed unanimously.

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

Director Fox reported that the Health Insurance and Managed Care (B) Committee met Dec. 2 and adopted its Nov. 2 and Summer National Meeting minutes. During its Nov. 2 meeting, the Committee took the following action: 1) adopted its task forces' 2024 proposed charges; 2) adopted its 2024 proposed charges; and 3) adopted the white paper, *A Guide to Understanding Pharmacy Benefit Manager and Associated Stakeholder Regulation*.

The Committee adopted its subgroup, working group, and task force reports and their interim meeting minutes.

The Committee received an update on the Consumer Information (B) Subgroup's work to educate consumers on their claim appeal rights. This work is a follow-up to the discussions the Committee had at the Spring National Meeting on the low number of consumer appeals of claim denials. Next year, the Subgroup plans to begin work on a consumer-facing document educating consumers on pre-service denials and the process of appealing such denials.

The Committee heard a discussion on the Georgia and Virginia state-based marketplaces (SBMs). The presenters discussed the rationale behind the creation of their SBMs, including reducing the number of uninsured by designing an SBM that is more consumer-friendly with respect to shopping for a plan, enrollment, and enhancing the ability to coordinate more closely with other state agencies.

The Committee heard a federal update on pharmacy benefit managers (PBMs), Medicare Advantage marketing, federal regulations, and federal court cases.

The Committee heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on activities related to the Medicaid unwinding and redetermination process at the end of the COVID-19 public health emergency (PHE), and the Notice of Benefit and Payment Parameters 2025 proposed rule.

The Committee heard a discussion of the Committee's 2023 activities related to the priorities it identified for the year.

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

Commissioner McClain reported that the Property and Casualty Insurance (C) Committee met Dec. 3 and took the following action: 1) adopted its Summer National Meeting minutes; and 2) adopted its 2024 proposed charges.

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

The Committee heard a presentation from NAMIC, the American Property Casualty Insurance Association (APCIA), and Cambridge Mobile Telematics (CMT) on the growing challenges of private passenger automobile (PPA) accidents and how the industry uses telematics to assess, underwrite, and rate risk.

The Committee also: 1) heard a presentation from RiverStone about third-party funding of litigation; and 2) heard an update on the state insurance regulator data call that collects insurer data to better assess homeowners insurance markets.

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

Commissioner Pike reported that the Market Regulation and Consumer Affairs (D) Committee met Dec. 3 and adopted its Summer National Meeting minutes and its 2024 proposed charges.

The Committee adopted revisions to the *Unfair Trade Practices Act* (#880) to provide state insurance departments the means to regulate lead generators. The revisions include a new definition of health insurance lead generator and clarify that health insurance lead generators are prohibited from engaging in unfair trade practices.

The Committee adopted updates to the Market Conduct Annual Statement (MCAS) revision process. Drafts will now be provided to the Working Group by April 1 of each year to allow sufficient time for the Working Group to review, discuss, and consider MCAS reporting data calls and definitions for new lines of business, substantial additions, and changes to existing lines of business.

The Committee adopted revisions to the Market Regulation Handbook Chapter 23—Conducting the Life and Annuity Examination. The revisions provide additional examination guidance to support state insurance regulators in assessing industry compliance with the standards of the revised Model #275, which the NAIC membership adopted in 2020.

The Committee adopted a new travel insurance in-force standardized data request (SDR) and travel insurance claims SDR revisions. The SDRs will become incorporated into the NAIC *Market Regulation Handbook* for states to voluntarily use during market conduct examinations.

The Committee adopted the reports of its task forces and working groups: the Antifraud (D) Task Force; the Market Information Systems (D) Task Force; the Producer Licensing (D) Task Force; the Market Analysis Procedures (D) Working Group; the Market Conduct Annual Statement Blanks (D) Working Group; the Market Conduct Examination Guidelines (D) Working Group; and the Speed to Market (D) Working Group. The adoption of the Market Conduct Annual Statement Blanks (D) Working Group report included the establishment of May 31 as the annual MCAS reporting deadline for the "other health" and short-term, limited-duration (STLD) MCAS lines of business.

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The Committee heard a presentation from the CEJ on public access to MCAS data and improving data collection and related tools for market analysis.

10. Adopted the Voluntary Market Regulation Certification Program, Implementation Plan, and Certification Scoring Definitions

Commissioner Pike reported that the Voluntary Market Certification Program, Implementation Plan, and Certification Scoring Definitions were adopted by the Market Regulation Consumer Affairs (D) Committee during the Summer National Meeting.

The Voluntary Market Regulation Certification Program is a response to the federal government's critiques of market conduct regulation in the separate states and territories of the U.S. It promotes best practices and consistency for all NAIC members' market regulation activities and also promotes collaboration among the NAIC members.

The voluntary certification program has 11 requirements that cover market conduct examinations; the qualifications of examiners and analysts; the use of market conduct tools; the implementation of NAIC model acts; collaboration with other jurisdictions; and participation in NAIC market regulation working groups and task forces.

Commissioner Pike made a motion, seconded by Commissioner Kreidler, to adopt the Voluntary Market Regulation Certification Program, Implementation Plan, and Certification Scoring Definitions (Attachment Four). The motion passed. New York and West Virginia abstained.

11. Adopted the Pet Insurance Market Conduct Annual Statement (MCAS)

Commissioner Pike reported that on July 27, the Market Regulation and Consumer Affairs (D) Committee adopted a new MCAS blank to collect underwriting, claims, marketing and sales, lawsuits, and complaint data from companies writing pet insurance.

The creation of the Pet Insurance MCAS blank is in response to the rapid growth of the pet insurance market and follows the recent adoption of the *Pet Insurance Model Act* (#633). The first collection of data will be on April 30, 2025.

Commissioner Pike made a motion, seconded by Director Fox, to adopt the Pet Insurance MCAS (Attachment Five). The motion passed. Indiana and New York abstained.

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

Director Dwyer reported that the Financial Condition (E) Committee met Dec. 3. During this meeting, the Committee adopted its Oct. 25 and Summer National Meeting minutes, which included the following action: 1) adopted its 2024 proposed charges; 2) adopted amendments to the *Property and Casualty Insurance Guaranty Association Model Act* (#540); and 3) received comments regarding its previously exposed *Framework for Regulation of Insurer Investments*.

The Committee received a summary of comments on its previously exposed *Framework for Regulation of Insurer Investments*.

The Committee adopted a list of qualified jurisdictions and reciprocal jurisdictions.

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The Committee adopted the reports of the following task forces and working groups: the Accounting Practices and Procedures (E) Task Force, the Capital Adequacy (E) Task Force, the Examination Oversight (E) Task Force, the Financial Stability (E) Task Force, the Receivership and Insolvency (E) Task Force, the Reinsurance (E) Task Force, the Risk Retention Group (E) Task Force; the Valuation of Securities (E) Task Force, the NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group; the National Treatment and Coordination (E) Working Group; and the Risk-Focused Surveillance (E) Working Group.

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

13. Adopted Amendments to the *Property and Casualty Insurance Guaranty Association Model* (#540)

Director Dwyer reported that in 2022 the Executive (EX) Committee approved two requests to amend Model #540. The first request was in response to a referral from the Restructuring Mechanisms (E) Working Group that identified the need to preserve guaranty fund coverage for policyholders subject to insurance business transfers (IBT) and corporate divisions (CD) where the policyholder had guaranty fund coverage before the transaction.

The second request originated from an issue raised by the National Conference of Insurance Guaranty Funds (NCIGF) that suggested the NAIC clarify any ambiguity in the coverage for cyber security insurance. The amendments presented address both of those topics.

Director Dwyer made a motion, seconded by Commissioner Donelon, to adopt Model #540 (Attachment Six). The motion passed. New York abstained.

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

Director Wing-Heier reported that the Financial Regulation Standards and Accreditation (F) Committee met Nov. 30 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings to: 1) discuss state-specific accreditation issues and 2) vote to award continued accreditation to the insurance departments of Illinois, Maine, Wisconsin, and Wyoming.

The Committee did not meet in open session.

15. Adopted Revisions to the Part A Insurance Holding Company Systems Accreditation Standard

Director Wing-Heier reported that the Committee voted to recommend adoption of the 2020 revisions to *Insurance Holding Company System Regulatory Act* (Model #440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (Model #450), which implement a group capital calculation (GCC) for the purpose of group solvency supervision and a liquidity stress test (LST) for macroprudential surveillance, as significant elements to the Holding Company Systems accreditation standard at the Summer National Meeting. The revised standard includes a provision allowing the commissioner to grant exemptions to the GCC for groups meeting standards set out in 21A and 21B of Model #450 without the requirement to file at least once. These updates will have an effective date of Jan. 1, 2026.

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Director Wing-Heier made a motion, seconded by Commissioner Clark, to adopt revisions to the Part A Insurance Holding Company Systems accreditation standard (Attachment Seven). The motion passed unanimously.

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

Commissioner Anderson reported that the International Insurance Relations (G) Committee met Dec. 1. During this meeting, the Committee adopted its Sept. 14 and Summer National Meeting minutes.

The Committee adopted its 2024 proposed charges, which included slight revisions to its 2023 charges to provide further clarification of international supervisory cooperation and work.

The Committee heard an update on the evolution of group capital and supervisory recognition in the U.S. and internationally.

The Committee also: 1) heard an update on recent activities of the International Association of Insurance Supervisors (IAIS), focusing on its annual conference in Tokyo and 2) heard an update on international activities, including: a) bilateral meetings with a variety of jurisdictions; b) recent meetings, events, and speaking engagements with international insurance regulators; and c) the NAIC Fall 2023 International Fellows Program.

17. Received the Report of the Innovation, Cybersecurity, and Technology (H) Committee

Commissioner Birrane reported that the Innovation, Cybersecurity, and Technology (H) Committee met Dec. 1. During this meeting, the Committee adopted its Nov. 16 minutes, which included the following action: 1) adopted its Summer National Meeting minutes; 2) approved the Privacy Protections (H) Working Group's request to extend the deadline for completion of the *Insurance Consumer Privacy Protection Model Law* until Dec. 31, 2024; 3) adopted its 2024 proposed charges; and 4) discussed comments received from interested parties on the second exposure draft of the *Model Bulletin on the Use of Algorithms, Predictive Models, and Artificial Intelligence Systems by Insurers*.

The Committee adopted the reports of its working groups: the Big Data and Artificial Intelligence (H) Working Group; Cybersecurity (H) Working Group; E-Commerce (H) Working Group; Innovation in Technology and Regulation (H) Working Group; and Privacy Protections (H) Working Group.

The Committee adopted the *Model Bulletin on the Use of Algorithms, Predictive Models, and Artificial Intelligence Systems by Insurers* as amended during the meeting, which resulted in a technical clarification of the language in Section 4.3.

The Committee heard a presentation on generative artificial intelligence (AI) from Professor Victor Winter (University of Nebraska—Omaha).

18. Adopted the *Model Bulletin on the Use of Algorithms, Predictive Models, and Artificial Intelligence (AI) Systems by Insurers*

Commissioner Birrane reported that the Innovation, Cybersecurity, and Technology (H) Committee was charged with considering and coordinating the development of regulatory guidance and examination standards related to innovation, cybersecurity, data privacy, and the use of big data and AI, including machine learning (ML) in the business of insurance and technology. This charge was accomplished through the *Model Bulletin on the Use of Algorithms, Predictive Models, and Artificial Intelligence Systems by Insurers*.

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The model bulletin informs insurance carriers that decisions impacting consumers that are made or supported by advanced analytical and computational technologies, including AI, must comply with all applicable insurance laws and regulations, including unfair trade practices. While compliance with these standards is required regardless of the tools and methods used to make such decisions, because AI has the potential to increase the risk of inaccurate, arbitrary, capricious, or unfairly discriminatory outcomes for consumers, it is important that insurers adopt and implement controls specifically related to their use of AI that are designed to mitigate the risk of adverse consumer outcomes.

Commissioner Birrane made a motion, seconded by Commissioner Godfread, to adopt the *Model Bulletin on the Use of Algorithms, Predictive Models, and Artificial Intelligence Systems by Insurers* (Attachment Eight). The motion passed unanimously.

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

Director Lindley-Myers referred attendees to the written report for updates on states' implementation of NAIC-adopted model laws and regulations (Attachment Nine).

20. Heard the Results of the 2024 NAIC Zone Officer Elections

The Executive (EX) Committee and Plenary received the results of the 2024 zone officer elections. Midwest Zone: Director Anita G. Fox, Chair (MI); Commissioner Vicki Schmidt, Vice Chair (KS); and Director Eric Dunning, Secretary (NE). Northeast Zone: Commissioner Trinidad Navarro, Chair (DE); Commissioner Kevin Gaffney, Vice Chair (VT); and Commissioner Gary D. Anderson, Secretary (MA). Southeast Zone: Commissioner Carter Lawrence, Chair (TN); Commissioner Sharon P. Clark, Vice Chair (KY); and Commissioner Alan McClain, Secretary (AR). Western Zone: Commissioner Michael Conway, Chair (CO); Commissioner Andrew R. Stolfi, Vice Chair (OR); and Commissioner Cassie Brown, Secretary (TX).

21. Elected the 2024 NAIC Officers

The NAIC membership elected the 2024 NAIC officers: Commissioner Andrew N. Mais, President (CT); Commissioner Jon Godfread, President-Elect (ND); Commissioner Scott A. White, Vice President (VA); and Director Elizabeth Kelleher Dwyer, Secretary-Treasurer (RI).

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

Executive Summary NAIC 2024 Budget



NATIONAL ASSOCIATION OF
INSURANCE COMMISSIONERS

About the NAIC

The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.

Through the NAIC, insurance regulators establish standards and best practices, conduct peer reviews, and coordinate their regulatory oversight activities. NAIC staff support these efforts and represent the collective domestic and international views of insurance regulators.

NAIC members, together with the central resources of the association, form the national system of state-based insurance regulation in the U.S. NAIC members are elected or appointed government officials who, along with their departments and staff, regulate the conduct of insurance companies and agents/brokers in their respective jurisdictions.

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

For the past three and a half years, the NAIC has faced unprecedented challenges. While the NAIC was not immune to many of the difficulties faced by members or the industry, it remained steadfast in support of regulators and achieved many objectives set forth in the organization's prior strategic plan, *State Ahead*. That strategic plan, while remaining flexible so that the organization can appropriately and sufficiently respond to emerging issues, was the compass to assist navigation through challenges. *State Ahead* served as a beacon, a guiding light, of the membership's vision for how the NAIC can help support the future of insurance regulation.

In 2022, the membership began a rigorous review of its strategic plan and laid a path for the next three to four years' worth of major initiatives and objectives. The work was strenuous but critical to ensure the NAIC can continue supporting regulators and is appropriately positioned to respond in the quickly evolving marketplace of insurance. The NAIC must be nimble enough to respond to technological driven advancements including the expanded use of artificial intelligence and to challenges including the availability and affordability of insurance due to catastrophic losses or increased frequency of loss.

Accordingly, the NAIC's new strategic plan, *State Connected*, builds on previous successes and prepares staff and system infrastructure for the next ten years of support. With 32 goals spread across six strategic focus areas, NAIC membership and leadership have laid a formidable path, upping the game of insurance regulation.

Highlighting just a few of the strategic focus areas, one can easily picture the vision for the next generation of insurance regulation. As an example, one strategic focus area centers around member connectivity and aims to strengthen collaboration and engagement among NAIC members and their staff through streamlined communications, a

dedicated member directory, and community portals. Regulators are on the ground floor of insurance regulation and the expertise they can share with other regulators will only benefit a cohesive and sound

regulatory environment. Another strategic focus will supplement the training, expertise, and technology offered by the NAIC. As the NAIC is often referred to as a hub for its members, a revamped and improved training platform, improved access to additional subject matter experts, and enhancements to the NAIC's technology infrastructure will help regulators address new insurance risks while utilizing new tools and information. In fact, data is so critical that it is the emphasis of its own strategic focus area, referred to as the data and analysis strategic focus. This will provide regulators with increased data access and will combine information from several independent sources. This will further enhance analysis and provide increased information for regulators to make informed decisions regarding the companies they regulate.

Beyond strategic objectives, the 2024 budget continues NAIC's commitment to supporting a variety of programs, products, and services in the financial solvency and market regulatory arenas. The NAIC offers a wide range of systems, services, data, accreditation reviews, and many other essential services to assist insurance regulators in achieving their fundamental insurance regulatory goals in a timely and cost-effective manner. Through this approach, the NAIC stands by to maintain the U.S. as one of the strongest and most resilient insurance markets in the world.

Support of the Membership

The mission of the NAIC is to assist insurance regulators in serving the public interest; promoting a competitive marketplace; facilitating the fair and equitable treatment of insurance customers; ensuring the reliability, solvency, and financial stability of insurers; and supporting and improving insurance regulation. Leveraging NAIC technology solutions, regulatory tools, and staff resources allow members to achieve these goals at significant cost savings. Without these options, many systems would be cost-prohibitive for the jurisdictions to implement on their own. If each member were to independently support the technological infrastructure required for effective insurance regulation, the cost to regulate insurers would be exponentially more expensive – costs that would be passed on to insurers and increase their cost of doing business.

Membership in the NAIC provides a range of benefits and services – often at no charge. Among other items, members receive jurisdiction funding, training, and access to data and numerous regulatory tools; the value of which far exceeds what a jurisdiction pays in member dues.

A Focus on Consumers

The NAIC provides a multi-channel approach to reach and assist consumers to help them make informed decisions and effectively use their insurance benefits. Using multi-pronged marketing communications campaigns, the NAIC strives to reach insurance consumers whether through consumer education articles, the NAIC Home Inventory mobile app, or targeted social media campaigns.

By the Numbers

NAIC products and services make life easier.

- ▶ **System for Electronic Rates & Forms Filing (SERFF)** – 520,910 transactions processed in 2022.
- ▶ **Online Premium Tax for Insurance (OPTins)** – 180,202 transactions processed in 2022.
- ▶ **State Based Systems (SBS)** – back-office services currently licensed to 34 jurisdictions with an additional jurisdiction onboarding in 2024.
- ▶ **Professional Designation Program** – 1,969 designations awarded since the program's inception in 2006 through year-end 2022.
- ▶ **Center for Insurance Policy and Research (CIPR) Key Research Issues** – nearly 150 briefs currently available online including NAIC key initiatives and topics ranging from cybersecurity and innovation to natural catastrophe risk and resiliency.

Valuable Products and Services

The NAIC seeks to support its mission through a wide variety of products and services offered to regulators, the insurance industry, and insurance consumers. For regulators and those in industry, the NAIC offers web-based systems that automate, standardize, and streamline regulatory processes by transmitting data and facilitating regulatory transactions. For consumers, the NAIC offers a wide range of informational products to help consumers make informed decisions.

The NAIC is committed to not only maintaining existing systems but is also dedicated to enhancing its infrastructure by staying current on new emerging technologies. This ensures regulators have the information they need to ensure consumer protection and a fair, competitive, healthy insurance market. Accordingly, the 2024 budget includes six fiscal impact statements (fiscals), four of which are technology based and either continue the work of ongoing modernization efforts or begin modernization efforts on other critical regulatory support systems. The remaining fiscals will increase the NAIC's ability to serve the membership through an improved regulator training platform with enhanced certification offerings and provide other specialized support services.

Building the Budget

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

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

Expected Results for 2023

Based on actual operating results through June 30, 2023, the NAIC projects an operating margin of \$1.7 million compared to a budgeted negative operating margin of \$6.0 million, an improvement of \$7.7 million. Investment income is projected to be a gain of \$7.3 million, resulting in a net asset increase of nearly \$9.0 million, ending the year at \$177.9 million. It's important to note that while investment income is projected at \$4.9 million over budget at year-end, markets remain volatile. Additionally, the projected gain does not cover the \$16.8 million investment loss suffered in 2022.

2024 Budget

Looking forward to 2024, NAIC's budget continues to demonstrate investment in critical regulatory support infrastructure and in items that will create meaningful impact for the members and industry, which of course then benefits the insurance consumer. In addition, NAIC's budget remains keenly focused on prudent financial management and ensures resources are being used in a way to create the most

value. If 2024 is anything like the past couple of years, it may very well present challenges not yet on the horizon. Membership and management remain dedicated to making investments in infrastructure and personnel as requirements evolve.

The 2024 NAIC operating budget (before including investment income) reflects revenues of \$154.0 million and expenses of \$158.4 million, which represent a 6.5% and a 5.2% increase, respectively, from the 2023 budget, resulting in \$4.4 million in projected expenses over revenues. Viewed in relation to the 2023 projected totals, the 2024 budget represents an operating revenue increase of 3.1% and operating expense increase of 7.2%. Additional information about the 2024 budget is included in the detailed footnotes of the budget.

A fiscal impact statement is prepared for new or existing NAIC initiatives with revenue, expense, or capital impacts of \$100,000 or more either in the current budget or within the following few years' budgets, or which require more than 1,150 hours of internal technical resources to accomplish. Each fiscal includes a detailed description of the initiative; impact on key stakeholders; financial and operational impact; and an assessment of the risks. The total financial impact of the six fiscals included in the 2024 budget is \$3.4 million in expenses and \$10.6 million in capital. Additional information about each initiative is included in the various fiscal sections of the budget.

The 2024 budget includes \$3.3 million in investment income from the NAIC's long-term investment portfolio. Investment income is composed of interest and dividends earned, reduced by investment management fees. Investment gains and losses are volatile and therefore are not projected

2024 Fiscal Impact Statements

- ▶ **SERFF Modernization – 2024 Transition Stages** This project is in its third year of a multi-year initiative to improve the SERFF platform. In 2024, users will move into the platform beginning with the Insurance Compact then life users. In 2025, property/casualty and health will transition followed by plan management in 2026. This request includes the addition of three headcount.
 - Expense of \$689K for headcount, travel, and amortization.
 - Capital of \$5.8M for professional and other services.
- ▶ **Enterprise Data Asset Management – Phase III** This fiscal continues to expand the Enterprise Data Platform through integrating additional datasets (such as SBS, SERFF, OPTins) and provides regulators with systems training. This fiscal includes the addition of two headcount for dataset integration and ongoing system maintenance.
 - Expense of \$1.2M for staffing, consulting, software, training, and travel.
- ▶ **Expand NAIC Expertise – 2024** Recognizing the need for specialty skillsets in a variety of areas, this fiscal includes the addition of the following four headcount:
 - P/C Modeling Analyst to assist with increasing demand for rate reviews.
 - Cybersecurity Policy Advisor to support cybersecurity and cyber insurance policy discussions.
 - Two Policy and Research Analysts to support data calls, dashboarding, and other research related items.
 - Expense of \$457K for staffing.
- ▶ **NAIC Education & Training Modernization Project** Expands and modernizes training and professional development programs available to insurance regulators. In addition to system modernization, the project envisions expanding offerings up to as many as 40 professional designations. This fiscal includes the addition of two headcount.
 - Expense of \$530K for staffing, consulting, training, and software.
- ▶ **IT VISION System Enhancements – 2024** A multi-year information technology related project necessary to optimize Multiple Issuer and Security Identifiers, enhance document management, ensure the system is flexible for future business capabilities, and upgrade the security valuation platform utilized by the Securities Valuation Office. This fiscal includes the addition of three headcount.
 - Expense of \$354K for staffing.
 - Capital of \$1.6M for professional and other services.
- ▶ **Uniform Certificate of Authority Application (UCAA) – Phase II** This project continues development and will integrate additional applications into the platform including corporate expansion, and domestic and foreign corporate amendments. This fiscal also includes the addition of one headcount.
 - Expense of \$130K for staffing.
 - Capital of \$3.2M for professional and other services.

nor included in the budget.

Combining budgeted results from operations with budgeted investment income, the 2024 budget has a reduction in net assets of \$1.1 million.

Ensuring Financial Stability

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

Operating Reserve Target

The reserve makes assets available to allow an organization to take mission-related risks and to absorb or respond to changes in its environment or circumstances.

In 2022, following an extensive review of current and future risks and an evaluation of comparable organizations by an independent financial advisory firm, the Executive (EX) Committee and Internal Administration (EX1) Subcommittee approved the establishment of a new methodology for determining the NAIC operating reserves.

The new methodology looks at three areas of reserves: working capital needed to maintain day-to-day operations over three months; an assessment of the funds needed to mitigate potential risks if certain events were to occur; and the funding necessary

for strategic initiatives planned in the upcoming three years that are not currently included in the budget. Based on the evaluation of these three areas, the Subcommittee increased NAIC's operating reserve target for 2023 to \$179.8 million. This target recognizes the increased level of uncertainty facing the NAIC and anticipated future investments required to enhance the association's information technology and technical infrastructure, represented by many elements that are now part of the 2024 budget.

Preparing for the Unknown

The budget includes all activities anticipated to occur in 2024. However, situations or additional strategic or emerging projects may arise during 2024 that require additional funding. In such an event, a funding request will be prepared and presented to the Executive (EX) Committee and Internal Administration (EX1) Subcommittee for consideration. Supplemental funding can come from the Regulatory Modernization and Initiatives Fund, an extra layer of protection established in 2005 to manage requests that arise following the adoption and implementation of an annual budget. This fund is based on 1.5% of the NAIC's projected net assets as of December 31, 2024, or \$2.7 million.

Contact Information

The NAIC appreciates the opportunity to present this 2024 budget and believes it provides a comprehensive review of the NAIC's business and financial operations for the current and upcoming fiscal year. A summary of the key components of the 2024 budget is included in the budget overview.

Please contact Jim Woody, Chief Financial Officer, at jwoody@naic.org, or Carol Thompson, Senior Controller, at cthompson@naic.org, should you have any questions or need additional information.

Draft: 12/4/23

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023
Adopted by the Executive (EX) Committee, Dec. 2, 2023

2024 Charges

EXECUTIVE (EX) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

1. The **Executive (EX) Committee** will:
 - A. Identify the goals and priorities of the organization and make recommendations to achieve such goals and priorities based on input of the membership. Make recommendations by the 2024 Commissioners' Conference.
 - B. Create/terminate task force(s) and/or Executive (EX) Committee-level working groups to address special issues and monitor the work of these groups. Create necessary task force(s) and/or Executive (EX) Committee-level working groups throughout 2024 as necessary.
 - C. Submit reports and recommendations to NAIC members concerning the activities of its subcommittee and the standing committees. Submit a report at each national meeting.
 - D. Consider requests from NAIC members for friend-of-the-court briefs.
 - E. Establish and allocate functions and responsibilities to be performed by each NAIC zone.
 - F. Pursuant to the Bylaws, oversee the NAIC offices to assist the organization and the individual members in achieving the goals of the organization.
 - G. Conduct strategic planning on an ongoing basis.
 - H. Plan, implement and coordinate communications and activities with the Federal Insurance Office (FIO).
 - I. Plan, implement and coordinate communications and activities with other state, federal, local and international government organizations to advance the goals of the NAIC and promote understanding of state insurance regulation.
 - J. Review and approve requests for the development of model laws and/or regulations. Coordinate the review of existing model laws and/or regulations.
 - K. Select NAIC national meeting sites five and six years in advance of the meeting date to ensure efficient and economical locations and facilities.
 - L. Review and revise, as necessary and appropriate, the criteria and categories for registrants at NAIC national meetings.

NAIC Support Staff: Andrew J. Beal/Kay Noonan

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Executive (EX) Committee, Dec. 2, 2023

Adopted by the Climate and Resiliency (EX) Task Force, Nov. 17, 2023

2024 Charges

CLIMATE AND RESILIENCY (EX) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Climate and Resiliency (EX) Task Force** will:
 - A. Consider how state insurance departments that opt into the insurer's climate risk disclosure reporting requirement review the information received.
 - B. Evaluate financial regulatory approaches to climate risk and resiliency in coordination with other relevant committees, task forces, and working groups, such as the International Insurance Relations (G) Committee, the Property and Casualty Insurance (C) Committee, the Financial Condition (E) Committee, and the Financial Stability (E) Task Force, including:
 - i. Evaluation of the use of modeling by carriers and their reinsurers concerning climate risk.
 - ii. Evaluation of how rating agencies incorporate climate risk into their analysis and governance.
 - iii. Evaluation of the potential solvency impact of insurers' exposures, including both underwriting and investments, to climate-related risks.
 - iv. Evaluation and development of climate risk-related disclosure, stress testing, and scenario modeling.
 - C. Consider innovative insurer solutions to climate risk and resiliency, including:
 - i. Evaluation of how to apply technology and innovation to the mitigation of storm, wildfire, other climate risks, and earthquake.
 - ii. Evaluation of insurance product innovation directed at reducing, managing, and mitigating climate risk, as well as closing protection gaps.
 - D. Identify adaptation, resilience, and mitigation issues and solutions related to the insurance industry.
 - E. Consider pre-disaster mitigation and resiliency and the role of state insurance regulators in resiliency.
 - F. Engage with the Center for Insurance Policy and Research (CIPR) Catastrophe Modeling Center of Excellence (COE) regarding climate-related risk and mitigation research and analysis.

NAIC Support Staff: Aaron Brandenburg

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Executive (EX) Committee, Dec. 2, 2023

Adopted by the Government Relations (EX) Leadership Council, Oct. 25, 2023

2024 Charges

GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

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

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

Ongoing Support of NAIC Programs, Products, or Services

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

NAIC Support Staff: Ethan Sonnichsen/Brian R. Webb/Shana Oppenheim

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Special (EX) Committee on Race and Insurance, Dec. 2, 2023

2024 Charges

SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The **Special (EX) Committee on Race and Insurance** will:
 - A. Serve as the NAIC's coordinating body on identifying issues related to: 1) race, diversity, and inclusion within the insurance sector; 2) race, diversity, and inclusion in access to the insurance sector and insurance products; and 3) practices within the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups.
 - B. Coordinate with existing groups such as the Innovation, Cybersecurity, and Technology (H) Committee, Big Data and Artificial Intelligence (H) Working Group and the Casualty Actuarial and Statistical (C) Task Force and encourage those groups to continue their work on issues affecting people of color and/or historically underrepresented groups, particularly in predictive modeling, price algorithms, and artificial intelligence (AI).
 - C. Receive updates on recommendations on action steps state insurance regulators and companies can take to improve the level of diversity and inclusion in the industry.
 - D. In coordination with the Executive (EX) Committee, receive reports on NAIC diversity, equity, and inclusion (DE&I) efforts. Serve as the coordinating body for state requests for assistance from the NAIC related to DE&I efforts.
 - E. Receive reports from the Member Diversity Leaders Forum concerning best practices among state insurance departments on DE&I efforts.
 - F. Continue research and analysis of insurance, legal, and regulatory approaches to addressing unfair discrimination, disparate treatment, proxy discrimination, and disparate impact. Make recommendations for statutory or regulatory changes and additional steps, including:
 1. (Life Workstream) The impact of traditional life insurance underwriting on traditionally underserved populations, considering the relationship between mortality risk and disparate impact.
 2. (Property/Casualty Workstream) Developing analytical and regulatory tools to assist state insurance regulators in defining, identifying, and addressing unfair discrimination in property/casualty (P/C) insurance, including issues related to:
 - a. Rating and underwriting variables, such as socioeconomic variables and criminal history, including:
 1. Identifying proxy variables for race.
 2. Correlation versus causation, including discussion of spurious correlation and rational explanation.
 3. Potential bias in underlying data.
 4. Proper use of third-party data.
 - b. Disparate impact considerations.

SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE *(continued)*

- G. (Life, Property/Casualty, and Health Workstreams) Consider enhanced data reporting and record-keeping requirements across product lines to identify race and other sociodemographic factors of insureds, including consideration of legal and privacy concerns. Consider a data call to identify insurance producer resources available and products sold in specific ZIP codes to identify barriers to access.
- H. Continue research and analysis related to insurance access and affordability issues, including:
 - 1. (Life Workstream) The marketing, distribution, and access to life insurance products in minority communities, including the role that financial literacy plays.
 - 2. (Life Workstream) Disparities in the number of cancellations/rescissions among minority policyholders.
 - 3. (Health Workstream) Measures to advance equity through lowering the cost of health care and promoting access to care and coverage, with a specific focus on measures to remedy impacts on people of color, low income and rural populations, and historically marginalized groups, such as the LGBTQ+ community, individuals with disabilities, and Alaska Native and other Native and Indigenous people.
 - 4. (Health Workstream) Examination of the use of network adequacy and provider directory measures (e.g., provider diversity, language, and cultural competence) to promote equitable access to culturally competent care.
 - 5. (Health Workstream) Conduct additional outreach to educate consumers and collect information on health and health care complaints related to discrimination and inequities in accessing care.
 - 6. (Property/Casualty Workstream) Whether steps need to be taken to mitigate the impact of residual markets, premium financing, and nonstandard markets on historically underrepresented groups.
 - 7. Make referrals for the development of consumer education and outreach materials, as appropriate.

NAIC Support Staff: Andrew J. Beal/Kay Noonan

Adopted by Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Executive (EX) Committee, Dec. 2, 2023

Adopted by the Internal Administration (EX1) Subcommittee, Aug. 22, 2023

2024 Charges

INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

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

NAIC Support Staff: Andrew J. Beal/Jim Woody

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Life Insurance and Annuities (A) Committee, Nov. 21, 2023

2024 Charges

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Life Insurance and Annuities (A) Committee** will:
 - A. Monitor the activities of the Life Actuarial (A) Task Force.
2. The **Accelerated Underwriting (A) Working Group** will:
 - A. Consider the use of external data and data analytics in accelerated life underwriting, including consideration of the ongoing work of the Life Actuarial (A) Task Force on the issue, and draft guidance for the states if appropriate.
3. The **Annuity Suitability (A) Working Group** will:
 - A. Consider how to promote greater uniformity in the adoption of the *Suitability in Annuity Transactions Model Regulation* (#275) across NAIC member jurisdictions.

NAIC Support Staff: Jennifer R. Cook/Jolie H. Matthews

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Life Insurance and Annuities (A) Committee, Nov. 21, 2023

Adopted by the Life Actuarial (A) Task Force, Oct. 5, 2023

2024 Charges

LIFE ACTUARIAL (A) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Life Actuarial (A) Task Force** will:
 - A. Work to keep reserve, reporting, and other actuarial-related requirements current. This includes principle-based reserving (PBR) and other requirements in the *Valuation Manual*, actuarial guidelines, and recommendations for appropriate actuarial reporting in blanks. Respond to charges from the Life Insurance and Annuities (A) Committee and referrals from other groups or committees, as appropriate.
 - B. Report progress on all work to the Life Insurance and Annuities (A) Committee and provide updates to the Financial Condition (E) Committee on matters related to life insurance company solvency. This work includes the following:
 - i. Work with the American Academy of Actuaries (Academy) and the Society of Actuaries (SOA) to develop new mortality tables for valuation and minimum nonforfeiture requirements for life insurance and annuities, as appropriate.
 - ii. Provide recommendations for guidance and requirements for accelerated underwriting (AU) and other emerging underwriting practices, as needed.
 - iii. Work with the SOA on the annual development of the Generally Recognized Expense Table (GRET) factors.
 - iv. Provide recommendations and changes to other reserve and nonforfeiture requirements to address issues as appropriate, and provide actuarial assistance and commentary to other NAIC committees relative to their work on actuarial matters.
 - v. Work with the selected vendor to develop and implement the new generator of economic scenarios (GOES) for use in regulatory reserve and capital calculations.
 - vi. Monitor international developments regarding life and health insurance reserving, capital, and related topics. Compare and benchmark these with PBR requirements.
2. The **Experience Reporting (A) Subgroup** will:
 - A. Continue the development of the experience reporting requirements within the *Valuation Manual*. Provide input on the process regarding the experience reporting agent, data collection, and subsequent analysis and use of experience submitted.
3. The **Generator of Economic Scenarios (GOES) (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
 - A. Monitor that the economic scenario governance framework is being appropriately followed by all relevant stakeholders involved in scenario delivery.
 - B. Review material GOES updates, either driven by periodic model maintenance or changes to the economic environment, and provide recommendations.
 - C. Regularly review key economic conditions and metrics to evaluate the need for off-cycle or significant GOES updates and maintain a public timeline for GOES updates.

LIFE ACTUARIAL (A) TASK FORCE (*continued*)

- D. Support the implementation of the GOES for use in statutory reserve and capital calculations.
 - E. Develop and maintain acceptance criteria that reflect history as well as plausibly more extreme scenarios.
4. The **Indexed Universal Life (IUL) Illustration (A) Subgroup** will:
- A. Consider changes to *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold on or After December 14, 2020* (AG 49-A), as needed. Provide recommendations for the consideration of changes to the *Life Insurance Illustrations Model Regulation* (#582) to the Task Force, as needed.
5. The **Longevity Risk (E/A) Subgroup** of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group will:
- A. Provide recommendations for recognizing longevity risk in statutory reserves and/or risk-based capital (RBC), as appropriate.
6. The **Variable Annuities Capital and Reserve (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
- A. Monitor the impact of the changes to the variable annuities (VA) reserve framework and RBC calculation and determine if additional revisions need to be made.
 - B. Develop and recommend appropriate changes, including those to improve the accuracy and clarity of VA capital and reserve requirements.
7. The **Valuation Manual (VM)-22 (A) Subgroup** will:
- A. Recommend requirements for non-variable (fixed) annuities in the accumulation and payout phases for consideration by the Task Force, as appropriate. Continue working with the Academy on a PBR methodology for non-variable annuities.

NAIC Support Staff: Scott O’Neal/Jennifer Frasier

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 2, 2023

2024 Charges

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Health Insurance and Managed Care (B) Committee** will:
 - A. Respond to inquiries from the U.S. Congress (Congress), the White House, and federal agencies; analyze policy implications and their effect on the states of proposed and enacted federal legislation and regulations; and communicate the NAIC's position through letters and testimony, when requested.
 - B. Monitor the activities of the Health Actuarial (B) Task Force.
 - C. Monitor the activities of the Long-Term Care Insurance (B) Task Force.
 - D. Monitor the activities of the Regulatory Framework (B) Task Force.
 - E. Monitor the activities of the Senior Issues (B) Task Force.
 - F. Serve as the official liaison between the NAIC and the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), the National Committee for Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC).
 - G. Examine factors that contribute to rising health care costs and insurance premiums. Review state initiatives to address cost drivers.
 - H. Coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues.
 - I. Coordinate with the Market Regulation and Consumer Affairs (D) Committee, as necessary, to collect uniform data and monitor market conduct trends on plans that are not regulated under the federal Affordable Care Act (ACA), including short-term, limited-duration (STLD) insurance, association health plans (AHPs), and packaged indemnity health products.
2. The **Consumer Information (B) Subgroup** will:
 - A. Develop information or resources, as needed, that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance.
 - B. Review NAIC publications that touch on health insurance to determine if they need updating. If updates are needed, suggest specific revisions to the appropriate NAIC group or NAIC division to make the changes.
3. The **Health Innovations (B) Working Group** will:
 - A. Gather and share information, best practices, experience, and data to inform and support health innovation at the state and national levels, including, but not limited to, state flexibility options through the ACA and other health insurance-related policy initiatives.
 - B. Discuss state innovations related to health care—i.e., access, insurance plan designs, underlying medical and prescription drug costs, stability for health care and insurance as a whole, health insurer and provider consolidation or competition, the use of data in regulatory and policy decision making, and health care delivery and financing models—to achieve better patient outcomes and lower spending trends.
 - C. Explore sources and methods for state insurance regulators to obtain data to inform health reform initiatives.

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

- D. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to use the information gathered by the Working Group.
- E. Take up other matters as directed by the Health Insurance and Managed Care (B) Committee.

NAIC Support Staff: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 2, 2023

Adopted by the Health Actuarial (B) Task Force, Sept. 26, 2023

2024 Charges

HEALTH ACTUARIAL (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

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

Staff Support: Eric King

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 2, 2023

Adopted by the Long-Term Care Insurance (EX) Task Force, Oct. 5, 2023

2024 Charges

LONG-TERM CARE INSURANCE (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Long-Term Care Insurance (B) Task Force** will:
 - A. Monitor and evaluate the progress of the multistate actuarial (MSA) rate review process as outlined in the Long-Term Care Insurance Multistate Rate Review Framework (MSA Framework) and make modifications as appropriate. Monitor state insurance department rate review actions subsequent to the implementation of the MSA Framework and MSA rate review recommendations.
 - B. Monitor and evaluate options to help consumers manage the impact of rate increases, including an evaluation of the use and impact of previously adopted guidance for states regarding reduced benefit options (RBOs).
 - C. Monitor the work performed by other NAIC solvency working groups and assist in the timely multistate coordination and communication of the review of the financial condition of LTC insurers.
 - D. Monitor the work performed by other NAIC committees, task forces, and working groups, as well as federal regulators, related to the LTCI industry.

2. The **Long-Term Care Actuarial (B) Working Group** will:
 - A. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate long-term care insurance (LTCI) rates, rating practices, and rate changes.
 - B. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.
 - C. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats.
 - D. Develop a uniform actuarial approach to multistate long-term care insurance (LTCI) rate increase reviews for use in the LTCI *Long-Term Care Insurance Multistate Rate Review Framework* (MSA Framework in support of completing Task Force Charge A: Monitor and evaluate the progress of the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document, and make modifications, as appropriate. Monitor state insurance department rate review actions subsequent to the implementation of the MSA Framework and MSA rate review.

Staff Support: Jane Koenigsman/Jeffrey C. Johnston

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 2, 2023

Adopted by the Regulatory Framework (B) Task Force, Sept. 29, 2023

2024 Charges

REGULATORY FRAMEWORK (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Regulatory Framework (B) Task Force** will:
 - A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
 - B. Review managed health care reforms, their delivery systems occurring in the marketplace, and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority, and structures.
 - C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
 - D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2024.
 - E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze, and report developments related to association health plans (AHPs).
 - F. Monitor, analyze, and report, as necessary, developments related to short-term, limited-duration (STLD) coverage.
2. The **Accident and Sickness Insurance Minimum Standards (B) Subgroup** will:
 - A. Review and consider revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)*.
3. The **ERISA (B) Working Group** will:
 - A. Monitor, report, and analyze developments related to ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
 - B. Monitor, facilitate, and coordinate with the states and the U.S. Department of Labor (DOL) efforts related to sham health plans.
 - C. Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to ERISA.
 - D. Review the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook) and modify it, as necessary, to reflect developments related to ERISA. Report annually.

REGULATORY FRAMEWORK (B) TASK FORCE *(continued)*

4. The **Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group** will:
 - A. Monitor, report, and analyze developments related to the MHPAEA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
 - B. Monitor, facilitate, and coordinate best practices with the states, the DOL, and the U.S. Department of Health and Human Services (HHS) related to the MHPAEA.
 - C. Develop and provide resources to the states to support a greater understanding of laws, policies, and market conditions related to the MHPAEA.
 - D. Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the *Market Regulation Handbook*.
 - E. Coordinate with and provide input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.

5. The **Pharmacy Benefit Manager Regulatory Issues (B) Subgroup** will:
 - A. Develop a white paper to: 1) analyze and assess the role pharmacy benefit managers (PBMs), pharmacy services administrative organizations (PSAOs), and other supply chain entities play in the provision of prescription drug benefits; 2) identify, examine, and describe current and emerging state regulatory approaches to PBM business practices, such as price transparency and reporting requirements, rebating, and spread pricing, including the implications of the *Rutledge v. Pharmaceutical Care Management Association (PCMA)* decision on such business practices; and 3) discuss any challenges, if any, the states have encountered in implementing such laws and/or regulations.
 - B. Consider developing a new NAIC model to establish a licensing or registration process for PBMs. Based on issues identified in the white paper, the Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.

NAIC Support Staff: Jolie H. Matthews/Jennifer R. Cook

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 2, 2023

Adopted by the Senior Issues (B) Task Force, Oct. 30, 2023

2024 Charges

SENIOR ISSUES (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

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

NAIC Support Staff: David Torian

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Property and Casualty Insurance (C) Committee, Dec. 3, 2023

2024 Charges

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

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

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE *(continued)*

- M. Assist state insurance regulators in better assessing their markets and insurer underwriting practices by developing property market data intelligence so regulators can better understand how markets are performing in their states, and identify potential new coverage gaps, including changes in deductibles and coverage types, and affordability and availability issues. Provide analysis of property insurance markets to states.
 - N. Provide a forum for discussing issues related to the use of telematics in insurance, and consider the development of a white paper or regulatory guidance.
2. The **Cannabis Insurance (C) Working Group** will:
- A. Assess and periodically report on the status of federal legislation and regulation involving cannabis, especially as it pertains to protecting financial institutions from liability associated with providing services to cannabis businesses operating legally under state law.
 - B. Support insurance regulators' efforts to encourage the development of admitted market insurers, as well as the expansion of existing admitted market insurers, and reinsurers supporting the market, to ensure coverage adequacy in states where cannabis, including hemp, is legal.
 - C. Stay abreast of new products and innovative ideas that may shape insurance in this space. Provide insurance resources to insurance regulators and stakeholders, as needed.
 - D. Explore potential sources of constraint to coverage limits and availability of cannabis insurance products within the admitted and non-admitted market. Explore the effect of the use of cannabis and related products on P/C insurance lines of business.
3. The **Catastrophe Insurance (C) Working Group** will:
- A. Monitor and recommend measures to improve the availability and affordability of insurance and reinsurance related to catastrophe perils for personal and commercial lines.
 - B. Evaluate potential state, regional, and national programs to increase capacity for insurance and reinsurance related to catastrophe perils, including mitigation efforts being used in states and investigating loss trends in homeowners markets, with the goal to provide rate stability in the marketplace and protect consumers.
 - C. Monitor and assess proposals that address disaster insurance issues at the federal and state levels. Assess concentration-of-risk issues and whether a regulatory solution is needed.
 - D. Provide a forum for discussing issues and recommending solutions related to insuring for catastrophe risk, including terrorism, war, and natural disasters.
 - E. Complete the drafting of a Catastrophe Modeling Primer that addresses the basic concepts of catastrophe modeling.
 - F. Investigate and recommend ways the NAIC can assist states in responding to disasters by continuing to build the NAIC's Catastrophe Resource Center for state insurance regulators to better prepare for disasters.
 - G. Continue to monitor the growth of the private flood insurance market and assess the actions taken by individual states to facilitate growth. Update the Considerations for Private Flood Insurance appendix to include new ways states are growing the private flood insurance market.
 - H. Study, in coordination with other NAIC task forces and working groups, earthquake, severe convective storms and wildfire matters of concern to state insurance regulators.

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE (*continued*)

4. The **NAIC/Federal Emergency Management Agency (FEMA) (C) Working Group** will:
 - A. Assist state insurance regulators in engaging and collaborating with FEMA on an ongoing basis by establishing a process for the oversight, prioritization, and reporting of disaster-related regional workshops and other exercises to improve disaster preparation and resilience.
 - B. Liaise with insurers and FEMA to provide timely information to necessary parties following a catastrophic loss.
 - C. Discuss ways in which states in the same FEMA region can collaborate and share information with other states in their FEMA region.

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

6. The **Transparency and Readability of Consumer Information (C) Working Group** will:
 - A. Facilitate consumers' capacity to understand the content of insurance policies and assess differences in insurers' policy forms.
 - B. Assist other groups with drafting language included within consumer-facing documents.
 - C. Discuss disclosures for premium increases related to P/C insurance products.
 - D. Update and develop web page and mobile content for *A Shopping Tool for Homeowners Insurance* and *A Shopping Tool for Automobile Insurance*.
 - E. Study and evaluate ways to engage department of insurance (DOI) communication with more diverse populations, such as rural communities.

NAIC Support Staff: Aaron Brandenburg

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Property and Casualty Insurance (C) Committee, Dec. 3, 2023

Adopted by the Casualty Actuarial and Statistical (C) Task Force, Oct. 10, 2023

2024 Charges

CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

The mission of the Casualty Actuarial and Statistical (C) Task Force is to identify, investigate, and develop solutions to actuarial problems and statistical issues in the property/casualty (P/C) insurance industry. The Task Force's goals are to assist state insurance regulators with: 1) maintaining the financial health of P/C insurers; 2) ensuring that P/C insurance rates are not excessive, inadequate, or unfairly discriminatory; and 3) ensuring that appropriate data regarding P/C insurance markets are available.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Casualty Actuarial and Statistical (C) Task Force** will:
 - A. Provide reserving, pricing, ratemaking, statistical, and other actuarial support to NAIC committees, task forces, and/or working groups. Propose changes to the appropriate work products, with the most common work products noted below, and present comments on proposals submitted by others relating to casualty actuarial and statistical matters. Monitor the activities regarding casualty actuarial issues, including the development of financial services regulations and statistical reporting, including disaster.
 - i. Property and Casualty Insurance (C) Committee: Ratemaking, reserving, or data issues.
 - ii. Blanks (E) Working Group: Property/casualty (P/C) annual financial statement, including Schedule P; P/C quarterly financial statement; P/C quarterly and annual financial statement instructions, including the Statement of Actuarial Opinion (SAO) and Actuarial Opinion Summary Supplement.
 - iii. Capital Adequacy (E) Task Force: P/C risk-based capital (RBC) report.
 - iv. Statutory Accounting Principles (E) Working Group: *Accounting Practices and Procedures Manual* (AP&P Manual) and review and provide comments on statutory accounting issues being considered under *Statement of Statutory Accounting Principles (SSAP) No. 65—Property and Casualty Contracts*.
 - v. Speed to Market (D) Working Group: P/C actuarial sections of the *Product Filing Review Handbook*.
 - B. Monitor national casualty actuarial developments and consider regulatory implications.
 - i. Casualty Actuarial Society (CAS): Statements of Principles and Syllabus of Basic Education.
 - ii. American Academy of Actuaries (Academy): Standards of Practices, Council on Professionalism, and Casualty Practice Council.
 - iii. Society of Actuaries (SOA): Anticipated changes to education pathways.
 - iv. Federal legislation.
 - C. Facilitate discussion among state insurance regulators regarding rate filing issues of common interest across the states through the scheduling of regulator-only conference calls.
 - D. Conduct the following predictive analytics work:
 - i. Facilitate training and the sharing of expertise through predictive analytics webinars (Book Club).
 - ii. Coordinate with the Innovation, Cybersecurity, and Technology (H) Committee and the Life Actuarial (A) Task Force on the tracking of new uses of artificial intelligence (AI), auditing algorithms, product development, and other emerging regulatory issues. Discuss regulatory oversight of AI and machine learning (ML) in insurers' ratemaking, reserving, and other activities.
 - iii. With the NAIC Rate Model Team's assistance, discuss guidance for the regulatory review of models used in rate filings.
 - E. Research cyber liability insurance and discuss regulatory data needs.

CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE *(continued)*

2. The **Actuarial Opinion (C) Working Group** will:
 - A. Propose revisions to the following as needed, especially to improve actuarial opinions, actuarial opinion summaries, and actuarial reports, as well as the regulatory analysis of these actuarial documents and loss and premium reserves:
 - i. *Financial Analysis Handbook*.
 - ii. *Financial Condition Examiners Handbook*.
 - iii. *Annual Statement Instructions—Property/Casualty*.
 - iv. Regulatory guidance to appointed actuaries and companies.
 - v. Other financial blanks and instructions, as needed.
 - B. Assess the need for changes to the Property and Casualty Statement of Actuarial Opinion instructions upon release of the SOA's proposed changes to its education pathways.

3. The **Statistical Data (C) Working Group** will:
 - A. Consider updates and changes to the *Statistical Handbook of Data Available to Insurance Regulators*.
 - B. Consider updates and developments, provide technical assistance, and oversee the production of the following reports and databases. Periodically, evaluate the demand and utility versus the costs of production of each product.
 - i. *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance* (Homeowners Report).
 - ii. *Auto Insurance Database Report* (Auto Report).
 - iii. *Competition Database Report* (Competition Report).
 - iv. *Report on Profitability by Line by State Report* (Profitability Report).
 - C. Enhance the expedited reporting and publication of average auto and average homeowners premium portions of the annual Auto Report and Homeowners Report.

NAIC Support Staff: Kris DeFrain/Libby Crews

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Property and Casualty Insurance (C) Committee, Dec. 3, 2023

Adopted by the Surplus Lines (C) Task Force, Aug. 13, 2023

2024 Charges

SURPLUS LINES (C) TASK FORCE

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

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

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

NAIC Support Staff: Andy Daleo

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Property and Casualty Insurance (C) Committee, Dec. 3, 2023

Adopted by the Title Insurance (C) Task Force, Oct. 20, 2023

2024 Charges

TITLE INSURANCE (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The **Title Insurance (C) Task Force** will:
 - A. Discuss and/or monitor issues and developments impacting the title insurance industry, and provide support and expertise to other NAIC committees, task forces and/or working groups, or outside entities, as appropriate.
 - B. Review and assist various regulatory bodies in combating fraudulent and/or unfair real estate settlement activities. Such efforts could include working with the Antifraud (D) Task Force and other NAIC committees, task forces and/or working groups to combat mortgage fraud and mitigating title agent defalcations through the promotion of closing protection letters (CPLs) and other remedies.
 - C. Consult with the Consumer Financial Protection Bureau (CFPB) and other agencies responsible for information; education; and disclosure for mortgage lending, closing and settlement services about the role of title insurance in the real estate transaction process.
 - D. Update the *Survey of State Insurance Laws Regarding Title Data and Title Matters, 2019*.
 - E. Stay abreast of consumer issues and complaints submitted to states regarding title insurance. Consider regulatory best practices or standards related to consumer protection. (*revised charge*)
 - F. Evaluate alternative title products and provide guidance to state insurance regulators as needed. (*new charge*)

NAIC Support Staff: Anne Obersteadt

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Property and Casualty Insurance (C) Committee, Dec. 3, 2023

Adopted by the Workers' Compensation (C) Task Force, Oct. 18, 2023

2024 Charges

WORKERS' COMPENSATION (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The **Workers' Compensation (C) Task Force** will:
 - A. Oversee the activities of the NAIC/International Association of Industrial Accident Boards and Commissions (IAIABC) Joint (C) Working Group.
 - B. Discuss issues with respect to advisory organizations, rating organizations, statistical agents and insurance companies in the workers' compensation arena.
 - C. Monitor the movement of business from the standard markets to the assigned risk pools. Alert state insurance department representatives if the growth of assigned risk pools changes dramatically.
 - D. Follow workers' compensation issues regarding cannabis in coordination with the Cannabis Insurance (C) Working Group.
 - E. Discuss workers' compensation issues related to COVID-19 and Teleworking.
2. The **NAIC/IAIABC Joint (C) Working Group** will:
 - A. Study issues of mutual concern to state insurance regulators and the IAIABC. Review relevant IAIABC model laws and white papers and consider possible charges in light of the Working Group's recommendations.

NAIC Support Staff: Sara Robben/Aaron Brandenburg

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Market Regulation and Consumer Affairs (D) Committee, Dec. 3, 2023

2024 Charges

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Market Regulation and Consumer Affairs (D) Committee** will:
 - A. Monitor the centralized collection and storage of market conduct data, national analysis, and reporting at the NAIC, including issues regarding the public availability of data.
 - B. Monitor and assess the current process for multi-jurisdictional market conduct activities, and provide appropriate recommendations for enhancement, as necessary.
 - C. Oversee the activities of the Antifraud (D) Task Force.
 - D. Oversee the activities of the Market Information Systems (D) Task Force.
 - E. Oversee the activities of the Producer Licensing (D) Task Force.
 - F. Monitor the underwriting and market practices of insurers and producers, as well as the conditions of insurance marketplaces, including urban markets, to identify specific market conduct issues of importance and concern. Hold public hearings on these issues at the NAIC national meetings, as appropriate.
 - G. In collaboration with other technical working groups, discuss and share best practices through public forums to address broad consumer concerns regarding personal insurance products.
 - H. Coordinate with the International Insurance Relations (G) Committee to develop input and submit comments to the International Association of Insurance Supervisors (IAIS) and/or other related groups on issues regarding market regulation concepts.
 - I. Coordinate with the Health Insurance and Managed Care (B) Committee to provide policy recommendations regarding uniform state enforcement of the federal Affordable Care Act (ACA).
2. The **Advisory Organization (D) Working Group** will:
 - A. Revise the protocols, as necessary, for the examination of national or multistate advisory organizations (including rating organizations and statistical agents) to be more comprehensive, efficient, and possibly less frequent than the current system of single-state exams. Solicit input and collaboration from other interested and affected committees and task forces.
 - B. Monitor the data reporting and data collection processes of advisory organizations (including rating organizations and statistical agents) to determine if they are implementing appropriate measures to ensure data quality. Report the results of this ongoing charge, as needed.
 - C. Actively assist with and coordinate multistate examinations of advisory organizations (including rating organizations and statistical agents).
3. The **Market Actions (D) Working Group** will:
 - A. Facilitate interstate communication and coordinate collaborative state regulatory actions.

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE *(continued)*

4. The **Market Analysis Procedures (D) Working Group** will:
 - A. Recommend changes to the market analysis framework based on results over the past five years, including the current set of Level 1 and Level 2 questions.
 - B. In accordance with the second recommendation of the adopted *Review of Artificial Intelligence Techniques in Market Analysis*, assess currently available market analysis data to identify needed improvements in the effectiveness of the data for market analysis and the predictive abilities of the market scoring systems utilizing the data.
 - C. Discuss other market data collection issues, and make recommendations, as necessary.
 - D. Consider recommendations for new lines of business for the Market Conduct Annual Statement (MCAS).

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

6. The **Market Conduct Examination Guidelines (D) Working Group** will:
 - A. Develop market conduct examination standards, as necessary, for inclusion in the *Market Regulation Handbook*.
 - B. Monitor the adoption and revision of NAIC models, and develop market conduct examination standards to correspond with adopted NAIC models.
 - C. Develop updated standardized data requests, as necessary, for inclusion in the *Market Regulation Handbook*.
 - D. Discuss the development of uniform market conduct procedural guidance (e.g., a library, repository, or shared collaborative space with market conduct examination templates, such as an exam call letter, exam exit agenda, etc.) for inclusion in, or for use in conjunction with, the *Market Regulation Handbook*.
 - E. Coordinate with the Innovation, Cybersecurity, and Technology (H) Committee to develop market conduct examiner guidance for the oversight of regulated entities’ use of insurance and non-insurance consumer data and models using algorithms and artificial intelligence (AI).

7. The **Market Regulation Certification (D) Working Group** will:
 - A. Implement the *Voluntary Market Regulation Certification Program* by: i) provisionally certifying each jurisdiction that submits a self-certification report; ii) assessing the submission and monitoring the progress of each provisionally certified jurisdiction towards compliance to each certification standard; and iii) providing peer-review and guidance for any participating jurisdiction that requests guidance.
 - B. Develop a mechanism for enabling participating jurisdictions to apply for full certification. This will include: i) forming an NAIC Review Team; and ii) developing methods for assessing and auditing full-certification requests.
 - C. Review feedback from jurisdictions concerning any issues or recommended changes to the *Voluntary Market Regulation Certification Program* requirements and the *Market Regulation Certification Program Self-Assessment Guidelines* and *Checklist Tool*
 - D. Consider new standards to be incorporated into the *Voluntary Market Regulation Certification Program*.

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE *(continued)*

8. The **Speed to Market (D) Working Group** will:
- A. Consider proposed System for Electronic Rates & Forms Filing (SERFF) features or functionality presented to the Working Group by the Product Steering Committee (PSC). Review periodic reports from the PSC, as needed.
 - B. Provide feedback and recommendations concerning the SERFF modernization when requested by the Executive (EX) Committee and any group assigned oversight of the SERFF modernization by the Executive (EX) Committee.
 - C. Discuss and oversee the implementation and ongoing maintenance/enhancement of speed to market operational efficiencies related to product filing needs, efficiencies, and effective consumer protection. This includes the following activities:
 - i. Provide a forum to gather information from the states and the industry regarding tools, policies, and resolutions to assist with common filing issues. Provide oversight in evaluating product filing efficiency issues for state insurance regulators and the industry, particularly regarding uniformity.
 - ii. Use SERFF data to develop, refine, implement, collect, and distribute common filing metrics that provide a tool to measure the success of the speed to market modernization efforts, as measured by nationwide and individual state speed to market compliance, with an emphasis on monitoring state regulatory and insurer responsibilities for speed to market for insurance products.
 - iii. Facilitate proposed changes to the product coding matrices (PCMs) and the uniform transmittal document (UTD) on an annual basis, including the review, approval, and notification of changes. Monitor, assist with, and report on state implementation of any PCM changes.
 - iv. Facilitate the review and revision of the *Product Filing Review Handbook*, which contains an overview of all the operational efficiency tools and describes best practices for industry filers and state reviewers regarding the rate and form filing and review process. Develop and implement a communication plan to inform the states about the *Product Filing Review Handbook*.
 - D. Provide direction to NAIC staff regarding SERFF functionality, implementation, development, and enhancements. Receive periodic reports from NAIC staff, as needed.
 - E. Conduct the following activities, as desired, by the Interstate Insurance Product Regulation Commission (Compact):
 - i. Provide support to the Compact as the speed-to-market vehicle for asset-based insurance products, encouraging the states' participation in, and the industry's usage of, the Compact.
 - ii. Receive periodic reports from the Compact, as needed.

NAIC Support Staff: Tim Mullen/Randy Helder

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Market Regulation and Consumer Affairs (D) Committee, Dec. 3, 2023

Adopted by the Antifraud (D) Task Force, Oct. 23, 2023

2024 Charges

ANTIFRAUD (D) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The **Antifraud (D) Task Force** will:
 - A. Work with NAIC committees, task forces, and working groups (e.g., Title Insurance (C) Task Force, etc.) to review issues and concerns related to fraud activities and schemes related to insurance fraud.
 - B. Coordinate efforts to address national concerns related to agent fraud and activities of unauthorized agents related to insurance sales.
 - C. Coordinate the enforcement and investigation efforts of state and federal securities regulators with state insurance fraud bureaus.
 - D. Coordinate with state, federal, and international law enforcement agencies in addressing antifraud issues relating to the insurance industry.
 - E. Review and provide comments to the International Association of Insurance Supervisors (IAIS) on its Insurance Core Principles (ICPs) related to insurance fraud.
 - F. Coordinate activities and information from national antifraud organizations and provide information to state insurance fraud bureaus.
 - G. Coordinate activities and information with state and federal fraud divisions to determine guidelines that will assist with reciprocal involvement concerning antifraud issues resulting from natural disasters and catastrophes.
 - H. Coordinate efforts with the insurance industry to address antifraud issues and concerns.
 - I. Evaluate and recommend methods to track national fraud trends.
 - J. Develop seminars, trainings, and webinars regarding insurance fraud. Provide three webinars by the 2024 Fall National Meeting.
2. The **Antifraud Technology (D) Working Group** will:
 - A. Work with the NAIC to develop an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions. Complete by the 2024 Fall National Meeting.
 - B. Evaluate sources of antifraud data and propose methods for enhancing the utilization and exchange of information among state insurance regulators, fraud investigative divisions, law enforcement officials, insurers, and antifraud organizations. Complete by the 2024 Fall National Meeting.

ANTIFRAUD (D) TASK FORCE *(continued)*

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

NAIC Support Staff: Greg Welker/Lois E. Alexander

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Market Regulation and Consumer Affairs (D) Committee, Dec. 3, 2023

Adopted by the Market Information Systems (D) Task Force, Oct. 20, 2023

2024 Charges

MARKET INFORMATION SYSTEMS (D) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Market Information Systems (D) Task Force** will:
 - A. Ensure that the MIS support the strategic direction set forth by the Market Regulation and Consumer Affairs (D) Committee.
 - B. Analyze the data in the MIS. In accordance with the first recommendation of the adopted *Review of Artificial Intelligence Techniques in Market Analysis*, recommend methods to ensure better data quality.
 - C. In conjunction with the Market Analysis Procedures (D) Working Group and in accordance with the second recommendation of the adopted *Review of Artificial Intelligence Techniques in Market Analysis*, assess currently available market analysis data to identify needed improvements in the effectiveness of the data for market analysis and the predictive abilities of the market scoring systems utilizing the data.
 - D. Provide guidance on the appropriate use of the MIS and the data entered in them.
 - i. Complaints Database System (CDS).
 - ii. Electronic Forums.
 - iii. Market Actions Tracking System (MATS).
 - iv. Market Analysis Profile.
 - v. Market Analysis Prioritization Tool (MAPT).
 - vi. Market Analysis Review System (MARS).
 - vii. Market Conduct Annual Statement (MCAS).
 - viii. Regulatory Information Retrieval System (RIRS).
 - ix. 1033 State Decision Repository (SDR1033) (in conjunction with the Antifraud (D) Task Force).
2. The **Market Information Systems Research and Development (D) Working Group** will:
 - A. Serve as the business partner to review and prioritize submitted Uniform System Enhancement Request (USER) forms to ensure an efficient use of available NAIC staffing and resources.
 - B. Assist the Task Force with tasks as assigned, such as:
 - i. Analyze MIS data.
 - ii. Provide state users with query access to MIS data.
 - iii. Provide guidance on the appropriate use of the MIS.

NAIC Support Staff: Randy Helder

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Market Regulation and Consumer Affairs (D) Committee, Dec. 3, 2023

Adopted by the Producer Licensing (D) Task Force, Oct. 23, 2023

2024 Charges

PRODUCER LICENSING (D) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Producer Licensing (D) Task Force** will:

- A. Work closely with NIPR to encourage the full utilization of NIPR products and services by all the states and producers, and encourage accurate and timely reporting of state administrative actions to the NAIC's Regulatory Information Retrieval System (RIRS) to ensure that this data is properly reflected in the State Producer Licensing Database (SPLD) and the Producer Database (PDB).
- B. Facilitate roundtable discussions, as needed, with the state producer licensing directors for the exchange of views, opinions, and ideas on producer licensing activities in the states and at the NAIC.
- C. Discuss, as necessary, state perspectives regarding the regulation and benefit of the activities of the federal Affordable Care Act (ACA), established enrollment assisters (including navigators and non-navigator assisters and certified application counselors), and the activities of producers in assisting individuals and businesses purchasing in the health insurance marketplaces. Coordinate with the Health Insurance and Managed Care (B) Committee and the Antifraud (D) Task Force, as necessary.
- D. Monitor the activities of the National Association of Registered Agents and Brokers (NARAB) in the development and enforcement of the NARAB membership rules, including the criteria for successfully passing a background check.
- E. Coordinate through NAIC staff to provide guidance to NIPR on producer licensing-related electronic initiatives. Hear a report from NIPR at each national meeting.
- F. Coordinate with the Market Information Systems (D) Task Force and the Antifraud (D) Task Force to evaluate and make recommendations regarding the entry, retention, and use of data in the NAIC's Market Information Systems (MIS).
- G. Coordinate with the Special (EX) Committee on Race and Insurance on referrals affecting insurance producers.
- H. Discuss how criminal convictions may affect producer licensing applicants, review, and amend the NAIC's *Guidelines for State Insurance Regulators to the Violent Crime Control and Law Enforcement Act of 1994* as needed to create a more simplified and consistent approach in how states review 1033 waiver requests.

2. The **Adjuster Licensing (D) Working Group** will:

- A. Monitor state implementation of adjuster licensing and reciprocity; update the NAIC adjuster licensing standards, as necessary.

PRODUCER LICENSING (D) TASK FORCE *(continued)*

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

4. The **Public Adjuster Licensing (D) Working Group** will:
 - A. Review and amend the *Public Adjuster Licensing Model Act* (#228) as needed to enhance consumer protections in the property/casualty (P/C) claims process.

5. The **Uniform Education (D) Working Group** will:
 - A. Update the reciprocity guidelines, the uniform application forms for continuing education (CE) providers, and the process for state review and approval of instructors and courses, as needed. Provide any recommended updates to the Producer Licensing (D) Task Force by the Fall National Meeting.
 - B. Coordinate with NAIC parent committees, task forces, and/or working groups to review and provide recommendations on prelicensing education and CE requirements that are included in NAIC model acts, regulations, and/or standards, as necessary.

NAIC Support Staff: Tim Mullen/Greg Welker

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023
Adopted by the Financial Condition (E) Committee, Oct. 25, 2023

2024 Charges

FINANCIAL CONDITION (E) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Financial Condition (E) Committee** will:
 - A. Monitor all of the changes to the annual/quarterly financial statement blanks and instructions, risk-based capital (RBC) formulas, *Financial Condition Examiners Handbook*, *Accounting Practices and Procedures Manual* (AP&P Manual), *Financial Analysis Handbook*, *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual), NAIC model laws, NAIC accreditation standards, and other NAIC publications.
 - B. Appoint and oversee the activities of the following: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Examination Oversight (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention Group (E) Task Force; and Valuation of Securities (E) Task Force.
 - C. Oversee a process to address financial issues that may compromise the consistency and uniformity of the U.S. solvency framework, referring valuation and other issues to the appropriate committees as needed.
 - D. Use the Risk-Focused Surveillance (E) Working Group to address specific industry concerns regarding regulatory redundancy and review any issues that the industry subsequently escalates to the Committee.
2. The **Financial Analysis (E) Working Group** will:
 - A. Analyze nationally significant insurers and groups that exhibit characteristics of trending toward or being financially troubled; determine if appropriate action is being taken.
 - B. Interact with domiciliary regulators and lead states to assist and advise on the most appropriate regulatory strategies, methods, and action(s).
 - C. Support, encourage, promote, and coordinate multistate efforts in addressing solvency problems, including identifying adverse industry trends.
 - D. Increase information-sharing and coordination between state insurance regulators and federal authorities, including through representation of state insurance regulators in national bodies with responsibilities for system-wide oversight.
3. The **Group Capital Calculation (E) Working Group** will:
 - A. Continually review and monitor the effectiveness of the group capital calculation (GCC) and consider revisions as necessary to maintain the effectiveness of its objective under the U.S. solvency system.
 - B. Liaise as necessary with the International Insurance Relations (G) Committee on international group capital developments and consider input from the participation of U.S. state insurance regulators in the International Association of Insurance Supervisors (IAIS) monitoring process.

FINANCIAL CONDITION (E) COMMITTEE *(continued)*

4. The **Group Solvency Issues (E) Working Group** will:
 - A. Continue to develop potential enhancements to the current regulatory solvency system as it relates to group solvency-related issues.
 - B. Critically review and provide input and drafting on IAIS material dealing with group supervision issues and identify best practices in group supervision emerging from the IAIS Supervisory Forum.
 - C. Continually review and monitor the effectiveness of the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) and consider revisions as necessary to maintain effective oversight of insurance groups.

5. The **Own Risk and Solvency Assessment (ORSA) Implementation (E) Subgroup** of the Group Solvency Issues (E) Working Group will:
 - A. Continue to provide and enhance an enterprise risk management (ERM) education program for state insurance regulators in support of the Own Risk and Solvency Assessment (ORSA) implementation.
 - B. Continually review and monitor the effectiveness of the *Risk Management and Own Risk and Solvency Assessment Model Act* (#505) and its corresponding *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual* (ORSA Guidance Manual); consider revisions as necessary.

6. The **Mutual Recognition of Jurisdictions (E) Working Group** will:
 - A. Oversee the process for evaluating jurisdictions and maintain a listing of jurisdictions that meet the NAIC requirements for recognizing and accepting the NAIC GCC.
 - B. Maintain the *NAIC List of Qualified Jurisdictions* and the *NAIC List of Reciprocal Jurisdictions* in accordance with the *Process for Evaluating Qualified and Reciprocal Jurisdictions*.

7. The **NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group** will:
 - A. Continually review the *Annual Financial Reporting Model Regulation* (#205) and its corresponding implementation guide; revise as appropriate.
 - B. Address financial solvency issues by working with the AICPA and responding to AICPA exposure drafts.
 - C. Monitor the federal Sarbanes-Oxley (SOX) Act of 2002, as well as rules and regulations promulgated by the U.S. Securities and Exchange Commission (SEC), the Public Company Accounting Oversight Board (PCAOB), and other financial services regulatory entities.
 - D. Review annually the premium threshold amount included in Section 16 of Model #205, with the general intent that those insurers subject to the Section 16 requirements would capture at least approximately 90% of industry premium and/or in response to any future regulatory or market developments.

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

FINANCIAL CONDITION (E) COMMITTEE *(continued)*

9. The **Restructuring Mechanisms (E) Working Group** will:
- A. Evaluate and prepare a white paper that:
 - i. Addresses the perceived need for restructuring statutes and the issues those statutes are designed to remedy. Also, consider alternatives that insurers are currently employing to achieve similar results.
 - ii. Summarizes the existing state restructuring statutes.
 - iii. Addresses the legal issues posed by an order of a court (or approval by an insurance department) in one state affecting the policyholders of other states.
 - iv. Considers the impact that a restructuring might have on guaranty associations and policyholders that had guaranty fund protection prior to the restructuring.
 - v. Identifies and addresses the legal issues associated with restructuring using a protected cell.
 - B. Consider requesting approval from the Executive (EX) Committee on developing changes to specific NAIC models as a result of findings from the development of the white paper.
 - C. Develop best practices to be used when considering the approval of proposed restructuring transactions, including, among other things, the expected level of reserves and capital expected after the transfer, along with the adequacy of long-term liquidity needs. Also, develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend the best practices to the Financial Regulation Standards and Accreditation (F) Committee for its consideration.
 - D. Consider the need to make changes to the RBC formula to better assess the minimum surplus requirements for companies in runoff.
 - E. Review the various restructuring mechanisms, and develop accounting and reporting requirements for referring to the Statutory Accounting Principles (E) Working Group if needed.
10. The **Risk-Focused Surveillance (E) Working Group** will:
- A. Continually review the effectiveness of risk-focused surveillance and develop enhancements to processes as necessary.
 - B. Continually review regulatory redundancy issues identified by interested parties and provide recommendations to other NAIC committee groups to address as needed.
 - C. Oversee and monitor the Peer Review Program to encourage consistent and effective risk-focused surveillance processes.
 - D. Continually maintain and update standardized job descriptions/requirements and salary range recommendations for common solvency monitoring positions to assist insurance departments in attracting and maintaining suitable staff.
11. The **Valuation Analysis (E) Working Group** will:
- A. Work with NAIC resources to assist in prioritizing and responding to issues and questions regarding principle-based reserving (PBR) and asset adequacy analysis, including actuarial guidelines or other requirements.
 - B. Develop and implement a plan to coordinate PBR reviews/examinations and provide a confidential forum to address questions and issues.
 - C. Review asset adequacy analysis filings for *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53) on a targeted basis and coordinate with states as appropriate.
 - D. Review long-term care (LTC) reserve adequacy filings for *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) on a targeted basis and coordinate with states as appropriate.

FINANCIAL CONDITION (E) COMMITTEE *(continued)*

- E. Provide a confidential forum to address questions/issues regarding reinsurance risk transfer with respect to PBR/asset adequacy analysis, and make referrals to other NAIC regulator groups as appropriate.
- F. Refer questions/issues to the Life Actuarial (A) Task Force as appropriate that may require consideration of changes/interpretations to be provided in the *Valuation Manual* or related actuarial guidelines.
- G. Assist NAIC resources in the use of models and other analytical tools to support the review of PBR/asset adequacy analysis.
- H. Make referrals to the Financial Analysis (E) Working Group as appropriate.
- I. Perform other work to carry out the Valuation Analysis (E) Working Group procedures.

NAIC Support Staff: Dan Daveline/Julie Gann/Bruce Jenson

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Financial Condition (E) Committee, Oct. 25, 2023

Adopted by the Accounting Practices and Procedures (E) Task Force, Aug. 14, 2023

2024 Charges

ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Accounting Practices and Procedures (E) Task Force** will:
 - A. Oversee the activities of the Blanks (E) Working Group and the Statutory Accounting Principles (E) Working Group.
2. The **Blanks (E) Working Group** will:
 - A. Consider improvements and revisions to the various annual/quarterly statement blanks to:
 - i. Conform these blanks to changes made in other areas of the NAIC to promote uniformity in the reporting of financial information by insurers.
 - ii. Develop reporting formats for other entities subject to the jurisdiction of state insurance departments.
 - iii. Conform the various NAIC blanks and instructions to adopted NAIC policies.
 - iv. Oversee the development of additional reporting formats within the existing annual financial statements as needs are identified.
 - B. Continue to monitor state filing checklists to maintain current filing requirements.
 - C. Continue to monitor and improve the quality of financial data filed by insurance companies by recommending improved or additional language for the *Annual Statement Instructions*.
 - D. Continue to monitor and review all proposals necessary for the implementation of statutory accounting guidance to ensure proper implementation of any action taken by the Accounting Practices and Procedures (E) Task Force affecting annual financial statements and/or instructions.
 - E. Continue to coordinate with other task forces of the NAIC to ensure proper implementation of reporting and instructions changes as proposed by these task forces.
 - F. Coordinate with the applicable task forces and working groups as needed to avoid duplication of reporting within the annual and quarterly statement blanks.
 - G. Consider proposals presented that would address duplication in reporting; eliminate data elements, financial schedules, and disclosures that are no longer needed; and coordinate with other NAIC task forces and working groups if applicable to ensure revised reporting still meets the needs of regulators.
 - H. Review requests for investment schedule blanks and instructions changes in connection with the work being performed by the Capital Adequacy (E) Task Force and its working groups.
 - I. Review changes requested by the Valuation of Securities (E) Task Force relating to its work on other invested assets reporting for technical consistency within the investment reporting schedules and instructions.

ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE *(continued)*

3. The **Statutory Accounting Principles (E) Working Group** will:
- A. Maintain codified statutory accounting principles by providing periodic updates to the guidance that address new statutory issues and new generally accepted accounting principles (GAAP) pronouncements. Provide authoritative responses to questions of application and clarifications for existing statutory accounting principles. Report all actions and provide updates to the Accounting Practices and Procedures (E) Task Force.
 - B. At the discretion of the Working Group chair, develop comments on exposed GAAP and International Financial Reporting Standards (IFRS) pronouncements affecting financial accounting and reporting. Any comments are subject to review and approval by the chairs of the Accounting Practices and Procedures (E) Task Force and the Financial Condition (E) Committee.
 - C. Coordinate with the Life Actuarial (A) Task Force on changes to the AP&P Manual related to the *Valuation Manual* VM-A, Requirements, and VM-C, Actuarial Guidelines, as well as other *Valuation Manual* requirements. This process will include the receipt of periodic reports on changes to the *Valuation Manual* on items that require coordination.
 - D. Obtain, analyze, and review information on permitted practices, prescribed practices, or other accounting treatments suggesting that issues or trends occurring within the industry may compromise the consistency and uniformity of statutory accounting, including, but not limited to, activities conducted by insurers for which there is currently no statutory accounting guidance or where the states have prescribed statutory accounting that differs from the guidance issued by the NAIC. Use this information to consider possible changes to statutory accounting.

NAIC Support Staff: Robin Marcotte

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Financial Condition (E) Committee, Oct. 25, 2023

Adopted by the Capital Adequacy (E) Task Force, Oct. 11, 2023

2024 Charges

CAPITAL ADEQUACY (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Capital Adequacy (E) Task Force** will:
 - A. Evaluate emerging “risk” issues for referral to the risk-based capital (RBC) working groups/subgroups for certain issues involving more than one RBC formula. Monitor emerging and existing risks relative to their consistent or divergent treatment in the three RBC formulas.
 - B. Review and evaluate company submissions for the schedule and corresponding adjustment to total adjusted capital (TAC).
 - C. Evaluate relevant historical data, and apply defined statistical safety levels over appropriate time horizons in developing recommendations for revisions to the current asset risk structure and factors in each of the RBC formulas.

2. The **Health Risk-Based Capital (E) Working Group, Life Risk-Based Capital (E) Working Group, and Property and Casualty Risk-Based Capital (E) Working Group** will:
 - A. Evaluate refinements to the existing NAIC RBC formulas implemented in the prior year. Forward the final version of the structure of the current year life and fraternal, property/casualty (P/C), and health RBC formulas to the Financial Condition (E) Committee by June.
 - B. Consider improvements and revisions to the various RBC blanks to: 1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity; and 2) oversee the development of additional reporting formats within the existing RBC blanks as needs are identified. Any proposal that affects the RBC structure must be adopted no later than April 30 of the reporting year, and any proposal that affects the RBC factors and/or instructions must be adopted no later than June 30 of the reporting year. Adopted changes will be forwarded to the Financial Condition (E) Committee by the next scheduled meeting. Any adoptions made to the annual financial statement blanks or statutory accounting principles that affect an RBC change adopted by June 30 and result in an amended change may be considered and adopted by July 30, where the Capital Adequacy (E) Task Force votes to pursue by super-majority (two-thirds) consent of members.
 - C. Monitor changes in accounting and reporting requirements resulting from the adoption and continuing maintenance of the revised *Accounting Practices and Procedures Manual* (AP&P Manual) to ensure that model laws, publications, formulas, analysis tools, etc., supported by the Task Force continue to meet regulatory objectives.
 - D. Review the effectiveness of the NAIC’s RBC policies and procedures as they affect the accuracy, audit ability, timeliness of reporting access to RBC results, and comparability between the RBC formulas. Report on data quality problems in the prior year RBC filings at the Summer National Meeting and Fall National Meeting.

CAPITAL ADEQUACY (E) TASK FORCE *(continued)*

3. The **Longevity Risk (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
 - A. Provide recommendations for the appropriate treatment of longevity risk transfers by new longevity factors.
4. The **Variable Annuities Capital and Reserve (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
 - A. Monitor the impact of the changes to the variable annuities reserve framework and RBC calculation, and determine if additional revisions need to be made.
 - B. Develop and recommend appropriate changes, including those to improve the accuracy and clarity of variable annuity (VA) capital and reserve requirements.
5. The **Catastrophe Risk (E) Subgroup** of the Property and Casualty Risk-Based Capital (E) Working Group will:
 - A. Recalculate the premium risk factors on an ex-catastrophe basis, if needed.
 - B. Continue to update the U.S. and non-U.S. catastrophe event list.
 - C. Continue to evaluate the need for exemption criteria for insurers with minimal risk.
 - D. Evaluate the RBC results inclusive of a catastrophe risk charge.
 - E. Refine instructions for the catastrophe risk charge.
 - F. Continue to evaluate any necessary refinements to the catastrophe risk formula.
 - G. Evaluate other catastrophe risks for possible inclusion in the charge.
6. The **Risk-Based Capital Investment Risk and Evaluation (E) Working Group** will:
 - A. Perform a comprehensive review of the RBC investment framework for all business types, which could include:
 - i. Identifying and acknowledging uses that extend beyond the purpose of the *Risk-Based Capital (RBC) for Insurers Model Act* (#312).
 - ii. Assessing the impact and effectiveness of potential changes in contributing to the identification of weakly capitalized companies; i.e., those companies at action levels.
 - iii. Documenting the modifications made over time to the formulas, including, but not limited to, an analysis of the costs in study and development, implementation (internal and external), assimilation, verification, analysis, and review of the desired change to the RBC formulas and facilitating the appropriate allocation of resources.
7. The **Generator of Economic Scenarios (GOES) (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
 - A. Monitor that the economic scenario governance framework is being appropriately followed by all relevant stakeholders involved in scenario delivery.
 - B. Review material economic scenario generator updates, either driven by periodic model maintenance or changes to the economic environment and provide recommendations.
 - C. Regularly review key economic conditions and metrics to evaluate the need for off-cycle or significant economic scenario generator updates and maintain a public timeline for economic scenario generator updates.
 - D. Support the implementation of an economic scenario generator for use in statutory reserve and capital calculations.
 - E. Develop and maintain acceptance criteria that reflect history as well as plausibly more extreme scenarios.

NAIC Support Staff: Eva Yeung

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023
Adopted by the Financial Condition (E) Committee, Oct. 25, 2023
Adopted by the Examination Oversight (E) Task Force, Sept. 22, 2023

2024 Charges

EXAMINATION OVERSIGHT (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Examination Oversight (E) Task Force** will:
 - A. Accomplish its mission using the following groups:
 - i. Electronic Workpaper (E) Working Group.
 - ii. Financial Analysis Solvency Tools (E) Working Group.
 - iii. Financial Examiners Coordination (E) Working Group.
 - iv. Financial Examiners Handbook (E) Technical Group.
 - v. Information Technology (IT) Examination (E) Working Group.
2. The **Electronic Workpaper (E) Working Group** will:
 - A. Monitor and support the state insurance departments in using electronic workpaper software tools to conduct and document solvency monitoring activities.
 - B. Provide ongoing oversight in the transition of electronic workpaper work to the TeamMate+ application.
 - C. Monitor state insurance regulator use of TeamMate+ to proactively identify best practices and improvements to the application, as necessary.
3. The **Financial Analysis Solvency Tools (E) Working Group** will:
 - A. Provide ongoing maintenance and enhancements to the *Financial Analysis Handbook* and related applications for changes to the NAIC annual/quarterly financial statement blanks based on input from other regulators and the work or referrals from other NAIC committees, task forces, and working groups to develop, as well as enhancements developed to assist in the risk-focused analysis and monitoring of the financial condition of insurance companies and groups.
 - B. Provide ongoing development maintenance and enhancements to the automated financial solvency tools that were developed to assist in conducting risk-focused analysis and the monitoring of the financial condition of insurance companies and groups. Prioritize and perform analysis to ensure that the tools remain reliable and accurate.
 - C. Coordinate with the Financial Examiners Handbook (E) Technical Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.

EXAMINATION OVERSIGHT (E) TASK FORCE (*continued*)

4. The **Financial Examiners Coordination (E) Working Group** will:
 - A. Develop enhancements that encourage the coordination of examination activities for holding company groups.
 - B. Promote coordination by assisting and advising domiciliary regulators and exam-coordinating states on the most appropriate regulatory strategies, methods, and actions regarding financial examinations of holding company groups.
 - C. Facilitate communication among regulators regarding common practices and issues arising from coordinating examination efforts.
 - D. Provide ongoing maintenance and enhancements to the Financial Exam Electronic Tracking System (FEETS).

5. The **Financial Examiners Handbook (E) Technical Group** will:
 - A. Continually review the *Financial Condition Examiners Handbook*, and revise when appropriate.
 - B. Coordinate with the Risk-Focused Surveillance (E) Working Group to monitor the implementation of the risk-assessment process by developing additional guidance and exhibits within the *Financial Condition Examiners Handbook*, including consideration of potential redundancies affected by the examination process, corporate governance, and other guidance as needed to assist examiners in completing financial condition examinations.
 - C. Coordinate with the Financial Analysis Solvency Tools (E) Working Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance to provide effective solvency monitoring.
 - D. Coordinate with the Information Technology (IT) Examination (E) Working Group and the Financial Examiners Coordination (E) Working Group to maintain specialized areas of guidance within the *Financial Condition Examiners Handbook* related to the charges of these specific working groups.

6. The **Information Technology (IT) Examination (E) Working Group** will:
 - A. Continually review, develop, and revise the guidance in the *Financial Condition Examiners Handbook* and other related tools, as needed, to address IT risks.
 - B. Coordinate with the Cybersecurity (H) Working Group to monitor cybersecurity trends, including emerging and/or ongoing vulnerabilities, and develop guidance within the *Financial Condition Examiners Handbook* or other tools, if necessary, to support IT examiners.

NAIC Support Staff: Bailey Henning

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Financial Condition (E) Committee, Oct. 25, 2023

Adopted by the Financial Stability (E) Task Force, Oct. 20, 2023

2024 Charges

FINANCIAL STABILITY (E) TASK FORCE

The mission of the Financial Stability (E) Task Force is to consider domestic or global financial stability issues and their impact on the role of state insurance regulators.

Ongoing Support of NAIC Program, Products, or Services

1. The **Financial Stability (E) Task Force** will:
 - A. Manage the macroprudential supervisory component of the NAIC financial solvency framework.
 - i. Monitor the U.S. insurance industry's macroprudential risk levels.
 - ii. Maintain macroprudential regulatory tools.
 - iii. Identify data gaps and enhanced disclosure needs for the statutory financial statement and/or other reporting mechanisms.
 - iv. Propose enhancements and/or additional supervisory measures to the Financial Condition (E) Committee or other relevant committees, and consult with such committees on implementation.
 - B. Monitor U.S. macroprudential policy issues, and respond as appropriate.
 - i. Support and work with the state insurance regulator representative to the Financial Stability Oversight Council (FSOC) to address confidential FSOC or other federal agency macroprudential work.
 - ii. Participate in public FSOC or other federal agency macroprudential work.
 - C. Monitor international macroprudential policy issues, and participate/respond as appropriate.
 - i. Coordinate with the International Insurance Relations (G) Committee to address International Association of Insurance Supervisors (IAIS) or other international macroprudential work.
2. The **Macroprudential (E) Working Group** will:
 - A. Oversee the implementation and maintenance of the Liquidity Stress Testing Framework (LST Framework).
 - B. Monitor domestic and global activities, including those enumerated in the "Plan for the List of Macroprudential Working Group (MWG) Considerations" document.
 - C. Execute the original Macroprudential Initiative (MPI) projects related to counterparty disclosures and capital stress testing.
 - D. Continue to develop and administer data collection tools as needed, leveraging existing data where feasible, to provide the Financial Stability (E) Task Force with meaningful macroprudential information regarding how the insurance sector is navigating the prevailing market conditions.
 - E. Oversee the development, implementation, and maintenance process for a new macroprudential risk assessment system (i.e., policies, procedures, and tools) to enhance regulators' ability to monitor industry trends from a macroprudential perspective.
 - F. Oversee the documentation of the NAIC's macroprudential policies, procedures, and tools.
 - G. Provide the Task Force with updates to IAIS and other international initiatives as needed.

NAIC Support Staff: Tim Nauheimer/Todd Sells

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Financial Condition (E) Committee, Oct. 25, 2023

Adopted by the Receivership and Insolvency (E) Task Force, Oct. 2, 2023

2024 Charges

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

The mission of the Receivership and Insolvency (E) Task Force is to be administrative and substantive on issues concerning insurer insolvencies and insolvency guarantees. Such duties include, without limitation: 1) monitoring the effectiveness and performance of the state administration of receiverships and the state guaranty fund system; 2) coordinating cooperation and communication among state insurance regulators, receivers, and guaranty funds; 3) monitoring ongoing receiverships and reporting on such receiverships to NAIC members; 4) developing and providing educational and training programs in the area of insurer insolvencies and insolvency guarantees to state insurance regulators, professionals, and consumers; 5) developing and monitoring relevant model laws, guidelines, and products; and 6) providing resources for state insurance regulators and professionals to promote efficient operations of receiverships and guaranty funds.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Receivership and Insolvency (E) Task Force** will:
 - A. Monitor and promote efficient operations of insurance receiverships and guaranty associations.
 - B. Monitor and promote state adoption of insurance receivership and guaranty association model acts and regulations, and monitor other legislation related to insurance receiverships and guaranty associations.
 - C. Provide input and comments to the International Association of Insurance Supervisors (IAIS), the Financial Stability Board (FSB), or other related groups on issues regarding international resolution authority.
 - D. Monitor, review, and provide input on federal rulemaking and studies related to insurance receiverships.
 - E. Provide an ongoing review of the *Receiver's Handbook for Insurance Company Insolvencies* (Receiver's Handbook), other related NAIC publications, and the Global Receivership Information Database (GRID), and make any necessary updates.
 - F. Monitor the work of other NAIC committees, task forces, and working groups to identify and address any issues that affect receivership law and/or regulatory guidance.
 - G. Perform additional work as directed by the Financial Condition (E) Committee and/or received through referrals by other groups.
2. The **Receivership Financial Analysis (E) Working Group** will:
 - A. Monitor receiverships involving nationally significant insurers/groups to support, encourage, promote, and coordinate multistate efforts in addressing problems.
 - B. Interact with the Financial Analysis (E) Working Group, domiciliary regulators, and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods, and/or action(s) regarding potential or pending receiverships.
3. The **Receivership Law (E) Working Group** will:
 - A. Review and provide recommendations on any issues identified that may affect states' receivership and guaranty association laws (e.g., any issues that arise as a result of market conditions; insurer insolvencies; federal rulemaking and studies; international resolution initiatives; or the work performed by or referred from other NAIC committees, task forces, and/or working groups).
 - B. Discuss significant cases that may affect the administration of receiverships.

NAIC Support Staff: Jane Koenigsman

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Financial Condition (E) Committee, Oct. 25, 2023

Adopted by the Reinsurance (E) Task Force, July 24, 2023

2024 Charges

REINSURANCE (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Reinsurance (E) Task Force** will:
 - A. Provide a forum for the consideration of reinsurance-related issues of public policy.
 - B. Oversee the activities of the Reinsurance Financial Analysis (E) Working Group.
 - C. Communicate and coordinate with the Federal Insurance Office (FIO), other federal authorities, and international regulators and authorities on matters pertaining to reinsurance.
 - D. Consider any other issues related to the revised *Credit for Reinsurance Model Law* (#785), *Credit for Reinsurance Model Regulation* (#786), and *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787).
 - E. Monitor the development of international principles, standards, and guidance with respect to reinsurance. This includes, but is not limited to, monitoring the activities of various groups within the International Association of Insurance Supervisors (IAIS), including the Reinsurance and Other Forms of Risk Transfer Subcommittee, the Reinsurance Mutual Recognition Subgroup, and the Reinsurance Transparency Group.
 - F. Consider the impact of reinsurance-related federal legislation, including, but not limited to, the federal Nonadmitted and Reinsurance Reform Act of 2010 (NRRA) and the Federal Insurance Office Act, and coordinate any appropriate NAIC action.
 - G. Continue to monitor the impact of reinsurance-related international agreements, including the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement).
2. The **Reinsurance Financial Analysis (E) Working Group** will:
 - A. Operate in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, and operate in open session when discussing certified reinsurance topics and policy issues, such as amendments to the Uniform Application for Certified or Reciprocal Reinsurers.
 - B. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. The process of reviewing applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.
 - C. Provide a forum for discussion among NAIC jurisdictions of reinsurance issues related to specific companies, entities, or individuals.
 - D. Support, encourage, promote, and coordinate multistate efforts in addressing issues related to certified reinsurers, including, but not limited to, multistate recognition of certified or reciprocal reinsurers.

REINSURANCE (E) TASK FORCE *(continued)*

- E. Provide analytical expertise and support to the states with respect to certified reinsurers and applicants.
- F. Provide advisory support on issues related to the determination of qualified jurisdictions.
- G. Ensure the public passporting website remains current.

NAIC Support Staff: Jake Stultz/Dan Schelp

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Financial Condition (E) Committee, Oct. 25, 2023

Adopted by the Risk Retention Group (E) Task Force, Oct. 18, 2023

2024 Charges

RISK RETENTION GROUP (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

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

NAIC Support Staff: Rodney Good/Andy Daleo

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023
Adopted by the Financial Condition (E) Committee, Oct. 25, 2023
Adopted by the Valuation of Securities (E) Task Force, Aug. 14, 2023

2024 Charges

VALUATION OF SECURITIES (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Charles Therriault/Marc Perlman/Eric Kolchinsky

Adopted by the Executive (EX) Committee and Plenary, Aug. 16, 2023

Adopted by the Financial Regulation Standards and Accreditation (F) Committee, Aug. 13, 2023

2024 Charges

FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

The mission of the Financial Regulation Standards and Accreditation (F) Committee is both administrative and substantive, as it relates to the administration and enforcement of the NAIC Financial Regulation Standards and Accreditation Program. This includes, without limitation: 1) the consideration of standards and revisions of standards for accreditation; 2) the interpretation of standards; 3) the evaluation and interpretation of the states' laws and regulations, as well as departments' practices, procedures, and organizations as they relate to compliance with standards; 4) the examination of members for compliance with standards; 5) the development and oversight of procedures for the examination of members for compliance with standards; 6) the selection of qualified individuals to examine members for compliance with standards; and 7) the determination of whether to accredit members.

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Bailey Henning/Sara Franson/Dan Schelp/Sherry Shull

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the International Insurance Relations (G) Committee, Dec. 2, 2023

2024 Charges

INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

The mission of the International Insurance Relations (G) Committee is to: 1) coordinate NAIC participation in discussions on international activities and issues and the development of insurance regulatory and supervisory standards and other materials; 2) promote international cooperation; 3) coordinate on international insurance matters with the U.S. federal government, including the U.S. Department of the Treasury (Treasury Department), the Federal Reserve Board (FRB), the Office of the U.S. Trade Representative (USTR), the U.S. Department of Commerce (DOC), and other federal agencies; and 4) provide an open forum for NAIC communication with U.S. interested parties, stakeholders, and among its members on international insurance matters.

Ongoing Support of NAIC Programs, Products or Services

1. The **International Insurance Relations (G) Committee** will:

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

NAIC Support Staff: Ryan Workman/Nikhail Nigam

Adopted by Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Innovation, Cybersecurity, and Technology (H) Committee, Nov. 16, 2023

2024 Charges

INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

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

INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE *(continued)*

- G. Track the implementation of and issues related to all model laws pertaining to innovation, technology, data privacy, and cybersecurity, including the *Insurance Data Security Model Law* (#668), the *NAIC Insurance Information and Privacy Protection Model Act* (#670), the *Privacy of Consumer Financial and Health Information Regulation* (#672), and the *Unfair Trade Practices Act* (#880) rebating language and providing assistance to state insurance regulators as needed.
 - H. Coordinate and facilitate collaboration with and among other NAIC committees and task forces to promote consistency and efficiency in the development of regulatory policy, education, training, and enforcement materials and tools related to innovation; cybersecurity; data privacy; and the use of technologies, big data and artificial intelligence (AI), including machine learning (ML), in the business of insurance. Evaluate and recommend certifications, continuing education (CE), and training for regulatory staff related to technology, innovation, cybersecurity, and data privacy.
 - I. Follow the work of federal, state, and international governmental bodies to avoid conflicting standards and practices.
2. The **Third-Party Data and Models (H) Task Force** will:
- A. Develop and propose a framework for the regulatory oversight of third-party data and predictive models.
 - B. Monitor and report on state, federal, and international activities related to governmental oversight and regulation of third-party data and model vendors and their products and services. Provide recommendations to the Innovation, Cybersecurity, and Technology (H) Committee regarding responses to such activities.
3. The **Big Data and Artificial Intelligence (H) Working Group** will:
- A. Research the use of big data and AI (including ML) in the business of insurance. Proactively communicate findings and present recommendations to the Innovation, Cybersecurity, and Technology (H) Committee.
 - B. Monitor state, federal, and international activities on AI, including working with the Innovation, Cybersecurity, and Technology (H) Committee, (i) to respond to such activities, where appropriate and (ii) address potential impacts on existing state insurance laws or regulations.
 - C. Oversee the completion of the work of the Collaboration Forum on Algorithmic Bias, including:
 - a. Monitor and support adoption of the Model Bulletin on the use of Artificial Intelligence Systems by Insurers.
 - b. Explore the creation of an independent synthetic data set to support testing of predictive models for unfair discrimination, in collaboration with the Center for Insurance Policy and Research, as appropriate.
 - c. Finalize and maintain a glossary/lexicon to guide regulators as they engage in AI and technology related discussions.
 - D. Facilitate and coordinate foundational and contextual educational content for regulators on topics related to the use of Big Data and Artificial Intelligence techniques, tools and systems in the insurance industry.
4. The **E-Commerce (H) Working Group** will:
- A. Examine e-commerce laws and regulations to aid in identifying updates to the E-Commerce Modernization Guide. This may include meeting with industry experts to understand industry trends that may impact laws and regulations.

INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE *(continued)*

5. The **Cybersecurity (H) Working Group** will:

Cybersecurity Charges

- A. Monitor cybersecurity trends such as vulnerabilities, risk management, governance practices, and breaches with the potential to affect the insurance industry.
- B. Facilitate communication across state insurance departments regarding cybersecurity risks and events.
- C. Develop and maintain a regulatory cybersecurity response guidance to assist state insurance regulators in the investigation of insurance cyber events.
- D. Monitor federal and international activities on cybersecurity engaging, in efforts to manage and evaluate cybersecurity risk.
- E. Coordinate NAIC committee cybersecurity work, including cybersecurity guidance developed by the Market Conduct Examination Guidelines (D) Working Group and the Information Technology (IT) Examination (E) Working Group.
- F. Advise on the development of cybersecurity training for state insurance regulators.
- G. Work with the CIPR to receive updates on cybersecurity research efforts, by the CIPR and others, and to analyze publicly available cybersecurity-related information.
- H. Support the states with implementation efforts related to the adoption of Model #668.

Cyber Insurance Charges

- A. Monitor industry trends pertaining to cyber insurance, including meeting with subject matter experts and evaluating data needs of state insurance regulators. Considerations may also include the availability and affordability/pricing of Cyber insurance, disclosures, limits and sub-limits in policies, policy language and trends in requirements, underwriting practices, and the role of reinsurance in the Cyber insurance market.
- B. Coordinate with NAIC work groups addressing cyber insurance related issues, such as the Casualty and Actuarial (C) Task Force.
- C. Monitor federal and international activities related to cyber insurance and financing mechanisms for cyber risk.

6. The **Privacy Protections (H) Working Group** will:

- A. Use state insurance privacy protections regarding the collection, data ownership and use rights, and disclosure of information gathered in connection with insurance transactions to draft a new/revised Privacy Protections Model Act to replace/update NAIC models such as Model #670 and/or Model #672.
- B. Monitor state, federal, and international activities on privacy engaging in efforts to manage and evaluate privacy.

7. The **Technology, Innovation, and InsurTech (H) Working Group** will:

- A. Monitor technology and innovation trends to identify services and products of importance to state insurance regulators.
- B. Facilitate technology, innovation, and InsurTech presentations to assist state insurance regulators in understanding related trends in the insurance industry.
- C. Develop opportunities for start-ups and InsurTechs to present to and receive feedback from state insurance regulators.

NAIC Support Staff: Miguel Romero/Scott Morris

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023
Reaffirmed by the NAIC/Consumer Liaison Committee, Oct. 13, 2023

2024 Mission Statement

NAIC/CONSUMER LIAISON COMMITTEE

The mission of the NAIC/Consumer Liaison Committee is to assist the NAIC in its mission to support state insurance regulation by providing consumer views on insurance regulatory issues. The Liaison Committee provides a forum for ongoing dialogue between NAIC members and NAIC consumer representatives. The Liaison Committee's activities in 2024 will be closely aligned with the priorities of the NAIC Consumer Board of Trustees.

NAIC Support Staff: Lois E. Alexander

Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023

Reaffirmed by the NAIC/American Indian and Alaska Native Liaison Committee, Oct. 13, 2023

2024 Mission Statement

NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE

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

NAIC Support Staff: Lois E. Alexander

Reaffirmed by the Executive (EX) Committee and Plenary, Dec. 4, 2023
Reaffirmed by the Executive (EX) Committee, Dec. 2, 2023
Reaffirmed by the Internal Administration (EX1) Subcommittee, Aug. 13, 2023
Reaffirmed by the Audit Committee, Aug. 3, 2023

2024 Committee Charter

AUDIT COMMITTEE

1. The **Audit Committee** will:
 - A. Provide continuous audit oversight, including:
 - i. Provide an open avenue of communication between the independent auditor and the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.
 - ii. Confirm and ensure the independence of the independent auditor.
 - iii. Inquire of management and the independent auditor about significant risks or exposures and assess the steps management has taken to minimize such risk.
 - iv. Consider and review with the independent auditor:
 - a. Significant findings during the year, including the status of previous audit recommendations.
 - b. Any difficulties encountered during audit work, including any restrictions on the scope of activities or access to required information.
 - c. The adequacy of internal controls, including computerized information system controls and security, as documented in the Statement on Auditing Standards (SAS) 115 letter from the independent auditor.
 - d. Related findings and recommendations of the independent auditor with management's responses, as documented in the SAS 114 letter from the independent auditor.
 - v. Meet periodically with the independent auditor in separate executive sessions to discuss any matters the Committee believes should be discussed privately with the Committee.
 - vi. Report periodically to the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee on significant results of the foregoing activities.
 - vii. Instruct the independent auditor that the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee are the auditor's clients.
 - B. Provide continuous oversight of reporting policies, including:
 - i. Advise financial management and the independent auditor that they are expected to provide a timely analysis of significant current financial reporting issues and practices.
 - ii. Inquire as to the auditor's independent qualitative judgments about the appropriateness, not just the acceptability, of the accounting principles and the clarity of the financial disclosure practices.
 - iii. Inquire as to the auditor's views about whether management's choices of accounting principles are conservative, moderate, or aggressive from the perspective of income, asset and liability recognition, and whether those principles are common practices or minority practices.
 - iv. Inquire as to the auditor's views about how choices of accounting principles and disclosure practices may affect NAIC members, the insurance industry, and public views and attitudes.
 - C. Provide continuous oversight of financial management, including:
 - i. Review the monthly consolidated financial statements and receive regular reports from executive management on the financial operations of the association.
 - ii. Meet prior to, or at, each national meeting or more frequently, as circumstances require. The Committee may ask members of management or others to attend meetings and provide pertinent information, as necessary.
 - iii. Report on significant results of the foregoing activities to the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee on a regular basis.

AUDIT COMMITTEE *(continued)*

- D. Provide continuous oversight of the service advisory firm that conducts the Service Organization Control (SOC) 1 and SOC 2 reviews.
 - i. Receive annual audit reports provided by the service advisory firm.
 - ii. Instruct the independent service advisory firm that the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee are the auditor's clients.
- E. Conduct scheduled audit activities, including:
 - i. Recommend the selection of the independent auditor for approval by the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, approve the compensation of the independent auditor, and review and approve the discharge of the independent auditor.
 - ii. Review annually the audit scope and plan of the independent auditor with management and the independent auditor, including:
 - a. The independent auditor's audit of the financial statements, accompanying footnotes, and its report thereon.
 - b. Any significant changes required in the independent auditor's audit plans.
 - c. Any difficulties or disputes with management encountered during the year under audit.
 - d. Other matters related to the conduct of the audit, which are to be communicated to the Committee under generally accepted auditing standards (GAAS).
 - iii. Arrange for the independent auditor to be available to the full Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, as needed.
- F. Conduct other activities when necessary, including:
 - i. Review and approve needs-based funding allocations, as needed.
 - ii. Review and update the Committee charter on at least an annual basis.
 - iii. Review and approve requests for any management consulting engagement to be performed by the independent auditor and be advised of any other study undertaken at the request of management that is beyond the scope of the audit engagement letter.
 - iv. Conduct and/or authorize investigations into any matters within the Committee's scope of responsibilities. The Committee shall be empowered to retain independent counsel and other professionals to assist in the conduct of any investigation.
 - v. Ensure that members of the Committee receive the appropriate orientation to the Committee and receive a copy of the policy manual.

NAIC Support Staff: Jim Woody



Adopted by the Executive (EX) Committee and Plenary on Dec. 4, 2023
Adopted by the Life Insurance and Annuities (A) Committee on Nov. 21, 2023
Adopted by the Life Actuarial (A) Task Force on Sept. 28, 2023

TABLE 1
PROPOSED 2024 GRET FACTORS, BASED ON AVERAGE OF 2021/2022 DATA

DESCRIPTION	Acquisition per Policy	Acquisition per Unit	Acquisition per Premium	Maintenance per Policy	Companies Included	Average Premium Per Policy Issued During Year	Average Face Amt (000) Per Policy Issued During Year
Independent	\$198	\$1.10	50%	\$59	140	3,433	222
Career	206	1.10	52%	62	90	2,325	196
Direct Marketing	217	1.20	54%	65	23	767	122
Niche Marketing	132	0.70	33%	40	31	347	10
Other*	162	0.90	41%	49	95	917	80
* Includes companies that did not respond to this or prior year surveys					379		

TABLE 2
CURRENT 2023 GRET FACTORS, BASED ON AVERAGE OF 2020/2021 DATA

Description	Acquisition per Policy	Acquisition per Unit	Acquisition per Premium	Maintenance per Policy	Companies Included	Average Premium Per Policy Issued During Year	Average Face Amt (000) Per Policy Issued During Year
Independent	\$180	\$1.00	45%	\$54	141	3,073	204
Career	203	1.10	51%	61	84	2,296	197
Direct Marketing	197	1.10	49%	59	21	899	57
Niche Marketing	147	0.80	37%	44	30	507	14
Other*	153	0.90	39%	46	106	853	72
* Includes companies that did not respond to this or prior year surveys					382		

APPENDIX A -- DISTRIBUTION CHANNELS

The following is a description of distribution channels used in the development of recommended 2022 GRET values:

1. Independent – Business written by a company that markets its insurance policies through an independent insurance agent or insurance broker not primarily affiliated with any one insurance company. These agencies or agents are not employed by the company and operate without an exclusive distribution contract with the company. These include most PPGA arrangements.
2. Career – Business written by a company that markets insurance and investment products through a sales force primarily affiliated with one insurance company. These companies recruit, finance, train, and often house financial professionals who are typically referred to as career agents or multi-line exclusive agents.
3. Direct Marketing – Business written by a company that markets its own insurance policies direct to the consumer through methods such as direct mail, print media, broadcast media, telemarketing, retail centers and kiosks, internet, or other media. No direct field compensation is involved.
4. Niche Marketers – Business written by home service, pre-need, or final expense insurance companies as well as niche-market companies selling small face amount life products through a variety of distribution channels.
5. Other – Companies surveyed were only provided with the four options described above. Nonetheless since there were many companies for which we did not receive a response (or whose response in past years’ surveys confirmed an “other” categorization (see below), values for the “other” category are given in the tables in this memo. It was also included to indicate how many life insurance companies with no response (to this survey and prior surveys) and to indicate whether their exclusion has introduced a bias into the resulting values.

APPENDIX B – UNIT EXPENSE SEEDS

The expense seeds used in the 2014 and prior GRETs were differentiated between branch office and all other categories, due to the results of a relatively old study that had indicated that branch office acquisition cost expressed on a per Face Amount basis was about double that of other distribution channels. Due to the elimination of the branch office category in the 2015 GRET, non-differentiated unit expense seeds have been used in the current and immediately prior studies.

The unit expense seeds used in the 2024 GRET and the 2023 GRET recommendations were based on the average of the 2006 through 2010 Annual SOA expense studies. These studies differentiated unit expenses by type of individual life insurance policy (term and permanent coverages). As neither the GRET nor the Annual Statement data provided differentiates between these two types of coverage, the unit expense seed was derived by judgment based this information. The following shows the averages derived from the Annual SOA studies and the seeds used in this study. Beginning with the 2020 Annual Statement submission this information will become more readily available.

2006-2010 (AVERAGE) CLICE STUDIES:

	Acquisition/ Policy	Acquisition/ Face Amount (000)	Acquisition/ Premium	Maintenance/ Policy
Term				
Weighted Average	\$149	\$0.62	38%	\$58
Unweighted Average	\$237	\$0.80	57%	\$76
Median	\$196	\$0.59	38%	\$64
Permanent				
Weighted Average	\$167	\$1.43	42%	\$56
Unweighted Average	\$303	\$1.57	49%	\$70
Median	\$158	\$1.30	41%	\$67

CURRENT UNIT EXPENSE SEEDS:

	Acquisition/ Policy	Acquisition/ Face Amount (000)	Acquisition/ Premium	Maintenance/ Policy
All distribution channels	\$200	\$1.10	50%	\$60

Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee on Aug. 15, 2023

Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group on June 6, 2023

Voluntary Market Regulation Certification Program Self-Assessment Guidelines, and Checklist Tool

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Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group on June 6, 2023

Purpose

The mission of the NAIC Market Regulation Certification Program is to establish and maintain minimum standards that promote sound practices relating to the market conduct examination, market analysis and related continuum activity functions performed for insurance consumer protection. Inasmuch as the program is anticipated to evolve and improve over time, it is anticipated that additional functions necessary for sound consumer protection may be developed in the future. The certification program is designed to provide an initial process that facilitates each jurisdiction's ability to conduct self-evaluation. An ultimate goal is to develop measurable and meaningful standards that can be independently evaluated and monitored.

Program standards, assessment checklist items and guidelines should:

- Provide a roadmap regarding resources, abilities and functions for jurisdictions wishing to build, maintain, or improve upon, their market regulation program.
- Promote consistency while respecting individual jurisdictional differences and circumstances by promoting use of NAIC resources.
- Demonstrate accountability and responsiveness to those impacted by the business of insurance, and to others that are charged with evaluating and assessing the effectiveness of state-based insurance regulation.
- Promote an environment of continuous process improvement for enhancing outcomes relating to insurance consumer protection.
- Improve predictability and understanding of processes for regulated entities.
- Enhance jurisdictional coordination and information-sharing.
- Enhance protection of insurance consumers through promotion of sound market regulation processes.

Definitions

When referenced in this document, the following terms mean:

- **Chief Market Regulator** is either elected or appointed and is the Commissioner of Insurance, Superintendent, Director, Secretary of Commerce, or other chief who oversees the regulation of insurance in each state or jurisdiction.
- **Department** is the chief governmental office invested with the responsibility of regulating the insurance industry within a jurisdiction.
- **Jurisdiction** is the territory within which power can be exercised. Within this document, jurisdiction will include but is not limited to: Departments of Insurance, Insurance Divisions, and other state specific agency titles which may include terms such as: Administration, Bureau, Commerce, Financial Services, Business Regulation, and Other Departments/Divisions that include the regulation of insurance. For example: Department of Professional and Financial Regulation, Office of Consumer Affairs and Business Regulation, Business and Industry, Banking and Insurance.

NOTE: When responding to checklist items for each requirement, if the response is N/A (not applicable), please provide an explanation for the "N/A" response in the comments.

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Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group on June 6, 2023

Voluntary Market Regulation Certification Guidelines and Checklists

Requirement 1 – Department’s Authority

The jurisdiction or department shall have the statutory authority to conduct market regulation activities, including market analysis; comprehensive and targeted market conduct examinations; the continuum of market regulation actions, including enforcement; and collaboration and coordination with other regulatory jurisdictions.

Objective

The objective of this requirement is to ensure the department has the statutory authority to effectively fulfill its market regulation responsibilities.

Measurement

To evaluate whether the jurisdiction “passes” Requirement 1, the jurisdiction must have the general authority to collect and analyze information and have authority to coordinate with other jurisdictions. If the jurisdiction does not have the authority to coordinate with other jurisdictions, it will not pass this requirement. Additionally, a jurisdiction should have authority to conduct analysis, examinations, and enforcement. Requirements to have reasonable cause to conduct an examination does not negatively impact the evaluation. Ability to perform these items without having the ability to perform continuum actions should be considered as “marginally passing but with strong recommendations for additional authority.”

Guidelines

When determining the department’s authority for conducting market regulation activities, several different considerations should be evaluated. Direct legal authority may exist in the jurisdiction’s insurance code or within its regulations. Insurer examination acts, specific market regulation acts, acts that outline the authority and duties of the department are all potential items to review. Generally, such authority is cited when requesting documents from an insurer. Jurisdictions may also have broad oversight authority within other consumer protection laws.

Additional authority may be implied or may exist on a less direct basis. Examples could include insurance consumer protection-related insurance laws or regulations and their associated enforcement provisions. Other potential areas of authority are activities performed pursuant to the powers or orders of the insurance commissioner, director, or superintendent (i.e., the applicable chief market regulator of the jurisdiction).

When evaluating checklist items for Requirement 1, it may be beneficial to look beyond the mere capability to perform the listed functions. If not directly addressed within the insurance code or regulations, consider whether direct authority for all mentioned items would be desirable (most continuum items would fall under examination, investigation, or analysis categories). Having direct authority may provide valuable guidance on such issues as application of administrative procedure act requirements, status of examination, investigational or analysis records, handling of associated costs, etc.

Consider which consumer protections model laws and regulations have been adopted in the jurisdiction. Investigation, subpoena, and cease and desist powers are found in most unfair trade and producer laws. Most chief market regulators also have a general powers statute that may contain similar enforcement authorities.

The key basic models or similar versions should include:

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- *Unfair Trade Practices Act (#880)*
- *Unfair Claims Settlement Practices Act (#900)*
- *Health Carrier Grievance Procedure Model Act (#72)*
- *Uniform Health Carrier External Review Model Act (#76)*
- *Producer Licensing Model Act (#218)*
- *Suitability in Annuity Transactions Model Regulation (#275)*
- *Life Insurance Illustrations Model Regulation (#582)*
- *Life Insurance and Annuities Replacement Model Regulation (#613)*
- *Standard Nonforfeiture Law for Life Insurance (#808)*
- *Standard Nonforfeiture Law for Individual Deferred Annuities (#805)*
- *Unfair Discrimination Against Subjects of Abuse in Health Benefit Plans Model Act (#895)*
- *Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#896)*
- *Unfair Discrimination Against Subjects of Abuse in Disability Income Insurance Model Act (#897)*
- *Unfair Discrimination Against Subjects of Abuse in Property and Casualty Insurance Model Act (#898)*
- *Model Law on Examinations (#390) or Market Conduct Surveillance Model Law (#693)*

Checklist

Please provide the statutory reference(s) the department relies on for the following:

	YES	NO
1a. Does the department have the general authority to collect and analyze information whenever it is deemed necessary?	_____	_____

REFERENCE _____

1b. Does the department have the authority to collaborate and coordinate with other regulatory agencies?	_____	_____
--	-------	-------

REFERENCE _____

1c. Is the department’s authority broad enough to cover market analysis, comprehensive and targeted market conduct examinations and the continuum of market regulation actions, including enforcement?

If yes, provide the citation reference(s) in the table below _____

	Citation
Market analysis	
Comprehensive and targeted market conduct exams	
Continuum of market regulation actions (including enforcement)	

Complete the following if this is an Interim Annual Review:

	YES	NO
Have there been any significant changes to the procedures since last year’s review? If “Yes,” please provide an explanation.	_____	_____

COMMENTS:

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Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee on Aug. 15, 2023
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group on June 6, 2023

Requirement 2 – Department’s Authority Regarding the *Market Regulation*

Handbook

The department shall have sufficient authority by appropriate statute, regulation, rule, or other authority to utilize the most recent version of the *Market Regulation Handbook*. When a department initiates a market conduct examination or continuum activity, it shall be guided by the version of the *Market Regulation Handbook* in effect at the time the examination was initiated.

Objective

The objective of this requirement is to promote guidance and consistent handling of examination processes and continuum activities through the use of the *Market Regulation Handbook*. Additionally, this promotes guidance and consistent handling of examination processes and continuum activities within each jurisdiction on an individual basis when it is deemed appropriate to deviate from the *Market Regulation Handbook*.

Measurement

To evaluate whether the jurisdiction “passes” Requirement 2, the jurisdiction must at a minimum have sufficient authority by appropriate statute, regulation, rule, or other authority to utilize the most recent version of the *Market Regulation Handbook*, and be able to demonstrate when conducting examinations or continuum activities their use of applicable *Market Regulation Handbook* review standards and related materials to the extent they are consistent with jurisdictional law. The department’s policies and procedures should properly reference the use of those materials set forth in the *Market Regulation Handbook*.

Guidelines

When determining the department’s authority by appropriate statute, regulation, rule, or other authority to utilize the most recent version of the *Market Regulation Handbook*, the department should identify the statute, regulation, rule, or other authority to use the *Market Regulation Handbook* within their response.

When evaluating checklist items for Requirement 2, a jurisdiction should be able to demonstrate, on an individual basis, when it is deemed appropriate to deviate from, or necessary to use an earlier version of, the *Market Regulation Handbook*. The jurisdiction must also be able to demonstrate that it has followed its own established policies and procedures for adopting processes that deviate from the *Market Regulation Handbook*.

Checklist

	YES	NO
2a. Does the department have authority by statute, rule or other authority to utilize the <i>Market Regulation Handbook</i> ?	_____	_____

REFERENCE _____

2b. When conducting examinations or continuum activities, does the department incorporate applicable <i>Market Regulation Handbook</i> review standards and related materials to the extent they are consistent with state laws?	_____	_____
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Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee on Aug. 15, 2023
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group on June 6, 2023

2c. Does the department have examination-specific policies and procedures in addition to those guidelines set forth in the *Market Regulation Handbook*?

2d. If the answer to item 2c. is “Yes”, is the jurisdiction able to demonstrate that it has followed its own established policies and procedures in adopting any process that deviates from the *Market Regulation Handbook*?

Complete the following if this is an Interim Annual Review:

Have there been any significant changes to the procedures since last year’s review? If “Yes,” please provide an explanation.

COMMENTS:

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Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee on Aug. 15, 2023
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group on June 6, 2023

Requirement 3 – Department Staffing: Resources

The department must have either, or a combination of:

- Its own staff sufficient to perform market regulation work, including market analysis, examinations and other continuum actions.
- Statutory authority sufficient to engage competent contractors on an as-needed basis and appropriate department staff to oversee and manage such contractors.

Objective

The objective of this requirement is to ensure the department has sufficient resources to meet the needs of the department's market regulation activities.

Measurement

To evaluate whether the jurisdiction "passes" Requirement 3, the jurisdiction, must be able to respond "Yes" to each of the following checklist items:

- Item 3a.
- Item 3d. and/or 3e.
- Item 3n.

Furthermore, if the answer to checklist item 3e. is "Yes", then a "Yes" response is required for item 3k., item 3l., and item 3m.

All remaining Requirement 3 checklist items should be collected and evaluated from year-to-year to evaluate the jurisdiction's abilities.

Guidelines

Requirement 3 provides guidance on whether a jurisdiction has resources and capabilities to conduct market analysis, market conduct examinations and/or continuum activities. The standard recognizes that some jurisdictions use contracted services to perform these functions. In the event that contracted services are used, the standard inquires if the jurisdiction has the authority to hire contractors, established processes for selecting contractors and whether the jurisdiction engages in oversight of the contracted services. It is understood that jurisdictions vary in their usage of examinations versus continuum activities.

This requirement anticipates that some data will be obtained through the *Insurance Department Resources Report*. Those results should be reviewed in the event that classifications differ. Additionally, it is anticipated that each jurisdiction will evaluate changes in its level of resources from year to year.

The number of staff listed below should be expressed in terms of full-time equivalent (FTE) positions. The use of FTEs recognizes that most employees perform multiple functions within a department, for example, if two employees each spend half their time doing market analysis that would equate to 1 full-time equivalent position.

To evaluate its own status regarding the checklist for Requirement 3, each jurisdiction determines its specific appropriate level of staffing and or use of contracted services. Levels will vary from jurisdiction to jurisdiction. Factors such as population size, premium volume, complexity of insurance issues with a particular jurisdiction, complaints, legal requirements, directives for conducting market conduct activities and ability to keep abreast of emerging market issues are valid factors when evaluating the jurisdiction's needs. Jurisdictions are encouraged to establish resource levels that permit them to meet their obligations or needs for market analysis, market conduct examinations and/or continuum actions.

Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee on Aug. 15, 2023
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group on June 6, 2023

During each jurisdiction’s evaluation of its staffing levels, it may also be helpful to determine what NAIC resources are relied upon for market regulation functions and how the use of those resources has changed over time. If additional NAIC resources are identified that may be beneficial, it is a good idea to bring forth those suggestions to NAIC staff. This will help to provide opportunities and diagnostic tools for improvement.

Where independent contractors are used to fulfill staffing needs, the department must be engaged and responsible throughout the examination and be responsive to issues and concerns that might arise.

Checklist

Sufficient Staff and Resources (Market Analysis)

The department should have the resources to analyze effectively on a periodic basis the market behavior of insurers doing business in the jurisdiction.

- | | YES | NO |
|--|-------|-------|
| 3a. Does the department have analysts on staff or under contract whose responsibility is to conduct market analysis of insurers doing business in the jurisdiction? | _____ | _____ |
| 3b. If the department utilizes contract analysts, please describe in a separate attachment the manner and extent of utilization in the department’s recent activities. | | |
| 3c. Indicate below the number of FTE contract and staff analysts for each of the last three years. | | |

	In-house Market Analysts	Contract Market Analysts
Current Year (CY)		
CY-1		
CY-2		

Indicate below the number of market analysis reviews for which market analysis was performed in the prior review period. Market analysis means formal review of a company through existing processes (e.g., Level 1, Level 2).

	Total Reviews
Current Year (CY)	
CY-1	
CY-2	

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Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee on Aug. 15, 2023
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group on June 6, 2023

Sufficient Staff and Resources (Examinations and/or Continuum Actions)

The department should have resources to effectively examine and/or conduct continuum actions of insurers as deemed appropriate by the department based upon its market analysis or as prescribed by jurisdiction laws.

- | | YES | NO |
|--|-------|-------|
| 3d. Does the department have examiners on staff whose responsibility is to examine and/or conduct continuum actions of insurance companies as indicated by the department’s market analysis or as prescribed by jurisdiction laws? | _____ | _____ |
| 3e. Does the department utilize contract examiners to examine and/or conduct continuum actions of insurance companies as indicated by the department’s market analysis or as prescribed by jurisdiction laws? | _____ | _____ |
| 3f. If the department utilizes contract examiners, please describe in a separate attachment the manner and extent of utilization in the department’s recent activities. | | |
| 3g. Indicate below the number of FTE market examiners, including supervisory personnel on the department’s staff and/or the number of individual contract examiners used compared to the last three years. | | |

	In-House Examiners	Contract Examiners	
Current Year (CY)			
CY-1			
CY-2			

- | | YES | NO |
|--|-------|-------|
| 3h. Has the department performed any targeted exams or market continuum actions in the prior two years? | _____ | _____ |
| 3i. If the answer to item 3h. is “Yes,” please provide a list of such exams or market continuum actions and the scope of the exams/actions. | | |
| 3j. If the answer to item 3h. is “No,” does the department have the on-staff resources or the ability to contract additional resources to perform targeted exams/actions, if deemed necessary? | _____ | _____ |

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Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee on Aug. 15, 2023
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group on June 6, 2023

Sufficient Staff and Resources (Contractor Selection and Oversight)

- | | YES | NO |
|--|-------|-------|
| 3k. Does the department have the authority to hire contractors as specialists to perform market regulation? | _____ | _____ |
| 3l. If the department has authority to hire contractors, does it have either a statewide or departmental established process it follows for selecting contractors for market regulation purposes? Briefly explain. | | |
| 3m. Does the department oversee and manage contractors? Briefly explain. | | |

Policies & Procedures and Output

- | | | |
|---|-------|-------|
| 3n. Does the department have policies and procedures, subject to periodic review and updates, for identifying and addressing market conduct issues using market analysis and market conduct continuum activities, including examinations? | _____ | _____ |
| 3o. If the answer to item 3n. is “Yes,” what quantitative and subjective measurements are available to evaluate whether the department is adhering to its policies and procedures? | | |
| 3p. Based on the review of staff resources, please provide an explanation of any significant changes in resources and/or workload over the three-year period covered in the data above. | | |

Complete the following if this is an Interim Annual Review:

- | | YES | NO |
|--|-------|-------|
| Have there been any significant changes to the procedures since last year’s review? If “Yes,” please provide an explanation. | _____ | _____ |

COMMENTS:

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Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee on Aug. 15, 2023
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Requirement 4 – Department Staffing: Qualifications

With respect to qualifications, the department:

- Shall ensure market regulation staff and contractors are qualified by establishing qualifications consistent with the standards for experience, education (including designations) and licenses in the *Market Regulation Handbook Core Competencies* (“Appendix D – Core Competencies – Resources – Staff and Training, Standard 2” and Appendix D – Core Competencies – Resources – Contractor Examiner, Standard 2” or successor documents).
- Should have a policy that encourages the professional development of all staff involved with market regulation through job-related college courses, professional designation programs or other training programs.

Objective

The objective of this requirement is to ensure the department staff is properly qualified to perform the market regulation functions for which they are responsible and have access to training and professional development opportunities.

Measurement

In order to successfully meet this requirement, the department must have policies and procedures in place regarding the appropriate credentials or minimum educational and experience requirements for selecting and hiring contractors. Furthermore the department should be able to demonstrate that it supports the hiring qualified staff and contractors; that it encourages and supports educational and training pursuits; that Examiners-in-Charge possess or are making progress toward completing appropriate designations; that the department recognizes licenses and other highly technical credentials of professionals and experts to perform certain market regulation activities where appropriate; and that it has a succession plan in place to ensure the maintenance of skills and records.

Guidelines

Notes to Evaluators:

- Equivalent substitutions may be considered with appropriate justification.
- Employees are exempt from this requirement if they have more than 20 years of service with the department or are less than five years from retirement.
- If collective bargaining or jurisdictional personnel policies prohibit any portion of such requirements, the department must show evidence that it has made good faith attempts to include such requirements.
- Evidence of good faith activities include, but are not limited to, the following:
 - The department adopts procedures to include a statement encouraging professional education.
 - The department has made arrangements to be a testing location for organizations such as Life Office Management Association (LOMA) or The Institutes.
 - The department attempts to secure funds for the professional development of market regulation personnel.

Hiring of Staff and Contractors

This area evaluates the effort of the department as it relates to the hiring of qualified staff and/or contractors. The department should have a policy or procedure in place on necessary credentials or minimum educational and experience requirements for selecting and hiring staff and contractors.

- The policies/procedures of the department should call for the inclusion of preferences for relevant experience, education and credentials in its job announcements/descriptions. In addition, the department should include in its specifications in requests for proposals (RFPs) requirements that contracted personnel (*with emphasis on supervisory personnel*) have relevant experience, and credentials.

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Relevant credentials would include a Market Conduct Management (MCM)¹ designation and any of the following designations:

- Certified Insurance Examiner (CIE)
- Accredited Insurance Examiner (AIE)
- Chartered Life Underwriter (CLU)
- Fellow, Life Management Institute (FLMI)
- Chartered Property Casualty Underwriter (CPCU)
- Certified Insurance Counselor (CIC)
- Fellow, Academy for Healthcare Management (FAHM)
- Professional in Insurance Regulation (PIR)
- Chartered Healthcare Consultant (ChHC)

Staff Development

The department should have a staff development program that encourages and supports educational and training pursuits, including training, courses, webinars, and certifications offered by the NAIC. Successful completion of this aspect of the requirement varies depending on an employee's length of service in insurance regulation.

(1) Staff Examiners/Analysts with More than Five Years of Service in Insurance Regulation

Examiners and analysts with more than five years of service with the department are “presumed qualified” and should be rated as a pass if they meet either of the following:

- Hold a juris doctor degree (J.D.) and an MCM designation.
- Hold an MCM designation and either an AIE or CIE designation.

Examiners and analysts with more than five years of service in the position of market conduct analyst or market conduct examiner who specialize in a particular line of business are “presumed qualified” and should be rated as a pass if they meet either of the following:

- Hold an MCM designation and either a CLU, FLMI, CPCU, CIC, FAHM or ChHC designation.
- Hold an MCM designation, a PIR designation and an associate's level designation from either The American College of Financial Services, The Institutes, America's Health Insurance Plans (AHIP) or similar organization such as LOMA or the Society of Financial Examiners (SOFE).

If all examiners and analysts with more than five years of service do not have the above qualifications, rate a pass if:

- The department has a training policy and/or job specifications that require completion and/or experience to attain the next highest level in their job classification series.
- The department has a policy that allows voluntary access to NAIC designation programs, and the department must show good faith attempts for encouragement and budgetary allowances to provide for voluntary training

¹ NAIC market conduct examination training may substitute for an MCM designation.

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at other sources of professional education such as the Insurance Regulatory Examiners Society (IRES), The American College of Financial Services, The Institutes, LOMA or AHIP.

(2) Staff Examiners/Analysts with Less than Five Years of Service

When the department has staff with less than five years of service, the department should:

- Have a formal training program whereby new personnel have a clear requirement to attain, within five years, an MCM designation and either a CIE, AIE, CLU, FLMI, CPCU, CIC, FAHM, PIR or ChHC designation.
 - Personnel with a J.D. and five years of regulatory experience are exempt, with the exception they must earn an MCM designation or complete NAIC market conduct examination training.
- The department must have a policy that allows voluntary access to NAIC designation programs and the department must show good faith attempts for encouragement and budget allowances to provide for voluntary training at other sources of professional education such as IRES, The American College of Financial Services, The Institutes, LOMA or AHIP.

Examiner-in-Charge Qualifications

Examiners-in-Charge (EICs) should possess (or be making progress towards completion of) relevant designations. Relevant designations would include a Market Conduct Management (MCM) designation and any of the following designations as appropriate by lines of business:

- CIE
- AIE
- CLU
- FLMI
- CPCU
- CIC
- FAHM
- PIR
- ChHC

When an EIC with specific qualifications is not available, other qualifications are acceptable so long as the department is compliant with checklist item 4c. (development program).

Recognition of Licenses & Technical Credentials of Professionals & Experts

The department should recognize licenses and other highly technical credentials of professionals and experts such as attorneys, actuaries, cybersecurity experts, certified public accountants, IT experts and other professionals and specialists as qualified to perform certain market regulation activities.

In evaluating this aspect of the requirement, it is important to determine if the department retained and utilized appropriate staff or contractors with highly technical credentials when appropriate. Note: it is possible that no examinations or continuum activities requiring highly technical specialties were conducted during the review period.

Succession Plan

The department should have a succession plan in place to ensure maintenance of skills and records. At a minimum, the department should maintain written procedure manuals and cross-train employees.

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Checklist

	YES	NO
4a. Does the department have policy and procedures in place on necessary credentials or minimum educational and experience requirements for selecting and hiring staff consistent with the detailed credentials listed in the Certification guidelines?	_____	_____
4b. Does the department have policy and procedures in place on necessary credentials or minimum educational and experience requirements for selecting and hiring contractors consistent with the detailed credentials listed in the Certification guidelines?	_____	_____
4c. Does the department have a staff development program that encourages and supports educational and training pursuits, including training, courses, webinars and certifications offered by the NAIC?	_____	_____
4d. Does each Examiner-in-Charge possess or is the Examiner-in-Charge making progress towards completion of noted designations?	_____	_____
4e. Does the department recognize licenses and other highly technical credentials of professionals and experts such as attorneys, actuaries, cybersecurity experts, certified public accountants, information technology (IT) experts and other professionals and specialists as qualified to perform certain market regulation activities?	_____	_____
4f. Does the department maintain written procedure manuals to demonstrate a succession plan?	_____	_____
4g. As a separate attachment, provide a list of market analysts/examiners that includes the following: name; professional designation(s); title; years employed by the department (include functional area); type of college degree; and prior regulatory or insurance experience. Also indicate those market conduct analysts/examiners that are contractual and whether each is full-time with the department.		

Complete the following if this is an Interim Annual Review:

	YES	NO
Have there been any significant changes to the procedures since last year's review? If "Yes," please provide an explanation.	_____	_____

COMMENTS:

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Requirement 5 – Confidentiality and Information-Sharing

The department shall have the authority and capability to:

- Request, hold and produce examination, investigation, and continuum workpapers, on a confidential basis and protect it from subpoena, as permitted by jurisdictional law.
- Maintain confidentiality of confidential information shared by other jurisdictional or federal agencies; and only share confidential information with jurisdictional and federal agencies that agree, in writing, to adequately protect such confidential information.

Objective

The objective of this requirement is to ensure the department is able to maintain the confidentiality of its own work product and the work product of jurisdictions with which it collaborates. This is foundational to all collaborative efforts.

Measurement

To evaluate whether the jurisdiction “passes” Requirement 5, the jurisdiction must answer “Yes” to checklist item 5a., item 5b., item 5c and item 5d.

Guidelines

The jurisdiction’s treatment of examination, investigation, and continuum workpapers and information shared by or with other jurisdictions has a significant impact on the various jurisdictions’ ability to communicate and collaborate on confidential matters. The provisions within each jurisdiction’s laws, regulations or case law may vary regarding the extent to which workpapers are confidential or to timing which such information becomes a public document. Some laws may extend beyond workpapers and apply to examination reports, as well. Research and documentation of the applicable jurisdiction’s confidentiality provisions should provide clear guidance for individuals within the market regulation division. Checklist item 5a. does not anticipate a uniform confidentiality framework among jurisdictions, but rather is viewed as a necessity to adequately fulfill the requirements of checklist item 5c.

Entering into the Multi-State Information-Sharing Agreement with other jurisdictions and the NAIC is also a necessary part of being able to adequately maintain confidentiality of information shared by other jurisdictions.

Checklist

	YES	NO
5a. Does the jurisdiction have laws, regulations or case law that specify how the confidentiality of market conduct examination workpapers is to be handled?	_____	_____

REFERENCE _____

5b. Has the department entered into the Multi-State Information-Sharing Agreement with other departments and the NAIC and does the department have written policies/procedures and communicate such policies/procedures to staff?	_____	_____
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5c. Does the department have written policies and procedures and communicated such policies and procedures to employees relating to the protection of confidential information which includes PII and PHI, handling of public records requests and requirements for confidentiality agreements when it becomes necessary to share confidential information with other federal and international regulatory or law enforcement agencies, not otherwise covered by the multi-state agreement? _____

5d. Does the department have a records retention schedule which outlines plans for secure storage and timeline for destruction of work papers? _____

Information-sharing agreements with federal or international regulatory agencies or law enforcement agencies may be handled either on a case-by-case basis or by way of properly executed memorandums of mutual understanding.

Complete the following if this is an Interim Annual Review:

	YES	NO
Have there been any significant changes to the procedures since last year's review? If "Yes," please provide an explanation.	_____	_____

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Requirement 6 – Collaboration with Other Jurisdictions

The department participates in collaborative actions with other jurisdictions.

The department follows the referral or reporting procedures outlined in the Market Actions (D) Working Group’s Policies and Procedures for any material action that has a potential for collaborative action. In order to determine if a referral or reporting to the Market Actions (D) Working Group is necessary, the department will notify all other Collaborative Action Designees (CADs) via meeting, bulletin board, or other method, of proposed activities that have the potential for collaboration.

In addition, the Market Analysis Chief (MAC), MAWG member, CAD and/or CAD alternate shall actively monitor the Market Regulation and Market Analysis Bulletin Boards.

The department will consider joining called Market Actions (D) Working Group collaborative actions relevant to its jurisdiction and provide a response indicating whether or not it will join the collaborative action.

[Collaboration-National Analysis. Formerly Req. 11] The department participates* in the review of national analysis data annually.

*Participation means either performing analysis on one of the selected companies or participating in the selection process. Please note if none of the selected companies wrote business in the jurisdiction. It should be noted that the national analysis process is subject to change. Therefore, it is understood that in the future it may be necessary to revisit what it means to “participate.”

Objective

The objective of this requirement is to encourage collaboration with other jurisdictions to help to keep market regulation more effective and efficient by preventing duplication of effort. Sharing of key information among jurisdictions helps to identify marketplace issues as they arise. By encouraging a multi-jurisdictional response to issues when practical, jurisdictions can more effectively direct their resources. Also, this requirement promotes collaboration and the sharing of perspectives and approaches to analyzing data among jurisdictions.

Measurement

To evaluate whether the jurisdiction “passes” Requirement 6, the jurisdiction must answer “Yes” to checklist item 6a. The jurisdiction should answer yes to item 6b. and item 6c., and item 6e. and item 6f. unless there is an applicable explanation given in checklist item 6g.

When evaluating checklist items for the MAWG national analysis process, it is important to remember that participation means either performing analysis on one of the selected companies or participating in the selection process.

To evaluate whether the jurisdiction “passes” the national analysis portion of this requirement, the jurisdiction should answer “Yes” to checklist item 6i., in addition to providing a name of the individual (or individuals) who participate in the annual national analysis project .

Drafting Note: Assumes at least one company to be reviewed is licensed or conducting business in the jurisdiction.

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Guidelines

The first portion of Requirement 6 relates to participation in the Market Actions (D) Working Group and is followed by checklist item 6a., item 6b., item 6c. and item 6d. The second portion of Requirement 6 relates to how the jurisdiction joins or considers joining Market Actions (D) Working Group actions and is followed by checklist item 6e., item 6f. and item 6g.

For regulators to fully adhere with Requirement 6, especially as it relates to handling of referrals, it is important to become familiar with both the *Market Regulation Handbook*, Chapter 6—Collaborative Actions, and the Market Actions (D) Working Group's Policies and Procedures.

Actively monitoring includes responding to posts or responding directly to the sender of a posting.

Examples of actively monitoring the bulletin boards could include regularly:

- Responding substantively to a bulletin board post.
- Reaching out directly to the poster.
- Communicating with other divisions within the department.
- Raising the issue to the Chief Market Regulator Forum (CMRF).

Examples of reasonable explanations for checklist item 6d. and item 6g. may include, but are not limited to, such justifications as:

- The issue has minimal or no consumer impact.
- The issue is not yet sufficiently defined, investigated, or analyzed.
- There are no known laws or regulations to address the issue.
- There are reasons why expediency to address the matter in the jurisdiction is of utmost concern.
- Significant differences in the jurisdiction's particular insurance laws or regulations.
- The matter has been previously addressed in a satisfactory manner by the jurisdiction.
- An executive decision made at the chief market regulator or general counsel level.

The MAWG national analysis process involves multiple jurisdictions conducting detailed analysis on companies that are shown as outliers. The approach to detailed analysis may differ among jurisdictions; therefore, participation encourages the sharing of ways to analyze data. The national analysis process is an evolving one that uses NAIC staff to provide information to the states. The states that participate in national analysis ultimately decide what to do with companies subject to their national analysis. Their results and recommendations are presented to the Market Actions (D) Working Group.

Additionally, it is important to know that the Market Action (D) Working Group's annual national analysis process uses the Market Conduct Annual Statement (MCAS) and other existing data to identify companies of national (or multi-jurisdictional) interest that exhibit potential market conduct issues. The goal is to find and address issues common across jurisdictions, while reducing the strain on single jurisdictional resources.

Overall, jurisdictions should work together to test the results of the market analysis process against their findings to refine the process. By doing this, the jurisdictions can develop a more efficient market analysis process that will provide more useful information about companies' market activities. By working together in this manner, jurisdictions will achieve the goal referenced above.

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Checklist

Participation in the Market Actions (D) Working Group

YES

NO

6a. Does the department have procedures for staff to follow when reporting potential collaborative actions to the department’s CAD?

6b. If the department identified a potential collaborative action, did the department notify all CADs—via meeting, bulletin board or other communication—of the activities identified that may have the potential for collaboration?

6c. If the department received a positive response to its inquiries to other CADs regarding a potential collaborative action, did the department refer the action to Market Actions (D) Working Group using the reporting procedures outlined in the Market Actions (D) Working Group’s Policies and Procedures, including completing the Request for Review form and submitting the form to the designated NAIC support staff?

6d. If the answer to item 6b. or item 6c. is “No,” please provide a brief explanation.

Examples of reasonable explanations:

- The issue has minimal/no consumer impact.
- The issue is not yet sufficiently defined, investigated, or analyzed.
- There are no known laws/regulations to address the issue.
- There are reasons why expediency to address the matter in the jurisdiction is of utmost concern.
- Significant differences in the jurisdiction’s insurance laws/regulations.
- The matter has been previously addressed in a satisfactory manner by the jurisdiction.
- An executive decision made at the chief market regulator/General Counsel level.

Consideration of Market Actions (D) Working Group Actions

YES

NO

6e. Does the department have written procedures for reviewing and evaluating its participation in potential collaborative actions brought to its attention, either through the Market Actions (D) Working Group or by another department?

6f. For any collaborative action for which the department declined participation, has the department provided a response to the Market Actions (D) Working Group?

6g. If the answer to item 6e. or item 6f. is “No,” please provide a brief explanation.

6h. Does the MAC, Market Actions (D) Working Group member, CAD and/or CAD alternate actively monitor the bulletin board discussions?

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- | | | |
|--|-------|-------|
| 6i. Does the department participate in the review of national analysis data on an annual basis? | _____ | _____ |
| 6j. If the answer to item 6i is “Yes”, who in the department, by functional title, participates in the annual national analysis project? | _____ | _____ |

Complete the following if this is an Interim Annual Review:	YES	NO
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Have there been any significant changes to the procedures since last year’s review? If “Yes,” please provide an explanation.	_____	_____
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COMMENTS:

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Requirement 7 – Market Conduct Annual Statement

The department participates in the centralized collection of the Market Conduct Annual Statement (MCAS) and utilizes the data in its market analysis process.

Objective

The objective of this requirement is to encourage utilization of the centralized collection of the MCAS to enhance each jurisdiction’s market analysis process. By using the data collected in the MCAS process, departments are able to reduce expenses and resources that would have to be used if data was requested and companies had to submit data to multiple jurisdictions.

Measurement

In order to successfully meet this requirement, jurisdictions should be able to verify that they utilize the data obtained from MCAS for market analysis. This verification can be accomplished by producing evidence of completed baseline analysis and Level 1 analysis which pull data from MCAS. Documentation of completed analysis will ensure usage of the MCAS data.

Guidelines

The department has written procedures that show that the use of MCAS data is a part of their market analysis process and assists in making decisions as to the next step in their regulation process.

In the event the department participates but does not require each line of insurance that is part of the MCAS program, a one-year “grace period” is allowed for newly adopted lines of insurance as being acceptable for a “pass.” Additionally, intention to perform analysis for newly adopted lines that have not yet been reported is acceptable for a “Yes” response to item 7c. If the department participates in MCAS but does not participate in all lines after the one-year grace period has elapsed, consider that the jurisdiction has passed with a strong recommendation to add the additional line(s).

In the event a department conducts its own individualized MCAS program, consider that scenario as marginally passing with a strong recommendation to participate in the standardized NAIC program.

Checklist

	YES	NO
7a. Does the department require eligible companies to file the MCAS with the NAIC?	_____	_____
7b. Does the department require that the MCAS be prepared in accordance with the NAIC MCAS user guides and instructions?	_____	_____
7c. Does the department utilize the data obtained from the MCAS for market analysis? (Examples of utilization include, but are not limited to, such activities as performing baseline or Level 1 analysis.)	_____	_____

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Complete the following if this is an Interim Annual Review:

Have there been any significant changes to the requirements since last year's review? If "Yes," please provide an explanation.

YES

NO

COMMENTS:

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Requirement 8 – Electronic Data Entry with the NAIC

The department enters data no less frequently than on a quarterly basis (but preferably monthly) to all NAIC systems, including, but not limited to, the Complaint Database System (CDS) and the Regulatory Information Retrieval System (RIRS). Except for immediate concerns as defined in the *Market Regulation Handbook*, the department enters data into the Market Actions Tracking System (MATS) concerning upcoming examinations. Additionally, the department enters continuum actions into MATS when initiating the action.

Objective

The objective of this requirement is to ensure that regulators in other jurisdictions are completely and timely informed of market conduct actions that have occurred, are ongoing, or that are anticipated.

Measurement

To evaluate whether the jurisdiction “passes” Requirement 8, the jurisdiction must answer “Yes” to checklist item 8a., item 8b and 8d., unless there is an applicable explanation, briefly explained, in applicable checklist item 8e. With respect to checklist item 8c., further clarification of what continuum items must be entered will be forthcoming; however, any item resulting in a formal order must be entered into RIRS. Source documents should be reviewed in order to ensure timeliness. Only entries after the certification program is adopted should be measured.

Guidelines

The Market Information Systems Research and Development (D) Working Group report on reporting timeliness, accuracy and completeness will be attached.

- Timeliness, accuracy and completion standards may be implemented upon consideration by the Market Regulation Certification (D) Working Group.
- Only entries after the certification program is adopted should be measured. De minimis variations (i.e., less than five business days) should be given a “pass.”

Any back-end system that auto-populates the referenced NAIC systems will meet this requirement. If a jurisdiction is using a back-end system which does not currently auto-populate the referenced NAIC systems, that jurisdiction must ensure that the information is entered in the NAIC systems. This may require dual entry until such time as the back-end system auto-populates the NAIC systems.

Significant Market Actions:

The *Market Regulation Handbook* provides guidance on continuum actions for example, “The continuum of market actions includes such initiatives as office-based information gathering, interview with the company, correspondence, policy and procedure reviews, interrogatories, desk audits, on-site audits, investigations, enforcement actions, company self-audits and voluntary compliance programs.” Such significant actions should be reported in MATS as determined by the department.

- If checklist item 8d. is answered “Yes,” ensure each examination is called 60 days prior to the start of the examination unless there is reason (noted in item 8e.) of “immediate concern” as set forth in the *Market Regulation Handbook*). Examples of immediate concerns include, but are not limited to:
 - Fraud allegations.
 - Imminent consumer harm.
 - Blatant disregard of a department order.
 - Imminent solvency concern.

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Checklist

	YES	NO
8a. Does the department enter or transmit data at least quarterly into the CDS?	_____	_____
8b. Does the department enter or transmit data at least quarterly into RIRS?	_____	_____
8c. Does the department enter non-examination continuum actions into MATS when initiated and the resulting applicable final status reports or updates (if applicable) at least quarterly?	_____	_____
8d. Did the department enter at least 75% of examinations into MATS at least 60 days before the start of the examination as set forth in the <i>Market Regulation Handbook</i> ? (Note: The start of the examination is the date the department began work on the examination materials received from the examined entity.)	_____	_____
8e. If the answer to item 8a., item 8b., item 8c., or item 8d. is “No,” please provide an explanation.		

Complete the following if this is an Interim Annual Review:

	YES	NO
Have there been any significant changes to the requirements since last year’s review? If “Yes,” please provide an explanation.		

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Requirement 9 – Participation in NAIC Market Conduct and Market Analysis

Working Groups

The department participates in or monitors NAIC market conduct and market analysis-related working groups as a member or interested regulator.

Objective

The objective of this requirement is to ensure jurisdictions are aware of market conduct and market analysis initiatives, and stay abreast of developments and improvements with respect to market analysis and examination tools, techniques and standards so that they can be applied in jurisdictions’ ongoing market regulation efforts.

Measurement

To evaluate whether the jurisdiction “passes” Requirement 9, the jurisdiction must, at a minimum, be able to answer “Yes” to checklist item 9a. and item 9c., as well as document who in the department or jurisdiction participates in or monitors the Market Analysis Procedures (D) Working Group and the Market Conduct Examination Guidelines (D) Working Group.

Guidelines

NAIC market conduct and market analysis-related working groups provide a national forum for jurisdictions to share and coordinate efforts.

When evaluating checklist items for Requirement 9, it is important to remember participation in the working group and task force meetings is tracked through the NAIC. In the absence of the ability to participate in every applicable meeting or conference call, it is anticipated that a passing jurisdiction will monitor the applicable working group activities through a review of available materials, minutes, and regulator materials.

At each jurisdiction’s discretion, consideration may be given to monitoring the Market Information Systems (D) Task Force and applicable working groups, task forces reporting to the Market Regulation and Consumer Affairs (D) Committee and other working groups, task forces and Committee relevant to consumer issues and market regulation.

Checklist

	YES	NO
9a. Does the department participate in or monitor the Market Analysis Procedures (D) Working Group as a working group member or interested regulator either by conference calls or by attending meetings?	_____	_____
9b. If the answer to item 9a. is “Yes”, who in the department, by functional title, participates in or monitors the Market Analysis Procedures (D) Working Group?		
9c. Does the department participate in or monitor the Market Conduct Examination Guidelines (D) Working Group as a working group member or interested regulator either by conference calls or by attending meetings?	_____	_____
9d. If the answer to item 9c. is “Yes”, who in the department, by functional title, participates in or monitors the Market Conduct Examination Guidelines (D) Working Group?		

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- 9e. List any other market conduct or market analysis-related working groups and/or task forces that the department participates in or monitors.

Complete the following if this is an Interim Annual Review:

Have there been any significant changes to the procedures since last year's review? If "Yes," please provide an explanation.

YES

NO

COMMENTS:

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Requirement 10 – Collaborative Action Designee

The department appoints a collaborative action designee (CAD). The department’s Market Actions (D) Working Group member, CAD and/or CAD alternate attends at least 50% of the discussions, either telephonically or in person, of the Market Actions (D) Working Group meetings they are eligible to attend every year.

Objective

The objective of this requirement is to promote collaboration with other CADs.

Measurement

To evaluate whether a jurisdiction “passes” Requirement 10, the jurisdiction must answer “Yes” to checklist item 10a., and item 10c. If the answer to item 10b is “No,” the jurisdiction is strongly encouraged to appoint a CAD alternative when possible.

Guidelines

When evaluating checklist items for Requirement 10, it is important to remember that the CAD is the one contact identified by the chief market regulator of each jurisdiction to have full responsibility for all communications related to collaborative efforts, including, but not limited to, multi-jurisdictional issues. This includes participating in, or assigning a designee to participate in, certain meetings or conference calls of the Market Actions (D) Working Group. While the market analysis chief (MAC) oversees the internal jurisdictional process of identifying entities with potential market regulatory issues, the CAD oversees the process of communicating about those entities and collaborating with other CADs, potentially through the Market Actions (D) Working Group.

The CAD is the person identified with authority to receive information regarding collaborative actions from the Market Actions (D) Working Group. Additionally, the department’s Market Actions (D) Working Group member, CAD or CAD alternate must attend at least 50% of the discussions, either telephonically or in person, of the Market Actions (D) Working Group meetings they are eligible to attend every year.

Checklist

	YES	NO
10a. Has the department appointed a CAD?	_____	_____
10b. Has the department appointed a CAD alternate?	_____	_____
10c. Does the CAD and/or CAD alternate attend at least 50% of all meetings and conference calls of the Market Actions (D) Working Group they are eligible to attend?	_____	_____

Complete the following if this is an Interim Annual Review:

Have there been any significant changes to the procedures since last year’s review? If “Yes,” please provide an explanation. _____

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Requirement 11 – Interdivisional Collaboration

The Department of Insurance has established and follows a systematic procedure for interdivisional communication (as referenced in the *Market Regulation Handbook*).

Objective

The objective is to establish and maintain a systematic procedure for interdivisional communication, as well as specific guidance regarding which requirements govern or define interdivisional collaboration. This includes identifying warning signs that all staff should share with the market analysis chief (MAC). In particular, all insurance department staff should report to the MAC when information of concern that may result in consumer harm is received in the department.

Measurement

To evaluate whether the jurisdiction “passes” Requirement 11, the jurisdiction must answer “Yes” to checklist item 11a., item 11b., and item 11c.

Guidelines

Insurance department staff should effectively communicate and coordinate with various areas within the department or other jurisdiction agencies/legislature, as appropriate. Such communication should consist of information shared by other areas of the department as well as key findings resulting from research conducted by the staff. Evidence of this communication should be clearly documented. The communication process should include a formal method that allows for pertinent information from other areas (e.g. legal, rates and forms, actuarial, etc.) within the department that could impact market conduct to be shared with the staff. Examples may include regularly scheduled department head meetings, department managers’ meetings, information requests to other areas of the department, etc.

As a means of improving the sharing of information among the jurisdictions, at the conclusion of an investigation that resulted from interdivisional communication, all jurisdictions are encouraged to contact the jurisdiction’s market analysis chief (MAC) in an affected jurisdiction and inform them of the results of the investigation.

When evaluating checklist items for Requirement 11, it is important to remember that market conduct problems do not occur in a vacuum. Complaint activity, legal issues, financial concerns or irregularities in rate and form filings often accompany them. At the same time, market conduct problems may be an early warning sign of other problems with a company, so it is essential for information to be shared and discussed between the MAC and other department staff. This should be done on a systematic basis, including, at a minimum, a quarterly meeting or questionnaire requesting other work areas within the department to report unusual activity that may be of interest to the MAC, such as patterns of adverse financial data, consumer complaints, policy termination activity, producer misconduct or use of noncompliant forms or rates.

Checklist

	YES	NO
11a. Has the department established procedures for the market analysis chief (MAC), or appropriate designee, to communicate interdepartmentally with the appropriate staff, either through written channels or by sufficient demonstration of action (such as regularly scheduled department head meetings, department managers’ meetings, or information requests to other areas of the department)?	_____	_____

Draft: 5/9/23

Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee on Aug. 15, 2023
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group on June 6, 2023

11b. Does the MAC, or appropriate designee provide the appropriate interdepartmental staff with market concerns such as, but not limited to, financial data, consumer complaints, policy termination activity, producer misconduct or use of noncompliant forms or rates, related to the following functional areas:

- i. Consumer Services
- ii. Enforcement
- iii. Legal
- iv. Forms and Filing
- v. Financial
- vi. Market Analysis
- vii. Market Conduct

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

11c. On a quarterly basis, does the MAC, or appropriate designee, solicit information from the above functional areas regarding adverse patterns on, but not limited to, financial data, consumer complaints, policy termination activity, producer misconduct, or use of noncompliant forms or rates?

_____	_____
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Complete the following if this is an Interim Annual Review:

Have there been any significant changes to the procedures since last year's review?
If "Yes," please provide an explanation.

_____	_____
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COMMENTS:

Adopted by the Market Regulation and Consumer Affairs (D) Committee on Aug. 15, 2023
Adopted by the Market Regulation Certification (D) Working Group on June 6, 2023

MARKET REGULATION CERTIFICATION SCORING DEFINITIONS
to be used as a guide to determining self- and full-certification

1st assessment	all mandatory must be met
1st 5-year re-assessment	50% of remaining available points
2nd 5-year re-assessment	90% of remaining available points

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
Requirement 1				
1a	Does the department have the general authority to collect and analyze information whenever it is deemed necessary?			
1b	Does the department have the authority to collaborate and coordinate with other regulatory agencies?			
1c	Is the department's authority broad enough to cover market analysis, comprehensive and targeted market conduct examinations and the continuum of market regulation actions, including enforcement?			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
Requirement 2				
2a	Does the department have authority by statute, rule or other authority to utilize the <i>Market Regulation Handbook</i> ?	No		
2b	When conducting examinations or continuum activities, does the department incorporate applicable <i>Market Regulation Handbook</i> review standards and related materials to the extent they are consistent with state laws?	No		
2c	Does the department have examination-specific policies and procedures in addition to those guidelines set forth in the <i>Market Regulation Handbook</i> ?	No		
2d	If the answer to item 2c. Is "Yes", is the jurisdiction able to demonstrate that it has followed its own established policies and procedures in adopting any process that deviates from the <i>Market Regulation Handbook</i> ?			Yes

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
Requirement 3				
3a	Does the department have analysts on staff or under contract whose responsibility is to conduct market analysis of insurers doing business in the jurisdiction?			
3b	If the department utilizes contract analysts, please describe in a separate attachment the manner and extent of utilization in the department's recent activities.			
3c(1)	Indicate below the number of FTE contract and staff analysts for each of the last three years.			
3c(2)	Indicate below the number of market analysis reviews for which market analysis was performed in the prior review period. Market analysis means formal review of a company through existing processes (e.g., Level 1, Level 2).			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
3d	Does the department have examiners on staff whose responsibility is to examine and/or conduct continuum actions of insurance companies as indicated by the department's market analysis or as prescribed by jurisdiction laws?	Read 3d and 3e together. Satisfaction of one satisfies both.		
3e	Does the department utilize contract examiners to examine and/or conduct continuum actions of insurance companies as indicated by the department's market analysis or as prescribed by jurisdiction laws?	Read 3d and 3e together. Satisfaction of one satisfies both.		
3f	If the department utilizes contract examiners, please describe in a separate attachment the manner and extent of utilization in the department's recent activities			
3g	Indicate below the number of FTE market examiners, including supervisory personnel on the department's staff and/or the number of individual contract examiners used compared to the last three years.			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
3h	Has the department performed any targeted exams or market continuum actions in the prior two years?			
3i	If the answer to item 3h. is "Yes," please provide a list of such exams or market continuum actions and the scope of the exams/actions.			
3j	If the answer to item 3h. is "No," does the department have the on-staff resources or the ability to contract additional resources to perform targeted exams/actions, if deemed necessary?			
3k	Does the department have the authority to hire contractors as specialists to perform market regulation?	If 3e is "yes"		
3l	If the department has authority to hire contractors, does it have either a statewide or departmental established process it follows for selecting contractors for market regulation purposes? Briefly explain	If 3e is "yes"		
3m	Does the department oversee and manage contractors? Briefly explain.	If 3e is "yes"		

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
3n	Does the department have policies and procedures, subject to periodic review and updates, for identifying and addressing market conduct issues using market analysis and market conduct continuum activities, including examinations?			
3o	If the answer to item 3n. is "Yes," what quantitative and subjective measurements are available to evaluate whether the department is adhering to its policies and procedures?			
3p	Based on the review of staff resources, please provide an explanation of any significant changes in resources and/or workload over the three-year period covered in the data above.			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
Requirement 4				
4a	Does the department have policy and procedures in place on necessary credentials or minimum educational and experience requirements for selecting and hiring staff consistent with the detailed credentials listed in the Certification guidelines?		Allows for unions*. Continue to discuss	
4b	Does the department have policy and procedures in place on necessary credentials or minimum educational and experience requirements for selecting and hiring contractors consistent with the detailed credentials listed in the Certification guidelines?			
4c	Does the department have a staff development program that encourages and supports educational and training pursuits, including training, courses, webinars and certifications offered by the NAIC?			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
4d	Does each Examiner-in-Charge possess or is the Examiner-in-Charge making progress towards completion of noted designations?			
4e	Does the department recognize licenses and other highly technical credentials of professionals and experts such as attorneys, actuaries, cybersecurity experts, certified public accountants, information technology (IT) experts and other professionals and specialists as qualified to perform certain market regulation activities?			
4f	Does the department maintain written procedure manuals to demonstrate a succession plan?			
4g	As a separate attachment, provide a list of market analysts/examiners that includes the following: name; professional designation(s); title; years employed by the department (include functional area); type of college degree; and prior regulatory or insurance experience. Also indicate those market conduct analysts/examiners that are contractual and whether each is full-time with the department.			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
Requirement 5				
5a	Does the jurisdiction have laws, regulations or case law that specify how the confidentiality of market conduct examination workpapers is to be handled?			
5b	Has the department entered into the Multi-State Information Sharing Agreement with other departments and the NAIC and does the department have written policies/procedures and communicate such policies/procedures to staff?			
5c	Does the department have written policies and procedures and communicated such policies and procedures to employees relating to the protection of confidential information which includes PII and PHI, handling of public records requests and requirements for confidentiality agreements when it becomes necessary to share confidential information with other federal and international regulatory or law enforcement agencies, not otherwise covered by the multi-state agreement?			
5d	Does the department have a records retention schedule which outlines plans for secure storage and timeline for destruction of work papers?			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
Requirement 6				
6a	Does the department have procedures for staff to follow when reporting potential collaborative actions to the department's CAD?			
6b	If the department identified a potential collaborative action, did the department notify all CADs—via meeting, bulletin board or other communication—of the activities identified that may have the potential for collaboration?			
6c	If the department received a positive response to its inquiries to other CADs regarding a potential collaborative action, did the department refer the action to Market Actions (D) Working Group using the reporting procedures outlined in the Market Actions (D) Working Group's Policies and Procedures, including completing the Request for Review form and submitting the form to the designated NAIC support staff?			
6d	If the answer to item 6b., or item 6c. is "No," please provide a brief explanation.			
6e	Does the department have written procedures for reviewing and evaluating its participation in potential collaborative actions brought to its attention, either through the Market Actions (D) Working Group or by another department?			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
6f	For any collaborative action for which the department declined participation, has the department provided a response to the Market Actions (D) Working Group?			
6g	If the answer to item 6e. or item 6f. is "No," please provide a brief explanation.			
6h	Does the MAC, Market Actions (D) Working Group member, CAD and/or CAD alternate actively monitor the bulletin board discussions?			
6i	Does the department participate in the review of national analysis data on an annual basis?			
6j	If the answer to item 6i is "Yes", who in the department, by functional title, participates in the annual national analysis project?			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
Requirement 7				
7a	Does the department require eligible companies to file the MCAS with the NAIC?			
7b	Does the department require that the MCAS be prepared in accordance with the NAIC MCAS user guides and instructions?			
7c	Does the department utilize the data obtained from the MCAS for market analysis? (Examples of utilization include, but are not limited to, such activities as performing baseline or Level 1 analysis.)			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
Requirement 8				
8a	Does the department enter or transmit data at least quarterly into the CDS?			
8b	Does the department enter or transmit data at least quarterly into RIRS?			
8c	Does the department enter non-examination continuum actions into MATS when initiated and the resulting applicable final status reports or updates (if applicable) at least quarterly?			
8d	Did the department enter at least 75% of examinations into MATS at least 60 days before the start of the examination as set forth in the <i>Market Regulation Handbook</i> ? (Note: The start of the examination is the date the department began work on the examination materials received from the examined entity.)			
8e	If the answer to item 8a., item 8b., item 8c., or item 8d. is "No," please provide an explanation.			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
Requirement 9				
9a	Does the department participate in or monitor the Market Analysis Procedures (D) Working Group as a working group member or interested regulator either by conference calls or by attending meetings?			
9b	If the answer to item 9a. is “Yes”, who in the department, by functional title, participates in or monitors the Market Analysis Procedures (D) Working Group?			
9c	Does the department participate in or monitor the Market Conduct Examination Guidelines (D) Working Group as a working group member or interested regulator either by conference calls or by attending meetings?			
9d	If the answer to item 9c. is “Yes”, who in the department, by functional title, participates in or monitors the Market Conduct Examination Guidelines (D) Working Group?			
9e	List any other market conduct or market analysis-related working groups and/or task forces that the department participates in or monitors.			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
Requirement 10				
10a	Has the department appointed a CAD?			
10b	Has the department appointed a CAD alternate?			
10c	Does the CAD and/or CAD alternate attend at least 50% of all meetings and conference calls of the Market Actions (D) Working Group they are eligible to attend?			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
Requirement 11				
11a	<p>Has the department established procedures for the market analysis chief (MAC), or appropriate designee, to communicate interdepartmentally with the appropriate staff, either through written channels or by sufficient demonstration of action (such as regularly scheduled department head meetings, department managers' meetings, or information requests to other areas of the department?)</p>			
11b	<p>Does the MAC, or appropriate designee provide the appropriate interdepartmental staff with market concerns such as, but not limited to, financial data, consumer complaints, policy termination activity, producer misconduct or use of noncompliant forms or rates, related to the following functional areas:</p> <ul style="list-style-type: none"> i. Consumer Services ii. Enforcement iii. Legal iv. Forms and Filing v. Financial vi. Market Analysis vii. Market Conduct 			
11c	<p>On a quarterly basis, does the MAC, or appropriate designee, solicit information from the above functional areas regarding adverse patterns on, but not limited to, financial data, consumer complaints, policy termination activity, producer misconduct, or use of noncompliant forms or rates?</p>			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
Certification Score Total				
Total Points Possible				
Score				
Pass/NoPass				
Points needed to pass		0		

<p>29 THIS SCORE SHOULD BE THE TOTAL OF MANDATORY ITEMS IDENTIFIED IN THE CHART ABOVE -- its not necessary to assign a score value for meeting expectations</p>	<p>17 The PRIMARY GOALS should be given a scorable point basis that is weighted by the total of primary goals inside each REQUIREMENT; this would include the requirements needed of any secondary goals == this would achieve the 100% assigned overall points to each REQUIREMENT;</p>	<p>17 Secondary goals that are "working toward" meeting the requirements of the Red Mandatory or Yellow Primary goals should be partial point values that equal up to 75% of the total score value that is assessed for the primary goals in this REQUIREMENT AREA. (All other green tagged secondary goals are designed to be supportive of requirements to meet red and yellow -- so those would not be given a partial score value at all when used to support only).</p>
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1st assessment	all mandatory must be met
1st 5-year re-assessment	50% of remaining available points
2nd 5-year re-assessment	90% of remaining available points

Draft: 12/2/22

Implementation Plan adopted Market Regulation and Consumer Affairs (D) Committee on Aug. 15, 2023
Implementation Plan adopted by the Market Regulation Certification (D) Working Group – Dec. 9, 2022

Voluntary Market Regulation Certification Program Proposal for Implementation

Current Charge of the Working Group

The Market Regulation Certification (D) Working Group will develop a formal market regulation certification proposal for consideration by the National Association of Insurance Commissioners (NAIC) membership that provides recommendations for the following:

- 1) Certification standards.
- 2) A process for the state implementation of the standards.
- 3) A process to measure the states' compliance with the standards.
- 4) A process for future revisions to the standards.

As per the charges adopted for the Market Regulation Certification (D) Working Group, the following is a draft proposal for charges 2 and 4.

Implementation Proposal

The Voluntary Market Regulation Certification Program will be overseen and administered by a working group (Market Regulation Standards and Certification (D) Working Group) established by the Market Regulation and Consumer Affairs (D) Committee. Members of the Working Group shall be appointed annually pursuant to the NAIC Bylaws.

Self-Certification Program

- Upon adoption/approval of the Voluntary Market Regulation Certification Program, the Market Regulation Certification Program Self-Assessment Guidelines and Checklist Tool and the Implementation Plan by the NAIC membership, participating jurisdictions may begin self-certification. No later than two weeks prior to the first Fall National Meeting following the adoption/approval of the program, a jurisdiction may submit a self-certification report that outlines the progress achieved towards implementation of the Voluntary Market Regulation Certification Program requirements. The self-certification will follow the formatted checklist designed and finalized by the Market Regulation Certification (D) Working Group.
- A jurisdiction's self-certification report will be submitted to NAIC staff. The Market Regulation Standards and Certification (D) Working Group will monitor and assess its progress towards compliance with the *Voluntary Market Regulation Certification Program* requirements. Each jurisdiction that submits a self-certification report will be provisionally certified. The Working Group will provide the jurisdiction with an acknowledgement and its assessment of the jurisdiction's self-certification.
- Prior to each Fall National Meeting following a jurisdiction's initial provisional certification, each provisionally certified jurisdiction will submit its self-certification report to NAIC staff. Jurisdictions that have not previously submitted a self-certification report, may do so prior to any Fall National Meeting using the process noted above to receive provisional certification.
- At any time, participating jurisdictions may request peer-review, guidance, and training. To the extent necessary to accommodate such requests, NAIC staff may work with seasoned regulators with market conduct examination and/or market analysis experience to assist in meeting the needs of such requestors.

Draft: 12/2/22

Implementation Plan adopted Market Regulation and Consumer Affairs (D) Committee on Aug. 15, 2023

Implementation Plan adopted by the Market Regulation Certification (D) Working Group on Dec. 9, 2022

- Once a mechanism is in place for implementing the Full Certification Program (see *Full Certification Program* below), jurisdictions will have the option to continue self-certifying or to apply for full certification. Jurisdictions that decide to continue self-certifying will use the same process described above.

Full Certification Program

- The Market Regulation Standards and Certification Working Group will determine whether jurisdictions that apply to be fully certified meet the certification standards. An NAIC Review Team (similarly constructed as the Financial Regulation and Accreditation Standards Accreditation Review Team) will conduct the certification reviews.
- No later than two weeks prior to the first Spring National Meeting after the Market Regulation Standards and Certification Working Group has been established (or no later than two weeks prior to any subsequent Spring National Meeting), any participating jurisdiction may apply for full certification by submitting a request for full certification along with a self-certification report to NAIC staff. The jurisdiction's request will be reviewed by the NAIC Review Team, which will provide its recommendation to the Market Regulation Standards and Certification Working Group. For jurisdictions applying for full certification, the Working Group will use applicable monitoring tools to verify the self-certification information reported by the participating jurisdictions. The NAIC Review Team may use additional forms of verification deemed necessary, such as interviews or on-site visits. Each fully certified jurisdiction will be reviewed every five years to assess the jurisdiction's ongoing compliance with the certification standards.
- The requests for full certification will be reviewed in the order in which they are received. No more than 12 reviews will be conducted in each of the first five years of the certification program. In each subsequent year, jurisdictions that request to have full certification must submit their request with its self-certification report to NAIC staff two weeks prior to the Spring National Meeting. The NAIC Review Team will conduct the five-year re-assessments and review all the requests. Recommendations for full certification and re-certifications will be provided to the Market Regulation Standards and Certification Working Group prior to the Fall National Meeting of the same calendar year. The Market Regulation Standards and Certification Working Group will make its decision regarding certification or re-certification by the end of the calendar year.
- All jurisdictions that submit a request for full certification will be provisionally certified by the Market Regulation Standards and Certification Working Group (as per the process described in the *Self-Certification Program* above) until their request for full certification is reviewed and a decision on the request is made by the Market Regulation Standards and Certification Working Group.
- Fully certified jurisdictions will submit a self-certification report during the third year to NAIC staff at least two weeks prior to the Summer National Meeting.
- A jurisdiction may withdraw its request for full certification at any time. A jurisdiction that is fully certified can exit the full certification re-assessment cycle and choose to be either provisionally certified (per the process described in the *Self-Certification Program* above) or to not participate in the Voluntary Market Regulation Certification Program.

Draft: 12/2/22

Implementation Plan adopted Market Regulation and Consumer Affairs (D) Committee on Aug. 15, 2023
Implementation Plan adopted by the Market Regulation Certification (D) Working Group on Dec. 9, 2022

- A fully certified jurisdiction may qualify for financial incentives. (Details will be determined and approved by the Executive (EX) Committee.)

Future Revisions

- The Market Regulation Standards and Certification Working Group will regularly review feedback from jurisdictions concerning any issues or recommended changes to the *Voluntary Market Regulation Certification Program* requirements and the *Market Regulation Certification Program Self-Assessment Guidelines and Checklist Tool* based on the use of the guidelines and checklist for self-certification.
- Future revisions of the market regulation certification standards will be made from time to time by the Market Regulation Standards and Certification Working Group with approval of the Market Regulation and Consumer Affairs (D) Committee and NAIC membership. New standards will be added only as necessary and added no more frequently than once per year. Revised sets of standards will constitute a new “certification tier.” An effective date will be specified for each new requirement within a tier. Self-certified and fully certified jurisdictions that comply with a previous tier of requirements will not be measured on compliance to new tier requirements until the first self-assessment audit or the five-year re-certification review (whichever occurs first) after the effective date of the new requirement.

Adopted by the Market Regulation and Consumer Affairs (D) Committee on July 27, 2023

Adopted by the Market Conduct Annual Statement Blanks (D) Working Group on May 30, 2023

**DRAFT - Property & Casualty Market Conduct Annual Statement
Pet Insurance Data Call & Definitions**

Line of Business: Pet

Reporting Period: January 1, 2024 through December 31, 2024

Filing Deadline: April 30, 2025

Contact Information

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestor	The person who attests to the completeness and accuracy of the MCAS data.

Schedule 1 – Interrogatories

ID	Description	Comment
1-01	Did the company conduct any business related to individual pet insurance policies during the period?	Yes/No
1-02	Did the company conduct any business related to group pet insurance policies during the period?	Yes/No
1-03	Did the company conduct any stand-alone pet Wellness Insurance business during the reporting period?	Yes/No
1-04	Did the company conduct any Accident & Illness, Accident only, or Illness only pet insurance business during the reporting period?	Yes/No
1-05	Did the company conduct any pet insurance business during the reporting period that does not fit into the following categories: Wellness Only, Accident & Illness, Accident only, or Illness only?	Yes/No
1-06	If yes, describe the other types of pet insurance business conducted during the reporting period	Comment
1-07	On which annual statement line(s) of business on the state page of the statutory annual statement does the company report pet insurance experience?	Comment
1-08	Was the company still actively marketing or writing pet insurance in the jurisdiction at the end of the reporting period?	Yes/No
1-09	Has the company had a significant event/business strategy change that would affect data for this reporting period?	Yes/No
1-10	If yes, explain the situation and how it may affect the data	Comment
1-11	Has all or part of the company’s pet insurance block of business been sold, closed or moved to another company during the reporting period?	Yes/No

Adopted by the Market Regulation and Consumer Affairs (D) Committee on July 27, 2023
Adopted by the Market Conduct Annual Statement Blanks (D) Working Group on May 30, 2023

**DRAFT - Property & Casualty Market Conduct Annual Statement
Pet Insurance Data Call & Definitions**

1-12	If yes, describe the nature and extent of the transaction(s)	Comment
1-13	How does the company treat subsequent supplemental or additional payments on previously closed claims?	Comment
1-14	Does the company use pet program administrators, managing general agents (MGA) or insurance producers for purposes of supporting the pet insurance business being reported, other than the sale, solicitation, or negotiation of business?	Yes/No
1-15	If yes, provide the names, NPN (if applicable) and functions for each third party identified in question 14	Comment
1-16	Does the company have a system of supervision in place to oversee and potentially audit each type of third party identified in question 14?	Yes/No
1-17	If yes, please provide frequency of audits, if any, for each type of third party identified in question 14	Comment
1-18	Does the company require third parties identified in question 14 to forward insurance-related complaints to the company so the company may report the complaints in its complaint logs?	Yes/No
1-19	Does the company or any of its pet program administrators, managing general agents (MGA) or insurance producers offer a non-insurance wellness program to the consumers of the company's pet insurance products?	Yes/No
1-20	Additional comments if desired:	Comment
1-21	Additional state specific Underwriting Activity comments (optional)	Comment
1-22	Additional state specific Claims Activity comments (optional)	Comment
1-23	Additional state specific Marketing & Sales comments (optional)	Comment
1-24	Additional state specific Lawsuit and Complaint comments (optional)	Comment

Schedule 2 – Underwriting Activity

The Underwriting Activity schedule is to be reported for both Individual and Group policies/certificates

ID	Description
2-25	Number of policies in force at the beginning of the period
2-26	Number of certificates in force at the beginning of the period (Group only)
2-27	Number of covered pets on policies/certificates in force at the beginning of the period
2-28	Number of policies in force during the period that included accident-only coverage
2-29	Number of certificates in force during the period that included accident-only coverage (Group only)
2-30	Number of policies in force during the period that included illness-only coverage
2-31	Number of certificates in force during the period that included illness-only coverage (Group

Adopted by the Market Regulation and Consumer Affairs (D) Committee on July 27, 2023

Adopted by the Market Conduct Annual Statement Blanks (D) Working Group on May 30, 2023

**DRAFT - Property & Casualty Market Conduct Annual Statement
Pet Insurance Data Call & Definitions**

	only)
2-32	Number of policies in force during the period that included accident and illness coverage
2-33	Number of certificates in force during the period that included accident and illness coverage (Group only)
2-34	Number of policies in force during the period that included wellness coverages (other than a wellness only policy)
2-35	Number of certificates in force during the period that included wellness coverages (other than a wellness only policy) (Group only)
2-36	Number of policies in force during the period that covered wellness as an insurance benefit (and did not cover accident and/or illness)
2-37	Number of certificates in force during the period that covered wellness as an insurance benefit (and did not cover accident and/or illness) (Group only)
2-38	Number of policies returned during the period under the consumer's "Right to Examine and Return the Policy"
2-39	Number of certificates returned during the period under the consumer's "Right to Examine and Return the Policy" (Group only)
2-40	Number of policies cancelled/terminated during the period at the policyholder's request
2-41	Number of certificates cancelled/terminated during the period at the certificate holders request (Group only)
2-42	Number of policies cancelled/terminated during the period by the insurer
2-43	Number of certificates cancelled/terminated during the period by the insurer (Group only)
2-44	Number of policies cancelled/terminated during the period for non-pay or non-sufficient funds
2-45	Number of certificates cancelled/terminated during the period for non-pay or non-sufficient funds (Group only)
2-46	Number of company-initiated policy non-renewals during the period
2-47	Number of company-initiated certificate non-renewals during the period (Group only)
2-48	Number of certificates expired during the period (Group only)
2-49	Number of new policies issued during the period
2-50	Number of new certificates issued during the period (Group only)
2-51	Number of covered pets on new policies/certificates issued during the period
2-52	Number of policies in force at end of the period
2-53	Number of certificates in force at the end of the period (Group only)
2-54	Number of covered pets on policies/certificates in force at the end of the period
2-55	Number of renewal policies issued during the period
2-56	Number of renewal certificates issued during the period (Group only)
2-57	Dollar amount of direct premium written during the period

Adopted by the Market Regulation and Consumer Affairs (D) Committee on July 27, 2023

Adopted by the Market Conduct Annual Statement Blanks (D) Working Group on May 30, 2023

**DRAFT - Property & Casualty Market Conduct Annual Statement
Pet Insurance Data Call & Definitions**

2-58	Dollar amount of direct premium earned during the period
2-59	Number of applications pending at beginning of the period
2-60	Number of new applications received during the period (Individual Only)
2-61	Number of new applications denied for health status or condition during the period (Individual Only)
2-62	Number of new applications denied for any other reason during the period (Individual Only)
2-63	Number of applications pending at the end of the period (Individual Only)
2-64	Number of policies issued during the period that included a preexisting condition exclusion
2-65	Number of certificates issued during the period that included a preexisting condition exclusion (Group only)

Schedule 3 – Claims Activity

The Claims Activity schedule is to be reported for Wellness (Only), Accident & Illness, and Other policy types. Report median day data elements in aggregate only.

ID	Description
3-66	Number of claims open at the beginning of the period
3-67	Number of claims opened during the period
3-68	Number of claims closed during the period
3-69	Number of claims closed during the period with full payment
3-70	Dollar amount of claims closed with full payment during the period
3-71	Median days to claim closure for claims closed with full payment (Aggregate only)
3-72	Number of claims closed during the period with partial payment
3-73	Dollar amount requested for claims closed with partial payment during the period
3-74	Dollar amount of claims closed with partial payment during the period
3-75	Median days to claim closure for claims closed with partial payment (Aggregate only)
3-76	Median days to final payment for all claims paid in full and closed with partial payment (Aggregate only)
3-77	Number of claims closed during the period, without payment
3-78	Dollar amount requested for claims closed without payment during the period
3-79	Median days to claim closure for claims closed without payment during the period (Aggregate only)
3-80	Number of claims open at the end of the period
3-81	Number of claims closed during the period with full payment 0-30 days
3-82	Number of claims closed during the period with full payment 31-60 days

Adopted by the Market Regulation and Consumer Affairs (D) Committee on July 27, 2023

Adopted by the Market Conduct Annual Statement Blanks (D) Working Group on May 30, 2023

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3-83	Number of claims closed during the period with full payment 61-90 days
3-84	Number of claims closed during the period with full payment 91-180 days
3-85	Number of claims closed during the period with full payment 181-365 days
3-86	Number of claims closed during the period with full payment beyond 365 days
3-87	Number of claims closed during the period with partial payment 0-30 days
3-88	Number of claims closed during the period with partial payment 31-60 days
3-89	Number of claims closed during the period with partial payment 61-90 days
3-90	Number of claims closed during the period with partial payment 91-180 days
3-91	Number of claims closed during the period with partial payment 181-365 days
3-92	Number of claims closed during the period with partial payment beyond 365 days
3-93	Number of claims closed during the period without payment within 0-30 days
3-94	Number of claims closed during the period without payment within 31-60 days
3-95	Number of claims closed during the period without payment within 61-90 days
3-96	Number of claims closed during the period without payment within 91-180 days
3-97	Number of claims closed during the period without payment within 181-365 days
3-98	Number of claims closed during the period without payment beyond 365 days
3-99	Number of claims closed during the period without payment – ineligibility
3-100	Number of claims closed during the period without payment – preexisting condition exclusion
3-101	Number of claims closed during the period without payment – waiting period
3-102	Number of claims closed during the period without payment – maximum benefit limit
3-103	Number of claims closed during the period without payment – claim amount less than deductible
3-104	Number of claims closed during the period without payment – inadequate documentation
3-105	Number of claims closed during the period without payment – hereditary disorder exclusion
3-106	Number of claims closed during the period without payment – congenital anomaly or disorder exclusion
3-107	Number of claims closed during the period without payment – chronic condition exclusion
3-108	Number of claims closed during the period without payment for reasons other than questions 99-107
3-109	Number of claims closed during the period with partial payment – maximum benefit limit
3-110	Number of claims closed during the period with partial payment – inadequate documentation
3-111	Number of claims closed during the period with partial payment for reasons other than questions 109-110

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3-112	Number of claimant requests/benefit requests subject to a preexisting condition exclusion
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Schedule 4 – Marketing and Sales

The Marketing and Sales schedule is to be reported for both Individual and Group policies/certificates

ID	Description
4-113	Dollar amount of commissions incurred during the period
4-114	Unearned commissions returned to the company during the period

Schedule 5 – Lawsuit and Complaint Activity

The Lawsuit and Complaint Activity schedule is to be reported for both Individual and Group policies/certificates

ID	Description
5-115	Number of complaints received directly from any person or entity other than the DOI
5-116	Number of lawsuits open at the beginning of the period
5-117	Number of lawsuits opened during the period
5-118	Number of lawsuits closed during the period
5-119	Number of lawsuits open at the end of the period
5-120	Number of lawsuits closed with consideration for the consumer

Schedule 6 – Pet Attestation

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or ommissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that

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the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

ID	Description
6-121	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
6-122	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
6-123	Overall Comments for the Period

In determining what business to report for a particular jurisdiction, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages. Specifically, the business to be reported is the direct business of the reporting company. Reinsurance ceded is not deducted and reinsurance assumed is not included.

Participation Requirements: All companies licensed and reporting any pet insurance within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

Definitions for the purposes of MCAS reporting:

Cancellations – Includes all cancellations of the policies where the cancellation effective date is during the reporting year.

- These should be reported every time a policy cancels during the reporting period. (i.e., if a policy cancels for non-pay three times in a policy period, and is reinstated each time; each cancellation should be counted.)

Exclude: Policies cancelled for 're-write' purposes where there is no lapse in coverage.

Chronic Condition – A condition that can be treated or managed, but not cured.

Claim – A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy/certificate. Each claimant/insured reporting a loss is counted separately.

Exclude:

- An event reported for "information only."
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.

Claims Closed with Payment – Claims closed with payment where the claim was closed

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during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported or between the date of the final payment and the date the request for supplemental payment was received. *See also "Date of Final Payment."*

Exclude:

- Claims where payment was made for company loss adjustment expenses if no payment was made to an insured/claimant.
- Claims that are closed because the amount claimed is below the insured's deductible.

Clarifications:

- If a claim is reopened for the sole purpose of refunding the insured's deductible, do not count it as a paid claim.
- For claims where the net payment is \$0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims.

Calculation Clarification:

- For each coverage identifier, the sum of the claims settled with payment across each closing time interval should equal the total number of claims closed with payment during the reporting period.

Handling additional payment on previously reported claim/subsequent supplemental payment for claims closed with payment during the reporting period:

- If a claim is reopened for a subsequent supplemental payment, count the reopened claim as a new claim. Calculate a separate aging on the supplemental payment from the time the request for supplemental payment was received to the date the final payment was made.

Claims Closed without Payment – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported and/or reopened. *See also "Date of Final Payment."*

Include:

- All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
- Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.
- A demand for payment for which it was determined that no relevant policy/certificate was in-force at the time of the loss if a claim file was set up and the loss was investigated.
- Claims that are closed because the amount claimed is below the insured's deductible.

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Calculation Clarification:

- For each coverage identifier, the sum of the claims closed without payment across each closing time interval should equal the total number of claims closed without payment during the reporting period.

Commissions – Compensation, as defined as Commissions and Brokerage Expenses in the statutory financial annual statement instructions, paid to a producer or appropriately licensed entity for the sale, solicitation or negotiation of pet insurance.

Complaints Received Directly from any Person or Entity Other than the Department of Insurance – Any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the jurisdiction’s insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.

Include:

- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
- Complaints received from third parties

Congenital Anomaly or Disorder – A condition that is present from birth, whether inherited or caused by the environment, which may cause or contribute to illness or disease.

Date of Final Payment – The date final payment was issued to the insured/claimant.

Calculation Clarification:

- If partial payments were made on the claim, the claim would be considered closed with payment if the final payment was made during the reporting period regardless of the date of loss or when the claim was received.
- Report a claim as “closed with payment” or “closed without payment” if it is closed in the company’s claims system during the reporting period (even if the final payment was issued in a prior reporting period.)
- If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company’s claims system, would you report the days to final payment.

Example:

- A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
 - The claim would be reported as open in the “00” MCAS submission and closed in the “01” MCAS submission.

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- The number of days to final payment would be calculated as 30 days and reported in the "01" MCAS submission.

Hereditary Disorder – An abnormality that is genetically transmitted from parent to offspring and may cause illness or disease.

Individual vs. Group Policies – Report business associated with individual policy forms as individual. Report business associated with group policy forms, such as certificates, as group. Report business issued to individuals in the Individual column even if it is marketed through a group channel.

Insurer Non-Renewals – Non-renewals initiated by the reporting entity. A non-renewal is the termination of coverage at the end of the policy contract period.

Exclude:

- Non-renewals occurring as a result of nonpayment of premium (these data are reported separately, as policyholder cancellations).

Lawsuit – An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits in the Pet MCAS blank:

- Include only lawsuits brought by an applicant for insurance or a policyholder or a claimant/beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each jurisdiction in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer – A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant or policyholder in an amount greater than offered by the reporting company before the lawsuit was brought.

Adopted by the Market Regulation and Consumer Affairs (D) Committee on July 27, 2023
Adopted by the Market Conduct Annual Statement Blanks (D) Working Group on May 30, 2023

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Managing General Agent (MGA) – An insurance producer authorized by an insurance company to manage all or part of the insurer’s business. Activities on behalf of the insurer may include marketing, underwriting, issuing policies, collecting premiums, appointing and supervising other agents, paying claims, and negotiating reinsurance. Many states regulate the activities and contracts of MGAs.

Median – A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

Consider the following simple example of the number of days it took to settle each of the following seven claims:

Claim	Nbr 1	Nbr 2	Nbr 3	Nbr 4	Nbr 5	Nbr 6	Nbr 7
Days to Settle	2	4	4	5	6	8	20

In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, & 4) and 3 values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values as demonstrated below.

Claim	Nbr 1	Nbr 2	Nbr 3	Nbr 4	Nbr 5	Nbr 6
Days to Settle	2	4	5	6	8	20

$$\text{Median Days to Final Payment} = (5 + 6)/2 = 5.5$$

The median should be consistent with the paid claim counts reported in the closing time intervals.

Example: A carrier reports the following closing times for paid claims.

Closing Time # of Claims

< 30	22
31-60	13
61-90	18
91-180	11
181-365	12
>365	15

The sum of the claims reported across each closing time interval is 91, so that the median is the

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46th claim. This claim falls into the closing time interval "61-90 days." Any reported median that falls outside of this range (i.e., less than 61 or greater than 90) will indicate a data error.

National Producer Number (NPN) – A specific number provided by National Insurance Producers Registry (NIPR) to individuals and most business entities that are listed in the NIPR's Producer Database (PDB).

Non-Insurance Wellness Program – a subscription or reimbursement-based program that is separate from an insurance policy that provides goods and services to promote the general health, safety, or wellbeing of the pet. This definition is not intended to classify a contract directly between a service provider and a pet owner that only involves the two parties as being "the business of insurance," unless other indications of insurance also exist.

Number of Policies Renewed – Number of pet insurance policies renewed during the specified period. If the policyholder number remains the same, count the policy as renewed.

Group Policy Clarifications:

- One group policy should be reported regardless of the number of products made available to the group.
- An insured group that changes products to another product offered by the same carrier should not be reported as a termination renewal, if a group changes to a new product with the same carrier this should be reported as a policy renewal (not as a policy issued).

Individual Policy Clarifications:

- An individual that changes policies to another policy offered by the same carrier should be reported as a termination.
- At renewal, if an individual changes to a new product with the same carrier this should be reported as a policy issued (not as a policy renewal).

Other Policy Type – Any policy type other than a Wellness Policy and/or an Accident/Illness Policy.

Pet Insurance means a property insurance policy that provides coverage for one or more of the following: accidents, illnesses or wellness of pets. Pet insurance does not include non-insurance wellness programs for pets.

Pet Program Administrator – An individual or entity that directly or indirectly underwrites, collects charges or premium from, or adjusts or settles claims on residents of a state, in connection with pet coverage offered or provided by an insurer, unless excepted by statute.

Policies/Certificates – Refers to the coverage documents provided to individuals or families (i.e., state residents) who are enrolled in coverage.

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Policyholder/Certificate Holder – Refers to the individual who is afforded benefits of the coverage according to the laws of the state in which they reside. Policyholder is the individual when purchased in the individual market. Certificate holder is the individual when purchased through a group, which is the policyholder.

Policyholder Cancellations – Policies cancelled at any point during the reporting period at the request of or in response to the policyholder. Exclude policies terminated for nonpayment of premium.

Preexisting Condition – Any condition for which any of the following are true prior to the effective date of a pet insurance policy or during any waiting period:

- A veterinarian provided medical advice;
- The pet received previous treatment; or
- Based on information from verifiable sources, the pet had signs or symptoms directly related to the condition for which a claim is being made.

A condition for which coverage is afforded on a policy cannot be considered a preexisting condition on any renewal of the policy.

Renewal – To issue and deliver at the end of an insurance policy period a policy which supersedes a policy previously issued and delivered by the same pet insurer or affiliated pet insurer and which provides types and limits of coverage substantially similar to those contained in the policy being superseded.

Right to Examine and Return the Policy (Free Look) – Report the number of policies/certificates that were returned by the owner under the free look provision during the period, regardless of the original issuance date. Count any policy returned under the Free Look provision even if an alternative policy was ultimately purchased by the insured.

Veterinarian – An individual who holds a valid license to practice veterinary medicine from the appropriate licensing entity in the jurisdiction in which he or she practices.

Waiting Period – The period of time specified in a pet insurance policy that is required to transpire before some or all of the coverage in the policy can begin. Waiting periods may not be applied to renewals of existing coverage.

Adopted by the Executive (EX) Committee on Aug. 11, 2022
Adopted by the Financial Condition (E) Committee on July 21, 2022
Adopted by the Receivership and Insolvency (E) Task Force on June 2, 2022

REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

1. Name of group to be responsible for drafting the model:

Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force to complete the drafting. Referred by the Restructuring Mechanisms (E) Working Group.

2. NAIC staff support contact information:

Jane Koenigsman
jkoenigsman@naic.org
816-783-8145

Dan Daveline
ddaveline@naic.org
816-783-8134

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

- ***Property and Casualty Insurance Guaranty Association Model Act (#540)***

In 2019, the Financial Condition (E) Committee formed the Restructuring Mechanisms (E) Working Group who was charged with the following:

1. Evaluate and prepare a white paper that:
 - a. Addresses the perceived need for restructuring statutes and the issues those statutes are designed to remedy. Also, consider alternatives that insurers are currently employing to achieve similar results.
 - b. Summarizes the existing state restructuring statutes.
 - c. Addresses the legal issues posed by an order of a court (or approval by an insurance department) in one state affecting the policyholders of other states.
 - d. Considers the impact that a restructuring might have on guaranty associations and policyholders that had guaranty fund protection prior to the restructuring.
 - e. Identifies and addresses the legal issues associated with restructuring using a protected cell.

Background for Proposed Change

This proposed change is being precipitated by discussions within the NAICs Restructuring Mechanisms (E) Working Group initiative, which is focused on documenting in the form of a White Paper, the various issues related to insurance business transfers (IBT) and corporate division (CD) transactions. The number of states adopting laws that permit either of these transactions is still relatively low; however, one of the most significant issues that has been discussed during the meetings of the Working Group is the need for policyholders subject to such transactions to retain guaranty fund coverage. Representatives of the National Conference of Insurance Guaranty Funds (NCIGF) have suggested that an amendment to a state's guaranty fund act, or other related law, is necessary to address this issue. They have specifically suggested that the NAIC update the Property and Casualty Insurance Guaranty Association Model Act, and they have developed specific language to address this issue. An amendment will better enable those states that have incorporated #540 into their laws to update their laws for this important issue, to ensure policyholders in all states retain their coverage. Because guaranty association coverage follows the state of licensure rather than the state of domicile, adequately addressing these concerns is necessary regardless of the type of transfer and regardless of how few states adopt changes to their laws to allow IBT and CD transactions.

Scope of the Proposed Revisions to Model 540

The scope of the request is limited to addressing the issue of continuity of guaranty fund coverage when a policy is transferred from one insurer to another. The request is therefore to the specific proposal to revise the definition of "Covered Claim" within #540, or other language determined to be appropriate to address the need for continuity of protection. The following is the additional language (underlined language) that has been proposed to be added to Section 5, Definitions, within #540.

H. "Covered claim" means the following:

- (a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or
- (b) The claim is a first party claim for damage to property with a permanent location in this State.
- (c) Notwithstanding any other provision in this Act, an insurance policy issued by a member insurer and later allocated, transferred, assumed by or otherwise made the sole responsibility of another insurer, pursuant to a state statute providing for the division of an insurance company or the statutory assumption or transfer of designated policies and under which there is no remaining obligation to the transferring entity (commonly known as "Division" or "Insurance Business Transfer" statutes), shall be considered to have been issued by a member insurer which is an Insolvent Insurer for the purposes of this Act in the event that the insurer to which the policy has been allocated, transferred, assumed or otherwise made the sole responsibility of is placed in liquidation.
- (d) An insurance policy that was issued by a non-member insurer and later allocated, transferred, assumed by or otherwise made the sole responsibility of a member insurer under a state statute described in subsection (a) shall not be considered to have been issued by a member insurer for the purposes of this Act.

4. Does the model law meet the Model Law Criteria? Yes or No (Check one)

(If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

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

If yes, please explain why:

This proposed change is needed to ensure policyholders in all states retain their guaranty fund coverage, which is necessary regardless of how few states adopted changes to their laws to allow IBT and CD transactions.

It should be noted that with respect to guaranty fund coverage for life and health insurance, the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) is suggesting a different approach to address the same issue in the life and health context. NOLHGA's proposal centers around the need for such transaction to require the assuming or resulting insurer to be licensed in all states where the issuing insurer was licensed or ever was licensed to retain the needed coverage for policyholders.

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

Yes or No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary: See previous discussion.

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

At this juncture, the changes in concepts being considered are simple and because they have the potential to reduce expenses incurred by receivership estates, we believe such changes will be widely supported by all parties.

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

Not referenced in Accreditation Standards.

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

No.

Adopted by the Financial Condition (E) Committee on Dec. 15, 2022
Adopted by the Receivership and Insolvency (E) Task Force on Dec. 14, 2022

REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

1. Name of group to be responsible for drafting the model:

Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force to complete the drafting.

Note that Model #540 is currently being amended to address restructuring mechanisms, per the request for model law development adopted by NAIC Executive (EX) Committee on August 11, 2022. The Task Force hopes to consider the adoption of further amendments for this request within a similar timeframe.

2. NAIC staff support contact information:

Jane Koenigsman
jkoenigsman@naic.org
816-783-8145

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

- ***Property and Casualty Insurance Guaranty Association Model Act (#540)***

As presented by the National Conference of Insurance Guaranty Funds (NCIGF), cyber security insurance coverage is trending into the admitted market. Consequently, NCIGF anticipates the insurance insolvency resolution system will be presented with claims and other issues related to this coverage. These policy obligations may flow both from standalone cyber policies, endorsements, or from coverages that may be found to exist in commercial general liability and other lines of business typically written for business entities. For this reason, policymakers need to determine how such coverages will be handled should an insurer writing this business become insolvent. While each jurisdiction will need to decide whether, and within what parameters, cyber claims will be covered, we offer for consideration and guidance recommended amendments to the NAIC Property and Casualty Insurance Guaranty Association Act (NAIC Model 540). Policy makers should also consider how such claims will be handled before guaranty funds and associations (hereinafter "guaranty funds") are triggered – for example in a rehabilitation proceeding. Likewise, current insolvency processes and transition to the guaranty funds will need to be changed and enhanced to deal with this unique line of business and especially its demanding claims administration standards.

4. Does the model law meet the Model Law Criteria? Yes or No (Check one)

(If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

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

If yes, please explain why:

This proposed change is needed to ensure cyber insurance policyholders in all states are provided with guaranty fund coverage for this trending line of business.

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

Yes or No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

NCIGF has provided a proposal of suggested amendments for consideration. Proposed amendments include a definition of cyber insurance, coverage limitations and updates to other references.

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary: See previous discussion.

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

At this juncture, the amendments being considered are simple and because they have the potential to address future policyholder protection for this line of business, we believe such changes will be widely supported by all parties.

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

No reference in Accreditation Standards.

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

No.

Draft: Oct 25, 2023

*Adopted by the Financial Condition (E) Committee on Oct. 25, 2023
Adopted by the Receivership and Insolvency (E) Task Force on Oct. 2, 2023
Adopted by the Receivership Law (E) Working Group on July 24, 2023*

PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

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Section 10.	Duties and Powers of the Commissioner
Section 11.	Coordination Among Guaranty Associations
Section 12.	Effect of Paid Claims
Section 13.	[Optional] Net Worth Exclusion
Section 14.	Exhaustion of Other Coverage
Section 15.	Prevention of Insolvencies
Section 16.	Tax Exemption
Section 17.	Recoupment of Assessments
Section 18.	Immunity
Section 19.	Stay of Proceedings

Section 1. Title

This Act shall be known as the [State] Insurance Guaranty Association Act.

Section 2. Purpose

The purpose of this Act is to provide a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment and to the extent provided in this Act minimize financial loss to claimants or policyholders because of the insolvency of an insurer, and to provide an association to assess the cost of such protection among insurers.

Section 3. Scope

This Act shall apply to all kinds of direct insurance, but shall not be applicable to the following:

- A. Life, annuity, health or disability insurance;
- B. Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;
- C. Fidelity or surety bonds, or any other bonding obligations;

- D. Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;
- E. Other than coverages that may be set forth in a cybersecurity insurance policy, insurance of warranties or service contracts including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;
- F. Title insurance;
- G. Ocean marine insurance;
- H. Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or
- I. Any insurance provided by or guaranteed by government.

Drafting Note: This Act focuses on property and liability kinds of insurance and therefore exempts those kinds of insurance deemed to present problems quite distinct from those of property and liability insurance. The Act further precludes from its scope certain types of insurance that provide protection for investment and financial risks. Financial guaranty is one of these. The NAIC Life and Health Insurance Guaranty Association Model Act provides for coverage of some, of the lines excluded by this provision.

For purposes of this section, "Financial guaranty insurance" includes any insurance under which loss is payable upon proof of occurrence of any of the following events to the damage of an insured claimant or obligee:

1. Failure of any obligor or obligors on any debt instrument or other monetary obligation, including common or preferred stock, to pay when due the principal, interest, dividend or purchase price of such instrument or obligation, whether failure is the result of a financial default or insolvency and whether or not the obligation is incurred directly or as guarantor by, or on behalf of, another obligor which has also defaulted;
2. Changes in the level of interest rates whether short term or long term, or in the difference between interest rates existing in various markets;
3. Changes in the rate of exchange of currency, or from the inconvertibility of one currency into another for any reason;
4. Changes in the value of specific assets or commodities, or price levels in general.

For purposes of this section, "credit insurance" means insurance on accounts receivable.

The terms "disability insurance" and "accident and health insurance," and "health insurance" are intended to be synonymous. Each State will wish to examine its own statutes to determine which is the appropriate phrase.

A State where the insurance code does not adequately define ocean marine insurance may wish to add the following to Section 5, Definitions: "Ocean marine insurance" means any form of insurance, regardless of the name, label or marketing designation of the insurance policy, which insures against maritime perils or risks and other related perils or risks, which are usually insured against by traditional marine insurance, such as hull and

machinery, marine builders risk, and marine protection and indemnity. Perils and risk insured against include without limitation loss, damage, expense or legal liability of the insured for loss, damage or expense arising out of or incident to ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways for commercial purposes, including liability of the insured for personal injury, illness or death or for loss or damage to the property of the insured or another person.

Section 4. Construction

This Act shall be construed to effect the purpose under Section 2 which will constitute an aid and guide to interpretation.

Section 5. Definitions

As used in this Act:

[Optional:

- A. *“Account” means any one of the three accounts created by Section 6.]*

Drafting Note: This definition should be used by those States wishing to create separate accounts for assessment purposes. For a note on the use of separate accounts for assessments see the Drafting Note after Section 6. If this definition is used, all subsequent subsections should be renumbered.

- A. “Affiliate” means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer.
- B. “Association” means the [State] Insurance Guaranty Association created under Section 6.
- C. “Association similar to the association” means any guaranty association, security fund or other insolvency mechanism that affords protection similar to that of the association. The term shall also include any property and casualty insolvency mechanism that obtains assessments or other contributions from insurers on a pre-insolvency basis.
- D. “Claimant” means any person instituting a covered claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.
- E. “Commissioner” means the Commissioner of Insurance of this State.

Drafting Note: Use the appropriate title for the chief insurance regulatory official wherever the term “commissioner” appears.

- F. “Control” means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the

voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

G. “Covered claim” means the following:

- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the policy was issued by an insurer that becomes an insolvent insurer after the effective date of this Act and:
 - (a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or
 - (b) The claim is a first party claim for damage to property with a permanent location in this State.
- (2) Covered claim includes claim obligations that arose through the issuance of an insurance policy by a member insurer, which are later allocated, transferred, merged into, novated, assumed by, or otherwise made the sole responsibility of a member or non-member insurer if:
 - (a) The original member insurer has no remaining obligations on the policy after the transfer;
 - (b) A final order of liquidation with a finding of insolvency has been entered against the insurer that assumed the member’s coverage obligations by a court of competent jurisdiction in the insurer’s State of domicile;
 - (c) The claim would have been a covered claim, as defined in Section 5G(1), if the claim had remained the responsibility of the original member insurer and the order of liquidation had been entered against the original member insurer, with the same claim submission date and liquidation date; and
 - (d) In cases where the member’s coverage obligations were assumed by a non-member insurer, the transaction received prior regulatory or judicial approval.

[Optional:

- (3) *Covered claim includes claim obligations that were originally covered by a non-member insurer, including but not limited to a self-insurer, non-admitted insurer or risk retention group, but subsequently became the sole direct obligation of a member insurer before the entry of a final order of liquidation with a finding of insolvency against the member insurer by a court of competent jurisdiction in its State of domicile, if the claim obligations were assumed by the member insurer in a transaction of one of the following types:*
 - (a) *A merger in which the surviving company was a member insurer immediately after the merger;*

- (b) *An assumption reinsurance transaction that received any required approvals from the appropriate regulatory authorities; or*
- (c) *A transaction entered into pursuant to a plan approved by the member insurer's domiciliary regulator.]*

Drafting Note: Optional Section 5G(3) provides coverage for certain claims that are not within the scope of Sections 5G(1) or (2) because the original coverage was not provided by a member insurer. Sections 5G(3)(a) and (3)(b) are based on Alternative 1 of the former definition of “assumed claims transaction” (below), and Section 5G(3)(c) is based on the additional scenario included in Alternative 2 of the former definition of assumed claims transaction (below). The reference to “assumption consideration” in that clause of the former definition is now addressed by Optional Section 8A(4).

[Assumed Claims Transaction Definition Alternative 1] “Assumed claims transaction” means the following:

- (1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies; or
- (2) An assumption reinsurance transaction in which all of the following has occurred:
 - (a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies; and
 - (b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and
 - (c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies

[Assumed Claims Transaction Definition Alternative 2] “Assumed claims transaction” means the following:

- (1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies, and for which Assumption Consideration has been paid to the applicable guaranty associations, if the merged entity is a non-member insurer; or
- (2) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:
 - (a) Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and
 - (b) For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer.
 - (c) For purposes of this section the term non-member insurer also includes a self-insurer, non-admitted insurer and risk retention group; or
- (3) An assumption reinsurance transaction in which all of the following has occurred:

- (a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies;
 - (b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and
 - (c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.
- (3) Except as provided elsewhere in this section, “covered claim” shall not include:
- (a) Any amount awarded as punitive or exemplary damages;
 - (b) Any amount sought as a return of premium under any retrospective rating plan;
 - (c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;
 - (d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;
 - (e) Any first party claims by an insured that is an affiliate of the insolvent insurer;
 - (f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;
 - (g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;
 - (h) Any claims for interest; or
 - (i) Any claim filed with the association or a liquidator for protection afforded under the insured’s policy for incurred-but-not-reported losses.

Drafting Note: The language in this provision referring to claims for incurred-but-not-reported losses has been inserted to expressly include the existing intent of this provision and make it clear that “policyholder protection” proofs of claim, while valid to preserve rights against the estate of the insolvent insurer under the Insurer Receivership Model Act, are not valid to preserve rights against the association.

[Optional:

- H. *“Cybersecurity insurance”, for purposes of this Act, includes first and third-party coverage, in a policy or endorsement, written on a direct, admitted basis for losses and loss mitigation arising out of or relating to data privacy breaches, unauthorized information network security intrusions, computer viruses, ransomware, cyber extortion, identity theft, and similar exposures.]*
- H. “Insolvent insurer” means an insurer that is licensed to transact insurance in this State, either at the time the policy was issued, or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer’s State of domicile.

Drafting Note: “Final order” as used in this section means an order which has not been stayed. States in which the “final order” language does not accurately reflect whether or not the order is subject to a stay should substitute appropriate language consistent with the statutes or rules of the State to convey the intended meaning.

- I. “Insured” means any named insured, any additional insured, any vendor, lessor or any other party identified as an insured under the policy.
- J. (1) “Member insurer” means any person who:
 - (a) Writes any kind of insurance to which this Act applies under Section 3, including the exchange of reciprocal or inter-insurance contracts; and
 - (b) Is licensed to transact insurance in this State (except at the option of the State).
- (2) An insurer shall cease to be a member insurer effective on the day following the termination or expiration of its license to transact the kinds of insurance to which this Act applies, however, the insurer shall remain liable as a member insurer for any and all obligations, including obligations for assessments levied prior to the termination or expiration of the insurer’s license and assessments levied after the termination or expiration, which relate to any insurer that became an insolvent insurer prior to the termination or expiration of the insurer’s license.
- K. “Net direct written premiums” means direct gross premiums written in this State on insurance policies to which this Act applies, including policy and membership fees, less the following amounts: (1) return premiums, (2) premiums on policies not taken, and (3) dividends paid or credited to policyholders on that direct business. “Net direct written premiums” does not include premiums on contracts between insurers or reinsurers.

[Optional:

- K. *“Net direct written premiums” means direct gross premiums written in this State on insurance policies to which this Act applies, including policy and membership fees and including all premiums and other compensation collected by a member insurer for obligations assumed under a transaction described in Section 5G(3), less the following amounts: (1) return premiums, (2) premiums on policies not taken, and (3) dividends paid or credited to policyholders on that direct business. “Net direct written premiums” does not include premiums on contracts between insurers or reinsurers, other than compensation received for entering into a transaction described in Section 5G(3).]*

Drafting Note: Optional Section 5K is for states that have adopted Optional Section 5G(3).

- L. “Person” means any individual, aggregation of individuals, corporation, partnership or other entity.
- M. “Receiver” means liquidator, rehabilitator, conservator or ancillary receiver, as the context requires.

Drafting Note: Each State should conform the definition of “receiver” to the definition used in the State’s insurer receivership act.

- N. “Self-insurer” means a person that covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance.

Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5J shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7.

[Alternate Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5J shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7. For purposes of administration and assessment, the association shall be divided into three separate accounts:

- A. *The workers’ compensation insurance account;*
- B. *The automobile insurance account; and*
- C. *The account for all other insurance to which this Act applies.]*

Drafting Note: The alternate Section 6 should be used if a State, after examining its insurance market, determines that separate accounts for various kinds of insurance are necessary and feasible. The major consideration is whether each account will have a base sufficiently large to cover possible insolvencies. Separate accounts will permit assessments to be generally limited to insurers writing the same kind of insurance as the insolvent company. If this approach is adopted the provision of alternate Sections 8A(3) and 8B(6) and optional Section 5A should also be used.

Section 7. Board of Directors

- A. The board of directors of the association shall consist of not less than five (5) nor more than [insert

number] persons serving terms as established in the plan of operation. The insurer members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining insurer members subject to the approval of the commissioner. If no members are selected within sixty (60) days after the effective date of this Act, the commissioner may appoint the initial members of the board of directors. Two (2) persons, who must be public representatives, shall be appointed by the commissioner to the board of directors. Vacancies of positions held by public representatives shall be filled by the commissioner. A public representative may not be an officer, director or employee of an insurance company or any person engaged in the business of insurance. For the purposes of this section, the term “director” shall mean an individual serving on behalf of an insurer member of the board of directors or a public representative on the board of directors.

Drafting Note: A State adopting this language should make certain that its insurance code includes a definition of “the business of insurance” similar to that found in the NAIC Insurer Receivership Model Act.

- B. In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.
- C. Members of the board of directors may be reimbursed from the assets of the association for reasonable expenses incurred by them as members of the board of directors.
- D. Any board member who is an insurer in receivership shall be terminated as a *board member*, effective as of the date of the entry of the order of receivership. Any resulting vacancies on the board shall be filled for the remaining period of the term in accordance with the provisions of Subsection A.
- E. In the event that a director shall, because of illness, nonattendance at meetings or any other reason, be deemed unable to satisfactorily perform the designated functions as a director by missing three consecutive board meetings, the board of directors may declare the office vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.
- F. If the commissioner has reasonable cause to believe that a director failed to disclose a known conflict of interest with his or her duties on the board, failed to take appropriate action based on a known conflict of interest with his or her duties on the board, or has been indicted or charged with a felony, or misdemeanor involving moral turpitude, the commissioner may suspend that director pending the outcome of an investigation or hearing by the commissioner or the conclusion of any criminal proceedings. A company elected to the board may replace a suspended director prior to the completion of an investigation, hearing or criminal proceeding. In the event that the allegations are substantiated at the conclusion of an investigation, hearing or criminal proceeding, the office shall be declared vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

Section 8. Powers and Duties of the Association

- A. The association shall:
 - (1) (a) Be obligated to pay covered claims existing prior to the order of liquidation, arising within thirty (30) days after the order of liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before

the insured replaces the policy or causes its cancellation, if the insured does so within thirty (30) days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:

- (i) The full amount of a covered claim for benefits under a workers' compensation insurance coverage;
 - (ii) An amount not exceeding \$10,000 per policy for a covered claim for the return of unearned premium;
 - (iii) An amount not exceeding \$500,000 per claimant for all other covered claims.
 - (iv) In no event shall the Association be obligated to pay an amount in excess of \$500,000 for all first and third-party claims under a policy or endorsement providing, or that is found to provide, cybersecurity insurance coverage and arising out of or related to a single insured event, regardless of the number of claims made or the number of claimants.
- (b) In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this Act, a covered claim shall not include a claim filed with the guaranty fund after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

For the purpose of filing a claim under this subsection, notice of claims to the liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of claims shall be periodically submitted to the association or association similar to the association in another State by the liquidator.

Drafting Note: On the general subject of the relationship of the association to the liquidator, the working group/task force takes the position that since this is a model State bill, it will be able to bind only two parties, the association and the in-State liquidator. Nevertheless, the provisions should be clear enough to outline the requests being made to out-of-State liquidators and the requirements placed on in-State liquidators in relation to out-of-State associations.

Drafting Note: Because of its potential impact on guaranty association coverage, it is recommended that the legislation include an appropriate provision stating that the bar date only applies to claims in liquidation commencing after its effective date. Drafters should insure that the State's insurance liquidation act would permit, upon closure, payments to the guaranty association and any association similar to the association for amounts that are estimated to be incurred after closure for workers compensation claims obligations. The amounts should be payable on these obligations related to losses both known and not known at the point of closure.

- (c) Any obligation of the association to defend an insured shall cease upon the association's payment or tender of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit.

Drafting Note: The obligation of the association is limited to covered claims unpaid prior to insolvency, and to

claims arising within thirty days after the insolvency, or until the policy is canceled or replaced by the insured, or it expires, whichever is earlier. The basic principle is to permit policyholders to make an orderly transition to other companies. There appears to be no reason why the association should become in effect an insurer in competition with member insurers by continuing existing policies, possibly for several years. It is also felt that the control of the policies is properly in the hands of the liquidator. Finally, one of the major objections of the public to rapid termination, loss of unearned premiums with no corresponding coverage, is ameliorated by this bill since unearned premiums are permissible claims, up to \$10,000, against the association. The maximums (\$10,000 for the return of unearned premium; \$500,000 for all other covered claims) represent the working group's concept of practical limitations, but each State will wish to evaluate these figures.

- (2) Be deemed the insurer to the extent of its obligation on the covered claims and to that extent, subject to the limitations provided in this Act, shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to, the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association. The association shall not be deemed the insolvent insurer for the purpose of conferring jurisdiction.

- (3) **[Alternative 1]** Assess insurers amounts necessary to pay the obligations of the association under Section 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

- (3) **[Alternative 2]** Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Section 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment

on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]

[Optional:

- (4) Assess member insurers that have entered into transactions described in Section 5G(3), in addition to the assessment levied under Section 8A(3), an amount reflecting liabilities that may have arisen before the date of the transaction. The assessment under this Section 8A(4) is not subject to the annual percentage limitation under Section 8A(3) and shall be the amount that would have been paid by the assuming insurer under Section 8A(3) during the three calendar years preceding the effective date of the transaction if the business had been written directly by the assuming insurer. If the amount of the applicable premiums for the three year period cannot be determined, the assessment shall be 130% of the sum of the unpaid losses, loss adjustment expenses, and incurred but not reported losses, as of the effective date of the assumed claims transaction, multiplied by the applicable guaranty association assessment percentage for the calendar year of the transaction.]*

Drafting Note: Optional Section 8A(4) is for states that have adopted Optional Section 5G(3) and choose to require an additional "assumption consideration" assessment when claim obligations are assumed from an entity other than a member insurer.

- (4) Investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association's obligation and deny all other claims. The association shall pay claims in any order that it may deem reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The association shall have the right to appoint and to direct legal counsel retained under liability insurance policies for the defense of covered claims and to appoint and direct other service providers for covered services.
- (5) Notify claimants in this State as deemed necessary by the commissioner and upon the

commissioner's request, to the extent records are available to the association.

Drafting Note: The intent of this paragraph is to allow, in exceptional circumstances, supplementary notice to that given by the domiciliary receiver.

- (6) (a) Have the right to review and contest as set forth in this subsection settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation. In an action to enforce settlements, releases and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation, the Association shall have the right to assert the following defenses, in addition to the defenses available to the insurer:
 - (i) The association is not bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver or judgment was:
 - (I) Executed or entered within 120 days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment; or
 - (II) Executed by or taken against an insured or the insurer based on default, fraud, collusion or the insurer's failure to defend.
 - (ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Subparagraph (a)(i), the settlement, release, compromise, waiver or judgment shall be set aside, and the association shall be permitted to defend any covered claim on the merits. The settlement, release, compromise, waiver or judgment may not be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under this Act.
 - (iii) The association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.
 - (b) As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend, the association, either on its own behalf or on behalf of an insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict or finding and shall be permitted to defend the claim on the merits.
- (7) Handle claims through its own employees, one or more insurers, or other persons

designated as servicing facilities, which may include the receiver for the insolvent insurer. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer.

- (8) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Act.
- (9) Submit, not later than 90 days after the end of the association's fiscal year, a financial report for the preceding fiscal year in a form approved by the commissioner.

B. The association may:

- (1) Employ or retain persons as are necessary to handle claims, provide covered policy benefits and services, and perform other duties of the association;
- (2) Borrow funds necessary to effect the purposes of this Act in accordance with the plan of operation;
- (3) Sue or be sued;
- (4) Negotiate and become a party to contracts necessary to carry out the purpose of this Act;
- (5) Perform other acts necessary or proper to effectuate the purpose of this Act;
- (6) Refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

[Alternate Section 8B(6)

- (6) *Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.]*

Drafting Note: The working group/task force feels that the board of directors should determine the amount of the refunds to members when the assets of the association exceed its liabilities. However, since this excess may be quite small, the board is given the option of retaining all or part of it to pay expenses and possibly remove the need for a relatively small assessment at a later time.

C. Suits involving the association:

- (1) Except for actions by the receiver, all actions relating to or arising out of this Act against the association shall be brought in the courts in this State. The courts shall have exclusive jurisdiction over all actions relating to or arising out of this Act against the association.

- (2) The exclusive venue in any action by or against the association is in [designate appropriate court]. The association may, at its option, waive this venue as to specific actions.

[Optional:

- D. (1) *The legislature finds:*
- (a) *The potential for widespread and massive damage to persons and property caused by natural disasters such as earthquakes, windstorms, or fire in this State can generate insurance claims of such a number as to render numerous insurers operating within this State insolvent and therefore unable to satisfy covered claims;*
 - (b) *The inability of insureds within this State to receive payments of covered claims or to timely receive the payments creates financial and other hardships for insureds and places undue burdens on the State, the affected units of local government, and the community at large;*
 - (c) *The insolvency of a single insurer in a material amount or a catastrophic event may result in the same hardships as those produced by a natural disaster;*
 - (d) *The State has previously taken action to address these problems by adopting the [insert name of guaranty association act], which among other things, provides a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer; and*
 - (e) *In order for the association to timely pay claims of insolvent insurers in this State and otherwise carry out its duties, the association may require additional financing options. The intent of the Legislature is to make those options available to the association in the event that a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection A(3). In cases where the association determines that it is cost effective, the association may issue bonds as provided in this subsection. In determining whether to issue bonds, the association shall consider the transaction costs of issuing the bonds.*
- (2) *In the event a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection 8A(3), the association, in its sole discretion, may by resolution request the [insert name of agency] Agency to issue bonds pursuant to [insert statutory authority], in such amounts as the association may determine to provide funds for the payment of covered claims and expenses related thereto. In the event bonds are issued, the association shall have the authority to annually assess member insurers for amounts necessary to pay the principal of, and interest on those bonds. Assessments collected pursuant to this authority shall be collected under the same procedures as provided in Subsection 8A(3) and, notwithstanding the two percent (2%) limit in Subsection 8A(3), shall be limited to an additional [insert percentage] percent of the*

annual net direct written premium in this State of each member insurer for the calendar year preceding the assessment. The commissioner's approval shall be required for any assessment greater than five percent (5%). Assessments collected pursuant to this authority may only be used for servicing the bond obligations provided for in this subsection and shall be pledged for that purpose.

- (3) In addition to the assessments provided for in this subsection, the association in its discretion, and after considering other obligations of the association, may utilize current funds of the association, assessments made under Subsection 8A(3) and advances or dividends received from the liquidators of insolvent insurers to pay the principal and interest on any bonds issued at the board's request.*
- (4) Assessments under this subsection shall be payable in twelve (12) monthly installments with the first installment being due and payable at the end of the month after an assessment is levied, and subsequent installments being due not later than the end of each succeeding month.*
- (5) In order to assure that insurers paying assessments levied under this subsection continue to charge rates that are neither inadequate nor excessive, within ninety (90) days after being notified of the assessments, each insurer that is to be assessed pursuant to this subsection shall make a rate filing for lines of business additionally assessed under this subsection. If the filing reflects a rate change that, as a percentage, is equal to the difference between the rate of the assessment and the rate of the previous year's assessment under this subsection, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of [cite appropriate statutory authority for provisions on filing and approval of rates].*

Drafting Note: This provision should only be considered by those States that have serious concerns that circumstances could result in a substantial capacity problem resulting in unpaid or pro rata payment of claims. An association intending to consider this provision should first consult with experienced bond counsel in its State to identify an appropriate State agency or bonding authority to act as vehicle for issuing the bonds. That agency or authority's statute may also have to be amended to specifically authorize these types of bonds and to cross-reference this provision in the guaranty association law. It is possible that in some situations a new bonding authority may have to be created for this purpose.

Regardless of the vehicle used, it is important that the decision-making authority on whether bonds are needed and in what amounts be retained by the association's board.

The extent of additional assessment authority under this subsection has not been specified. When considering the amount of additional authority that will be needed, a determination should be made as to the amount of funds needed to service the bonds. More specifically, consideration should be given to the amount of the bonds to be issued, interest rate and the maturity date of the bonds. The association should be able to raise sufficient funds through assessments to pay the interest and retire the bonds after some reasonable period (e.g. ten (10) years). Subsection D(2) requires the Commissioner's approval before the association can impose an additional assessment in excess of 5%. This is to assure that the additional assessment will not result in financial hardship to the member insurers and additional insolvencies.

The intent of Subsection D(4) is to permit recoupment by member insurers of the additional cost of assessments under this subsection without any related regulatory approval. A State enacting this subsection may need to revise

Subsection D(4) so that it conforms to the particular State's recoupment provisions, as well as the provisions on filing and approval of rates.]

Section 9. Plan of Operation

- A. (1) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and amendments shall become effective upon approval in writing by the commissioner.
- (2) If the association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.
- B. All member insurers shall comply with the plan of operation.
- C. The plan of operation shall:
 - (1) Establish the procedures under which the powers and duties of the association under Section 8 will be performed;
 - (2) Establish procedures for handling assets of the association;
 - (3) Require that written procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer;
 - (4) Require that written procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 7;
 - (5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;
 - (6) Establish regular places and times for meetings of the board of directors;
 - (7) Require that written procedures be established for records to be kept of all financial transactions of the association, its agents and the board of directors;
 - (8) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision;
 - (9) Establish the procedures under which selections for the board of directors will be submitted to the commissioner;
 - (10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

- D. The plan of operation may provide that any or all powers and duties of the association, except those under Sections 8A(3) and 8B(2), are delegated to a corporation, association similar to the association or other organization which performs or will perform functions similar to those of this association or its equivalent in two (2) or more States. The corporation, association similar to the association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 10. Duties and Powers of the Commissioner

- A. The commissioner shall:
- (1) Notify the association of the existence of an insolvent insurer not later than three (3) days after the commissioner receives notice of the determination of the insolvency. The association shall be entitled to a copy of a complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that the complaint is filed with a court of competent jurisdiction;
 - (2) Provide the association with a statement of the net direct written premiums of each member insurer upon request of the board of directors.
- B. The commissioner may:
- (1) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on a member insurer that fails to pay an assessment when due. The fine shall not exceed five percent (5%) of the unpaid assessment per month, except that a fine shall not be less than \$100 per month;
 - (2) Revoke the designation of a servicing facility if the commissioner finds claims are being handled unsatisfactorily.
 - (3) Examine, audit, or otherwise regulate the association.

Drafting Note: This section does not require periodic examinations of the guaranty associations but allows the commissioner to conduct examinations as the commissioner deems necessary.

- C. A final action or order of the commissioner under this Act shall be subject to judicial review in a court of competent jurisdiction.

Section 11. Coordination Among Guaranty Associations

- A. The association may join one or more organizations of other State associations of similar purposes, to further the purposes and administer the powers and duties of the association. The association may designate one or more of these organizations to act as a liaison for the association and, to the extent the association authorizes, to bind the association in agreements or settlements with receivers of insolvent insurance companies or their designated representatives.
- B. The association, in cooperation with other obligated or potentially obligated guaranty

associations, or their designated representatives, shall make all reasonable efforts to coordinate and cooperate with receivers, or their designated representatives, in the most efficient and uniform manner, including the use of Uniform Data Standards as promulgated or approved by the National Association of Insurance Commissioners.

Section 12. Effect of Paid Claims

- A. Any person recovering under this Act shall be deemed to have assigned any rights under the policy to the association to the extent of his or her recovery from the association. Every insured or claimant seeking the protection of this Act shall cooperate with the association to the same extent as the person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for sums it has paid out except any causes of action as the insolvent insurer would have had if the sums had been paid by the insolvent insurer and except as provided in Subsection B and in Section 13. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of the insureds to the receiver, liquidator or statutory successor for unpaid assessments.
- B. The association shall have the right to recover from any person who is an affiliate of the insolvent insurer all amounts paid by the association on behalf of that person pursuant to the Act, whether for indemnity, defense or otherwise.
- C. The association and any association similar to the association in another State shall be entitled to file a claim in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as determined under this Act or similar laws in other States and shall receive dividends and other distributions at the priority set forth in [insert reference to Statepriority of distribution in liquidation act].
- D. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

Section 13 [Optional] Net Worth Exclusion

Drafting Note: Various alternatives are provided for a net worth limitation in the guaranty association act. States may choose any of the Subsection B alternatives below or may elect to not have any net worth limitation. Subsection A, which defines “high net worth insured,” has two alternates allowing States to choose different net worth limitations for first and third party claims if that State chooses alternatives 1 or 2 to Subsection B. Subsections C, D and E are recommended to accompany any of the Subsection B alternatives. In cases where States elect not to include net worth, States may either omit this section in its entirety or include only Subsection C, which excludes from coverage claims denied by other States’ net worth restrictions pursuant to those States’ guaranty association laws.

- A. For purposes of this section “high net worth insured” shall mean any insured whose net worth exceeds \$50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.

Alternate Section 13A

- A. (1) *For the purposes of Subsection B(1), “high net worth insured” shall mean any insured whose net worth exceeds \$25 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.]*
- (2) *For the purpose of Subsection B(2) [and B(4) if Alternative 2 for Subsection B is selected] “high net worth insured” shall mean any insured whose net worth exceeds \$50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.*

Drafting Note: Alternate Subsection A language should only be considered in cases where a State is considering Alternative 1 or 2 of Subsection B and would like to set different dollar thresholds for the first party claim exclusion provision and the third party recovery provision.

Drafting Note: States may wish to consider the impact on governmental entities and charitable organizations of the application of the net worth exclusion contained in the definition of “covered claim.” The Michigan Supreme Court, in interpreting a “net worth” provision in the Michigan guaranty association statute, held that governmental entities possess a “net worth” for purposes of the provision in the Michigan guaranty association statute that prohibits claims against the guaranty association by a person who has a specified net worth. Oakland County Road Commission vs. Michigan Property & Casualty Guaranty Association, 575 N.W. 2d 751 (Mich. 1998).

[Alternative 1 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise.
- (3) The Association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured as defined in Section 13A(1). In that case, the Association shall recover from the high net worth insured under this section all amounts paid on its behalf, all allocated claim adjusted expenses related to such claims, the Association’s attorney’s fees, and all court costs in any action necessary to collect the full amount to the Association’s reimbursement under this section.]

Drafting Note: Alternative 1 for Section 13B(3), would only be a consideration in states with a net worth exclusion.

[Alternative 2 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.

- (2) Subject to Paragraph (3), the association shall not be obligated to pay any third party claim relating to a policy of a high net worth insured. This exclusion shall not apply to third party claims against the high net worth insured where:
- (a) The insured has applied for or consented to the appointment of a receiver, trustee or liquidator for all or a substantial part of its assets;
 - (b) The insured has filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law; or
 - (c) An order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.
- (3) Paragraph (2) shall not apply to workers' compensation claims, personal injury protection claims, no-fault claims and any other claims for ongoing medical payments to third parties.
- (4) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, covered policy benefits and services, defense or otherwise.
- (5) The Association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any third-party claims or cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured as defined in Section 13A(2). In that case, the Association shall recover from the high net worth insured under this section all amounts paid on its behalf, all allocated claim adjusted expenses related to such claims, the Association's attorney's fees, and all court costs in any action necessary to collect the full amount to the Association's reimbursement under this section.]

Drafting Note: Alternative 2 to Section 13B(5) would only be a consideration in states with a net worth exclusion.

[Alternative 3 for Section 13B

- B. The association shall not be obligated to pay any first party claims by a high net worth insured.]
- C. The association shall not be obligated to pay any claim that would otherwise be a covered claim that is an obligation to or on behalf of a person who has a net worth greater than that allowed by the insurance guaranty association law of the State of residence of the claimant at the time specified by that State's applicable law, and which association has denied coverage to that claimant on that basis.
- D. The association shall establish reasonable procedures subject to the approval of the commissioner for requesting financial information from insureds on a confidential basis for purposes of applying this section, provided that the financial information may be shared with any other association similar to the association and the liquidator for the insolvent insurer on the same confidential basis. Any request to an insured seeking financial information must advise the insured of the consequences of failing to provide the financial information. If an insured refuses to provide the

requested financial information where it is requested and available, the association may, until such time as the information is provided, provisionally deem the insured to be a high net worth insured for the purpose of denying a claim under Subsection B.

- E. In any lawsuit contesting the applicability of this section where the insured has refused to provide financial information under the procedure established pursuant to Subsection D, the insured shall bear the burden of proof concerning its net worth at the relevant time. If the insured fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the association its full costs, expenses and reasonable attorneys' fees in contesting the claim.

Section 14. Exhaustion of Other Coverage

- A. (1) Any person having a claim against an insurer,, shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the association. The requirement to exhaust shall apply without regard to whether the other insurance policy is a policy written by a member insurer. However, no person shall be required to exhaust any right under the policy of an insolvent insurer or any right under a life insurance policy.
- (2) Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in the other insurance policy, or by the amount of the recovery under the other insurance policy as provided herein. The association shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy. If the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy, or if there are no applicable stated limits under the policy, the association shall receive a full credit for the total recovery.

[Alternative 1 for Section 14A(2)(a)]

- (a) The credit shall be deducted from the lesser of:
- (i) The association's covered claim limit;
 - (ii) The amount of the judgment or settlement of the claim; or
 - (iii) The policy limits of the policy of the insolvent insurer.]

[Alternative 2 for Section 14A(2)(a)]

- The credit shall be deducted from the lesser of:
- (i) The amount of the judgment or settlement of the claim; or
 - (ii) The policy limits of the policy of the insolvent insurer.]
- (b) In no case, however, shall the obligation of the association exceed the covered claim limit embodied in Section 8 of this Act.

- (3) Except to the extent that the claimant has a contractual right to claim defense under an insurance policy issued by another insurer, nothing in this section shall relieve the association of the duty to defend under the policy issued by the insolvent insurer. This duty shall, however, be limited by any other limitation on the duty to defend embodied in this Act.
 - (4) A claim under a policy providing liability coverage to a person who may be jointly and severally liable as a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the association.
 - (5) For purposes of this section, a claim under an insurance policy other than a life insurance policy shall include, but is not limited to:
 - (a) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation or disability insurance policy; and
 - (b) Any amount payable by or on behalf of a self-insurer.
 - (6) The person insured by the insolvent insurer's policy may not be pursued by a third-party claimant for any amount paid to the third party by which the association's obligation is reduced by the application of this section.
- B. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property. If it is a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from another insurance guaranty association or its equivalent.

Drafting Note: This subsection does not prohibit recovery from more than one association, but it does describe the association to be approached first and then requires that any previous recoveries from like associations must be set off against recoveries from this association.

Section 15. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

- A. The board of directors may, upon majority vote, make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency.
- B. At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, the board of directors may, upon majority vote, prepare a report on the history and causes of the insolvency, based on the information available to the association and submit the report to the commissioner.
- C. Reports and recommendations provided under this section shall not be considered public documents.

Section 16. Tax Exemption

The association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions except taxes levied on real or personal property.

Section 17. Recoupment of Assessments

Drafting Note: States may choose how they wish to allow member insurers to recoup assessments paid by selecting one of three alternatives for Section 17.

[Alternative 1 for Section 17

- A. Except as provided in Subsection D, each member insurer shall annually recoup assessments it remitted in preceding years under Section 8. The recoupment shall be by means of a policyholder surcharge on premiums charged for all kinds of insurance in the accounts assessed. The surcharge shall be at a uniform percentage rate determined annually by the commissioner that is reasonably calculated to recoup the assessment remitted by the insurer, less any amounts returned to the member insurer by the association. Changes in this rate shall be effective no sooner than 180 days after insurers have received notice of the changed rate.
- B. If a member insurer fails to recoup the entire amount of the assessment in the first year under this section, it shall repeat the surcharge procedure provided for herein in succeeding years until the assessment is fully recouped or a de minimis amount remains uncollected. Any such de minimis amount shall be collected as provided in Subsection D of this section. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.
- C. The amount and nature of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The surcharge shall not be considered premium for any purpose, including the [insert all appropriate taxes] or agents' commission.
- D. A member may elect not to collect the surcharge from its insureds only when the expense of collecting the surcharge would exceed the amount of the surcharge. In that case, the member shall recoup the assessment through its rates, provided that:
 - (1) The insurer shall be obligated to remit the amount of surcharge not collected by election under this subsection; and
 - (2) The last sentence in Subsection C above shall not apply.
- E. In determining the rate under Subsection A for the first year of recoupment under this section, under rules prescribed by the commissioner, the commissioner shall provide for the recoupment in that year, or in such reasonable period as the commissioner may determine, of any assessments that have not been recouped as of that year. Insurers shall not be required to recoup assessments through surcharges under this section until 180 days after this section takes effect.]

[Alternative 2 for Section 17]

- A. Notwithstanding any provision of [insert citation to relevant tax and insurance codes] to the contrary, a member insurer may offset against its [insert all appropriate taxes] liability the entire amount of the assessment imposed under this Act at a rate of [insert number] percent per year for [insert number of years] successive years following the date of assessment. If the assessment is not fully recovered over the [insert number of years] period, the remaining unrecovered assessment may be claimed for subsequent calendar years until fully recovered.

Drafting Note: States may choose the number of years to allow an insurer to offset an assessment against the insurer's premium tax liability.

- B. Any tax credit under this section shall, for the purposes of Section [insert citation to retaliatory tax statute] be treated as a tax paid both under the tax laws of this State and under the laws of any other State or country.
- C. If a member insurer ceases doing business in this State, any uncredited assessment may be credited against its [insert all appropriate taxes] during the year it ceases doing business in this State.
- D. Any sums that are acquired by refund from the association by member insurers and that have been credited against [insert all appropriate taxes], as provided in this section, shall be paid by member insurers to this State as required by the department. The association shall notify the department that the refunds have been made.]

[Alternative 3 for Section 17]

The rates and premiums charged for insurance policies to which this section applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association. Rates shall not be deemed excessive because they contain an additional amount reasonably calculated to recoup all assessments paid by the member insurer.]

Section 18. Immunity

There shall be no liability on the part of, and no cause of action of any nature shall arise against a member insurer, the association or its agents or employees, the board of directors, or any person serving as an alternate or substitute representative of any director, or the commissioner or the commissioner's representatives for any action taken or any failure to act by them in the performance of their powers and duties under this Act

Section 19. Stay of Proceedings

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this State shall, subject to waiver by the association in specific cases involving covered claims, be stayed for six (6) months and such additional time as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the State, whichever is later, to permit proper defense by the association of all pending causes of action.

The liquidator, receiver or statutory successor of an insolvent insurer covered by this Act shall permit access by the board or its authorized representative to such of the insolvent insurer's records which are necessary for the board in carrying out its functions under this Act with regard to covered claims. In addition, the liquidator, receiver or statutory successor shall provide the board or its representative with copies of those records upon the request

by the board and at the expense of the board.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1970 Proc. I 218, 252, 253-262, 298 (adopted).
1972 Proc. I 15, 16, 443, 477-478, 479-480 (amended).
1973 Proc. I 9, 11, 140, 154, 155-157 (amended).
1973 Proc. II 18, 21, 370, 394, 396 (recoupment formula adopted).
1979 Proc. I 44, 46, 126, 217 (amended).
1981 Proc. I 47, 50, 175, 225 (amended).
1984 Proc. I 6, 31, 196, 326, 352 (amended).
1986 Proc. I 9-10, 22, 149, 294, 296-305 (amended and reprinted).
1986 Proc. II 410-411 (amendments adopted later printed here).
1987 Proc. I 11, 18, 161, 421, 422, 429, 450-452 (amended).
1993 Proc. 2nd Quarter 12, 33, 227, 600, 602, 621 (amended).
1994 Proc. 4th Quarter 17, 26, 566, 576, 579-589 (amended and reprinted).
1996 Proc. 1st Quarter 29-30, 123, 564, 570, 570-580 (amended and reprinted).
2009 Proc. 1st Quarter, Vol I 111, 139, 188, 288-317 (amended).

PROJECT HISTORY-2023

Property and Casualty Insurance Guaranty Association Model Act (#540)

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

Restructuring

In 2019, the Financial Condition (E) Committee formed the Restructuring Mechanisms (E) Working Group, which was charged with documenting the various issues related to insurance business transfers (IBT) and corporate division (CD) transactions in the form of a white paper. Included in the charge was to “[consider] the impact that a restructuring might have on guaranty associations and policyholders that had guaranty fund protection prior to the restructuring.”

The proposed amendments to the *Property and Casualty Insurance Guaranty Association Model Act (#540)* were precipitated by discussions within the Restructuring Mechanisms (E) Working Group’s charge. The number of states adopting laws that permit either of these transactions is still relatively low. However, one of the most significant issues that had been discussed during the Working Group’s meetings was the need for policyholders subject to such transactions to retain guaranty fund coverage. The National Conference of Insurance Guaranty Funds (NCIGF) representatives suggested that an amendment to a state’s guaranty fund act, or other related law, is necessary to address this issue. They specifically suggested that the NAIC update Model #540, and they developed specific language to address this issue. An amendment to Model #540 will better enable states that have incorporated Model #540 into their laws to update their laws for this important issue, ensuring policyholders in all states retain their coverage. Because guaranty association coverage follows the state of licensure rather than the state of domicile, adequately addressing these concerns is necessary regardless of the type of transfer and how few states adopt changes to their laws to allow IBT and CD transactions.

It should be noted that with respect to guaranty fund coverage for life and health insurance, the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) is suggesting a different approach to address the same issue in the life and health context. NOLHGA’s proposal centers around the need for such transactions to require the assuming or resulting insurer to be licensed in all states where the issuing insurer was licensed or ever was licensed to retain the needed coverage for policyholders.

On March 28, 2022, the Restructuring Mechanisms (E) Working Group sent a referral to the Receivership and Insolvency (E) Task Force to request amendments to Model #540.

The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #540 during the 2022 Summer National Meeting. The amendments are intended to preserve guaranty fund coverage for policyholders subject to insurance business transfers (IBT) and corporate divisions (CD) where the policyholder had guaranty fund coverage before the transaction.

Cybersecurity Insurance

In December 2022, NCIGF requested the Task Force amend Model #540 to ensure cybersecurity insurance policyholders in all states are provided with guaranty fund coverage for this trending line of business. According to NCIGF, cybersecurity insurance coverage is trending into the admitted market. Consequently, NCIGF anticipates the insurance insolvency resolution system will be presented with claims and other issues related to this coverage. These policy obligations may flow both from standalone cyber policies, endorsements, or from coverages that may be found to exist in commercial general liability and other lines of business typically written for business

entities. For this reason, policymakers need to determine how such coverages will be handled should an insurer writing this business become insolvent.

The Executive (EX) Committee approved a separate Request for NAIC Model Law Development for additional amendments to Model #540 during the 2023 Spring National Meeting. The amendments will address clarifying guaranty association coverage of cybersecurity insurance.

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

The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force was given the task of drafting the initial revisions to Model #540. The 2022 and 2023 members of the Working Group were Illinois (Co-Chair), Pennsylvania (Co-Chair), Arkansas, California, Colorado, Connecticut, Florida, Iowa, Louisiana, Maine, Massachusetts, Michigan, Missouri, Nebraska, Puerto Rico, Texas, and Washington.

A drafting group was formed in November 2022 to review comments received on the first exposure draft of the restructuring amendments and to draft additional revisions. Members included Illinois, Maine, Pennsylvania, Oregon, Barbara F. Cox (Barbara F. Cox LLC), Roger Schmelzer (NCIGF), Rowe Snider (Locke Lord LLP), Stephen W. Schwab (DLA Piper LLP), and Patrick H. Cantilo (Cantilo and Bennett LLP).

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

As described, the initial charge prompting a review of Model #540 was given to the Receivership Law (E) Working Group at the 2022 Summer National Meeting. The two separate Requests for NAIC Model Law Development to open Model #540 for revision were adopted by the Executive (EX) Committee at the 2022 Summer National Meeting (restructuring) and the 2023 Summer National Meeting (cybersecurity insurance).

4. A General Description of the Drafting Process (e.g., Drafted by a Subgroup, Interested Parties, the Full Group, etc.)—Include Any Parties Outside the Members That Participated

For both the restructuring and the cybersecurity insurance amendments, NCIGF proposed an initial draft of amendments to Model #540. As noted above, a drafting group was formed in November 2022 to review comments received on the first exposure draft of restructuring amendments and consider further edits to Model #540. Upon completion of the drafting group's efforts, the Receivership Law (E) Working Group exposed and addressed comments on both sets of amendments—restructuring and cybersecurity insurance.

After the adoption of the amendments by the Receivership Law (E) Working Group on July 24, 2023, on Aug. 14, 2023, the Receivership and Insolvency (E) Task Force exposed and considered subsequent edits to the amendments before adopting the amendments on Oct. 2, 2023.

5. A General Description of the Due Process (e.g., Exposure Periods, Public Hearings, or Any Other Means by Which Widespread Input From Industry, Consumers and Legislators Was Solicited)

On Sept. 14, 2022, the Receivership Law (E) Working Group met in open session to expose proposed amendments to the definition of covered claims in Section 5 of Model #540 a 30-day public comment period ending Oct. 14, 2022. The initial draft of amendments was proposed by NCIGF. Comments were received from Robert Wake (ME).

On Nov. 7, 2022, the Receivership Law (E) Working Group met in open session to discuss comments received. A drafting group was formed to review the comments on the restructuring amendments and to consider further edits to the Model #540 amendments.

Between January and May 2023, the drafting group met four times and had many email exchanges as they worked through different drafts. The drafting group determined it had reached a point where they needed the broader Receivership Law (E) Working Group's input before moving forward with a single version of the amendments. The drafting group delivered two versions of the amendments for restructuring, albeit each with multiple alternatives, as proposed by different members of the drafting group, to the Receivership Law (E) Working Group for consideration.

On May 23, 2023, the Receivership Law (E) Working Group met in open session to consider the two versions of the amendments. After hearing presentations from the drafting group members and receiving summary explanations of each version, the Working group agreed to move forward with one version of the amendments. The amendments to Model #540 for restructuring were exposed for a 30-day comment period that ended June 23, 2023.

On May 23, 2023, the Receivership Law (E) Working Group exposed the draft amendments regarding guaranty fund coverage of cybersecurity insurance for a 30-day comment period that ended June 23, 2023.

Three comment letters were received on the exposure of restructuring amendments from Barbara F. Cox (Barbara F. Cox LLC) representing NCIGF, Patrick H. Cantilo (Cantilo and Bennett LLP), and Joseph Torti (Fairfax (US) Inc.). No comments were received on the cybersecurity insurance amendments.

On July 24, 2023, the Receivership Law (E) Working Group met in open session to consider comments received on the restructuring amendments. NAIC staff proposed non-substantive grammatical and formatting edits. The amendments were adopted by the Receivership Law (E) Working Group on July 24, 2023, by unanimous vote.

On Aug. 14, 2023, the Receivership and Insolvency (E) Task force met in option session at the Summer National Meeting. The Task Force heard comments from Barbara F. Cox (Barbara F. Cox LLC) representing NCIGF, Patrick H. Cantilo (Cantilo and Bennett LLP), and Joseph Torti (Fairfax (US) Inc.). The Task Force exposed the Model #540 amendments, including certain subsequent editorial clean-up revisions, for a 30-day public comment period ending Sept. 14.

On Oct. 2, 2023, the Receivership and Insolvency (E) Task force met in option session on a virtual meeting to discuss comments on the exposure that were received from Dan Bumpus (VA), Robert Wake (ME), Roger Schmelzer (NCIGF), and Patrick H. Cantilo (Cantilo and Bennett LLP). No further changes were made. The amendments were adopted by the Receivership and Insolvency (E) Task Force on Oct. 2, 2023, by unanimous vote.

All exposures were distributed by email to members, interested state insurance regulators, and interested parties of both the Receivership Law (E) Working Group and the Receivership and Insolvency (E) Task Force and were posted to the NAIC website.

All issues raised by members, interested state insurance regulators, and interested parties were discussed, explained, or addressed through revisions to the original proposed amendments.

The amendments were adopted by the Financial Condition (E) Committee on Oct. 25, 2023.

6. A Discussion of the Significant Issues (Items of Some Controversy Raised During the Due Process and the Group's Response)

Amendments to the Assumed Claims Transaction Provisions in Model #540:

The Restructuring Mechanisms (E) Working Group referral on IBT and CD transactions that kicked off this project included initial draft language suggested by NCIGF specific to the definition of covered claims. During the initial exposure of that draft definition, concerns were raised that the proposed definition for expanding the definition of guaranty association covered claims did not fully address the issue of continuing coverage when a policy is transferred by assumption, rather IBT or CD; and that any amendments to preserve guaranty fund coverage for policyholders subject to IBT and CDs, should not be at the exclusion of preserving coverage for policyholders subject to other transfers, such as assumption transactions where business is transferred by non-guaranty association members, like a reciprocal, fraternal or trust, to GA member insurers. The amendment adopted by the Working Group and the Task Force is intended to preserve both through the new Section 5G(2) and the new optional Section 5G(3). Therefore, the Working Group and the Task Force believe it met the charge.

Two commenters disagreed with amending the provisions in Model #540 related to deleting the 2009 assumed claims transactions provision and one interested party proposed alternative language. Specifically, provisions in Section 5D, Section 5Q, and the alternatives in Section 8A(3) related to assumed claims transactions were deleted. A new Section 5G(2) was added to ensure that coverage is preserved if coverage existed before an IBT or CD transaction. Because this amendment is broad, it automatically includes common law novation and assumption reinsurance without stating those specifically. In drafting the new Sections 5G(2) and 5G(3), the Working Group understood that there may be some states that feel there is a need for coverage in certain situations where a non-member transfers claims to a member insurer when it is not clear whether the member insurer issued a replacement policy. A new Section 5G(3) was added as optional for those states that want to include assumed claims transaction language.

With regard to the optional Section 5G(3), while the 2009 amendments were proposed to be deleted, the optional language was added, in essence, to preserve the assumed claims transaction language for those states that still may want to consider proposing that coverage to their legislatures. It was noted that only three states have adopted the 2009 assumed claims transaction language. It was the belief of members of the Working Group that the new language in Section 5G(2) and the optional language in Sections 5G(3), 5K and 8A4 are more streamlined and consequently result in greater clarity between the two options, rather than simply adding 5G(2) while retaining the former definition of assumed claim transaction. They also felt that the new proposed language would fit better into the existing statutes of the 47 states that have not adopted the 2009 assumed claims transaction language. By making the replacement language in Section 5G(3) optional, it gives states two avenues to pursue. States can try to pass both Sections 5G(2) and 5G(3) through their legislatures or if they have significant legislative objection to 5G(3), they can propose 5G(2) to address specifically the IBT and CD coverage issue. Members did not agree that the interested party's proposal would sufficiently address the transfer of policyholders being discussed.

The issue was discussed by the drafting group, the Receivership Law (E) Working Group, and the Receivership and Insolvency (E) Task Force.

7. Any Other Important Information (e.g., Amending an Accreditation Standard).

The Receivership and Insolvency (E) Task Force has not had formal discussions with respect to whether the current Guaranty Association accreditation standard under the NAIC Financial Regulation Standards and Accreditation Program should be amended to include the current revision to Model #540. However, it should be noted that the

accreditation standard for Model #540 is not a substantially similar standard. The Task Force will consider this and make appropriate referrals prior to the 2024 Spring National Meeting.

The following significant elements were adopted by the Financial Standards and Accreditation (F) Committee on Aug. 13, 2023 (pending approval by Plenary at the Fall National Meeting), with an effective date of January 1, 2026.

Background: The significant elements were modified from the initial March 8, 2021 E Committee referral and exposed by the Financial Standards and Accreditation (F) Committee on Aug. 14, 2021 for a 1-year exposure from Jan. 1, 2022 to Dec. 31, 2022. The modifications to n(i) and n(ii) allow Commissioners to grant exemptions to the group capital calculation to groups meeting the standards set forth in Model Regulation #450 Section 21A and Section 21B without the requirement to file at least once.

The significant elements are separated into those that incorporate the group capital calculation and those that incorporate the liquidity stress test.

6. Insurance Holding Company Systems (Group Capital Calculation)

State law should contain the NAIC *Insurance Holding Company System Regulatory Act* (#440), or an act substantially similar, and the department should have adopted the NAIC *Insurance Holding Company System Model Regulation* (#450).

Insurance Holding Company Systems – continued

Changes to Existing

k. Filing requirements for the enterprise risk filing similar to those specified in Section 4L(1) of the Model #440?

New

- l. Filing requirements for the group capital calculation filing similar to those specified in Section 4L(2) of Model #440?
 - i. The ultimate controlling person of every insurer subject to registration shall annually file a group capital calculation completed in accordance with the NAIC Group Capital Calculation Instructions as directed by the lead state commissioner similar to section 4L(2)?
 - ii. Provision for exempting an insurance holding company system that has only one insurer within its holding company structure, that only writes business [and is only licensed] in its domestic state and assumes no business from any other insurer, similar to 4L(2)(a)?
 - iii. Provision for exempting an insurance holding company system that is required to perform a group capital calculation specified by the U.S. Federal Reserve? If the Federal Reserve Board cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the GCC, similar to 4L(2)(b)?
 - iv. Provision for exempting an insurance holding company system whose non-U.S. group-wide supervisor is located within a Reciprocal Jurisdiction that recognizes the U.S. state regulatory approach to group supervision and group capital, similar to 4L(2)(c)?
 - v. Provision for exempting an insurance holding company system that provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program and whose non-U.S. group-wide supervisor that is not in a Reciprocal Jurisdiction recognizes and accepts the GCC as the world-wide group capital assessment for U.S. insurance groups who operate in that jurisdiction, similar to 4L(2)(d)?
 - vi. Provision that gives the lead state the authority to require the GCC for U.S. operations of any non-U.S. based insurance holding company system where after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes, similar to 4L(2)(e)?

Changes to Existing

- cc. Provisions for protecting confidential information submitted to the commissioner, including provisions maintaining confidentiality for information shared with state, federal and international regulators similar to Section 8? If sharing confidential information with the NAIC and third-party consultants is permitted, appropriate confidentiality protections should be included.

New

- m. Provision prohibiting the making, publishing, disseminating, circulating or placing before the public in any way the group capital calculation and resulting group capital ratio under Section 4L(2) and/or the liquidity stress test along with its results and supporting disclosures required under Section 4L(3), by any insurer, broker, or other person engaged in any manner of the insurance business, except if the sole purpose of the announcement is to rebut a materially false statement, similar to Section 8G of Model #440?
- n. Filing requirements for the group capital calculation filing similar to those specified in Section 21 of Model #450?
 - i. Provision that gives the lead state the authority to exempt the filing of the group capital calculation provided the criteria are similar to those allowed under Section 21A of Model #450?
 - o Although not required for accreditation, in order to grant an exemption, is the filing required at least once?
 - ii. Provision that gives the lead state the authority to accept a limited group capital filing provided the criteria are similar to those allowed under Section 21B of Model #450?
 - o Although not required for accreditation, in order to grant an exemption, is the filing required at least once?
 - iii. Provision that gives the lead state the authority to require the group capital calculation of any group that previously met an exemption or submitted a limited filing if any insurer in the holding company system either triggers an RBC action level event, is deemed in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer, similar to those allowed under Section 21C of Model #450?
 - iv. Provision that sets forth the criteria for a jurisdiction to be included on the NAIC listing that “recognize and accept the group capital calculation” similar to that required under Section 21D and Section 21E of Model #450?

6. Insurance Holding Company Systems (Liquidity Stress Test)

State law should contain the NAIC *Insurance Holding Company System Regulatory Act* (#440), or an act substantially similar.

Insurance Holding Company Systems – continued

Changes to Existing

- o. Additions to the filing requirements for the enterprise risk filing specified in Section 4L(1) of the Model #440 (see next item).

New

- c. Define “NAIC Liquidity Stress Test Framework” similar to that in Section 1K?
- d. Define “Scope Criteria” similar to that in Section 1M?
- p. Filing requirements for the liquidity stress test filing similar to those specified in Section 4L(3) of Model #440:
 - vii. The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC Liquidity Stress Test Framework shall file the results of a specific year’s Liquidity Stress Test to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the *Financial Analysis Handbook* similar to Section 4L(3)?
 - viii. Insurers meeting at least one threshold of the Scope Criteria for a specific data year are scoped into that year’s NAIC Liquidity Stress Test Framework unless the lead state, after consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should not be scoped into the Framework for that data year similar to Section 4L(3)(a)? Insurers that do not trigger at least one threshold of the Scope Criteria are considered scoped out of the NAIC Liquidity Stress Test Framework for the specified data year, unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should be scoped into the Framework for that data year?

- ix. Provision requiring compliance with the NAIC Liquidity Stress Test Framework's instructions and reporting templates for the specific data year and any lead state insurance commissioner determinations in consultation with the Financial Stability Task Force or its successor, provided within the Framework similar to Section 4L(3)(b)?

Changes to Existing

- cc. Provisions for protecting confidential information submitted to the commissioner, including provisions maintaining confidentiality for information shared with state, federal and international regulators similar to Section 8? If sharing confidential information with the NAIC and third-party consultants is permitted, appropriate confidentiality protections should be included.
- q. Provision prohibiting the making, publishing, disseminating, circulating or placing before the public in any way the group capital calculation and resulting group capital ratio under Section 4L(2) and/or the liquidity stress test along with its results and supporting disclosures required under Section 4L(3), by any insurer, broker, or other person engaged in any manner of the insurance business, except if the sole purpose of the announcement is to rebut a materially false statement, similar to Section 8G of Model #440?

Draft: 12/3/2023

Adopted by Executive (EX) Committee and Plenary, Dec. 4, 2023

Adopted by the Innovation, Cybersecurity, and Technology (H) Committee, Dec. 1, 2023

NAIC MODEL BULLETIN:

USE OF ARTIFICIAL INTELLIGENCE SYSTEMS BY INSURERS

TO: All Insurers Licensed to Do Business In (*Insert Name of Jurisdiction*) (“Insurers”)

FROM: [Department/Commissioner]

DATE: [Insert]

RE: The Use of Artificial Intelligence Systems in Insurance

This bulletin is issued by the [] (Department) to remind all Insurers that hold certificates of authority to do business in the state that decisions or actions impacting consumers that are made or supported by advanced analytical and computational technologies, including Artificial Intelligence (AI) Systems (as defined below), must comply with all applicable insurance laws and regulations. This includes those laws that address unfair trade practices and unfair discrimination. This bulletin sets forth the Department’s expectations as to how Insurers will govern the development/acquisition and use of certain AI technologies, including the AI Systems described herein. This bulletin also advises Insurers of the type of information and documentation that the Department may request during an investigation or examination of any Insurer regarding its use of such technologies and AI Systems.

SECTION 1: INTRODUCTION, BACKGROUND, AND LEGISLATIVE AUTHORITY

Background

AI is transforming the insurance industry. AI techniques are deployed across all stages of the insurance life cycle, including product development, marketing, sales and distribution, underwriting and pricing, policy servicing, claim management, and fraud detection.

AI may facilitate the development of innovative products, improve consumer interface and service, simplify and automate processes, and promote efficiency and accuracy. However, AI, including AI Systems, can present unique risks to consumers, including the potential for inaccuracy, unfair discrimination, data vulnerability, and lack of transparency and explainability. Insurers should take actions to minimize these risks.

The Department encourages the development and use of innovation and AI Systems that contribute to safe and stable insurance markets. However, the Department expects that decisions made and actions taken by Insurers using AI Systems will comply with all applicable federal and state laws and regulations.

The Department recognizes the *Principles of Artificial Intelligence* that the NAIC adopted in 2020 as an appropriate source of guidance for Insurers as they develop and use AI systems. Those principles emphasize the importance of the fairness and ethical use of AI; accountability; compliance with state laws and regulations; transparency; and a safe, secure, fair, and robust system. These fundamental principles should guide Insurers in their development and use of AI Systems and underlie the expectations set forth in this bulletin.

Legislative Authority

The regulatory expectations and oversight considerations set forth in Section 3 and Section 4 of this bulletin rely on the following laws and regulations:

- **Unfair Trade Practices Model Act (#880)**: The *Unfair Trade Practices Act* [insert citation to state statute or regulation corresponding to Model #880] (UTPA), regulates trade practices in insurance by: 1) defining practices that constitute unfair methods of competition or unfair or deceptive acts and practices; and 2) prohibiting the trade practices so defined or determined.
- **Unfair Claims Settlement Practices Model Act (#900)**: The *Unfair Claims Settlement Practices Act*, [insert citation to state statute or regulation corresponding to Model #900] (UCSPA), sets forth standards for the investigation and disposition of claims arising under policies or certificates of insurance issued to residents of [insert state].

Actions taken by Insurers in the state must not violate the UTPA or the UCSPA, regardless of the methods the Insurer used to determine or support its actions. As discussed below, Insurers are expected to adopt practices, including governance frameworks and risk management protocols, that are designed to ensure that the use of AI Systems does not result in: 1) unfair trade practices, as defined in []; or 2) unfair claims settlement practices, as defined in [].

- **Corporate Governance Annual Disclosure Model Act (#305)**: The *Corporate Governance Annual Disclosure Act* [insert citation to state statute or regulation corresponding to Model #305] (CGAD), requires Insurers to report on governance practices and to provide a summary of the Insurer's corporate governance structure, policies, and practices. The content, form, and filing requirements for CGAD information are set forth in the *Corporate Governance Annual Disclosure Model Regulation (#306)* [insert citation to state statute or regulation corresponding to Model #306] (CGAD-R).

The requirements of CGAD and CGAD-R apply to elements of the Insurer's corporate governance framework that address the Insurer's use of AI Systems to support actions and decisions that impact consumers.

- **Property and Casualty Model Rating Law (#1780)**: The *Property and Casualty Model Rating Law*, [insert citation to state statute or regulation corresponding to the Model #1780], requires that property/casualty (P/C) insurance rates not be excessive, inadequate, or unfairly discriminatory.

The requirements of [] apply regardless of the methodology that the Insurer used to develop rates, rating rules, and rating plans subject to those provisions. That means that an Insurer is responsible for assuring that rates, rating rules, and rating plans that are developed using AI techniques and Predictive Models that rely on data and Machine Learning do not result in excessive, inadequate, or unfairly

discriminatory insurance rates with respect to all forms of casualty insurance—including fidelity, surety, and guaranty bond—and to all forms of property insurance—including fire, marine, and inland marine insurance, and any combination of any of the foregoing.

- **Market Conduct Surveillance Model Law (#693)**: The *Market Conduct Surveillance Model Law* [insert citation to state statute or regulation corresponding to Model #693] establishes the framework pursuant to which the Department conducts market conduct actions. These are comprised of the full range of activities that the Department may initiate to assess and address the market practices of Insurers, beginning with market analysis and extending to targeted examinations. Market conduct actions are separate from, but may result from, individual complaints made by consumers asserting illegal practices by Insurers.

An Insurer's conduct in the state, including its use of AI Systems to make or support actions and decisions that impact consumers, is subject to investigation, including market conduct actions. Section 4 of this bulletin provides guidance on the kinds of information and documents that the Department may request in the context of an AI-focused investigation, including a market conduct action.

SECTION 2: DEFINITIONS

For the purposes of this bulletin the following terms are defined¹:

“Adverse Consumer Outcome” refers to a decision by an Insurer that is subject to insurance regulatory standards enforced by the Department that adversely impacts the consumer in a manner that violates those standards.

“Algorithm” means a clearly specified mathematical process for computation; a set of rules that, if followed, will give a prescribed result.

“AI System” is a machine-based system that can, for a given set of objectives, generate outputs such as predictions, recommendations, content (such as text, images, videos, or sounds), or other output influencing decisions made in real or virtual environments. AI Systems are designed to operate with varying levels of autonomy.

“Artificial Intelligence (AI)” refers to a branch of computer science that uses data processing systems that perform functions normally associated with human intelligence, such as reasoning, learning, and self-improvement, or the capability of a device to perform functions that are normally associated with human intelligence such as reasoning, learning, and self-improvement. This definition considers machine learning to be a subset of artificial intelligence.

“Degree of Potential Harm to Consumers” refers to the severity of adverse economic impact that a consumer might experience as a result of an Adverse Consumer Outcome.

“Generative Artificial Intelligence (Generative AI)” refers to a class of AI Systems that generate content in the form of data, text, images, sounds, or video, that is similar to, but not a direct copy of, pre-existing data or content.

¹ Drafting note: Individual states may have adopted definitions for terms that are included in the model bulletin that may be different from the definitions set forth herein.

“Machine Learning (ML)” Refers to a field within artificial intelligence that focuses on the ability of computers to learn from provided data without being explicitly programmed.

“Model Drift” refers to the decay of a model’s performance over time arising from underlying changes such as the definitions, distributions, and/or statistical properties between the data used to train the model and the data on which it is deployed.

“Predictive Model” refers to the mining of historic data using algorithms and/or machine learning to identify patterns and predict outcomes that can be used to make or support the making of decisions.

“Third Party” for purposes of this bulletin means an organization other than the Insurer that provides services, data, or other resources related to AI.

SECTION 3: REGULATORY GUIDANCE AND EXPECTATIONS

Decisions subject to regulatory oversight that are made by Insurers using AI Systems must comply with the legal and regulatory standards that apply to those decisions, including unfair trade practice laws. These standards require, at a minimum, that decisions made by Insurers are not inaccurate, arbitrary, capricious, or unfairly discriminatory. Compliance with these standards is required regardless of the tools and methods Insurers use to make such decisions. However, because, in the absence of proper controls, AI has the potential to increase the risk of inaccurate, arbitrary, capricious, or unfairly discriminatory outcomes for consumers, it is important that Insurers adopt and implement controls specifically related to their use of AI that are designed to mitigate the risk of Adverse Consumer Outcomes.

Consistent therewith, all Insurers authorized to do business in this state are expected to develop, implement, and maintain a written program (an “AIS Program”) for the responsible use of AI Systems that make, or support decisions related to regulated insurance practices. The AIS Program should be designed to mitigate the risk of Adverse Consumer Outcomes, including, at a minimum, the statutory provisions set forth in Section 1 of this bulletin.

The Department recognizes that robust governance, risk management controls, and internal audit functions play a core role in mitigating the risk that decisions driven by AI Systems will violate unfair trade practice laws and other applicable existing legal standards. The Department also encourages the development and use of verification and testing methods to identify errors and bias in Predictive Models and AI Systems, as well as the potential for unfair discrimination in the decisions and outcomes resulting from the use of Predictive Models and AI Systems.

The controls and processes that an Insurer adopts and implements as part of its AIS Program should be reflective of, and commensurate with, the Insurer’s own assessment of the degree and nature of risk posed to consumers by the AI Systems that it uses, considering: (i) the nature of the decisions being made, informed, or supported using the AI System; (ii) the type and Degree of Potential Harm to Consumers resulting from the use of AI Systems; (iii) the extent to which humans are involved in the final decision-making process; (iv) the transparency and explainability of outcomes to the impacted consumer; and (v) the extent and scope of the insurer’s use or reliance on data, Predictive Models, and AI Systems from third parties. Similarly, controls and processes should be commensurate with both the risk of Adverse Consumer Outcomes and the Degree of Potential Harm to Consumers.

As discussed in Section 4, the decisions made as a result of an Insurer's use of AI Systems are subject to the Department's examination to determine that the reliance on AI Systems are compliant with all applicable existing legal standards governing the conduct of the Insurer.

AIS Program Guidelines

1.0 General Guidelines

1.1 The AIS Program should be designed to mitigate the risk that the Insurer's use of an AI System will result in Adverse Consumer Outcomes.

1.2 The AIS Program should address governance, risk management controls, and internal audit functions.

1.3 The AIS Program should vest responsibility for the development, implementation, monitoring, and oversight of the AIS Program and for setting the Insurer's strategy for AI Systems with senior management accountable to the board or an appropriate committee of the board.

1.4 The AIS Program should be tailored to and proportionate with the Insurer's use and reliance on AI and AI Systems. Controls and procedures should be focused on the mitigation of Adverse Consumer Outcomes and the scope of the controls and procedures applicable to a given AI System use case should reflect and align with the Degree of Potential Harm to Consumers with respect to that use case.

1.5 The AIS Program may be independent of or part of the Insurer's existing Enterprise Risk Management (ERM) program. The AIS Program may adopt, incorporate, or rely upon, in whole or in part, a framework or standards developed by an official third-party standard organization, such as the National Institute of Standards and Technology (NIST) Artificial Intelligence Risk Management Framework, Version 1.0.

1.6 The AIS Program should address the use of AI Systems across the insurance life cycle, including areas such as product development and design, marketing, use, underwriting, rating and pricing, case management, claim administration and payment, and fraud detection.

1.7 The AIS Program should address all phases of an AI System's life cycle, including design, development, validation, implementation (both systems and business), use, on-going monitoring, updating and retirement.

1.8 The AIS Program should address the AI Systems used with respect to regulated insurance practices whether developed by the Insurer or a third-party vendor.

1.9 The AIS Program should include processes and procedures providing notice to impacted consumers that AI Systems are in use and provide access to appropriate levels of information based on the phase of the insurance life cycle in which the AI Systems are being used.

2.0 Governance

The AIS Program should include a governance framework for the oversight of AI Systems used by the Insurer. Governance should prioritize transparency, fairness, and accountability in the design and implementation of the AI Systems, recognizing that proprietary and trade secret information must be protected. An Insurer may consider adopting new internal governance structures or rely on the Insurer's existing governance structures; however, in developing its governance framework, the Insurer should consider addressing the following items:

2.1 The policies, processes, and procedures, including risk management and internal controls, to be followed at each stage of an AI System life cycle, from proposed development to retirement.

2.2 The requirements adopted by the Insurer to document compliance with the AIS Program policies, processes, procedures, and standards. Documentation requirements should be developed with Section 4 in mind.

2.3 The Insurer's internal AI System governance accountability structure, such as:

- a) The formation of centralized, federated, or otherwise constituted committees comprised of representatives from appropriate disciplines and units within the Insurer, such as business units, product specialists, actuarial, data science and analytics, underwriting, claims, compliance, and legal.
- b) Scope of responsibility and authority, chains of command, and decisional hierarchies.
- c) The independence of decision-makers and lines of defense at successive stages of the AI System life cycle.
- d) Monitoring, auditing, escalation, and reporting protocols and requirements.
- e) Development and implementation of ongoing training and supervision of personnel.

2.4 Specifically with respect to Predictive Models: the Insurer's processes and procedures for designing, developing, verifying, deploying, using, updating, and monitoring Predictive Models, including a description of methods used to detect and address errors, performance issues, outliers, or unfair discrimination in the insurance practices resulting from the use of the Predictive Model.

3.0 Risk Management and Internal Controls

The AIS Program should document the Insurer's risk identification, mitigation, and management framework and internal controls for AI Systems generally and at each stage of the AI System life cycle. Risk management and internal controls should address the following items:

3.1 The oversight and approval process for the development, adoption, or acquisition of AI Systems, as well as the identification of constraints and controls on automation and design to align and balance function with risk.

3.2 Data practices and accountability procedures, including data currency, lineage, quality, integrity, bias analysis and minimization, and suitability.

3.3 Management and oversight of Predictive Models (including algorithms used therein), including:

- a) Inventories and descriptions of the Predictive Models.
- b) Detailed documentation of the development and use of the Predictive Models.
- c) Assessments such as interpretability, repeatability, robustness, regular tuning, reproducibility, traceability, model drift, and the auditability of these measurements where appropriate.

3.4 Validating, testing, and retesting as necessary to assess the generalization of AI System outputs upon implementation, including the suitability of the data used to develop, train, validate and audit the model. Validation can take the form of comparing model performance on unseen data available at the time of model development to the performance observed on data post-implementation, measuring performance against expert review, or other methods.

3.5 The protection of non-public information, particularly consumer information, including unauthorized access to the Predictive Models themselves.

3.6 Data and record retention.

3.7 Specifically with respect to Predictive Models: a narrative description of the model's intended goals and objectives and how the model is developed and validated to ensure that the AI Systems that rely on such models correctly and efficiently predict or implement those goals and objectives.

4.0 Third-Party AI Systems and Data

Each AIS Program should address the Insurer's process for acquiring, using, or relying on (i) third-party data to develop AI Systems; and (ii) AI Systems developed by a third party, which may include, as appropriate, the establishment of standards, policies, procedures, and protocols relating to the following considerations:

4.1 Due diligence and the methods employed by the Insurer to assess the third party and its data or AI Systems acquired from the third party to ensure that decisions made or supported from such AI Systems that could lead to Adverse Consumer Outcomes will meet the legal standards imposed on the Insurer itself.

4.2 Where appropriate and available, the inclusion of terms in contracts with third parties that:

- a) Provide audit rights and/or entitle the Insurer to receive audit reports by qualified auditing entities.
- b) Require the third party to cooperate with the Insurer with regard to regulatory inquiries and investigations related to the Insurer's use of the third-party's product or services.

4.3 The performance of contractual rights regarding audits and/or other activities to confirm the third-party's compliance with contractual and, where applicable, regulatory requirements.

SECTION 4: REGULATORY OVERSIGHT AND EXAMINATION CONSIDERATIONS

The Department's regulatory oversight of Insurers includes oversight of an Insurer's conduct in the state, including its use of AI Systems to make or support decisions that impact consumers. Regardless of the existence or scope of a written AIS Program, in the context of an investigation or market conduct action, an Insurer can expect to be asked about its development, deployment, and use of AI Systems, or any specific Predictive Model, AI System or application and its outcomes (including Adverse Consumer Outcomes) from the use of those AI Systems, as well as any other information or documentation deemed relevant by the Department.

Insurers should expect those inquiries to include (but not be limited to) the Insurer's governance framework, risk management, and internal controls (including the considerations identified in Section 3). In addition to conducting a review of any of the items listed in this Bulletin, a regulator may also ask questions regarding any specific model, AI System, or its application, including requests for the following types of information and/or documentation:

1. Information and Documentation Relating to AI System Governance, Risk Management, and Use Protocols

1.1. Information and documentation related to or evidencing the Insurer's AIS Program, including:

- a) The written AIS Program.
- b) Information and documentation relating to or evidencing the adoption of the AIS Program.
- c) The scope of the Insurer's AIS Program, including any AI Systems and technologies not included in or addressed by the AIS Program.
- d) How the AIS Program is tailored to and proportionate with the Insurer's use and reliance on AI Systems, the risk of Adverse Consumer Outcomes, and the Degree of Potential Harm to Consumers.
- e) The policies, procedures, guidance, training materials, and other information relating to the adoption, implementation, maintenance, monitoring, and oversight of the Insurer's AIS Program, including:
 - i. Processes and procedures for the development, adoption, or acquisition of AI Systems, such as:
 - (1) Identification of constraints and controls on automation and design.
 - (2) Data governance and controls, any practices related to data lineage, quality, integrity, bias analysis and minimization, suitability, and Data Currency.

- ii. Processes and procedures related to the management and oversight of Predictive Models, including measurements, standards, or thresholds adopted or used by the Insurer in the development, validation, and oversight of models and AI Systems.
- iii. Protection of non-public information, particularly consumer information, including unauthorized access to Predictive Models themselves.

1.2. Information and documentation relating to the Insurer's pre-acquisition/pre-use diligence, monitoring, oversight, and auditing of data or AI Systems developed by a third party.

1.3. Information and documentation relating to or evidencing the Insurer's implementation and compliance with its AIS Program, including documents relating to the Insurer's monitoring and audit activities respecting compliance, such as:

- a) Documentation relating to or evidencing the formation and ongoing operation of the Insurer's coordinating bodies for the development, use, and oversight of AI Systems.
- b) Documentation related to data practices and accountability procedures, including data lineage, quality, integrity, bias analysis and minimization, suitability, and Data Currency.
- c) Management and oversight of Predictive Models and AI Systems, including:
 - i. The Insurer's inventories and descriptions of Predictive Models, and AI Systems used by the Insurer to make or support decisions that can result in Adverse Consumer Outcomes.
 - ii. As to any specific Predictive Model or AI System that is the subject of investigation or examination:
 - (1) Documentation of compliance with all applicable AI Program policies, protocols, and procedures in the development, use, and oversight of Predictive Models and AI Systems deployed by the Insurer.
 - (2) Information about data used in the development and oversight of the specific model or AI System, including the data source, provenance, data lineage, quality, integrity, bias analysis and minimization, suitability, and Data Currency.
 - (3) Information related to the techniques, measurements, thresholds, and similar controls used by the Insurer.
- d) Documentation related to validation, testing, and auditing, including evaluation of Model Drift to assess the reliability of outputs that influence the decisions made based on Predictive Models. Note that the nature of validation, testing, and auditing

should be reflective of the underlying components of the AI System, whether based on Predictive Models or Generative AI.

2. Third-Party AI Systems and Data

In addition, if the investigation or examination concerns data, Predictive Models, or AI Systems collected or developed in whole or in part by third parties, the Insurer should also expect the Department to request the following additional types of information and documentation.

- 2.1 Due diligence conducted on third parties and their data, models, or AI Systems.
- 2.2 Contracts with third-party AI System, model, or data vendors, including terms relating to representations, warranties, data security and privacy, data sourcing, intellectual property rights, confidentiality and disclosures, and/or cooperation with regulators.
- 2.3 Audits and/or confirmation processes performed regarding third-party compliance with contractual and, where applicable, regulatory obligations.
- 2.4 Documentation pertaining to validation, testing, and auditing, including evaluation of Model Drift.

The Department recognizes that Insurers may demonstrate their compliance with the laws that regulate their conduct in the state in their use of AI Systems through alternative means, including through practices that differ from those described in this bulletin. The goal of the bulletin is not to prescribe specific practices or to prescribe specific documentation requirements. Rather, the goal is to ensure that Insurers in the state are aware of the Department's expectations as to how AI Systems will be governed and managed and of the kinds of information and documents about an Insurer's AI Systems that the department expects an Insurer to produce when requested.

As in all cases, investigations and market conduct actions may be performed using procedures that vary in nature, extent, and timing in accordance with regulatory judgment. Work performed may include inquiry, examination of company documentation, or any of the continuum of market actions described in the NAIC's *Market Regulation Handbook*. These activities may involve the use of contracted specialists with relevant subject matter expertise. Nothing in this bulletin limits the authority of the Department to conduct any regulatory investigation, examination, or enforcement action relative to any act or omission of any Insurer that the Department is authorized to perform.

Date: Nov. 2, 2023

State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

Executive (EX) Committee

- Amendments to the ***Unfair Trade Practices Act (#880)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2021 Spring National Meeting. Fourteen jurisdictions have adopted revisions to this model.

Life Insurance and Annuities (A) Committee

- Amendments to the ***Annuity Disclosure Model Regulation (#245)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2021 Summer National Meeting. Two jurisdictions have adopted revisions to this model.
- Amendments to the ***Standard Nonforfeiture Law for Individual Deferred Annuities (#805)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Twenty-four jurisdictions have adopted revisions to this model.

Health Insurance and Managed Care (B) Committee

- Amendments to the ***Health Maintenance Organization Model Act (#430)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. One jurisdiction has adopted revisions to this model.
- Amendments to the ***Insurance Holding Company System Regulatory Act (#440)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Fourteen jurisdictions have adopted revisions to this model.
- Amendments to the ***Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Seven jurisdictions have adopted revisions to this model.

Property and Casualty Insurance (C) Committee

- Adoption of the ***Real Property Lender-Placed Insurance Model Act (#631)***—This model was adopted by the Executive (EX) Committee and Plenary at the 2021 Spring National Meeting. One jurisdiction has adopted this model.
- Adoption of the ***Pet Insurance Model Act (#633)***—This model was adopted by the Executive (EX) Committee and Plenary at the 2022 Summer National Meeting. Six jurisdictions have adopted this model.



- Adoption of the ***Nonadmitted Insurance Model Act (#870)***—This model was adopted by the Executive (EX) Committee and Plenary at the 2023 Summer National Meeting. NAIC staff are not aware of adoption by any jurisdiction.

Financial Condition (E) Committee

- Adoption of the ***Mortgage Guaranty Insurance Model Act (#630)*** — This model was adopted by the Executive (EX) Committee and Plenary at the 2023 Summer National Meeting. NAIC staff are not aware of adoption by any jurisdiction.