

# **2023 Proceedings of the National Association of Insurance Commissioners**

**2023 Spring National Meeting  
March 21 – 25, 2023**

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**Held at the  
Omni Louisville, Louisville Marriott Downtown, &  
Kentucky International Convention Center  
Louisville, Kentucky**

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

**I. Name**

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

**II. Duration**

The period of duration of the NAIC is perpetual.

**III. Registered Office and Agent**

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

**IV. Authority to Issue Stock**

The NAIC shall have no authority to issue capital stock.

**V. Incorporators**

The name and address of the incorporator are as follows:

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

**VI. Purpose**

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

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

**VII. Restrictions**

- A. No substantial part of the activities of the Corporation shall be the carrying of propaganda, or otherwise attempting to influence legislation except as otherwise permitted by Section 501(h) of the Code and in any corresponding laws of the State of Delaware, and the Corporation shall not participate in or intervene

in including the publishing or distribution of statements concerning any political campaign on behalf of or in opposition to any candidate for public office.

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

### **VIII. Membership**

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

### **IX. Activities**

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

### **X. Powers**

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

**XI. Immunity**

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

**XII. Exculpation and Indemnification**

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

The NAIC shall indemnify to the full extent authorized or permitted by the laws of the State of Delaware, as now in effect or as hereafter amended, any person made or threatened to be made a party to any threatened, pending or completed action, suit or proceeding (whether civil, criminal, administrative or investigative, including an action by or in the right of the NAIC) by reason of the fact that the person is or was a member of the Executive Committee, officer, member, committee member, employee or agent of the NAIC or serves any other enterprise as such at the request of the NAIC.

The foregoing right of indemnification shall not be deemed exclusive of any other rights to which such person may be entitled apart from this Article XII. The foregoing right of indemnification shall continue as to a person who has ceased to be a member of the Executive Committee, officer, member, committee member, employee or agent and shall inure to the benefit of the heirs, the executors and administrators of such a person.

**XIII. Dissolution**

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

**XIV. Bylaws**

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

**XV. Amendments**

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

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

/signature/

Catherine J. Weatherford, Incorporator

*ADOPTED 1999, Proc. Third Quarter*

*Adopted October 1999*  
*Amended November 2002*  
*Amended June 2003*  
*Amended March 2004*  
*Amended December 2004*  
*Amended March 2009*  
*Amended September 2009*  
*Amended October 2011*  
*Amended December 2015*  
*Amended December 2021*

*Bylaws of the NAIC, a Delaware Non-Profit Corporation*

**BYLAWS OF THE  
 NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS**

**ARTICLE I**

**Name, Organization and Location**

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

**ARTICLE II**

**Membership**

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

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

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

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

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

### **ARTICLE III**

#### **Officers**

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

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

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

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

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

The Secretary-Treasurer shall assist the President and, as applicable, the President-Elect or the Vice President in the conduct of meetings of the Executive Committee and members. For member meetings, the Secretary-Treasurer shall call the roll of the membership and certify the presence of a quorum and shall receive, validate and maintain all proxies for elections held at member meetings. The Secretary-Treasurer shall also recommend to the Executive Committee such policies and procedures to maintain the history and continuity of the NAIC. The

Secretary-Treasurer shall also assist the President and President-Elect in all matters relating to the budget, accounting, expenditure and revenue practices of the NAIC; including, but not limited to reviewing the financial information of the organization and consulting with NAIC management, independent auditors, and other necessary parties regarding the financial operations and condition of the organization.

## **ARTICLE IV**

### **Executive Committee**

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

1. The Executive Committee shall have the authority and responsibility to:
  - (a) manage the affairs of the NAIC in a manner consistent with the Certificate of Incorporation and Bylaws.
  - (b) make recommendations to achieve the goals of the NAIC based upon either its own initiative or the recommendations of the Standing Committees or Subcommittees reporting to it, for consideration and action by the members at any NAIC Plenary Session.
  - (c) create and terminate one or more Task Forces reporting to it to the extent needed and appropriate.
  - (d) establish and allocate, from time to time, functions and responsibilities to be performed by each Zone.
  - (e) to the extent needed and appropriate, oversee NAIC Offices to assist the NAIC and the individual members in achieving the goals of the NAIC.
  - (f) submit to the NAIC at each National Meeting, during which a Plenary Session is held, its report and recommendations concerning the reports of the Standing Committees. All Standing Committee reports shall be included as part of the Executive Committee report.
  - (g) plan, implement and coordinate communications and activities with other state, federal and local government organizations in order to advance the goals of the NAIC and promote understanding of state insurance regulation.
  
2. Duties and Operations of the Executive Committee.
  - (a) The Executive Committee shall hold at least two (2) regular meetings annually at a designated time and place. Special meetings may be held when called by the President, or by at least three (3) members of the Executive Committee in writing. In any case, the Executive Committee shall meet at least once per calendar month. At least five (5) days notice shall be given of all regular and special meetings. Meetings

may be held in person or by means of conference telephone or other communication equipment by means of which all persons participating in the meeting can hear each other, and such participation in a meeting shall constitute presence in person at such meeting in accordance with applicable laws. The presiding member of the Executive Committee shall only cast his or her vote in order to break a tie vote. In addition, the Executive Committee may act by written consent as provided by law.

- (b) The Executive Committee may, with the concurrence of two-thirds of the members of the Executive Committee, establish rules for its conduct that shall not conflict with the Certificate of Incorporation and Bylaws. Such rules may be changed only by a concurrence of two-thirds of the members of the Executive Committee after twenty-four (24) hours notice to all members of the Executive Committee.
- (c) Any action required or permitted to be taken at any meeting of the Executive Committee or any committee thereof may be taken without a meeting if all members of the Executive Committee or such committee, as the case may be, consent thereto in writing in accordance with applicable law.
- (d) The Executive Committee shall cause to be kept minutes of its meeting and have information of any action of a general character taken by it published to members qualified to vote.

(e) NAIC OFFICES

- (i) The Executive Committee shall oversee an Executive Office and a Central Office with management and staff personnel and appropriate resources for performance of duties and assigned responsibilities. Additional satellite offices may be established as needed. The Executive Committee shall have the authority to select, employ and terminate a Chief Executive Officer who shall not be a member of the NAIC and who shall have the primary responsibility for the internal management and functioning of the NAIC Offices within the direction of the Executive Committee, as well as other duties assigned by the Executive Committee through execution of an Employment Agreement or other authorization. The Chief Executive Officer appointed by the Executive Committee pursuant to this section shall not be considered an officer for purposes of Article III hereof and shall not be a member of the Executive Committee. The Executive Committee, through the Internal Administration (EX1) Subcommittee, shall provide oversight and direction to the Chief Executive Officer regarding Office operations.
- (ii) Consistent with the purposes of the NAIC, the role of the NAIC Offices is to: (1) provide services to the NAIC through support to the NAIC Committees, Subcommittees, Task Forces or otherwise; (2) provide services to individual State insurance departments; and (3) develop recommendations for consideration as to NAIC policy and administrative decisions of the NAIC.
- (iii) In performing its role, subject to the oversight and direction specified in (paragraph i) the NAIC Offices may engage in a variety of functions including but not limited to the following: research; analysis; information gathering and dissemination; library services; data collection; data base building and maintenance; report generation and dissemination; government liaison; non-regulatory liaison; securities valuation; administration; litigation; legislative and regulatory drafting; and educational development.
- (iv) The Chief Executive Officer shall prepare an annual budget, related to the priorities of the NAIC, for the NAIC Offices to be submitted through the EX1 Subcommittee to the Executive Committee, which shall make its recommendations to the members of the NAIC for action at the next Plenary Session of the NAIC.



### 3. Internal Administration (EX1) Subcommittee

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

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

The Internal Administration (EX1) Subcommittee shall:

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

### 4. Audit Committee

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

## **ARTICLE V**

### **Zones**

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

NAIC or by the members of the NAIC as a whole or by the members of the Zone. Each Zone may hold Zone Meetings for such purposes as may be deemed appropriate by members of the Zone.

## **ARTICLE VI**

### **Standing Committees and Task Forces**

#### 1. General

The Standing Committees shall not be subcommittees of the Executive Committee and shall have no power or authority for the management of the business and affairs of the NAIC. Each Standing Committee shall be composed of not more than 15 members, including a Chair and one or more Vice Chairs, appointed by the President and President-Elect, and such appointments shall remain effective until the succeeding President and President-Elect appoint members for the following year. Standing Committees shall meet at least twice a year at National Meetings and may meet more often at the call of the Chair as required to complete its assignments from the Executive Committee in a timely manner.

The Executive Committee shall make all assignments of subject matter to the Standing Committees and shall require coordination between Committees and Task Forces of the subject matter if more than one Committee or Task Force is affected. The format of the Committee reports shall be prescribed by the Executive Committee. All appointments or elections of members of the NAIC to any office or Committee of the NAIC shall be deemed the appointment or election of a particular member and shall not automatically pass to a successor in office.

#### 2. Specific Duties

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

- (a) Life Insurance and Annuities (A) Committee: This Standing Committee shall consider issues relating to life insurance and annuities.
- (b) Health Insurance and Managed Care (B) Committee: This Standing Committee shall consider issues relating to health and accident insurance and managed care.
- (c) Property and Casualty Insurance (C) Committee: This Standing Committee shall consider issues relating to personal and commercial lines of property and casualty insurance, worker's compensation insurance, statistical information, surplus lines, and casualty actuarial matters.
- (d) Market Regulation and Consumer Affairs (D) Committee: This Standing Committee shall consider issues involving market conduct in the insurance industry; competition in insurance markets; the qualifications and conduct of agents and brokers; market conduct examination practices; the control and management of insurance institutions; consumer services of State insurance departments; and consumer participation in NAIC activities.
- (e) Financial Condition (E) Committee: This Standing Committee shall consider both administrative and substantive issues as they relate to accounting practices and procedures; blanks; valuation of securities; the Insurance Regulatory Information System (IRIS), as it relates to solvency and profitability; the call, monitoring and concluding report of Zone Examinations; and financial examinations and examiner training.
- (f) Financial Regulation Standards and Accreditation (F) Committee: This Standing Committee shall consider

both administrative and substantive issues as they relate to administration and enforcement of the NAIC Accreditation Program, including without limitation, consideration of standards and revisions of standards for accreditation, interpretation of standards, evaluation and interpretation of states' laws and regulations, and departments' practices, procedures and organizations as they relate to compliance with standards, examination of members for compliance with standards, development and oversight of procedures for examination of members for compliance with standards, qualification and selection of individuals to perform the examination of members for compliance with standards, and decisions regarding whether to accredit members.

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

(h) Innovation, Cybersecurity and Technology (H) Committee. This Standing Committee shall consider issues related to cybersecurity, innovation, data security and privacy, and emerging technology issues.

### 3. Task Forces

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

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

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

## **ARTICLE VII**

### **Meetings of the Membership**

#### 1. Regular Meetings

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

#### 2. Special Meetings

Special meetings of the members may be called by any five (5) members of the Executive Committee by giving all members notice of such meeting at least ten (10) but not more than sixty (60) days prior thereto, or by any twenty (20) members of the NAIC by giving all members notice of such meeting at least thirty (30) but not more than sixty (60) days prior thereto. Notice of the special meeting shall state the place, day and hour of the

special meeting and the purpose or purposes for which the special meeting is called, and shall be delivered by the persons calling the meeting within the applicable time period set forth herein, either personally, by mail or by other lawful means, to each member entitled to be present and vote at such meeting.

### 3. Waiver of Notice; Postponement

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

### 4. Quorum

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

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

## **ARTICLE VIII**

### **Elections**

1. The election of officers of the NAIC shall be scheduled for the plenary session of the last National Meeting of the calendar year or at such other plenary session as agreed to by the members.
2. At the beginning of such Plenary Session, the Secretary-Treasurer shall ascertain and announce the presence of a quorum.
3. Upon the determination of a quorum, the chair shall briefly review the provisions of the Certificate of Incorporation and Bylaws in regard to voting.
4. The President shall ask for and announce all proxies. Proxies shall be held by the Secretary-Treasurer or a designee throughout the election session. Proxies shall be valid, subject to their term, until superseded by the member and shall be governed by ARTICLE IX of the Bylaws.
5. Every individual voting by proxy must meet the requirements of Article II of the Bylaws of the NAIC which requires that such a person be "...officially affiliated with the member's (the member delegating authority to vote) department, and is wholly or principally employed by said department."
6. Prior to opening the nominations for office, the Chair shall appoint three (3) members of the NAIC to act as

voting inspectors. The voting inspectors shall distribute, collect, count and/or verify ballots, and report their findings to the Secretary-Treasurer. If a voting inspector is nominated for an office and does not withdraw as a candidate, he or she shall not be a voting inspector for the election of the office to which he or she is nominated and the chair shall appoint another voting inspector in his or her place.

7. The Chair shall announce the opening of nominations for offices in the following order:
  - (a) President. Provided, however, where the President does not run for re-election, the President-Elect shall become President at the conclusion of the President's term of office. In those cases where the President runs for re-election or where a vacancy exists because the President-Elect fails or is otherwise unable to assume the Presidency, this office will be subject to an election.
  - (b) President-Elect.
  - (c) Vice President.
  - (d) Secretary-Treasurer.
8. Only members or duly authorized proxyholders may make nominations.
9. One nominating speech, not to exceed three (3) minutes in duration, shall be allowed for each nominee.
10. After nominations are closed for each office, each nominee must indicate whether he or she accepts the nomination and, if he or she accepts, shall be permitted to address the membership for a period of up to seven (7) minutes. Such addresses shall be given in the order by which the nominations were made.
11. The votes of members, in person or by proxy, constituting a majority of the quorum present at the meeting shall be necessary for election to such office. If no candidate receives a majority, the two candidates with the most votes will participate in a run-off election. The candidate with the most votes in the run-off election shall win such election.
12. Voting need not be by written ballot, unless otherwise required by these Bylaws, the Certificate of Incorporation, or applicable law.

## **ARTICLE IX**

### **Proxies; Waiver of Notice**

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

Whenever any notice is required to be given to any member (for a meeting of members or the Executive Committee) under the provisions of the Certificate of Incorporation, these Bylaws or applicable law, a written

waiver, signed by the person entitled to notice, or a waiver by electronic transmission by person entitled to notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice. Neither the business to be transacted at, nor the purpose of, any annual or special meeting of the members or any committee, subcommittee or task force need be specified in any waiver of notice of such meeting.

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

Any notice required under these Bylaws may be provided by mail, facsimile, or electronic transmission.

## **ARTICLE X**

### **Procedures: Books and Records**

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

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

## **ARTICLE XI**

### **Amendments**

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

Adopted October 1999, see 1999 Proc., Third Quarter page 7

Amended November 2002, see 2002 Proc., Fourth Quarter page 25

Amended June 2003, see 2003 Proc., Second Quarter page 28

Amended March 2004, see 2004 Proc., First Quarter page 119

Amended December 2004, see 2004 Proc., Fourth Quarter page 58

Amended March 2009, see 2009 Proc., First Quarter page 3–67

Amended September 2009, see 2009 Proc., Third Quarter

Amended October 2011, see Proc., Summer 2011

Amended December 2015, see Proc., Spring 2016  
Amended December 2021, see Proc., Spring 2022

**NAIC Policy Statement on Open Meetings**  
**Revised: April 1, 2014**

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

1. Potential or pending litigation or administrative proceedings which may involve the NAIC, any NAIC member, or their staffs, in any capacity involving their official or prescribed duties, requests for briefs of amicus curiae, or legal advice.
2. Pending investigations which may involve either the NAIC or any member in any capacity.
3. Specific companies, entities or individuals, including, but not limited to, collaborative financial and market conduct examinations and analysis.
4. Internal or administrative matters of the NAIC or any NAIC member, including budget, personnel and contractual matters, and including consideration of internal administration of the NAIC, including, but not limited to, by the Internal Administration (EX1) Subcommittee or any subgroup appointed thereunder.
5. Voting on the election of officers of the NAIC.
6. Consultations with NAIC staff members related to NAIC technical guidance, including, but not limited to, Annual and Quarterly Statement Blanks and Instructions, the Accounting Practices and Procedures Manual, and similar materials.
7. Consideration of individual state insurance department's compliance with NAIC financial regulation standards by the Financial Regulation Standards and Accreditation (F) Committee or any subgroup appointed thereunder.
8. Consideration of strategic planning issues relating to federal legislative and regulatory matters or international regulatory matters.
9. Any other subject required to be kept confidential under any Memorandum of Understanding or other agreement, state or federal law or under any judicial or administrative order.

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

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

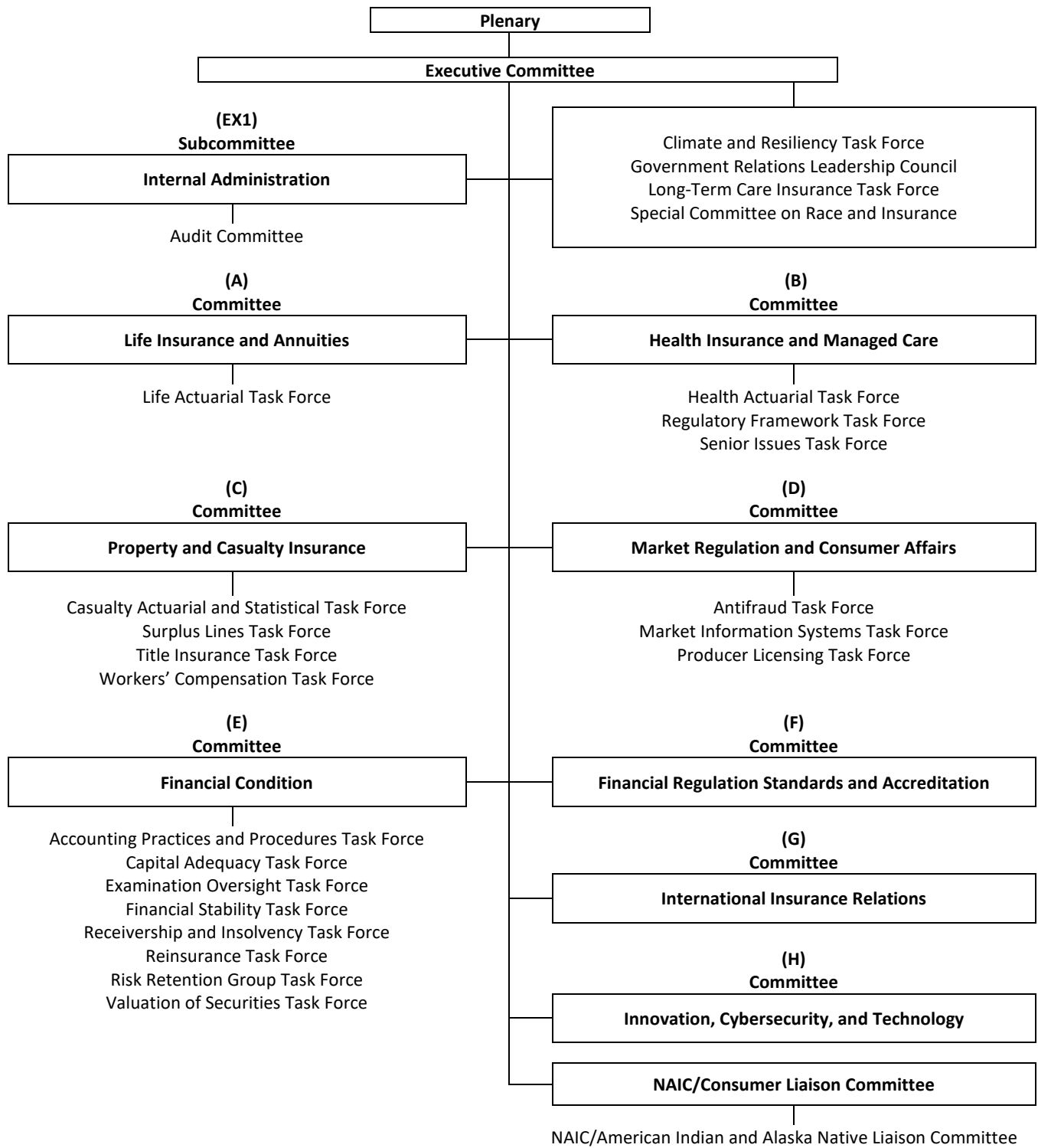


[NOTE: (Effective Jan. 1, 1996, conference call meetings are included in the application of the policy statement, by action of the NAIC on June 4, 1995). This policy statement was originally adopted by the NAIC membership during the 1994 Fall National Meeting in Minneapolis, Minnesota, Sept. 18–20, 1994.]

*Revisions Adopted by the NAIC Membership, April 1, 2014*

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## 2023 COMMITTEE AND TASK FORCE STRUCTURE



## APPOINTED AND DISBANDED

### Current and Previous Year

APPOINTED SINCE JANUARY 2023	Effective Date	NAIC Support Staff
<b>RENAMED SINCE JANUARY 2023</b>		
<b>DISBANDED SINCE JANUARY 2023</b>		
DISBANDED IN 2022	Effective Date	NAIC Support Staff
Antifraud Education Enhancement (D) Working Group .....	04/07/2022	Greg Welker
Guaranteed Issue (GI) Life Valuation (A) Subgroup.....	03/31/2022	Scott O’Neal
Information Systems (EX1) Task Force .....	01/14/2022	Sherry Stevens
Life Insurance Online Guide (A) Working Group .....	12/16/2022	Jennifer Cook
Long-Term Care Insurance Model Update (B) Subgroup.....	08/11/2022	David Torian
Long-Term Care Insurance Multistate Rate Review (EX) Subgroup.....	12/16/2022	Eric King
Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup.....	08/11/2022	Eric King
Long-Term Care Insurance Restructuring (E) Subgroup .....	01/19/2022	Dan Daveline
Pet Insurance (C) Working Group .....	12/16/2022	Aaron Brandenburg

## 2023 MEMBERS BY ZONE

Northeast Zone		Southeast Zone	
Kathleen A. Birrane, Chair	Maryland	James J. Donelon, Chair	Louisiana
Trinidad Navarro, Vice Chair	Delaware	Carter Lawrence, Vice Chair	Tennessee
Kevin Gaffney, Secretary	Vermont	Sharon P. Clark, Secretary	Kentucky
Andrew N. Mais	Connecticut	Mark Fowler	Alabama
Karima M. Woods	District of Columbia	Alan McClain	Arkansas
Timothy N. Schott	Maine	Michael Yaworsky	Florida
Gary D. Anderson	Massachusetts	John F. King	Georgia
Chris Nicolopoulos	New Hampshire	Mike Chaney	Mississippi
Marlene Caride	New Jersey	Mike Causey	North Carolina
Adrienne A. Harris	New York	Alexander S. Adams Vega	Puerto Rico
Michael Humphreys	Pennsylvania	Michael Wise	South Carolina
Elizabeth Kelleher Dwyer	Rhode Island	Tregenza A. Roach	U.S. Virgin Islands
		Scott A. White	Virginia
		Allan L. McVey	West Virginia
Midwest Zone		Western Zone	
Doug Ommen, Chair	Iowa	Lori K. Wing-Heier, Chair	Alaska
Anita G. Fox, Vice Chair	Michigan	Michael Conway, Vice Chair	Colorado
Vicki Schmidt, Secretary	Kansas	Andrew R. Stolfi, Secretary	Oregon
Dana Popish Severinghaus	Illinois	Peni Itula Sapini Teo	American Samoa
Amy L. Beard	Indiana	Barbara D. Richardson	Arizona
Grace Arnold	Minnesota	Ricardo Lara	California
Chlora Lindley-Myers	Missouri	Michelle B. Santos	Guam
Eric Dunning	Nebraska	Gordon I. Ito	Hawaii
Jon Godfread	North Dakota	Dean L. Cameron	Idaho
Judith L. French	Ohio	Troy Downing	Montana
Glen Mulready	Oklahoma	Joseph Rios Jr.	N. Mariana Islands
Larry D. Deiter	South Dakota	Scott Kipper	Nevada
Nathan Houdek	Wisconsin	Jennifer Catechis	New Mexico
		Cassie Brown	Texas
		Jon Pike	Utah
		Mike Kreidler	Washington
		Jeff Rude	Wyoming

*Updated March 6, 2023*

## 2023 EXECUTIVE (EX) COMMITTEE

Chlora Lindley-Myers, President	Missouri
Andrew N. Mais, President-Elect	Connecticut
Jon Godfread, Vice President	North Dakota
Scott A. White, Secretary-Treasurer	Virginia

Most Recent Past President: Dean L. Cameron	Idaho
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### Northeast Zone

Kathleen A. Birrane, Chair	Maryland
Trinidad Navarro, Vice Chair	Delaware
Kevin Gaffney, Secretary	Vermont

### Southeast Zone

James J. Donelon, Chair	Louisiana
Carter Lawrence, Vice Chair	Tennessee
Sharon P. Clark, Secretary	Kentucky

### Midwest Zone

Doug Ommen, Chair	Iowa
Anita G. Fox, Vice Chair	Michigan
Vicki Schmidt, Secretary	Kansas

### Western Zone

Lori K. Wing-Heier, Chair	Alaska
Michael Conway, Vice Chair	Colorado
Andrew R. Stolfi, Secretary	Oregon

NAIC Support Staff: Andrew J. Beal/Kay Noonan

**CLIMATE AND RESILIENCY (EX) TASK FORCE**  
*of the Executive (EX) Committee*

Lori K. Wing-Heier, Co-Chair	Alaska
Ricardo Lara, Co-Chair	California
James J. Donelon, Co-Vice Chair	Louisiana
Mike Kreidler, Co-Vice Chair	Washington
Mark Fowler	Alabama
Peni Itula Sapini Teo	American Samoa
Barbara D. Richardson	Arizona
Michael Conway	Colorado
Andrew N. Mais	Connecticut
Trinidad Navarro	Delaware
Karima M. Woods	District of Columbia
Michael Yaworsky	Florida
Gordon I. Ito	Hawaii
Dana Popish Severinghaus	Illinois
Amy L. Beard	Indiana
Doug Ommen	Iowa
Sharon P. Clark	Kentucky
Timothy N. Schott	Maine
Kathleen A. Birrane	Maryland
Gary D. Anderson	Massachusetts
Anita G. Fox	Michigan
Grace Arnold	Minnesota
Mike Chaney	Mississippi
Chlora Lindley-Myers	Missouri
Troy Downing	Montana
Joseph Rios Jr.	N. Mariana Islands
Eric Dunning	Nebraska
Scott Kipper	Nevada
Marlene Caride	New Jersey
Jennifer Catechis	New Mexico
Adrienne A. Harris	New York
Mike Causey	North Carolina
Jon Godfread	North Dakota
Judith L. French	Ohio
Glen Mulready	Oklahoma
Andrew R. Stolfi	Oregon
Michael Humphreys	Pennsylvania
Alexander S. Adams Vega	Puerto Rico
Elizabeth Kelleher Dwyer	Rhode Island
Michael Wise	South Carolina
Kevin Gaffney	Vermont
Scott A. White	Virginia
Nathan Houdek	Wisconsin
Jeff Rude	Wyoming

NAIC Support Staff: Aaron Brandenburg/Libby Crews

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

Chlora Lindley-Myers, Chair	Missouri
Andrew N. Mais, Vice Chair	Connecticut
Alan McClain	Arkansas
Michael Conway	Colorado
Trinidad Navarro	Delaware
John F. King	Georgia
Dean L. Cameron	Idaho
Kathleen A. Birrane	Maryland
Gary D. Anderson	Massachusetts
Grace Arnold	Minnesota
Troy Downing	Montana
Jon Godfread	North Dakota
Glen Mulready	Oklahoma
Carter Lawrence	Tennessee
Scott A. White	Virginia
Mike Kreidler	Washington

NAIC Support Staff: Ethan Sonnichsen/Brian R. Webb

**LONG-TERM CARE INSURANCE (EX) TASK FORCE**  
*of the Executive (EX) Committee*

Michael Conway, Chair	Colorado	Grace Arnold	Minnesota
Andrew R. Stolfi, Vice Chair	Oregon	Chlora Lindley-Myers	Missouri
Mark Fowler	Alabama	Troy Downing	Montana
Lori K. Wing-Heier	Alaska	Eric Dunning	Nebraska
Barbara D. Richardson	Arizona	Scott Kipper	Nevada
Alan McClain	Arkansas	Marlene Caride	New Jersey
Ricardo Lara	California	Jennifer Catechis	New Mexico
Andrew N. Mais	Connecticut	Mike Causey	North Carolina
Trinidad Navarro	Delaware	Jon Godfread	North Dakota
Karima M. Woods	District of Columbia	Judith L. French	Ohio
Michael Yaworsky	Florida	Glen Mulready	Oklahoma
Gordon I. Ito	Hawaii	Michael Humphreys	Pennsylvania
Dean L. Cameron	Idaho	Elizabeth Kelleher Dwyer	Rhode Island
Amy L. Beard	Indiana	Larry D. Deiter	South Dakota
Doug Ommen	Iowa	Cassie Brown	Texas
Vicki Schmidt	Kansas	Jon Pike	Utah
Sharon P. Clark	Kentucky	Kevin Gaffney	Vermont
James J. Donelon	Louisiana	Scott A. White	Virginia
Timothy N. Schott	Maine	Mike Kreidler	Washington
Kathleen A. Birrane	Maryland	Allan L. McVey	West Virginia
Gary D. Anderson	Massachusetts	Nathan Houdek	Wisconsin
Anita G. Fox	Michigan	Jeff Rude	Wyoming

NAIC Support Staff: Jeffrey C. Johnston/Jane Koenigsman



**SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE**  
*of the Executive (EX) Committee*

Andrew N. Mais, Co-Chair	Connecticut	Grace Arnold	Minnesota
Chlora Lindley-Myers, Co-Chair	Missouri	Troy Downing	Montana
Jon Godfread, Co-Vice Chair	North Dakota	Eric Dunning	Nebraska
Scott A. White, Co-Vice Chair	Virginia	Scott Kipper	Nevada
Mark Fowler	Alabama	Marlene Caride	New Jersey
Lori K. Wing-Heier	Alaska	Jennifer Catechis	New Mexico
Peni Itula Sapini Teo	American Samoa	Mike Causey	North Carolina
Alan McClain	Arkansas	Judith L. French	Ohio
Michael Conway	Colorado	Glen Mulready	Oklahoma
Karima M. Woods	District of Columbia	Andrew R. Stolfi	Oregon
Michael Yaworsky	Florida	Michael Humphreys	Pennsylvania
Dean L. Cameron	Idaho	Alexander S. Adams Vega	Puerto Rico
Dana Popish Severinghaus	Illinois	Elizabeth Kelleher Dwyer	Rhode Island
Amy L. Beard	Indiana	Michael Wise	South Carolina
Doug Ommen	Iowa	Larry D. Deiter	South Dakota
Sharon P. Clark	Kentucky	Jon Pike	Utah
James J. Donelon	Louisiana	Kevin Gaffney	Vermont
Timothy N. Schott	Maine	Mike Kreidler	Washington
Kathleen A. Birrane	Maryland	Nathan Houdek	Wisconsin
Gary D. Anderson	Massachusetts	Jeff Rude	Wyoming
Anita G. Fox	Michigan		

NAIC Support Staff: Andrew J. Beal/Michael F. Consedine

**AUDIT COMMITTEE**

Scott A. White, Chair

Andrew N. Mais

Sharon P. Clark

Kathleen A. Birrane

Gary D. Anderson

Chloria Lindley-Myers

Eric Dunning

Marlene Caride

Jon Godfread

Andrew R. Stolfi

Larry D. Deiter

Carter Lawrence

Virginia

Connecticut

Kentucky

Maryland

Massachusetts

Missouri

Nebraska

New Jersey

North Dakota

Oregon

South Dakota

Tennessee

NAIC Support Staff: Jim Woody

**INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE**

Chlora Lindley-Myers, Chair

Andrew N. Mais, Vice Chair

Lori K. Wing-Heier

Dean L. Cameron

Sharon P. Clark

Kathleen A. Birrane

Jon Godfread

Scott A. White

Missouri

Connecticut

Alaska

Idaho

Kentucky

Maryland

North Dakota

Virginia

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

## LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

Judith L. French, Chair	Ohio
Carter Lawrence, Vice Chair	Tennessee
Mark Fowler	Alabama
Barbara D. Richardson	Arizona
Karima M. Woods	District of Columbia
Doug Ommen	Iowa
Vicki Schmidt	Kansas
James J. Donelon	Louisiana
Eric Dunning	Nebraska
Scott Kipper	Nevada
Marlene Caride	New Jersey
Adrienne A. Harris	New York
Glen Mulready	Oklahoma
Scott A. White	Virginia
Nathan Houdek	Wisconsin

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

### **Accelerated Underwriting (A) Working Group** *of the Life Insurance and Annuities (A) Committee*

Nathan Houdek, Chair	Wisconsin
Grace Arnold, Vice Chair	Minnesota
Jason Lapham	Colorado
Russ Gibson	Iowa
Tom Travis	Louisiana
Nour Benchaaboun	Maryland
Cynthia Amann	Missouri
Maggie Reinert/Megan VanAusdall	Nebraska
Chris Aufenthie/Ross Hartley	North Dakota
Lori Barron	Ohio
Elizabeth Kelleher Dwyer/Matt Gendron	Rhode Island
Lichiou Lee	Washington

NAIC Support Staff: Jennifer R. Cook

**LIFE INSURANCE AND ANNUITIES (A) COMMITTEE (*Continued*)****Annuity Suitability (A) Working Group**  
*of the Life Insurance and Annuities (A) Committee*

Doug Ommen, Chair	Iowa
Craig VanAalst, Vice Chair	Kansas
Jimmy Gunn	Alabama
Jodi Lerner	California
Jessica Luff	Delaware
Dean L. Cameron	Idaho
Renee Campbell	Michigan
Eric Dunning	Nebraska
Keith Nyhan	New Hampshire
Daniel Bradford	Ohio
Andrew Schallhorn	Oklahoma
Matt Gendron	Rhode Island
Richard Wicka	Wisconsin

NAIC Support Staff: Jolie H. Matthews

**LIFE ACTUARIAL (A) TASK FORCE**  
*of the Life Insurance and Annuities (A) Committee*

Cassie Brown, Chair	Texas
Scott A. White, Vice Chair	Virginia
Mark Fowler	Alabama
Lori K. Wing-Heier	Alaska
Ricardo Lara	California
Andrew N. Mais	Connecticut
Dana Popish Severinghaus	Illinois
Amy L. Beard	Indiana
Doug Ommen	Iowa
Vicki Schmidt	Kansas
Timothy N. Schott	Maine
Grace Arnold	Minnesota
Chlora Lindley-Myers	Missouri
Eric Dunning	Nebraska
Marlene Caride	New Jersey
Adrienne A. Harris	New York
Judith L. French	Ohio
Glen Mulready	Oklahoma
Michael Humphreys	Pennsylvania
Jon Pike	Utah
Allan L. McVey	West Virginia

NAIC Support Staff: Scott O'Neal/Jennifer Frasier

**Experience Reporting (A) Subgroup**  
*of the Life Actuarial (A) Task Force*

Fred Andersen, Chair	Minnesota
Ahmad Kamil	California
Wanchin Chou	Connecticut
Nicole Boyd	Kansas
Bill Carmello	New York
Rachel Hemphill	Texas

NAIC Support Staff: Angela McNabb

**LIFE ACTUARIAL (A) TASK FORCE (*Continued*)****Indexed Universal Life (IUL) Illustration (A) Subgroup  
of the Life Actuarial (A) Task Force**

Fred Andersen, Chair	Minnesota
Ted Chang	California
Manny Hidalgo	Connecticut
Vincent Tsang	Illinois
Scott Shover	Indiana
Mike Yanacheak	Iowa
Michael Muldoon	Nebraska
Bill Carmello	New York
Peter Weber	Ohio
Maribel Castillo/Darlene Plyler/Heike Ulrich	Texas
Tomasz Serbinowski	Utah
Craig Chupp	Virginia

NAIC Support Staff: Jennifer Frasier

**Index-Linked Variable Annuity (A) Subgroup  
of the Life Actuarial (A) Task Force**

Peter Weber, Chair	Ohio
Tomasz Serbinowski, Vice Chair	Utah
Sarvjit Samra	California
Vincent Tsang	Illinois
Scott Shover	Indiana
Michael Muldoon	Nebraska
David Wolf	New Jersey
Bill Carmello/Michael Cebula	New York
Rachel Hemphill	Texas
Craig Chupp	Virginia
David Hippen	Washington

NAIC Support Staff: Jim Stinson

**LIFE ACTUARIAL (A) TASK FORCE (*Continued*)****Longevity Risk (E/A) Subgroup***of the Life Risk-Based Capital (E) Working Group and Life Actuarial (A) Task Force*

Seong-min Eom, Chair	New Jersey
Lei Rao-Knight	Connecticut
Mike Yanacheak	Iowa
Bill Carmello	New York
Peter Weber	Ohio

NAIC Support Staff: Dave Fleming

**Variable Annuities Capital and Reserve (E/A) Subgroup***of the Life Risk-Based Capital (E) Working Group and Life Actuarial (A) Task Force*

Peter Weber, Chair	Ohio
Thomas Reedy	California
Philip Barlow	District of Columbia
Nicole Boyd	Kansas
Fred Andersen	Minnesota
William Leung	Missouri
Seong-min Eom	New Jersey
Bill Carmello	New York
Rachel Hemphill	Texas

NAIC Support Staff: Dave Fleming/Jim Stinson

**Valuation Manual (VM)-22 (A) Subgroup***of the Life Actuarial (A) Task Force*

Ben Slutsker, Chair	Minnesota
Elaine Lam/Thomas Reedy	California
Lei Rao-Knight	Connecticut
Vincent Tsang	Illinois
Mike Yanacheak	Iowa
Nicole Boyd	Kansas
William Leung	Missouri
Seong-min Eom	New Jersey
Bill Carmello	New York
Rachel Hemphill	Texas
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Andrew R. Stolfi	Oregon
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NAIC Support Staff: Joe Tuschner

**HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE (*Continued*)****Health Innovations (B) Working Group***of the Health Insurance and Managed Care (B) Committee*

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Mark Garratt	Nevada
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Chrystal Bartuska	North Dakota
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Doug Ommen	Iowa
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Timothy N. Schott	Maine
Kathleen A. Birrane	Maryland
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Joseph Rios Jr.	N. Mariana Islands
Eric Dunning	Nebraska
Marlene Caride	New Jersey
Jennifer Catechis	New Mexico
Judith L. French	Ohio
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Michael Humphreys	Pennsylvania
Alexander S. Adams Vega	Puerto Rico
Michael Wise	South Carolina
Cassie Brown	Texas
Jon Pike	Utah
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Marti Hooper	Maine
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Anna Krylova	New Mexico
Bill Carmello	New York
Laura Miller	Ohio
Andrew Schallhorn	Oklahoma
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Aaron Hodges	Texas
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**HEALTH ACTUARIAL (B) TASK FORCE (*Continued*)****Long-Term Care Pricing (B) Subgroup**  
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Amy L. Beard	Indiana
Doug Ommen	Iowa
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Timothy N. Schott	Maine
Gary D. Anderson	Massachusetts
Grace Arnold	Minnesota
Joseph Rios Jr.	N. Mariana Islands
Eric Dunning	Nebraska
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Mike Causey	North Carolina
Jon Godfread	North Dakota
Judith L. French	Ohio
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Michael Humphreys	Pennsylvania
Alexander S. Adams Vega	Puerto Rico
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Cassie Brown	Texas
Jon Pike	Utah
Scott A. White	Virginia
Mike Kreidler	Washington
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NAIC Support Staff: Jolie H. Matthews/Jennifer R. Cook

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Michael Anderson/Martin Swanson	Nebraska
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Laura Miller	Ohio
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Jill Kruger	South Dakota
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Dean L. Cameron	Idaho
Amy L. Beard	Indiana
Doug Ommen	Iowa
Vicki Schmidt	Kansas
Sharon P. Clark	Kentucky
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Anita G. Fox	Michigan
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Chlora Lindley-Myers	Missouri
Troy Downing	Montana
Joseph Rios Jr.	N. Mariana Islands
Eric Dunning	Nebraska
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Jon Godfread	North Dakota
Judith L. French	Ohio
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NAIC Support Staff: Aaron Brandenburg

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Andrew R. Stolfi	Oregon
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NAIC Support Staff: Anne Obersteadt/Aaron Brandenburg

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Jerry Condon/Matthew Mancini	Massachusetts
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Carl Sornson	New Jersey
Melissa Robertson	New Mexico
Tom Botsko	Ohio
Cuc Nguyen	Oklahoma
David Dahl/Ying Liu/Raven Collins	Oregon
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NAIC Support Staff: Sara Robben

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NAIC Support Staff: Aaron Brandenburg/Sara Robben

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NAIC Support Staff: Aaron Brandenburg

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Doris Diaz	Puerto Rico
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NAIC Support Staff: Sara Robben

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Doug Ommen	Iowa
Vicki Schmidt	Kansas
James J. Donelon	Louisiana
Timothy N. Schott	Maine
Kathleen A. Birrane	Maryland
Anita G. Fox	Michigan
Grace Arnold	Minnesota
Troy Downing	Montana
Joseph Rios Jr.	N. Mariana Islands
Eric Dunning	Nebraska
Scott Kipper	Nevada
Marlene Caride	New Jersey
Jennifer Catechis	New Mexico
Mike Causey	North Carolina
Judith L. French	Ohio
Glen Mulready	Oklahoma
Andrew R. Stolfi	Oregon
Michael Humphreys	Pennsylvania
Michael Wise	South Carolina
Cassie Brown	Texas
Kevin Gaffney	Vermont
Mike Kreidler	Washington
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NAIC Support Staff: Kris DeFrain



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Dean L. Cameron	Idaho
Dana Popish Severinghaus	Illinois
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Joseph Rios Jr.	N. Mariana Islands
Scott Kipper	Nevada
Mike Causey	North Carolina
Glen Mulready	Oklahoma
Michael Humphreys	Pennsylvania
Alexander S. Adams Vega	Puerto Rico
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NAIC Support Staff: Andy Daleo

**SURPLUS LINES (C) TASK FORCE (*Continued*)**

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Troy Downing	Montana
Jennifer Catechis	New Mexico
Mike Causey	North Carolina
Judith L. French	Ohio
Glen Mulready	Oklahoma
Michael Humphreys	Pennsylvania
Elizabeth Kelleher Dwyer	Rhode Island
Michael Wise	South Carolina
Larry D. Deiter	South Dakota
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NAIC Support Staff: Anne Obersteadt/Aaron Brandenburg

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Gary D. Anderson	Massachusetts
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Scott Kipper	Nevada
Mike Causey	North Carolina
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Elizabeth Kelleher Dwyer	Rhode Island
Michael Wise	South Carolina
Larry D. Deiter	South Dakota
Carter Lawrence	Tennessee
Kevin Gaffney	Vermont
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NAIC Support Staff: Sara Robben/Aaron Brandenburg

**WORKERS' COMPENSATION (C) TASK FORCE (*Continued*)****NAIC/International Association of Industrial Accident Boards and  
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Cuc Nguyen/Andrew Schallhorn	Oklahoma
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NAIC Support Staff: Sara Robben/Aaron Brandenburg

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Jennifer Catechis	New Mexico
Jon Godfread	North Dakota
Michael Wise	South Carolina
Cassie Brown	Texas
Kevin Gaffney	Vermont
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NAIC Support Staff: Paul Santillanes/Randy Helder

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NAIC Support Staff: Paul Santillanes/Randy Helder



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Damion Hughes	Colorado
Steve DeAngelis	Connecticut
Susan Jennette	Delaware
Sharon Shipp/Cheryl Wade/Patrima Lele	District of Columbia
Scott Woods	Florida
Erica Weyhenmeyer	Illinois
LeAnn Crow	Kansas
Sandra Stumbo/Lori Cunningham	Kentucky
Lisa Fullington	Louisiana
Timothy N. Schott	Maine
Dawna Kokosinski	Maryland
Mary Lou Moran	Massachusetts
Jeff Hayden	Michigan
Paul Hanson	Minnesota
David Dachs/Troy Smith	Montana
Martin Swanson/Robert McCullough	Nebraska
Peggy Willard-Ross	Nevada
Maureen Belanger/Edwin Pugsley	New Hampshire
Ralph Boeckman	New Jersey
Leatrice Geckler	New Mexico
Larry Wertel	New York
Todd Oberholtzer	Ohio
Landon Hubbart	Oklahoma
Karen Veronikis	Pennsylvania
Brett Bache/Matt Gendron	Rhode Island
Gwendolyn McGriff/Rachel Moore	South Carolina
Tanji J. Northrup	Utah
Kevin Gaffney	Vermont
Will Felvey	Virginia
Tom Whitener	West Virginia
Rebecca Rebholz	Wisconsin

NAIC Support Staff: Teresa Cooper/Randy Helder

**MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE (*Continued*)****Market Conduct Annual Statement Blanks (D) Working Group**  
*of the Market Regulation and Consumer Affairs (D) Committee*

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Scott Woods	Florida
Elizabeth Nunes/Scott Sanders	Georgia
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Lori Cunningham	Kentucky
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Mary Lou Moran	Massachusetts
Jeff Hayden	Michigan
Paul Hanson	Minnesota
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Shelley Wiseman	Utah
Melissa Gerachis/Will Felvey	Virginia
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NAIC Support Staff: Teresa Cooper/Hal Marsh

**MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE (*Continued*)****Market Conduct Examination Guidelines (D) Working Group**  
*of the Market Regulation and Consumer Affairs (D) Committee*

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Doug Ommen	Iowa
Ron Kreiter	Kentucky
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Sylvia Lawson	New York
Teresa Knowles	North Carolina
Todd Oberholtzer	Ohio
Landon Hubbart	Oklahoma
Brian Fordham/Tashia Sizemore	Oregon
Gary Jones/Paul Towsen	Pennsylvania
Matt Gendron/Brett Bache	Rhode Island
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Julie Fairbanks	Virginia
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NAIC Support Staff: Petra Wallace/Lois E. Alexander

**MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE (*Continued*)****Market Regulation Certification (D) Working Group**  
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Chlora Lindley-Myers	Missouri
Martin Swanson/Robert McCullough	Nebraska
Chris Nicolopoulos	New Hampshire
Marlene Caride	New Jersey
Jennifer Catechis	New Mexico
Mike Causey	North Carolina
Judith L. French	Ohio
Glen Mulready	Oklahoma
Andrew R. Stolfi	Oregon
Michael Humphreys	Pennsylvania
Michael Wise	South Carolina
Tanji J. Northrup	Utah
Kevin Gaffney	Vermont
Don Beatty/Katie Johnson	Virginia
Allan L. McVey	West Virginia

NAIC Support Staff: Randy Helder/Tim Mullen

**MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE (*Continued*)****Speed to Market (D) Working Group***of the Market Regulation and Consumer Affairs (D) Committee*

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Dean L. Cameron	Idaho
Julie Rachford	Illinois
Craig VanAalst	Kansas
Tammy Lohmann	Minnesota
Camille Anderson-Weddle	Missouri
Joseph Rios Jr.	N. Mariana Islands
Frank Cardamone	New Hampshire
Jennifer Catechis	New Mexico
Ted Hamby	North Carolina
Jon Godfread	North Dakota
Cuc Nguyen/Glen Mulready	Oklahoma
Andrew R. Stolfi	Oregon
Mark Worman/Debra Diaz-Lara	Texas
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Lichiou Lee	Washington
Allan L. McVey	West Virginia
Barry Haney	Wisconsin

NAIC Support Staff: Randy Helder

NAIC Technical Support: Renee Brownfield/Alex Rogers

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John F. King, Vice Chair	Georgia
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Dean L. Cameron	Idaho
Doug Ommen	Iowa
Vicki Schmidt	Kansas
Sharon P. Clark	Kentucky
Kathleen A. Birrane	Maryland
Grace Arnold	Minnesota
Mike Chaney	Mississippi
Troy Downing	Montana
Scott Kipper	Nevada
Chris Nicolopoulos	New Hampshire
Marlene Caride	New Jersey
Jennifer Catechis	New Mexico
Mike Causey	North Carolina
Jon Godfread	North Dakota
Judith L. French	Ohio
Glen Mulready	Oklahoma
Andrew R. Stolfi	Oregon
Michael Humphreys	Pennsylvania
Elizabeth Kelleher Dwyer	Rhode Island
Michael Wise	South Carolina
Larry D. Deiter	South Dakota
Cassie Brown	Texas
Jon Pike	Utah
Kevin Gaffney	Vermont
Scott A. White	Virginia
Allan L. McVey	West Virginia

NAIC Support Staff: Greg Welker/Lois E. Alexander

**ANTIFRAUD (D) TASK FORCE (*Continued*)****Antifraud Technology (D) Working Group**  
*of the Antifraud (D) Task Force*

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Paul Keller/Russ Galbraith	Arkansas
George Mueller	California
Simon Blank	Florida
Roberta Baca	New Mexico
Michelle Brugh Rafeld	Ohio
Christopher Davis/Kyson Johnson	Texas
Richard Tozer	Virginia

NAIC Support Staff: Greg Welker/Lois E. Alexander

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*of the Antifraud (D) Task Force*

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Kurt Swan	Connecticut
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Andria Seip	Iowa
Randall Gregg	Michigan
Cam Jenkins	Minnesota
Cynthia Amann	Missouri
Susan Brown	Montana
Michael Fissel	Pennsylvania
Carlos Vallés	Puerto Rico
Patrick Smock	Rhode Island
Jill Kruger/Travis Jordan	South Dakota
Matthew Tarpley	Texas
Randi Osberg/Tyler Robbins	Washington

NAIC Support Staff: Greg Welker/Lois E. Alexander

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*of the Market Regulation and Consumer Affairs (D) Committee*

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Andrew N. Mais	Connecticut
Trinidad Navarro	Delaware
Doug Ommen	Iowa
Vicki Schmidt	Kansas
Sharon P. Clark	Kentucky
James J. Donelon	Louisiana
Grace Arnold	Minnesota
Scott Kipper	Nevada
Marlene Caride	New Jersey
Jennifer Catechis	New Mexico
Glen Mulready	Oklahoma
Michael Humphreys	Pennsylvania
Cassie Brown	Texas
Allan L. McVey	West Virginia
Nathan Houdek	Wisconsin

NAIC Support Staff: Randy Helder

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Ron Kreiter	Kentucky
Martin Swanson/Robert McCullough	Nebraska
Todd Oberholtzer/Rodney Beetch	Ohio
TK Keen	Oregon
Rachel Cloyd/Matthew Tarpley	Texas
Jeannie Tincher	West Virginia
Mark Prodoehl	Wisconsin

NAIC Support Staff: Ginny Ewing/Randy Helder



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Karima M. Woods	District of Columbia
Dean L. Cameron	Idaho
Amy L. Beard	Indiana
Doug Ommen	Iowa
Vicki Schmidt	Kansas
James J. Donelon	Louisiana
Kathleen A. Birrane	Maryland
Anita G. Fox	Michigan
Grace Arnold	Minnesota
Chlora Lindley-Myers	Missouri
Troy Downing	Montana
Joseph Rios Jr.	N. Mariana Islands
Eric Dunning	Nebraska
Chris Nicolopoulos	New Hampshire
Marlene Caride	New Jersey
Jennifer Catechis	New Mexico
Mike Causey	North Carolina
Jon Godfread	North Dakota
Judith L. French	Ohio
Glen Mulready	Oklahoma
Andrew R. Stolfi	Oregon
Michael Humphreys	Pennsylvania
Elizabeth Kelleher Dwyer	Rhode Island
Cassie Brown	Texas
Jon Pike	Utah
Kevin Gaffney	Vermont
Scott A. White	Virginia
Mike Kreidler	Washington
Allan L. McVey	West Virginia
Nathan Houdek	Wisconsin
Jeff Rude	Wyoming

NAIC Support Staff: Tim Mullen/Greg Welker

**PRODUCER LICENSING (D) TASK FORCE (*Continued*)****Adjuster Licensing (D) Working Group**  
*of the Producer Licensing (D) Task Force*

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Courtney Khodabakhsh	Oklahoma
Jodie Delgado	Texas
Randy Overstreet	Utah
Richard Tozer	Virginia
Jeff Baughman	Washington
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NAIC Support Staff: Greg Welker/Tim Mullen

**Producer Licensing Uniformity (D) Working Group**  
*of the Producer Licensing (D) Task Force*

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Eric Fletcher/Lori Thomason	Idaho
Lorelei Brillante	Maryland
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Kevin Schlautman	Nebraska
Stephanie McGee	Nevada
Victoria Baca	New Mexico
Janelle Middlestead	North Dakota
Karen Vourvopoulos	Ohio
Courtney Khodabakhsh	Oklahoma
Rachel Chester	Rhode Island
Larry D. Deiter	South Dakota
Randy Overstreet	Utah
Richard Tozer	Virginia
Jeff Baughman	Washington
Melody Esquivel	Wisconsin

NAIC Support Staff: Greg Welker/Tim Mullen

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

**Uniform Education (D) Working Group**  
*of the Producer Licensing (D) Task Force*

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Russ Galbraith	Arkansas
Charlene Ferguson	California
Matt Guy/Matt Tamplin	Florida
Vanessa Miller	Mississippi
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Larry D. Deiter	South Dakota
Christopher Davis	Texas
Pat Murray	Vermont
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NAIC Support Staff: Greg Welker/Tim Mullen

## FINANCIAL CONDITION (E) COMMITTEE

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Michael Conway	Colorado
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Doug Ommen	Iowa
Timothy N. Schott	Maine
Mike Chaney	Mississippi
Chlora Lindley-Myers	Missouri
Marlene Caride	New Jersey
Adrienne A. Harris	New York
Michael Wise	South Carolina
Cassie Brown	Texas
Scott A. White	Virginia

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

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Greg Chew, Vice Chair	Virginia
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Jack Broccoli	Connecticut
Rylynn Brown	Delaware
Virginia Christy/Carolyn Morgan	Florida
Cindy Andersen	Illinois
Kim Cross	Iowa
Kathleen Orth	Minnesota
Debbie Doggett	Missouri
Lindsay Crawford	Nebraska
John Sirovetz	New Jersey
Mark McLeod/Marc Allen	New York
Jackie Obusek	North Carolina
Dale Bruggeman	Ohio
Diana Sherman	Pennsylvania
Amy Garcia	Texas
Amy Malm	Wisconsin

NAIC Support Staff: Bruce Jenson/Andy Daleo/Jane Koenigsmann/  
Ralph Villegas/Rodney Good/Bill Rivers

**FINANCIAL CONDITION (E) COMMITTEE (*Continued*)****Group Capital Calculation (E) Working Group**  
*of the Financial Condition (E) Committee*

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Susan Bernard/Michelle Lo	California
John Loughran	Connecticut
Philip Barlow	District of Columbia
Ray Spudeck	Florida
Susan Berry	Illinois
Roy Eft	Indiana
Kevin Clark	Iowa
John Turchi/Christopher Joyce	Massachusetts
Judy Weaver	Michigan
Barbara Carey	Minnesota
Lindsay Crawford	Nebraska
David Wolf	New Jersey
Bob Kasinow	New York
Dale Bruggeman/Tim Biler	Ohio
Diana Sherman	Pennsylvania
Trey Hancock	Tennessee
Jamie Walker	Texas
Doug Stolte/David Smith	Virginia
Amy Malm	Wisconsin

NAIC Support Staff: Dan Daveline

**FINANCIAL CONDITION (E) COMMITTEE (*Continued*)****Group Solvency Issues (E) Working Group**  
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Charles Santana	Delaware
Virginia Christy/Carolyn Morgan	Florida
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Roy Eft	Indiana
Kim Cross	Iowa
John Turchi	Massachusetts
Judy Weaver	Michigan
Debbie Doggett/Shannon Schmoeger	Missouri
David Wolf	New Jersey
Margot Small	New York
Dale Bruggeman/Tim Biler	Ohio
Diana Sherman/Matt Milford	Pennsylvania
Ted Hurley	Rhode Island
Doug Stolte	Virginia
Amy Malm/Mark McNabb	Wisconsin

NAIC Support Staff: Bruce Jenson/Ramon Calderon

**Own Risk and Solvency Assessment (ORSA) Implementation (E) Subgroup**  
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Nicole Crockett	Florida
Cindy Andersen/Susan Berry	Illinois
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Lindsay Crawford	Nebraska
Doug Bartlett/Pat Gosselin	New Hampshire
Victor Agbu	New York
David Cook/Jeff Lehr	Ohio
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Glorimar Santiago/Maria Morcelo	Puerto Rico
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NAIC Support Staff: Bruce Jenson/Eli Russo

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Margot Small	New York
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Amy Garcia	Texas
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NAIC Support Staff: Andy Daleo

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Tom Travis	Louisiana
Shelley Woods	Missouri
Lindsay Crawford	Nebraska
David Wolf	New Jersey
Michael Campanelli	New York
Diana Sherman	Pennsylvania
Daniel Morris	South Carolina
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NAIC Support Staff: Dan Schelp/Jake Stultz

**FINANCIAL CONDITION (E) COMMITTEE (*Continued*)****NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group  
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Judy Weaver	Michigan
Shannon Schmoeger	Missouri
Lindsay Crawford	Nebraska
Doug Bartlett	New Hampshire
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Ryan Keeling	Oregon
Diana Sherman	Pennsylvania
Johanna Nickelson	South Dakota
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NAIC Support Staff: Bruce Jenson

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of the Financial Condition (E) Committee**

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Sherry Wilson	Delaware
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Kari Leonard	Montana
Ursula Almada	New Mexico
Doug Hartz	Oregon
Karen Feather	Pennsylvania
Amy Garcia	Texas
Jay Sueoka	Utah
Ron Pastuch	Washington
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NAIC Support Staff: Jane Barr



**FINANCIAL CONDITION (E) COMMITTEE (*Continued*)****Restructuring Mechanisms (E) Working Group**  
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Michael Conway	Colorado
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Judy Weaver	Michigan
Fred Andersen	Minnesota
John Rehagen/James Le	Missouri
Lindsay Crawford	Nebraska
Marlene Caride	New Jersey
Bob Kasinow	New York
Diana Sherman	Pennsylvania
Michael Wise	South Carolina
Amy Garcia	Texas
Dan Petterson/Heidi Rabtoy	Vermont
Scott A. White	Virginia
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NAIC Support Staff: Dan Daveline/Casey McGraw

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David Wolf	New Jersey
Dale Bruggeman	Ohio
Andrew Schallhorn	Oklahoma
Ted Hurley	Rhode Island
Amy Garcia	Texas
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NAIC Support Staff: Dan Daveline/Robin Marcotte

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Jack Broccoli/William Arfanis	Connecticut
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Cindy Andersen	Illinois
Roy Eft	Indiana
Daniel Mathis	Iowa
Stewart Guerin	Louisiana
Vanessa Sullivan	Maine
Dmitriy Valekha	Maryland
Judy Weaver	Michigan
Debbie Doggett/Shannon Schmoeger	Missouri
Pat Gosselin	New Hampshire
John Sirovetz/Paul Lupo	New Jersey
Mark McLeod	New York
Jackie Obusek/Monique Smith	North Carolina
Dwight Radel/Tracy Snow	Ohio
Eli Snowbarger	Oklahoma
Ryan Keeling	Oregon
Diana Sherman/Matt Milford	Pennsylvania
John Tudino/Ted Hurley	Rhode Island
Johanna Nickelson	South Dakota
Amy Garcia	Texas
Jake Garn	Utah
Dan Petterson	Vermont
David Smith/Greg Chew	Virginia
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NAIC Support Staff: Bruce Jenson/Jane Koenigsman

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Michael Muldoon	Nebraska
Seong-min Eom	New Jersey
Bill Carmello	New York
Peter Weber	Ohio
Tomasz Serbinowski	Utah
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Karima M. Woods	District of Columbia
Michael Yaworsky	Florida
Michelle B. Santos	Guam
Dean L. Cameron	Idaho
Doug Ommen	Iowa
Vicki Schmidt	Kansas
Sharon P. Clark	Kentucky
James J. Donelon	Louisiana
Timothy N. Schott	Maine
Gary D. Anderson	Massachusetts
Anita G. Fox	Michigan
Grace Arnold	Minnesota
Chlora Lindley-Myers	Missouri
Troy Downing	Montana
Joseph Rios Jr.	N. Mariana Islands
Eric Dunning	Nebraska
Chris Nicolopoulos	New Hampshire
Marlene Caride	New Jersey
Adrienne A. Harris	New York
Jon Godfread	North Dakota
Judith L. French	Ohio
Glen Mulready	Oklahoma
Andrew R. Stolfi	Oregon
Michael Humphreys	Pennsylvania
Elizabeth Kelleher Dwyer	Rhode Island
Michael Wise	South Carolina
Larry D. Deiter	South Dakota
Carter Lawrence	Tennessee
Jon Pike	Utah
Kevin Gaffney	Vermont
Scott A. White	Virginia
Mike Kreidler	Washington
Allan L. McVey	West Virginia
Nathan Houdek	Wisconsin

NAIC Support Staff: Robin Marcotte

**ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE (*Continued*)****Blanks (E) Working Group***of the Accounting Practices and Procedures (E) Task Force*

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N. Kevin Brown	District of Columbia
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Daniel Mathis	Iowa
Kristin Hynes	Michigan
Debbie Doggett/Danielle Smith	Missouri
Lindsay Crawford	Nebraska
John Sirovetz/Amal Mechaiel	New Jersey
Tracy Snow	Ohio
Diane Carter	Oklahoma
Ryan Keeling	Oregon
Diana Sherman	Pennsylvania
Shawn Frederick	Texas
Jake Garn	Utah
Steve Drutz	Washington
Mary Jo Lewis	West Virginia
Adrian Jaramillo	Wisconsin

NAIC Support Staff: Mary Caswell/Jill Youtsey/Julie Gann

**ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE (*Continued*)****Statutory Accounting Principles (E) Working Group**  
*of the Accounting Practices and Procedures (E) Task Force*

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Kim Hudson	California
William Arfanis/Michael Estabrook	Connecticut
Rylynn Brown	Delaware
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Judy Weaver	Michigan
Doug Bartlett	New Hampshire
Bob Kasinow	New York
Diana Sherman/Matt Milford	Pennsylvania
Jamie Walker	Texas
Doug Stolte/David Smith	Virginia
Amy Malm/Elena Vetrina	Wisconsin

NAIC Support Staff: Julie Gann/Robin Marcotte/Jake Stultz/Jason Farr/  
William Oden

**CAPITAL ADEQUACY (E) TASK FORCE**  
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Grace Arnold, Vice Chair	Minnesota
Mark Fowler	Alabama
Lori K. Wing-Heier	Alaska
Peni Itula Sapini Teo	American Samoa
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Andrew N. Mais	Connecticut
Karima M. Woods	District of Columbia
Michael Yaworsky	Florida
Dana Popish Severinghaus	Illinois
Amy L. Beard	Indiana
Doug Ommen	Iowa
Vicki Schmidt	Kansas
Sharon P. Clark	Kentucky
Kathleen A. Birrane	Maryland
Chlora Lindley-Myers	Missouri
Troy Downing	Montana
Eric Dunning	Nebraska
Marlene Caride	New Jersey
Mike Causey	North Carolina
Jon Godfread	North Dakota
Glen Mulready	Oklahoma
Michael Wise	South Carolina
Cassie Brown	Texas
Mike Kreidler	Washington
Nathan Houdek	Wisconsin

NAIC Support Staff: Eva Yeung

**Health Risk-Based Capital (E) Working Group**  
*of the Capital Adequacy (E) Task Force*

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Matthew Richard, Vice Chair	Texas
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Carolyn Morgan/Kyle Collins	Florida
Tish Becker	Kansas
Danielle Smith/Debbie Doggett	Missouri
Michael Muldoon	Nebraska
Tom Dudek	New York
Jeffery Smith	Pennsylvania

NAIC Support Staff: Crystal Brown

**CAPITAL ADEQUACY (E) TASK FORCE (*Continued*)****Life Risk-Based Capital (E) Working Group**  
*of the Capital Adequacy (E) Task Force*

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NAIC Support Staff: Lois E. Alexander

## MEMBERS OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Alabama Commissioner Mark Fowler	Montgomery 36130	Montana Commissioner/State Auditor Troy Downing	Helena 59601
Alaska Director Lori K. Wing-Heier	Anchorage 99501	Nebraska Director Eric Dunning	Lincoln 68501
American Samoa Commissioner Peni Itula Sapini Teo	Pago Pago 96799	Nevada Commissioner Scott Kipper	Carson City 89706
Arizona Director Barbara D. Richardson	Phoenix 85018	New Hampshire Commissioner Chris Nicolopoulos	Concord 03301
Arkansas Commissioner Alan McClain	Little Rock 72202	New Jersey Commissioner Marlene Caride	Trenton 08625
California Commissioner Ricardo Lara	Oakland 94612	New Mexico Interim Superintendent Jennifer A. Catechis	Santa Fe 87501
Colorado Commissioner Michael Conway	Denver 80202	New York Superintendent Adrienne A. Harris	New York 10004
Connecticut Commissioner Andrew N. Mais	Hartford 06103	North Carolina Commissioner Mike Causey	Raleigh 27603
Delaware Commissioner Trinidad Navarro	Dover 19904	North Dakota Commissioner Jon Godfread	Bismarck 58505
District of Columbia Commissioner Karima M. Woods	Washington 20002	N. Mariana Islands Acting Secretary of Commerce Joseph Rios Jr.	Saipan 96950
Florida Commissioner Michael Yaworsky	Tallahassee 32399	Ohio Director Judith L. French	Columbus 43215
Georgia Commissioner John F. King	Atlanta 30334	Oklahoma Commissioner Glen Mulready	Oklahoma City 73112
Guam Commissioner Michelle B. Santos	Barrigada 96913	Oregon Commissioner Andrew R. Stolfi	Salem 97301
Hawaii Commissioner Gordon I. Ito	Honolulu 96813	Pennsylvania Acting Commissioner Michael Humphreys	Harrisburg 17120
Idaho Director Dean L. Cameron	Boise 83720	Puerto Rico Commissioner Alexander S. Adams Vega	Guaynabo 00968
Illinois Director Dana Popish Severinghaus	Springfield 62767	Rhode Island Superintendent Elizabeth Kelleher Dwyer	Cranston 02920
Indiana Commissioner Amy L. Beard	Indianapolis 46204	South Carolina Acting Director Michael Wise	Columbia 29201
Iowa Commissioner Doug Ommen	Des Moines 50319	South Dakota Director Larry D. Deiter	Pierre 57501
Kansas Commissioner Vicki Schmidt	Topeka 66612	Tennessee Commissioner Carter Lawrence	Nashville 37243
Kentucky Commissioner Sharon P. Clark	Frankfort 40601	Texas Commissioner Cassie Brown	Austin 78701
Louisiana Commissioner James J. Donelon	Baton Rouge 70802	Utah Commissioner Jon Pike	Salt Lake City 84114
Maine Acting Superintendent Timothy N. Schott	Augusta 04333	Vermont Commissioner Kevin Gaffney	Montpelier 05620
Maryland Commissioner Kathleen A. Birrane	Baltimore 21202	Virgin Islands Lt. Governor/Commissioner Tregenza A. Roach	St. Thomas 00802
Massachusetts Commissioner Gary D. Anderson	Boston 02118	Virginia Commissioner Scott A. White	Richmond 23219
Michigan Director Anita G. Fox	Lansing 48933	Washington Commissioner Mike Kreidler	Olympia 98504
Minnesota Commissioner Grace Arnold	St. Paul 55101	West Virginia Commissioner Allan L. McVey	Charleston 25301
Mississippi Commissioner Mike Chaney	Jackson 39201	Wisconsin Commissioner Nathan Houdek	Madison 53703
Missouri Director Chlora Lindley-Myers	Jefferson City 65101	Wyoming Commissioner Jeff Rude	Cheyenne 82002

Updated: 03/13/2023

**NAIC MEMBER TENURE LIST**

<b>STATE/MEMBER TITLE</b>	<b>MEMBER NAME</b>	<b>BEG. DATE</b>	<b>END DATE</b>	<b>YRS. SERVED</b>	<b>MOS. SERVED</b>
<b>ALABAMA</b> —Appointed, at the pleasure of the Governor; term concurrent with that of the Governor by whom appointed or for the unexpired portion of the term					
Insurance Commissioner	Mark Fowler	1/16/2023		incumbent	
Acting Insurance Commissioner	Mark Fowler	7/1/2022	1/16/2023	0	6
Insurance Commissioner	Jim L. Ridling <i>(Appointed Sept. 15, 2008; Reappointed Jan. 17, 2011; Reappointed November 2017)</i>	9/15/2008	6/30/2022	9	3
Acting Insurance Commissioner	D. David Parsons	9/1/2008	9/15/2008	0	1
Insurance Commissioner	Walter A. Bell*	1/21/2003	8/31/2008	5	7
Insurance Commissioner	D. David Parsons	12/1/2000	1/21/2003	2	1
Acting Insurance Commissioner	D. David Parsons	1/20/1999	12/1/2000	1	11
Insurance Commissioner	Richard H. Cater	2/1/1998	1/19/1999	0	11
Insurance Commissioner	Michael ‘Mickey’ DeBellis	3/6/1996	1/31/1998	1	11
Acting Insurance Commissioner	Michael ‘Mickey’ DeBellis	1/16/1995	3/6/1996	1	2
Insurance Commissioner	James H. ‘Jimmy’ Dill	5/5/1993	1/16/1995	1	8
Insurance Commissioner	Michael C. ‘Mike’ Weaver	8/16/1988	5/5/1993	4	9
Insurance Commissioner	John S. Greeno	2/6/1987	8/16/1988	1	6
Insurance Commissioner	Michael ‘Mickey’ DeBellis	1/1/1986	1/19/1987	1	0
Insurance Commissioner	Tharpe Forrester	6/8/1984	1/1/1986	1	7
Insurance Commissioner	Joseph R. ‘Joe’ Holt	5/21/1984	6/5/1984	0	1
Insurance Commissioner	William G. ‘Bill’ Ward, Jr.	1/17/1983	5/21/1984	1	4
Insurance Commissioner	Tharpe Forrester, Jr.	5/19/1980	1/17/1983	2	8
Insurance Commissioner	Haskell H. Sumrall, Jr.	8/15/1979	5/19/1980	0	9
Acting Insurance Commissioner	Albert Jackson ‘Jack’ Winfield	2/2/1979	8/15/1979	0	6
Insurance Commissioner	Charles H. Payne	1/20/1975	2/2/1979	4	0
Insurance Commissioner	John G. Bookout	1/1/1972	1/20/975	3	0
Superintendent of Insurance	John G. Bookout	1/18/1971	1/1/1972	1	0
Superintendent of Insurance	R. Frank Ussery <i>(Died Nov. 13, 2021)</i>	12/14/1968	1/18/1971	2	1
Superintendent of Insurance	Walter S. Houseal	1/15/1963	12/14/1968	5	11
Superintendent of Insurance	William D. Page	5/23/1961	1/15/1963	1	8
Superintendent of Insurance	Edmon L. Rinehart	1/19/1959	5/23/1961	2	4
Superintendent of Insurance	James H. Horn	10/3/1956	1/19/1959	2	3
Superintendent of Insurance	Leslie Lee Gwaltney, Jr.	1/18/1955	10/3/1956	1	9
Superintendent of Insurance	Herman A. Longshore	1/16/1951	1/18/1955	4	0
Superintendent of Insurance	Leslie Lee Gwaltney, Jr.	1/31/1947	1/16/1951	4	0
Director of Commerce/Superintendent of Insurance	Addie Lee Farish	12/1/1944	1/31/1947	2	1
Superintendent of Insurance	Frank N. Julian* <i>(Died Nov. 30, 1944)</i>	2/1/1935	11/30/1944	9	10
Superintendent of Insurance	Charles C. Greer	2/1/1931	2/1/1935	4	0
Superintendent of Insurance	George H. Thigpen	10/1/1927	2/1/1931	3	4
Superintendent of Insurance	Frank N. Julian* <i>(Died Nov. 30, 1944)</i>	9/30/1923	10/1/1927	4	0
Commissioner of Insurance	Frank N. Julian* <i>(Died Nov. 30, 1944)</i>	3/1/1923	9/30/1923	0	7
Commissioner of Insurance	Russell B. Coleman	11/2/1922	3/1/1923	0	4
Commissioner of Insurance	Albert Walter Briscoe	10/1/1919	11/2/1922	3	1
Commissioner of Insurance	Leonard Y. Dean	7/1/1919	10/1/1919	0	3
Commissioner of Insurance	C. Brooks Smith	10/1/1915	7/1/1919	3	9
Secretary of State	John Purifoy	1/19/1915	10/1/1915	0	9

\* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

## NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>ALABAMA—Continued</b>					
Secretary of State	Cyrus B. Brown	10/5/1910	1/19/1915	4	3
Secretary of State	Frank N. Julian* (Died Nov. 30, 1944)	1/14/1907	10/5/1910	3	10
Secretary of State	Edmund R. 'Ned' McDavid	5/1/1904	1/14/1907	2	8
Secretary of State	J. Thomas Heflin	1/22/1903	5/1/1904	1	4
Secretary of State	Robert P. McDavid	12/1/1898	1/22/1903	4	1
Secretary of State	James K. Jackson	2/18/1897	12/1/1898	1	10
State Auditor	Walter S. White	12/1/1896	2/18/1897	0	2
State Auditor	John Purifoy	6/5/1892	12/1/1896	3	3
State Auditor	Cyrus D. Hogue (Died June 4, 1892)	12/1/1888	6/4/1892	3	6
State Auditor	Malcolm C. Burke	11/3/1884	11/30/1888	4	0
State Auditor	Jesse M. Carmichael	11/9/1880	11/2/1884	4	0
State Auditor	Willis Brewer	11/25/1876	11/9/1880	4	0
State Auditor	Robert T. Smith	11/26/1872	11/25/1876	4	0
State Auditor	Robert M. Reynolds	5/24/1871	11/25/1872	0	6
<b>ALASKA—Appointed, at the pleasure of the Commissioner of Commerce, Community, and Economic Development</b>					
Insurance Director	Lori K. Wing-Heier	2/25/2014		incumbent	
Acting Insurance Director	Marty Hester	12/20/2013	2/25/2014	0	2
Insurance Director	Bret S. Kolb	5/30/2012	11/30/2013	1	6
Insurance Director	Linda S. Hall	3/3/2003	5/29/2012	9	2
Acting Insurance Director	Stan Ridgeway	1/1/2003	3/3/2003	0	2
Insurance Director	Robert A. 'Bob' Lohr	8/11/1999	1/1/2003	3	5
Insurance Director	John Ference	7/1/1999	8/11/1999	0	1
Insurance Director	Marianne K. Burke	3/1/1995	7/1/1999	4	4
Acting Insurance Director	Thelma Walker	1/1/1995	3/1/1995	0	2
Insurance Director	David J. Walsh*	2/15/1990	1/1/1995	4	11
Acting Insurance Director	Dick Monkman	2/1/1990	2/15/1990	0	1
Acting Insurance Director	James Jordan	9/1/1989	2/1/1990	0	5
Insurance Director	Paul Roller	4/1/1988	9/1/1989	1	5
Insurance Director	John George	11/1/1984	4/1/1988	3	5
Acting Insurance Director	John George	7/1/1984	11/1/1984	0	4
Insurance Director	Kenneth C. Moore	2/28/1979	7/1/1984	5	5
Insurance Director	Richard L. 'Dick' Block	12/7/1975	2/1/1979	3	2
Insurance Director	John J. O'Shea	6/4/1973	6/8/1975	2	0
Insurance Director	Cloyce A. 'Red' Drake	7/1/1971	12/3/1972	1	5
Insurance Director	William W. 'Bill' Fritz	1/1/1967	6/14/1971	4	5
Insurance Director	A. W. Lingle	3/1/1964	12/4/1966	2	9
Director of Insurance	Joseph B. Loonam	6/18/1962	3/1/1964	1	9
Director of Insurance	William M. Scott	5/30/1960	5/29/1962	2	0
Insurance Commissioner	Ross P. Duncan	11/1/1955	12/22/1959	4	1
Insurance Commissioner	Neil Moore	12/4/1950	5/1/1955	4	5
Auditor of Territory	Frank A. Boyle (Died Dec. 15, 1950)	4/1/1933	12/4/1950	17	8
Auditor of Territory	Cash Cole	12/16/1929	4/1/1933	3	4
Secretary of Territory	Karl Theile	7/22/1921	12/16/1929	8	5
Secretary of Territory	Robert J. Sommers	9/25/1919	7/22/1921	1	10
Secretary of Territory	Charles E. 'Chas' Davidson (Died Aug. 8, 1919)	10/18/1913	8/8/1919	5	10

\* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

**NAIC MEMBER TENURE LIST**

<b>STATE/MEMBER TITLE</b>	<b>MEMBER NAME</b>	<b>BEG. DATE</b>	<b>END DATE</b>	<b>YRS. SERVED</b>	<b>MOS. SERVED</b>
<b>ALASKA—Continued</b>					
Surveyor-General/Secretary	William L. Distin	8/7/1897	10/18/1913	16	2
<b>AMERICAN SAMOA—Appointed, at the pleasure of the Governor</b>					
Insurance Commissioner	Peni ‘Ben’ Itlala Sapini Teo	2/15/2022		incumbent	
Acting Insurance Commissioner	Elizabeth S. Perri	8/5/2021	2/14/2022	0	6
Insurance Commissioner	Peni ‘Ben’ Itlala Sapini Teo	1/3/2021	8/4/2021	0	7
Acting Insurance Commissioner	Elizabeth S. Perri	10/23/2019	1/3/2021	1	3
Insurance Commissioner	Peteru M. ‘Peter’ Fuimaono	2/12/2019	10/23/2019	0	8
Acting Insurance Commissioner	Elizabeth S. Perri	7/26/2018	2/12/2019	0	7
Insurance Commissioner	Peteru M. ‘Peter’ Fuimaono	1/16/2017	7/26/2018	1	6
Insurance Commissioner	Tau Fati Tanuvasa	11/25/2013	1/16/2017	3	2
Insurance Commissioner	<i>Position Vacant</i>	2/1/2013	11/25/2013	0	9
Insurance Commissioner	Aoomalo Manupo Turituri	4/28/2010	1/31/2013	2	9
Insurance Commissioner	Fiaigoa A. Paogofie	2/3/2009	4/28/2010	1	2
Insurance Commissioner	Laloulu Tagoilelagi	1/15/2008	2/3/2009	2	1
Insurance Commissioner	Elisara T. Togiai	6/2/1997	12/2/2007	10	6
Insurance Commissioner	Tauivi Tuinei	1/1/1997	6/2/1997	0	5
Acting Insurance Commissioner	Tafaoata Gaoteote	12/1/1996	1/1/1997	0	1
Insurance Commissioner	Albert Atuatasi	7/1/1996	12/1/1996	0	5
Insurance Commissioner	Moetulu’i T. Iuvale	1/1/1996	7/1/1996	0	6
Insurance Commissioner	Tauivi Tuinei	2/12/1995	1/1/1996	0	11
Insurance Commissioner	Moetulu’i T. Iuvale	3/7/1993	2/12/1995	2	1
Insurance Commissioner	Fanene Su’a Scanlan	6/4/1989	1/1/1993	3	7
Insurance Commissioner	Afa Roberts	6/9/1985	12/11/1988	3	6
Insurance Commissioner	John W. von Cramm	12/4/1983	12/9/1984	1	0
Acting Insurance Commissioner	Lyle L. Richmond	11/28/1982	12/4/1983	1	1
Insurance Commissioner	Patricia G. Trammel	6/15/1980	11/28/1982	2	5
<b>ARIZONA—Appointed, at the pleasure of the Governor, with the consent of the Arizona State Senate</b>					
Director, Department of Insurance & Financial Institutions (DIFI)	Barbara D. Richardson	3/6/2023		incumbent	
Acting Director, DIFI	Shane W. Foster	1/13/2023	3/5/2023	0	2
Director, DIFI	<i>Position Vacant</i>	1/7/2023	1/12/2023	0	1
Director, DIFI	Evan G. Daniels	7/18/2020	1/6/2023	2	6
Interim Insurance Director	Christina Corieri	2/15/2020	7/17/2020	0	5
Insurance Director	Keith A. Schraad	12/14/2018	2/14/2020	1	2
Interim Insurance Director	Keith A. Schraad	2/12/2018	12/14/2018	0	10
Acting Insurance Director	Robert D. Charlton	1/29/2018	2/11/2018	0	1
Interim Insurance Director	Leslie R. Hess	2/8/2016	1/26/2018	1	11
Insurance Director	Andrew M. Tobin	10/12/2015	2/1/2016	0	4
Interim Insurance Director	Darren T. Ellingson	8/17/2015	10/11/2015	0	2
Insurance Director	Germaine L. ‘Gerrie’ Marks	11/27/2012	8/15/2015	2	9
Acting Insurance Director	Germaine L. ‘Gerrie’ Marks	6/30/2012	11/27/2012	0	5
Insurance Director	Christina Urias	11/3/2003	6/30/2012	8	7
Insurance Director	Charles R. ‘Chuck’ Cohen	10/10/1998	10/31/2003	5	0
Acting Insurance Director	Charles R. ‘Chuck’ Cohen	9/16/1998	10/10/1998	0	1
Insurance Director	John A. Greene	1/16/1997	9/16/1998	1	8
Acting Insurance Director	John King	8/1/1996	1/15/1997	0	5
Insurance Director	Chris Herstam	1/1/1994	8/1/1996	2	7
Insurance Director	Susan Gallinger	5/1/1988	12/31/1993	5	7

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## NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>ARIZONA—Continued</b>					
Acting Insurance Director	Vern R. Pierson	10/1/1987	5/1/1988	0	7
Insurance Director	S. David Childers	6/18/1984	9/30/1987	3	3
Insurance Director	J. Michael Low	1/1/1980	6/18/1984	4	5
Insurance Director	John N. 'Jack' Trimble	1/1/1976	1/1/1980	4	0
Insurance Director	Thomas Millard Humphrey	1/29/1969	12/31/1975	6	11
Insurance Director	Jerry P. Shea	2/1/1968	1/28/1969	1	0
Acting Insurance Director	George A. Livermore	10/28/1967	1/31/1968	0	3
Insurance Director	George A. Bushnell	12/12/1951	10/27/1967	15	10
Insurance Director	Roy B. Rummage (Died Dec. 1, 1951)	1/5/1937	12/1/1951	14	11
Insurance Director	George A. Brown	6/1/1933	1/4/1937	3	7
Insurance Director	Glenn D. Grant	9/17/1929	6/1/1933	3	9
Chair, Corporation Commission	Amos A. Betts	6/27/1921	9/17/1929	8	3
Chair, Corporation Commission	Forest A. Jones	9/1/1917	9/1/1920	3	0
Superintendent of Insurance	Cleveland C. Thompson	9/21/1915	8/28/1917	1	11
Chair, Corporation Commission	William P. Geary	7/29/1913	9/21/1915	2	2
<b>ARKANSAS—Appointed, at the pleasure of the Governor with the advice and consent of the Senate</b>					
Insurance Commissioner	Alan McClain	4/3/2020		incumbent	
Insurance Commissioner	Allen W. Kerr	1/13/2015	3/27/2020	5	2
Insurance Commissioner	Jay Bradford	1/15/2009	1/13/2015	6	0
Interim Insurance Commissioner	Lenita Blasingame	1/1/2009	1/15/2009	0	1
Insurance Commissioner	Julie Benafield Bowman	1/15/2005	12/31/2008	3	11
Insurance Commissioner	J. Michael 'Mike' Pickens*	1/15/1997	1/15/2005	8	0
Insurance Commissioner	Lee Douglass*	12/14/1990	1/15/1997	6	1
Insurance Commissioner	Ron Taylor III	12/23/1988	12/14/1990	2	0
Insurance Commissioner	Robert M. Eubanks III	1/21/1985	12/23/1988	3	11
Insurance Commissioner	Linda N. Garner	1/3/1983	1/21/1985	2	0
Insurance Commissioner	William H. L. Woodyard III*	7/2/1976	12/31/1982	6	6
Insurance Commissioner	Ark Monroe III	10/2/1972	7/2/1976	3	9
Insurance Commissioner	A. Gene Sykes	9/16/1970	10/2/1972	2	1
Acting Insurance Commissioner	Ernest J. W. 'Ernie' Fennell	6/15/1970	9/16/1970	0	3
Insurance Commissioner	Allan W. 'Dick' Horne	2/21/1968	6/15/1970	2	4
Insurance Commissioner	John Norman Harkey	1/30/1967	2/21/1968	1	1
Insurance Commissioner	Harvey G. Combs	4/15/1953	1/30/1967	13	9
Insurance Commissioner	Usco A. Gentry	1/15/1953	4/15/1953	0	3
Insurance Commissioner	J. Herbert Graves	1/11/1949	1/15/1953	4	0
Insurance Commissioner	Jack G. McKenzie	1/15/1945	1/11/1949	4	0
Insurance Commissioner	J. Herbert Graves	1/14/1941	1/15/1945	4	0
Insurance Commissioner	M. J. Harrison	1/15/1937	1/14/1941	4	0
Ins. Cmsr. and State Fire Marshal	Usco A. Gentry	3/4/1933	1/15/1937	3	10
Ins. Cmsr. and State Fire Marshal	Arlander D. DuLaney	3/4/1931	3/4/1933	2	0
Ins. Cmsr. and State Fire Marshal	William E. Floyd	5/23/1929	3/4/1931	1	10
Ins. Cmsr. and State Fire Marshal	John S. Maloney (Died May 22, 1929)	3/8/1927	5/22/1929	2	2
Cmsr. of Insurance and Revenue	J. Frank Beasley	2/8/1927	3/8/1927	0	1
Cmsr. of Insurance and Revenue	William E. Floyd	6/11/1925	2/8/1927	1	8
Acting Cmsr. of Ins. and Revenue	J. W. Hatley	5/15/1925	6/11/1925	0	1
Insurance Commissioner	M. J. Harrison	1/12/1925	5/15/1925	0	5
Insurance Commissioner	Bruce T. Bullion	3/7/1917	12/31/1924	7	9

\* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

**NAIC MEMBER TENURE LIST**

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>ARKANSAS—Continued</b>					
State Auditor/Ins. Commissioner	Hogan Oliver	1/10/1917	3/7/1917	0	2
State Auditor/Ins. Commissioner	M. F. Dickinson	3/5/1915	1/10/1917	2	10
State Auditor/Ins. Commissioner	Lafayette L. Coffman	6/23/1913	3/4/1915	1	9
State Auditor/Ins. Commissioner	John M. Oathout <i>(Died June 20, 1913)</i>	1/17/1913	6/20/1913	0	5
State Auditor/Ins. Commissioner	John R. Jobe	1/14/1909	1/17/1913	4	0
State Auditor/Ins. Commissioner	Avery E. Moore	1/12/1905	1/14/1909	4	0
State Auditor/Ins. Commissioner	Thomas C. Monroe	1/18/1901	1/12/1905	4	0
State Auditor/Ins. Commissioner	Clay Sloan	1/15/1897	1/18/1901	4	0
State Auditor/Ins. Commissioner	Charles B. Mills	1/14/1893	1/15/1897	4	0
State Auditor/Ins. Commissioner	William S. Dunlop	11/30/1887	1/14/1893	5	2
State Auditor/Ins. Commissioner	William R. Miller <i>(Died Nov. 29, 1887)</i>	1/14/1887	11/29/1887	0	10
State Auditor/Ins. Commissioner	A.W. Files	1/11/1883	1/14/1887	4	0
State Auditor/Ins. Commissioner	John Crawford	1/11/1877	1/11/1883	6	0
State Auditor/Ins. Commissioner	William R. Miller	11/12/1874	1/11/1877	2	2
Insurance Commissioner	Lucien J. Barnes	4/29/1873	11/12/1874	1	6
State Auditor	Stephen Wheeler	1/6/1873	4/29/1873	0	3
State Auditor	James R. Berry	5/24/1871	1/6/1873	1	8

<b>CALIFORNIA—Elected; 4-year term (not to exceed two 4-year terms)</b>					
Insurance Commissioner	Ricardo Lara <i>(Elected Nov. 6, 2018; Re-elected Nov. 8, 2022)</i>	1/7/2019		incumbent	
Insurance Commissioner	David E. 'Dave' Jones <i>(Elected Nov. 2, 2010; Re-elected Nov. 4, 2014)</i>	1/3/2011	1/6/2019	8	0
Insurance Commissioner	Steve Poizner	1/8/2007	1/3/2011	4	0
Insurance Commissioner	John R. Garamendi	1/6/2003	1/8/2007	4	0
Insurance Commissioner	Harry W. Low	9/18/2000	1/6/2003	2	4
Acting Insurance Commissioner	J. Clark Kelso	7/10/2000	9/18/2000	0	2
Insurance Commissioner	Charles 'Chuck' Quackenbush	1/2/1995	7/10/2000	5	6
Insurance Commissioner	John R. Garamendi	1/7/1991	1/2/1995	4	0
Insurance Commissioner	Roxani M. Gillespie	1/5/1987	12/31/1990	4	0
Insurance Commissioner	Bruce A. Bunner	3/21/1983	7/1/1986	3	4
Insurance Commissioner	Robert C. Quinn	1/1/1981	3/21/1983	2	2
Insurance Commissioner	Wesley J. Kinder*	3/1/1975	1/1/1981	5	10
Insurance Commissioner	Gleeson L. 'Tige' Payne	11/1/1972	3/1/1975	2	4
Insurance Commissioner	Richards D. 'Dick' Barger*	8/21/1968	11/1/1972	4	3
Insurance Commissioner	Richard S. L. Roddis	1/20/1966	1/1/1969	3	0
Insurance Commissioner	Stafford R. Grady	1/1/1964	1/1/1966	2	0
Insurance Commissioner	F. Britton McConnell	1/1/1955	1/1/1964	9	0
Insurance Commissioner	John R. Maloney	1/1/1951	1/1/1955	4	0
Insurance Commissioner	Wallace K. Downey	2/1/1947	1/1/1951	3	11
Insurance Commissioner	Maynard Garrison	10/1/1943	2/1/1947	3	4
Insurance Commissioner	Anthony J. Caminetti, Jr.	6/28/1939	10/1/1943	4	4
Insurance Commissioner	Rex B. Goodcell	7/15/1938	6/28/1939	0	11
Insurance Commissioner	Samuel L. Carpenter, Jr.	4/4/1935	7/15/1938	3	3
Insurance Commissioner	E. Forrest Mitchell	4/24/1929	4/4/1935	6	0
Insurance Commissioner	Charles R. 'Charlie' Detrick*	1/13/1925	4/24/1929	4	3

\* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

## NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>CALIFORNIA—Continued</b>					
Insurance Commissioner	George D. Squires	3/22/1923	1/13/1925	1	10
Acting Insurance Commissioner	Edward C. Cooper	1/1/1923	3/22/1923	0	2
Insurance Commissioner	Alexander L. McCabe	3/15/1917	1/1/1923	5	10
Insurance Commissioner	Joseph E. Phelps	7/1/1914	3/15/1917	2	8
Insurance Commissioner	Edward C. Cooper	6/16/1910	7/1/1914	4	1
Insurance Commissioner	E. Myron Wolf	4/8/1902	4/8/1910	8	0
Insurance Commissioner	Andrew J. Clunie	3/15/1897	4/8/1902	5	1
Insurance Commissioner	M. R. Higgins	4/8/1894	3/15/1897	2	11
Insurance Commissioner	J. N. E. Wilson	4/8/1890	4/8/1894	4	0
Insurance Commissioner	J. C. L. Wadsworth	4/19/1886	4/8/1890	4	0
Insurance Commissioner	George A. Knight	4/8/1882	4/19/1886	4	0
Insurance Commissioner	J. C. Maynard	4/8/1878	4/8/1882	4	0
Insurance Commissioner	John W. Foard	4/1/1872	4/8/1878	6	0
Insurance Commissioner	George W. Mowe	5/24/1871	4/1/1872	0	11
<b>COLORADO—Appointed, at the pleasure of the Governor; subject to confirmation by the Senate</b>					
Insurance Commissioner	Michael Conway	1/22/2019		incumbent	
Interim Insurance Commissioner	Michael Conway	1/1/2018	1/21/2019	1	0
Insurance Commissioner	Marguerite Salazar	8/19/2013	12/31/2017	4	4
Interim Insurance Commissioner	Doug Dean	7/8/2013	8/14/2013	0	1
Insurance Commissioner	James L. 'Jim' Riesberg	7/1/2011	7/8/2013	2	0
Interim Insurance Commissioner	John J. Postolowski	12/1/2010	7/1/2011	0	7
Insurance Commissioner	Marcy Morrison	1/9/2007	12/1/2010	3	11
Insurance Commissioner	David Rivera	4/20/2005	1/9/2007	1	9
Insurance Commissioner	Doug Dean	1/7/2003	4/20/2005	2	3
Acting Insurance Commissioner	M. Michael Cooke	8/9/2002	1/7/2003	0	5
Insurance Commissioner	William J. Kirven III	2/26/1999	8/9/2002	3	6
Insurance Commissioner	John B. 'Jack' Ehnes	2/11/1994	2/26/1999	5	0
Insurance Commissioner	<i>Position Vacant</i>	1/1/1994	1/31/1994	0	1
Insurance Commissioner	Joanne Hill	10/1/1989	12/31/1993	4	2
Acting Insurance Commissioner	Bruce Smith	9/1/1989	10/1/1989	0	1
Insurance Commissioner	John Kezer	2/5/1985	9/1/1989	4	7
Acting Insurance Commissioner	D. Colaiannia	2/1/1984	2/5/1985	1	0
Insurance Commissioner	J. Richard Barnes	3/23/1964	1/31/1984	19	10
Insurance Commissioner	Sam N. Beery*	1/1/1955	3/1/1964	9	2
Insurance Commissioner	Luke J. Kavanaugh	4/22/1939	12/31/1954	15	8
Insurance Commissioner	Jackson Cochrane	11/1/1921	4/22/1939	17	5
Insurance Commissioner	Earl Wilson	11/5/1920	10/15/1921	0	11
Insurance Commissioner	Claude W. Fairchild*	3/24/1917	11/5/1920	3	8
Acting Insurance Commissioner	Mrs. D. M. Rolph	1/23/1917	3/24/1917	0	2
Insurance Commissioner	Erastus R. Harper	6/14/1915	1/22/1917	1	7
Acting Insurance Commissioner	Mrs. D. M. Rolph	1/16/1915	6/14/1915	0	5
Insurance Commissioner	Saul Epstein	5/10/1913	1/16/1915	1	8
Insurance Commissioner	William L. Clayton	1/31/1909	5/10/1913	4	4
Insurance Commissioner	Elmer E. Rittenhouse	7/1/1907	1/31/1909	1	6
Superintendent of Insurance	Alfred E. Bent	6/1/1905	6/30/1907	2	0
Superintendent of Insurance	John A. Holmberg	6/1/1903	6/1/1905	2	0
Superintendent of Insurance	Charles W. Crouter	6/1/1901	6/1/1903	2	0
Superintendent of Insurance	George W. Temple	6/1/1899	6/1/1901	2	0
Superintendent of Insurance	John M. Lowell	6/1/1897	6/1/1899	2	0

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**NAIC MEMBER TENURE LIST**

<b>STATE/MEMBER TITLE</b>	<b>MEMBER NAME</b>	<b>BEG. DATE</b>	<b>END DATE</b>	<b>YRS. SERVED</b>	<b>MOS. SERVED</b>
<b>COLORADO—Continued</b>					
Superintendent of Insurance	Clifford C. Parks	6/1/1895	6/1/1897	2	0
Superintendent of Insurance	F. M. Goodykoontz	6/1/1893	6/1/1895	2	0
Superintendent of Insurance	John M. Henderson	6/1/1891	6/1/1893	2	0
Auditor of State	Louis B. Schwanbeck	9/1/1889	6/1/1891	1	9
Auditor of State	Darwin P. Kingsley	9/1/1887	9/1/1889	2	0
Superintendent of Insurance	Hiram A. Spruance	9/1/1885	9/1/1887	2	0
Superintendent of Insurance	John C. Abbott	4/1/1883	9/1/1885	2	5
<b>CONNECTICUT—Appointed, at the pleasure of the Governor with the advice and consent of either house of the General Assembly; 4-year term</b>					
Insurance Commissioner	Andrew N. ‘Andy’ Mais <i>(Reappointed Jan. 4, 2023)</i>	3/4/2019		incumbent	
Acting Insurance Commissioner	Paul Lombardo	12/20/2018	3/1/2019	0	3
Insurance Commissioner	Katharine L. ‘Katie’ Wade	3/24/2015	12/19/2018	3	9
Acting Insurance Commissioner	Anne Melissa Dowling	12/11/2014	3/24/2015	0	3
Insurance Commissioner	Thomas B. Leonardi	2/4/2011	12/11/2014	3	10
Acting Insurance Commissioner	Barbara C. Spear	11/12/2010	2/4/2011	0	3
Insurance Commissioner	Thomas R. Sullivan	4/1/2007	11/12/2010	3	7
Insurance Commissioner	Susan F. Cogswell	6/22/2000	4/1/2007	6	10
Acting Insurance Commissioner	William J. Gilligan	5/8/2000	6/22/2000	0	1
Insurance Commissioner	George M. Reider Jr.*	5/1/1995	5/5/2000	5	0
Acting Insurance Commissioner	William J. Gilligan	6/1/1994	5/1/1995	0	11
Insurance Commissioner	Robert R. Googins	3/1/1991	6/1/1994	3	3
Acting Insurance Commissioner	Robert R. Googins	2/1/1991	3/1/1991	0	1
Insurance Commissioner	Peter F. Kelly	8/17/1988	2/1/1991	2	6
Acting Insurance Commissioner	William J. Gilligan	7/1/1988	8/1/1988	0	1
Insurance Commissioner	Peter W. Gillies	1/5/1983	7/1/1988	5	6
Insurance Commissioner	Joseph C. Mike	6/1/1977	1/1/1983	5	7
Insurance Commissioner	T. F. Gilroy Daly	6/1/1976	6/1/1977	1	0
Insurance Commissioner	Jay W. Jackson	6/1/1975	6/1/1976	1	0
Insurance Commissioner	Thomas C. White	6/1/1973	6/1/1975	2	0
Insurance Commissioner	Paul B. Altermatt	6/1/1971	6/1/1973	2	0
Insurance Commissioner	Robert F. Claffey	1/1/1971	6/1/1971	0	5
Insurance Commissioner	William R. Cotter	7/1/1966	12/31/1970	4	5
Acting Insurance Commissioner	James G. McCabe	6/1/1966	7/1/1966	0	1
Insurance Commissioner	William R. Cotter	5/4/1964	6/1/1966	2	1
Insurance Commissioner	Alfred N. Premo	6/1/1958	5/4/1964	5	11
Insurance Commissioner	Thomas J. Spellacy	6/1/1955	6/1/1958	3	0
Insurance Commissioner	W. Ellery Allyn*	7/1/1943	6/1/1955	11	11
Insurance Commissioner	John C. Blackall*	7/1/1935	7/1/1943	8	0
Insurance Commissioner	Howard P. Dunham	7/1/1923	7/1/1935	12	0
Insurance Commissioner	Burton Mansfield*	7/1/1911	7/1/1923	12	0
Insurance Commissioner	Theodore H. Macdonald	7/1/1907	7/1/1911	4	0
Insurance Commissioner	Theron Upson	6/1/1902	7/1/1907	5	1
Insurance Commissioner	Edwin L. Scofield	7/1/1899	6/1/1902	2	11
Insurance Commissioner	Frederick A. Betts	7/1/1895	7/1/1899	4	0
Insurance Commissioner	Burton Mansfield*	4/11/1893	7/1/1895	2	3
Acting Insurance Commissioner	John S. Seymour	3/3/1893	4/11/1893	0	1
Insurance Commissioner	Orsamus R. Fyler*	7/1/1886	3/3/1893	6	8
Insurance Commissioner	Ephraim Williams	7/1/1883	7/1/1886	3	0

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## NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>CONNECTICUT—Continued</b>					
Insurance Commissioner	John W. Brooks	7/27/1880	7/1/1883	3	0
Insurance Commissioner	John W. Steadman	7/27/1874	7/27/1880	6	0
Insurance Commissioner	George S. Miller	7/27/1871	7/27/1874	3	0
Insurance Commissioner	Benjamin Noyes	5/24/1871	7/27/1871	0	2
<b>DELAWARE—Elected; 4-Year Term</b>					
Insurance Commissioner	Trinidad Navarro <i>(Elected Nov. 8, 2016; Re-elected Nov. 3, 2020)</i>	1/3/2017		incumbent	
Insurance Commissioner	Karen Weldin Stewart	1/6/2009	1/3/2017	8	0
Insurance Commissioner	Matthew Denn	1/4/2005	1/6/2009	4	0
Insurance Commissioner	Donna Lee Williams	1/1/1993	1/4/2005	12	0
Insurance Commissioner	David N. Levinson	1/1/1985	1/1/1993	8	0
Insurance Commissioner	David H. Elliot	1/4/1977	1/1/1985	8	0
Insurance Commissioner	John F. Richardson	4/1/1976	1/4/1977	0	9
Insurance Commissioner	Robert A. Short	1/1/1963	4/1/1976	13	3
Insurance Commissioner	Harry S. Smith	1/1/1955	1/1/1963	8	0
Insurance Commissioner	William R. Murphy	1/1/1951	1/1/1955	4	0
Insurance Commissioner	William J. Swain	1/1/1939	1/1/1951	12	0
Insurance Commissioner	J. Postles Hammond	1/1/1935	1/1/1939	4	0
Insurance Commissioner	James G. Shaw	1/1/1927	1/1/1935	8	0
Insurance Commissioner	Charles M. Hollis	1/1/1923	1/1/1927	4	0
Insurance Commissioner	William J. Swain	7/24/1922	1/1/1923	0	6
Insurance Commissioner	Horace Sudler <i>(Died July 24, 1922)</i>	1/1/1921	7/24/1922	1	6
Insurance Commissioner	Thomas R. Wilson	1/1/1917	1/1/1921	4	0
Insurance Commissioner	William R. McCabe	1/1/1913	1/1/1917	4	0
Insurance Commissioner	Charles H. Maull	1/5/1909	1/1/1913	4	0
Insurance Commissioner	George W. Marshall	1/1/1901	1/5/1909	8	0
Insurance Commissioner	Edward D. Fowler	3/23/1897	1/1/1901	3	10
Insurance Commissioner	Peter K. Meredith	3/22/1893	3/23/1897	4	0
Insurance Commissioner	Isaac N. Fooks	3/23/1889	3/22/1893	4	0
Insurance Commissioner	Nathan Pratt	3/21/1885	3/23/1889	4	0
Insurance Commissioner	Henry C. Douglass <i>(Died Feb. 27, 1885)</i>	4/21/1883	2/27/1885	1	10
Insurance Commissioner	John R. McFee	4/21/1879	4/21/1883	4	0
Secretary of State	Ignatius C. Grubb	1/18/1875	4/21/1879	4	3
Secretary of State	John H. Paynter	5/24/1871	1/18/1875	3	8
<b>DISTRICT OF COLUMBIA—Appointed, at the pleasure of the Mayor; confirmed by the Council of District Columbia</b>					
Commissioner, Dept. of Insurance, Securities & Banking (DISB)	Karima M. Woods	7/28/2020		incumbent	
Acting Commissioner, DISB	Karima M. Woods	1/21/2020	7/28/2020	0	6
Commissioner, DISB	Stephen C. Taylor	11/3/2015	1/20/2020	4	2
Acting Commissioner, DISB	Stephen C. Taylor	6/19/2015	11/3/2015	0	5
Acting Commissioner, DISB	Chester A. McPherson	4/20/2014	6/19/2015	1	2
Interim Commissioner, DISB	Chester A. McPherson	11/15/2013	4/20/2014	0	5
Commissioner, DISB	William P. White	6/7/2011	11/15/2013	2	5
Acting Commissioner, DISB	William P. White	2/14/2011	6/7/2011	0	4
Commissioner, DISB	Gennet Purcell	11/3/2009	2/14/2011	1	3

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**NAIC MEMBER TENURE LIST**

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>DISTRICT OF COLUMBIA—Continued</b>					
Acting Commissioner, DISB	Gennet Purcell	9/2/2009	11/3/2009	0	2
Commissioner, DISB	Thomas E. Hampton	5/9/2006	8/28/2009	3	3
Acting Commissioner, DISB	Thomas E. Hampton	10/1/2005	5/9/2006	0	7
Commissioner, DISB	Lawrence H. ‘Larry’ Mirel	3/1/2004	9/30/2005	1	7
Commissioner of Ins. & Securities	Lawrence H. ‘Larry’ Mirel	10/5/1999	3/1/2004	4	5
Acting Cmsr. of Ins. & Securities	Lawrence H. ‘Larry’ Mirel	7/6/1999	10/5/1999	0	3
Acting Cmsr. of Ins. & Securities	Reginald Berry	1/4/1999	7/12/1999	0	6
Commissioner of Ins. & Securities	Patrick E. Kelly	7/21/1998	1/4/1999	0	6
Interim Cmsr. of Ins. & Securities	Patrick E. Kelly	7/22/1997	7/21/1998	1	0
Interim Commissioner of Insurance	Patrick E. Kelly	1/1/1995	7/22/1997	2	6
Commissioner of Insurance	Robert M. Willis <i>(Died Oct. 21, 2020)</i>	8/12/1991	1/1/1995	3	5
Acting Commissioner of Insurance	Patrick E. Kelly	4/1/1991	8/12/1991	0	4
Commissioner of Insurance	Margurite Stokes	4/1/1983	4/1/1991	8	0
Acting Superintendent of Insurance	James R. Montgomery III	11/8/1978	4/1/1983	3	10
Superintendent of Insurance	Maximilian ‘Max’ Wallach <i>(Died Nov. 7, 1978)</i>	11/24/1973	11/7/1978	4	10
Acting Superintendent of Insurance	Maximilian ‘Max’ Wallach <i>(Died Nov. 7, 1978)</i>	9/16/1973	11/24/1973	0	2
Superintendent of Insurance	Edward P. Lombard	3/1/1970	9/14/1973	3	6
Acting Superintendent of Insurance	Edward P. Lombard	1/24/1970	3/1/1970	0	2
Superintendent of Insurance	Albert F. Jordan	8/1/1939	1/23/1970	30	5
Superintendent of Insurance	J. Balch Moor <i>(Died July 22, 1939)</i>	3/23/1936	7/22/1939	3	4
Superintendent of Insurance	John A. Marshall	2/19/1934	3/23/1936	2	1
Superintendent of Insurance	Herbert L. Davis	5/1/1931	2/19/1934	2	9
Acting Superintendent of Insurance	Frank B. Bryan, Jr.	4/28/1931	5/1/1931	0	1
Superintendent of Insurance	Thomas M. Baldwin, Jr.	9/16/1924	4/28/1931	7	1
Acting Superintendent of Insurance	Thomas M. Baldwin, Jr.	3/29/1924	9/16/1924	0	6
Superintendent of Insurance	Burt A. Miller	6/22/1922	3/28/1924	1	9
Superintendent of Insurance	Lewis A. Griffith	6/4/1919	6/22/1922	3	0
Superintendent of Insurance	Lee B. Mosher	11/14/1917	5/7/1919	1	6
Acting Superintendent of Insurance	Charles C. Wright	10/22/1917	11/14/1917	0	1
Superintendent of Insurance	Charles F. Nesbit	1/10/1914	10/22/1917	3	9
Superintendent of Insurance	George W. Ingham	11/17/1910	12/22/1913	3	1
Acting Superintendent of Insurance	Daniel E. Curry	7/23/1910	11/17/1910	0	4
Superintendent of Insurance	Thomas E. Drake <i>(Died July 23, 1910)</i>	1/1/1902	7/23/1910	8	6
Assessor of the District	Hopewell H. Darnelle	12/1/1899	12/31/1901	1	1
Assessor of the District	Matthew Trimble	3/16/1890	12/1/1899	9	9
Assessor of the District	Roger Williams	3/19/1889	3/16/1890	1	0
Assessor of the District	Roswell A. Fish	5/23/1887	3/19/1889	1	10
Treasurer and Assessor	Robert P. Dodge <i>(Died May 21, 1887)</i>	7/11/1876	5/21/1887	10	10
Treasurer of the District	James S. Wilson	12/1/1873	7/11/1876	2	8
Treasurer of the District	John T. Johnson	10/18/1871	11/29/1873	2	1
<b>FLORIDA—Appointed, at the Pleasure of the Financial Services Commission</b>					
Insurance Commissioner	Michael Yaworsky	3/13/2023		incumbent	
Interim Insurance Commissioner	Michael Yaworsky	1/13/2023	3/13/2023	0	1

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## NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>FLORIDA—Continued</b>					
Insurance Commissioner	<i>Position Vacant</i>	12/29/2022	1/12/2023	0	1
Insurance Commissioner	David Altmaier*	4/29/2016	12/28/2022	6	8
Insurance Commissioner	Kevin M. McCarty*	1/9/2003	4/29/2016	13	0
State Treasurer/Ins. Commissioner	C. Thomas 'Tom' Gallagher	1/3/2001	1/3/2003	2	0
State Treasurer/Ins. Commissioner	C. William 'Bill' Nelson	1/3/1995	1/3/2001	6	0
State Treasurer/Ins. Commissioner	C. Thomas 'Tom' Gallagher	1/3/1989	1/3/1995	6	0
State Treasurer/Ins. Commissioner	William D. 'Bill' Gunter*	11/9/1976	1/3/1989	12	2
State Treasurer/Ins. Commissioner	Philip F. Ashler	6/3/1975	11/9/1976	1	5
State Treasurer/Ins. Commissioner	Thomas D. O'Malley	1/5/1971	6/3/1975	4	5
State Treasurer/Ins. Commissioner	Broward Williams	1/25/1965	1/5/1971	5	11
State Treasurer/Ins. Commissioner	J. Edwin Larson* <i>(Died Jan. 24, 1965)</i>	1/7/1941	1/24/1965	24	0
State Treasurer/Ins. Commissioner	William V. Knott	9/28/1928	1/7/1941	12	3
State Treasurer/Ins. Commissioner	John C. Luning* <i>(Died Sept. 26, 1928)</i>	2/19/1912	9/26/1928	16	7
State Treasurer	William V. Knott	3/1/1903	2/19/1912	8	11
State Treasurer	James B. Whitfield	6/19/1897	3/1/1903	5	9
State Treasurer	Clarence B. Collins	1/3/1893	6/19/1897	4	5
State Treasurer	Eduardo J. Triay	12/31/1891	1/3/1893	2	0
State Treasurer	Francis J. Pons <i>(Died Dec. 24, 1891)</i>	1/8/1889	12/24/1891	2	11
State Treasurer	Edward S. Crill	2/19/1885	1/8/1889	3	11
State Treasurer	Henry A. L'Engle	2/1/1881	2/19/1885	4	0
State Treasurer	Walter H. Gwynn	1/9/1877	2/1/1881	3	11
State Treasurer	Charles H. Foster	1/16/1873	1/9/1877	4	0
State Treasurer	Simon B. Conover	5/24/1871	1/16/1873	1	4
<b>FLORIDA (Department of Financial Services)—Elected; 4-Year Term</b>					
Chief Financial Officer	Jimmy T. Patronis, Jr. <i>(Appointed June 25, 2017; Elected Nov. 6, 2018; Re-elected Nov. 8, 2022)</i>	6/30/2017		incumbent	
Chief Financial Officer	Jeffrey H. 'Jeff' Atwater	1/4/2011	6/30/2017	6	6
Chief Financial Officer	Adelaide Alexander 'Alex' Sink	1/2/2007	1/4/2011	4	0
Chief Financial Officer	C. Thomas 'Tom' Gallagher	1/3/2003	1/2/2007	4	0
<b>GEORGIA—Elected; 4-Year Term</b>					
Insurance Commissioner	John F. King <i>(Appointed June 12, 2019; Elected Nov. 8, 2022)</i>	7/1/2019		incumbent	
Insurance Commissioner	<i>Position Vacant</i>	5/17/2019	6/30/2019	0	1
Insurance Commissioner	Jim Beck <i>(Suspended May 16, 2019)</i>	1/14/2019	5/16/2019	0	4
Insurance Commissioner	Ralph T. Hudgens	1/10/2011	1/13/2019	8	0
Insurance Commissioner	John Oxendine	1/20/1995	1/1/2011	16	0
Insurance Commissioner	Tim Ryles	1/20/1991	1/20/1995	4	0
Insurance Commissioner	Warren D. Evans	11/1/1985	1/3/1991	5	2
Ins. Commissioner/Comptroller General	Johnnie L. Caldwell*	1/12/1971	11/1/1985	14	0
Ins. Commissioner/Comptroller General	James L. Bentley*	1/1/1963	11/1/1971	8	10
Ins. Commissioner/Comptroller General	Zachariah D. 'Zack' Cravey	1/1/1947	1/1/1963	16	0
Ins. Commissioner/Comptroller General	William R. Mitchell	6/25/1946	1/1/1947	0	7

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**NAIC MEMBER TENURE LIST**

<b>STATE/MEMBER TITLE</b>	<b>MEMBER NAME</b>	<b>BEG. DATE</b>	<b>END DATE</b>	<b>YRS. SERVED</b>	<b>MOS. SERVED</b>
<b>GEORGIA—Continued</b>					
Ins. Commissioner/Comptroller General	Homer C. Parker <i>(Died June 22, 1946)</i>	1/14/1941	6/22/1946	5	5
Ins. Commissioner/Comptroller General	C. Downing Musgrove	6/7/1940	1/14/1941	0	7
Ins. Commissioner/Comptroller General	William B. Harrison <i>(Died June 3, 1940)</i>	1/12/1937	6/3/1940	3	5
Ins. Commissioner/Comptroller General	Homer C. Parker	6/16/1936	1/12/1937	0	7
Ins. Commissioner/Comptroller General	Glenn B. Carreker	2/24/1936	6/16/1936	0	4
Ins. Commissioner/Comptroller General	William B. Harrison	9/18/1929	2/24/1936	6	5
Ins. Commissioner/Comptroller General	William A. Wright <i>(Died Sept. 13, 1929)</i>	9/17/1879	9/13/1929	50	0
Comptroller-General	Washington L. Goldsmith	1/11/1873	9/17/1879	6	8
Comptroller-General	Madison Bell	5/24/1871	1/11/1873	1	8

<b>GUAM—Appointed, at the pleasure of the Governor</b>					
Cmsr. of Banking and Insurance	Michelle B. Santos	12/7/2020		incumbent	
Director of Rev. & Taxation/Acting Cmsr. of Banking & Insurance	Dafne M. Shimizu	1/7/2019	12/7/2020	1	11
Director of Rev. & Taxation/Acting Cmsr. of Banking & Insurance	John P. Camacho	2/5/2018	12/31/2018	0	10
Cmsr. of Banking and Insurance	Artemio B. 'Art' Ilagan	5/17/2011	2/5/2018	6	9
Director of Rev. & Taxation/Acting Cmsr. of Banking & Insurance	John P. Camacho	1/3/2011	5/17/2011	0	4
Cmsr. of Banking and Insurance	John P. Camacho	10/29/2008	1/3/2011	2	3
Director of Rev. & Taxation/Acting Cmsr. of Banking & Insurance	Artemio B. 'Art' Ilagan	1/1/2008	10/29/2008	0	9
Cmsr. of Banking and Insurance	John P. Camacho	6/26/2007	1/1/2008	0	7
Director of Rev. & Taxation/Acting Cmsr. of Banking & Insurance	Artemio B. 'Art' Ilagan	3/9/2007	6/26/2007	0	3
Cmsr. of Banking and Insurance	Andreas J. 'Andy' Jordanou	8/27/2004	3/9/2007	2	7
Director of Revenue and Taxation	Artemio B. 'Art' Ilagan	1/6/2003	8/27/2004	1	7
Acting Director of Revenue and Taxation/Acting Insurance Cmsr.	George V. Cruz	9/28/2001	1/6/2003	1	4
Director of Revenue and Taxation/Insurance Commissioner	Joseph T. 'Joey' Duenas	1/1/1995	9/28/2001	6	8
Director of Revenue and Taxation/Insurance Commissioner	Joaquin G. Blaz	1/1/1988	1/1/1995	7	0
Acting Director of Revenue and Taxation/Acting Insurance Cmsr.	J.C. Carr Bettis	1/1/1987	1/1/1988	1	0
Director of Revenue and Taxation/Insurance Commissioner	David J. 'Dave' Santos	1/3/1983	1/1/1987	4	0
Director of Revenue and Taxation/Insurance Commissioner	Jose R. Rivera	1/2/1981	1/3/1983	2	0
Director of Revenue and Taxation/Insurance Commissioner	Ignacio C. Borja	1/2/1979	1/2/1981	2	0
Director of Revenue and Taxation/Insurance Commissioner	Manuel A. Chaco	1/6/1975	1/2/1979	4	0
Director of Revenue and Taxation/Insurance Commissioner	Joaquin G. Blaz	7/20/1969	12/31/1974	4	5
Director of Revenue and Taxation/Insurance Commissioner	Joaquin C. Guerrero	10/1/1968	7/20/1969	0	9
Director of Finance/Insurance Commissioner	Joaquin C. Guerrero	1/4/1965	10/1/1968	3	9

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**NAIC MEMBER TENURE LIST**

<b>STATE/MEMBER TITLE</b>	<b>MEMBER NAME</b>	<b>BEG. DATE</b>	<b>END DATE</b>	<b>YRS. SERVED</b>	<b>MOS. SERVED</b>
<b>GUAM—Continued</b>					
Acting Director of Finance/Acting Insurance Commissioner	Segundo C. Aguon	6/1/1964	1/4/1965	0	7
Acting Director of Finance/Acting Insurance Commissioner	Robert A. Smith	1/1/1964	6/1/1964	0	5
Director of Finance/Insurance Commissioner	George W. Ingling <i>(Died March 26, 1979)</i>	3/6/1961	1/1/1964	2	10
Director of Finance/Insurance Commissioner	Richard F. 'Dick' Taitano <i>(Died Jan. 4, 1997)</i>	6/8/1959	3/6/1961	0	9
<b>HAWAII—Appointed, at the pleasure of the Director of Commerce and Consumer Affairs; approved by the Governor</b>					
Insurance Commissioner	Gordon I. Ito	12/16/2022		incumbent	
Insurance Commissioner	Colin M. Hayashida <i>(Died Feb. 28, 2023)</i>	1/1/2019	12/16/2022	3	11
Insurance Commissioner	Gordon I. Ito	12/1/2010	12/31/2018	8	0
Acting Insurance Commissioner	Gordon I. Ito	7/20/2010	12/1/2010	0	5
Insurance Commissioner	J. P. Schmidt	2/3/2003	7/1/2010	7	5
Acting Insurance Commissioner	Gordon I. Ito	11/29/2002	2/3/2003	0	3
Insurance Commissioner	Wayne C. Metcalf	3/1/1999	11/1/2002	3	8
Insurance Commissioner	Rey Gaulty	2/4/1997	3/1/1999	2	1
Insurance Commissioner	Wayne C. Metcalf	1/1/1995	2/1/1997	2	1
Insurance Commissioner	Lawrence M. Reifurth	3/1/1994	1/1/1995	0	10
Insurance Commissioner	Linda Chu Takayama	12/16/1991	2/28/1994	2	2
Insurance Commissioner	Robin Campaniano	1/1/1987	12/16/1991	4	11
Insurance Commissioner	Mario R. Ramil	5/1/1984	1/1/1987	2	8
Insurance Commissioner	Susan Kee-Young Park	7/1/1982	5/1/1984	1	10
Insurance Commissioner	Mary G. F. Bitterman	2/1/1981	7/1/1982	1	5
Insurance Commissioner	Tany S. Hong	1/1/1979	2/1/1981	1	11
Insurance Commissioner	Wayne Minami	1/1/1975	1/1/1979	4	0
Insurance Commissioner	Edwin H. Honda	1/8/1968	12/31/1974	6	11
Insurance Commissioner	Sidney I. Hashimoto	1/17/1963	1/1/1968	5	0
Insurance Commissioner	Charles H. Silva	1/1/1960	1/17/1963	3	0
Insurance Commissioner	Raymond Y. C. Ho	1/1/1959	1/1/1960	1	0
Insurance Commissioner	Kam Tai Lee	1/1/1953	1/1/1959	6	0
Insurance Commissioner	Sakae Takahashi	1/1/1952	1/1/1953	1	0
Insurance Commissioner	Howard H. Adams	1/1/1951	1/1/1952	1	0
Insurance Commissioner	William B. Brown	12/15/1947	1/1/1951	3	11
Insurance Commissioner	Walter D. Ackerman, Jr.	2/19/1943	12/15/1947	4	10
Insurance Commissioner	Norman D. Godbold, Jr.	11/7/1940	2/19/1943	2	3
Insurance Commissioner	W. C. McGonagle	6/30/1934	11/7/1940	6	5
Insurance Commissioner	E. S. Smith	7/15/1929	6/30/1934	4	11
Insurance Commissioner	Henry C. Hapai	11/1/1922	7/15/1929	6	8
Insurance Commissioner	A. Lewis, Jr.	12/1/1921	11/1/1922	0	11
Insurance Commissioner	Delbert E. Metzger	6/22/1918	12/1/1921	3	6
Insurance Commissioner	Charles J. McCarthy	10/31/1914	6/22/1918	3	8
Insurance Commissioner	David L. Conkling	7/1/1909	10/31/1914	5	3
Insurance Commissioner	A. J. Campbell	1/1/1907	7/1/1909	2	6
Insurance Commissioner	A. N. Keoikai	1/1/1903	1/1/1907	4	0

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**NAIC MEMBER TENURE LIST**

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>IDAHO—Appointed; 4-year term, subject to earlier removal by the Governor</b>					
Insurance Director	Dean L. Cameron <i>(Reappointed March 19, 2019)</i>	6/15/2015		incumbent	
Acting Insurance Director	Thomas A. ‘Tom’ Donovan	1/5/2015	6/15/2015	0	5
Insurance Director	William W. ‘Bill’ Deal	1/2/2007	12/31/2014	7	11
Acting Insurance Director	Shad Priest	7/1/2006	1/1/2007	0	6
Insurance Director	Gary L. Smith	12/1/2004	6/30/2006	1	6
Insurance Director	Mary L. Hartung	1/4/1999	11/30/2004	5	10
Acting Insurance Director	Mary L. Hartung	4/17/1998	1/3/1999	0	9
Insurance Director	James M. Alcorn	3/1/1996	4/17/1998	2	1
Acting Insurance Director	James M. Alcorn	12/1/1995	3/1/1996	0	3
Insurance Director	John Michael ‘Mike’ Brassey	1/16/1995	12/1/1995	0	11
Acting Insurance Director	James M. Alcorn	6/1/1994	1/16/1995	0	7
Insurance Director	Harry C. Walrath	7/1/1991	6/1/1994	2	11
Acting Insurance Director	George J. Neumayer	3/1/1991	7/1/1991	0	4
Insurance Director	Anthony J. ‘Tony’ Fagiano	1/5/1987	3/1/1991	4	2
Insurance Director	Wayne L. Soward	5/14/1984	1/5/1987	3	5
Insurance Director	Trent M. Woods	9/12/1980	5/14/1984	3	8
Insurance Director	Monroe C. Gollaher	1/1/1974	9/12/1980	6	8
Acting Insurance Commissioner	Monroe C. Gollaher	8/29/1973	1/1/1974	0	5
Insurance Commissioner	Robert Hay	4/18/1972	8/29/1973	1	4
Insurance Commissioner	John R. Blaine	1/11/1967	4/18/1972	6	3
Insurance Commissioner	Leo O’Connell	7/29/1950	1/11/1967	16	5
Insurance Commissioner	James Hubbard	7/1/1947	7/28/1950	3	0
Insurance Director	Edward B. McMonigle	8/1/1945	7/1/1947	1	11
Acting Insurance Director	Laura E. Dewey	4/5/1945	8/1/1945	0	4
Insurance Director	Howard C. Cullimore	5/21/1944	4/5/1945	0	11
Insurance Director	James A. Dement	4/8/1944	5/21/1944	0	1
Insurance Director	Howard C. Cullimore	1/4/1943	4/8/1944	1	3
Insurance Director	Joel Jenifer	1/7/1941	1/4/1943	2	0
Insurance Director	Ted M. Walrath	3/1/1939	1/7/1941	1	10
Insurance Director	Warren H. Bakes	3/2/1931	3/1/1939	8	0
Insurance Director	David C. Neifert	6/1/1924	3/1/1931	6	9
Insurance Director	Harry D. Smith	12/22/1922	6/1/1924	0	6
Insurance Director	Howard J. Brace	10/18/1919	12/22/1922	3	2
Insurance Director	Willet R. Hyatt	5/15/1917	10/18/1919	1	11
Insurance Commissioner	George F. Steele	7/1/1915	5/15/1917	1	10
Insurance Commissioner	Elmer F. Van Valkenberg	4/1/1913	7/1/1915	2	3
Insurance Commissioner	Isaac C. Hattabaugh	4/1/1911	4/1/1913	2	0
Insurance Commissioner	Charles D. Goaslind	8/24/1909	4/1/1911	1	7
<b>ILLINOIS—Appointed, at the Pleasure of the Governor</b>					
Insurance Director	Dana Popish Severinghaus	2/22/2022		incumbent	
Acting Insurance Director	Dana Popish Severinghaus	1/19/2021	2/22/2022	1	1
Interim Acting Insurance Director	Shannon Whalen	12/11/2020	1/18/2021	0	1
Insurance Director	Robert H. Muriel	5/31/2019	12/11/2020	1	7
Acting Insurance Director	Robert H. Muriel	3/11/2019	5/31/2019	0	2
Acting Insurance Director	Kevin Fry	1/25/2019	3/8/2019	0	2
Acting Insurance Director	Karin Zosel	12/12/2018	1/25/2019	0	1
Insurance Director	Jennifer W. Hammer	2/15/2017	12/10/2018	0	10
Acting Insurance Director	Jennifer W. Hammer	1/17/2017	2/15/2017	0	1

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## NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>ILLINOIS—Continued</b>					
Acting Insurance Director	Anne Melissa Dowling	7/1/2015	1/17/2017	1	6
Acting Insurance Director	James A. Stephens	1/12/2015	7/1/2015	0	6
Insurance Director	Andrew Boron	1/27/2012	1/12/2015	3	0
Acting Insurance Director	Robert E. 'Bob' Wagner	1/1/2012	1/27/2012	0	1
Acting Insurance Director	Andrew R. Stolfi	10/1/2011	12/31/2011	0	2
Acting Insurance Director	Jack Messmore	6/1/2011	10/1/2011	0	4
Insurance Director	Michael T. McRaith	3/21/2005	5/31/2011	6	3
Acting Insurance Director	Deirdre K. Manna	2/17/2004	3/21/2005	1	1
Insurance Director	J. Anthony Clark	3/31/2003	1/31/2004	0	10
Acting Insurance Director	Arnold Dutcher	1/1/2003	3/31/2003	0	2
Insurance Director	Nathaniel S. 'Nat' Shapo	1/19/1999	1/1/2003	4	0
Acting Insurance Director	Arnold Dutcher	2/27/1998	1/19/1999	0	11
Insurance Director	Mark Boozell	7/1/1995	2/27/1998	2	7
Acting Insurance Director	James W. 'Jim' Schacht	2/1/1994	7/1/1995	1	5
Insurance Director	Stephen F. Selcke	9/3/1991	2/1/1994	2	5
Acting Insurance Director	James W. 'Jim' Schacht	2/15/1991	9/3/1991	0	7
Insurance Director	Zachary 'Zack' Stamp	9/14/1989	2/15/1991	1	5
Insurance Director	John E. Washburn*	11/16/1983	9/14/1989	5	10
Acting Insurance Director	James W. 'Jim' Schacht	7/19/1982	11/16/1983	1	4
Insurance Director	Philip R. O'Connor	7/11/1979	7/19/1982	3	0
Insurance Director	Richard L. Mathias	2/2/1977	7/11/1979	2	5
Insurance Director	Michael P. Duncan	7/1/1976	2/2/1977	0	7
Acting Insurance Director	Dennis W. Toivonen	6/14/1976	7/1/1976	0	1
Insurance Director	Robert B. 'Bob' Wilcox	8/13/1974	6/14/1976	1	10
Insurance Director	Fred A. Mauck	1/19/1973	8/13/1974	1	7
Insurance Director	James R. Baylor	1/20/1969	1/19/1973	4	0
Insurance Director	John F. Bolton, Jr.	2/16/1965	1/20/1969	3	11
Insurance Director	Richard G. Hershey	1/29/1963	2/16/1965	2	1
Insurance Director	Joseph S. Gerber	1/11/1957	1/29/1963	6	0
Insurance Director	Justin T. McCarthy	8/30/1954	1/11/1957	2	5
Acting Insurance Director	Laddie T. Pelnar	6/14/1954	8/30/1954	0	2
Insurance Director	Robert E. Barrett (Died June 14, 1954)	1/11/1953	6/14/1954	1	5
Insurance Director	J. Edward Day	9/1/1950	1/11/1953	2	4
Insurance Director	Harry B. Hershey	1/17/1949	9/1/1950	1	8
Insurance Director	Nellis P. Parkinson	4/4/1945	1/17/1949	3	9
Acting Insurance Director	Nellis P. Parkinson	4/15/1944	4/4/1945	1	0
Insurance Director	Paul F. Jones	1/15/1941	4/15/1944	3	3
Insurance Director	C. Hayden Davis	11/7/1940	1/15/1941	0	2
Insurance Director	Ernest Palmer*	7/1/1933	11/7/1940	6	4
Insurance Superintendent	Ernest Palmer*	1/23/1933	7/1/1933	0	6
Insurance Superintendent	Harry W. Hanson	7/1/1930	1/23/1933	2	6
Insurance Superintendent	George W. Huskinson	1/26/1927	7/1/1930	3	6
Director of Trade and Commerce	H. U. Bailey	1/27/1926	1/26/1927	1	0
Director of Trade and Commerce	Clifford C. Ireland	11/15/1923	1/27/1926	2	2
Insurance Superintendent	Thomas J. Houston	8/8/1921	11/15/1923	2	3
Insurance Superintendent	Frederick W. 'Fred' Potter*	5/15/1917	8/8/1921	4	3
Insurance Superintendent	Rufus M. Potts	8/11/1913	5/15/1917	3	9
Insurance Superintendent	Frederick W. 'Fred' Potter*	1/1/1907	8/11/1913	6	7
Insurance Superintendent	William R. Vredenburg	5/2/1903	1/1/1907	3	8

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**NAIC MEMBER TENURE LIST**

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>ILLINOIS—Continued</b>					
Insurance Superintendent	Henry Yates <i>(Died May 1, 1903)</i>	5/6/1901	5/1/1903	2	0
Insurance Superintendent	James R. B. Van Cleave	5/1/1897	5/6/1901	4	0
Insurance Superintendent	Bradford K. Durfee*	7/13/1893	5/1/1897	3	10
Auditor of State	David P. Gore	1/10/1893	7/13/1893	0	6
Auditor of State	Charles W. Pavey	1/14/1889	1/10/1893	4	0
Auditor of State	Charles P. Swigert*	1/10/1881	1/14/1889	8	0
Auditor of State	Thomas B. Needles	1/8/1877	1/10/1881	4	0
Auditor of State	Charles E. Lippencott	5/24/1871	1/8/1877	5	8
<b>INDIANA—Appointed, at the Pleasure of the Governor</b>					
Insurance Commissioner	Amy L. Beard	6/2/2021		incumbent	
Insurance Commissioner	Stephen W. ‘Steve’ Robertson	10/13/2010	6/1/2021	10	8
Acting Insurance Commissioner	Stephen W. ‘Steve’ Robertson  <b>NOTE:</b> Robertson began serving as acting commissioner when Cutter went on medical leave in June 2010.	6/14/2010	10/13/2010	0	4
Insurance Commissioner	Carol Cutter <i>(Died Sept. 6, 2010)</i>	6/22/2009	9/6/2010	1	3
Insurance Commissioner	James D. ‘Jim’ Atterholt	2/22/2005	6/22/2009	4	4
Acting Insurance Commissioner	James D. ‘Jim’ Atterholt	1/10/2005	2/22/2005	0	1
Interim Insurance Commissioner	Amy E. Strati	7/15/2004	1/10/2005	0	6
Insurance Commissioner	Sarah Ann ‘Sally’ McCarty	6/26/1997	7/15/2004	7	1
Insurance Commissioner	John J. Quinn	4/16/1997	6/26/1997	0	2
Insurance Commissioner	Marjorie Maginn	7/12/1996	4/16/1997	0	9
Insurance Commissioner	Donna D. Bennett	6/24/1994	7/12/1996	2	1
Interim Insurance Commissioner	Donna D. Bennett	2/17/1994	6/24/1994	0	4
Insurance Commissioner	John F. ‘Jack’ Mortell	9/1/1991	2/16/1994	2	5
Acting Insurance Commissioner	John F. ‘Jack’ Mortell	7/15/1991	9/1/1991	0	2
Insurance Commissioner	John J. Dillon III	7/3/1989	7/15/1991	2	0
Acting Insurance Commissioner	Bettye L. Foy	1/9/1989	7/3/1989	0	6
Insurance Commissioner	Harry E. Eakin	4/1/1985	1/9/1989	3	9
Insurance Commissioner	Donald H. ‘Don’ Miller	2/16/1981	4/1/1985	4	2
Insurance Commissioner	H. Peter ‘Pete’ Hudson*	12/10/1979	2/16/1981	1	2
Acting Insurance Commissioner	Richard S. Baldwin	11/15/1979	12/10/1979	0	1
Insurance Commissioner	H. Peter ‘Pete’ Hudson*	8/4/1975	11/15/1979	4	3
Insurance Commissioner	Lloyd M. Allen	4/23/1973	8/4/1975	2	4
Insurance Commissioner	Oscar H. Ritz	1/13/1969	4/23/1973	4	4
Insurance Commissioner	Joseph G. Wood, Sr.	2/1/1965	1/13/1969	3	11
Insurance Commissioner	Harry E. McClain	1/10/1961	2/1/1965	4	1
Insurance Commissioner	James K. Ashley	6/15/1960	1/10/1961	0	7
Insurance Commissioner	Alden C. Palmer	1/16/1957	6/15/1960	3	5
Insurance Commissioner	William J. Davey	10/15/1955	1/16/1957	1	3
Insurance Commissioner	Harry E. Wells	1/12/1953	10/15/1955	2	9
Insurance Commissioner	Frank J. Viehmann	1/10/1949	1/12/1953	4	0
Insurance Commissioner	John D. Pearson	1/8/1945	1/10/1949	4	0
Insurance Commissioner	Frank J. Viehmann	3/1/1940	1/8/1945	4	10
Insurance Commissioner	George H. Newbauer	2/1/1937	3/1/1940	3	1
Insurance Commissioner	Harry E. McClain	4/1/1933	2/1/1937	3	10
Insurance Commissioner	John C. Kidd	1/1/1931	4/1/1933	2	3

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## NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>INDIANA—Continued</b>					
Insurance Commissioner	Clarence C. Wysong*	10/1/1926	1/1/1931	4	3
Insurance Commissioner	Thomas S. McMurray, Jr.	4/1/1921	10/1/1926	5	6
Insurance Commissioner	Miles Schaeffer	10/1/1920	4/1/1921	0	6
State Auditor	Otto L. Klauss	12/1/1916	10/1/1920	3	10
State Auditor	Dale J. Crittenberger	12/1/1914	12/1/1916	2	0
State Auditor	William H. O'Brien	12/1/1910	12/1/1914	4	0
State Auditor	John C. Billheimer	11/24/1906	12/1/1910	4	0
State Auditor	Warren Bigler	9/14/1905	11/24/1906	1	2
State Auditor	David E. Sherrick	1/26/1903	9/14/1905	1	8
State Auditor	William H. Hart*	1/26/1899	1/26/1903	4	0
State Auditor	Americus C. Dailey	1/26/1895	1/26/1899	4	0
State Auditor	John O. Henderson	1/26/1891	1/26/1895	4	0
State Auditor	Bruce Carr	1/26/1887	1/26/1891	4	0
State Auditor	James H. 'Jim' Rice	1/27/1883	1/26/1887	4	0
State Auditor	Edward H. Wolfe	1/26/1881	1/27/1883	2	0
State Auditor	Mahlon D. Manson	1/27/1879	1/26/1881	2	0
State Auditor	Ebenezer Henderson	1/26/1875	1/27/1879	4	0
State Auditor	James A. Wildman	1/25/1873	1/26/1875	2	0
State Auditor	John C. Shoemaker	5/24/1871	1/25/1873	1	8
<b>IOWA—Appointed, at the Pleasure of the Governor; 4-Year Term</b>					
Insurance Commissioner	Douglas M. 'Doug' Ommen	1/30/2017		incumbent	
Interim Insurance Commissioner	Douglas M. 'Doug' Ommen	12/26/2016	1/30/2017	0	1
Insurance Commissioner	Nicholas C. 'Nick' Gerhart	2/1/2013	12/23/2016	3	10
Insurance Commissioner	Susan E. Voss*	1/1/2005	1/31/2013	8	1
Insurance Commissioner	Therese M. 'Terri' Vaughan*	8/1/1994	12/31/2004	10	4
Insurance Commissioner	David J. Lyons	11/21/1990	7/1/1994	3	7
Acting Insurance Commissioner	David J. Lyons	6/1/1990	11/21/1990	0	6
Insurance Commissioner	William D. Hager	7/1/1986	5/31/1990	3	11
Insurance Commissioner	Fred M. Haskins	5/19/1986	6/30/1986	0	1
Insurance Commissioner	Bruce W. Foudree*	2/11/1980	5/19/1986	6	3
Acting Insurance Commissioner	Richard S. Baldwin	10/8/1979	2/11/1980	0	4
Insurance Commissioner	Herbert W. Anderson (Died Oct. 8, 1979)	6/17/1976	10/8/1979	3	4
Insurance Commissioner	William H. Huff III*	7/1/1971	6/17/1976	4	11
Insurance Commissioner	Lorne R. Worthington*	1/1/1967	7/1/1971	4	6
Insurance Commissioner	William E. Timmons*	7/1/1959	12/31/1966	7	6
Insurance Commissioner	Oliver P. Bennett	10/12/1955	6/30/1959	3	8
Insurance Commissioner	Charles R. Fischer	7/1/1951	10/12/1955	4	3
Insurance Commissioner	Sterling Alexander	7/1/1947	6/30/1951	4	0
Insurance Commissioner	Charles R. Fischer	2/11/1939	6/30/1947	8	4
Insurance Commissioner	Maurice V. Pew	2/15/1938	2/9/1939	1	0
Insurance Commissioner	Ray Murphy	7/1/1935	2/15/1938	2	7
Insurance Commissioner	Edward W. Clark	6/23/1931	7/1/1935	4	1
Insurance Commissioner	Ray A. Yenter	3/1/1926	6/23/1931	5	3
Insurance Commissioner	William R. C. Kendrick*	2/1/1923	3/1/1926	3	1
Insurance Commissioner	Arthur C. Savage	2/3/1919	2/1/1923	4	0
Insurance Commissioner	John F. Taake	1/16/1918	2/3/1919	1	1
Insurance Commissioner	Emory H. English	7/1/1914	1/16/1918	3	7
State Auditor	John L. Bleakley	11/3/1908	7/1/1914	5	8

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**NAIC MEMBER TENURE LIST**

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>IOWA—Continued</b>					
State Auditor	Beryl F. Carroll	11/4/1902	11/3/1908	6	0
State Auditor	Frank F. Merriam	11/8/1898	11/4/1902	4	0
State Auditor	Cornelius G. McCarthy	11/8/1892	11/8/1898	6	0
State Auditor	James A. Lyons	11/2/1886	11/8/1892	6	0
State Auditor	John L. Brown	7/14/1886	11/2/1886	0	4
State Auditor	Charles Beardsley	4/13/1886	7/14/1886	0	3
State Auditor	John L. Brown	1/23/1886	4/13/1886	0	3
State Auditor	Jonathan W. Cattell	3/19/1885	1/23/1886	0	10
State Auditor	John L. Brown	10/7/1882	3/19/1885	2	5
State Auditor	William V. Lucas	11/2/1880	10/7/1882	1	11
State Auditor	Buren R. Sherman	10/13/1874	11/2/1880	6	1
State Auditor	John Russell	10/18/1871	10/13/1874	3	0

<b>KANSAS—Elected; 4-Year Term</b>					
Insurance Commissioner	Vicki Schmidt <i>(Elected Nov. 6, 2018 Re-elected Nov. 8, 2022)</i>	1/14/2019		incumbent	
Insurance Commissioner	Kenneth A. 'Ken' Selzer	1/12/2015	1/14/2019	4	0
Insurance Commissioner	Sandra K. 'Sandy' Praeger*	1/13/2003	1/12/2015	12	0
Insurance Commissioner	Kathleen Sebelius*	1/9/1995	1/13/2003	8	0
Insurance Commissioner	Ronald L. 'Ron' Todd	1/14/1991	1/9/1995	4	0
Insurance Commissioner	W. Fletcher Bell*	1/11/1971	1/14/1991	20	0
Insurance Commissioner	Frank Sullivan*	1/13/1947	1/1/1971	24	0
Insurance Commissioner	Charles F. Hobbs*	1/14/1929	1/13/1947	18	0
Insurance Superintendent	William R. Baker	1/8/1923	1/14/1929	6	0
Insurance Superintendent	Frank L. Travis	1/13/1919	1/8/1923	4	0
Insurance Superintendent	Carey J. Wilson	1/11/1915	1/13/1919	4	0
Insurance Superintendent	Isaac S. 'Ike' Lewis	1/9/1911	1/11/1915	4	0
Insurance Superintendent	Charles W. Barnes	1/1/1907	1/9/1911	4	0
Insurance Superintendent	Charles H. Luling	1/1/1903	1/1/1907	4	0
Insurance Superintendent	Willard V. Church	1/1/1899	1/1/1903	4	0
Insurance Superintendent	Webb McNall	1/1/1897	1/1/1899	2	0
Insurance Superintendent	Alexander P. Riddle	1/1/1896	1/1/1897	1	0
Insurance Superintendent	George Tobey Anthony	1/1/1895	1/1/1896	1	0
Insurance Superintendent	Simon H. Snider	1/1/1893	1/1/1895	2	0
Insurance Superintendent	William H. McBride	1/1/1891	1/1/1893	2	0
Insurance Superintendent	Daniel W. Wilder	1/1/1887	1/1/1891	4	0
Insurance Superintendent	Richard D. Morris	1/1/1883	1/1/1887	4	0
Insurance Superintendent	Orrin T. Welch	1/1/1875	1/1/1883	8	0
Insurance Superintendent	Harrison Clarkson	1/1/1874	1/1/1875	1	0
Insurance Superintendent	Edward Russell	1/1/1873	1/1/1874	1	0
Insurance Superintendent	William C. Webb	5/24/1871	1/1/1873	1	8

<b>KENTUCKY—Appointed, at the Pleasure of the Governor</b>					
Insurance Commissioner	Sharon P. Clark	1/6/2020		incumbent	
Insurance Commissioner	Nancy G. Atkins	5/1/2017	1/3/2020	2	8
Insurance Commissioner	Brian Maynard	1/12/2016	4/30/2017	1	3
Insurance Commissioner	Sharon P. Clark	6/30/2008	1/11/2016	7	6
Acting Insurance Commissioner	John Burkholder	3/1/2008	6/30/2008	0	4
Acting Insurance Commissioner	Timothy LeDonne	12/1/2007	3/1/2008	0	3

\* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

## NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>KENTUCKY—Continued</b>					
Insurance Commissioner	Julie Mix McPeak*	7/17/2006	12/1/2007	1	5
Executive Director	Glenn Jennings	4/27/2005	7/17/2006	1	3
Executive Director	Martin J. Koettters	7/15/2004	4/27/2005	0	9
Acting Insurance Commissioner	Glenn Jennings	12/1/2003	7/15/2004	0	7
Insurance Commissioner	Janie A. Miller	12/1/2000	12/1/2003	3	0
Insurance Commissioner	George Nichols III*	4/1/1996	12/1/2000	4	8
Insurance Commissioner	Theodore 'Ted' Rich	1/24/1996	4/1/1996	0	3
Acting Insurance Commissioner	Laura Douglas	12/29/1995	1/24/1996	0	1
Acting Insurance Commissioner	Suetta Dickinson	12/8/1995	12/29/1995	0	1
Insurance Commissioner	Donald W. 'Don' Stephens	11/16/1992	12/8/1995	3	1
Insurance Commissioner	Ronnie Moore	12/1/1991	11/16/1992	0	11
Insurance Commissioner	Elizabeth Wright	5/1/1990	12/1/1991	1	7
Insurance Commissioner	Leroy Morgan	3/1/1988	5/1/1990	2	2
Insurance Commissioner	Gill McCarty	12/1/1983	3/1/1988	4	3
Insurance Commissioner	Daniel D. Briscoe	1/1/1980	12/1/1983	3	11
Acting Insurance Commissioner	Donald N. Rhody	12/1/1979	12/31/1979	0	1
Insurance Commissioner	Harold B. McGuffey*	12/8/1971	12/1/1979	8	0
Insurance Commissioner	Robert D. Preston	12/1/1968	12/8/1971	3	0
Acting Insurance Commissioner	Robert D. Preston	1/1/1968	12/1/1968	0	11
Insurance Commissioner	S. Roy Woodall, Jr.	12/1/1966	12/31/1967	1	0
Insurance Commissioner	William E. Bivin	1/1/1965	12/1/1966	1	11
Insurance Commissioner	J. Elliott Flanery	12/1/1963	12/31/1964	1	0
Insurance Commissioner	Lawrence D. Cassady	1/1/1963	12/1/1963	0	11
Insurance Commissioner	William T. Hockensmith	11/1/1960	12/31/1962	2	1
Insurance Commissioner	C. P. Thurman	1/1/1957	11/1/1960	3	10
Insurance Commissioner	S. H. Goebel	6/1/1953	12/31/1956	3	6
Insurance Commissioner	Spaulding Southall	5/1/1949	6/1/1953	4	1
Insurance Commissioner	Cad. P. Thurman	4/1/1948	5/1/1949	1	1
Insurance Commissioner	Harry B. Wilson	5/1/1945	4/1/1948	2	11
Insurance Commissioner	Sherman Goodpaster	6/1/1936	5/1/1945	8	11
Insurance Commissioner	J. Dan Talbott	1/31/1936	6/1/1936	0	5
Acting Insurance Commissioner	Charles I. Brown	1/1/1936	1/31/1936	0	1
Insurance Commissioner	McKay Reed	4/11/1935	1/1/1936	0	9
Insurance Commissioner	Gemill B. Senff	11/1/1932	4/1/1935	2	5
Insurance Commissioner	Bush W. Allin	4/1/1929	11/1/1932	3	7
Insurance Commissioner	Shelton M. Saufley	1/1/1924	4/1/1929	5	3
Insurance Commissioner	A. M. Wash	5/1/1923	1/1/1924	0	8
Insurance Commissioner	James F. Ramey	1/1/1920	5/1/1923	3	4
Insurance Commissioner	Charles F. Thomas	3/1/1916	1/1/1920	3	10
Insurance Commissioner	M. C. Clay	3/1/1912	3/1/1916	4	0
Insurance Commissioner	Charles W. Bell	9/1/1907	3/1/1912	4	6
Insurance Commissioner	Henry R. Prewitt	9/1/1904	9/1/1907	3	0
Insurance Commissioner	John B. Chenault	9/1/1900	9/1/1904	4	0
Insurance Commissioner	Will H. Stone	9/1/1898	9/1/1900	2	0
Insurance Commissioner	David N. Comingore	9/22/1896	9/1/1898	2	0
Insurance Commissioner	Henry F. Duncan	8/1/1890	9/1/1896	6	1
Insurance Commissioner	Leslie C. Norman	9/20/1881	8/1/1890	8	11
Insurance Commissioner	Bedford Leslie	9/18/1877	9/1/1881	4	0
Insurance Commissioner	Gustavus W. Smith	5/24/1871	9/19/1876	5	4

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**NAIC MEMBER TENURE LIST**

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>LOUISIANA—Elected; 4-Year Term</b>					
Insurance Commissioner	James J. ‘Jim’ Donelon* <i>(Appointed Feb. 15, 2006; Elected Sept. 30, 2006; Re-elected Oct. 20, 2007; Re-elected Oct. 22, 2011; Re-elected Oct. 24, 2015; Re-elected Oct. 12, 2019)</i>	2/15/2006		incumbent	
Insurance Commissioner	J. Robert ‘Robert’ Wooley	4/1/2003	2/15/2006	2	10
Acting Insurance Commissioner	J. Robert ‘Robert’ Wooley	10/1/2000	4/1/2003	2	6
Insurance Commissioner	James H. ‘Jim’ Brown	12/1/1991	10/1/2000	8	10
Acting Insurance Commissioner	Darrell Cobb	8/1/1991	12/1/1991	0	4
Acting Insurance Commissioner	Hunter O. Wagner, Jr.	3/1/1991	8/1/1991	0	5
Insurance Commissioner	Doug Green	4/1/1988	3/1/1991	2	11
Insurance Commissioner	Sherman A. Bernard	5/1/1972	4/1/1988	15	11
Insurance Commissioner	Dudley A. Guglielmo	5/1/1964	5/1/1972	8	0
Insurance Commissioner	Rufus D. Hayes*	8/1/1956	5/1/1964	7	9
Secretary of State/Insurance Cmsr.	Wade O. Martin, Jr.*	12/4/1944	6/1/1956	11	6
Secretary of State/Insurance Cmsr.	James A. Gremillion	6/24/1940	6/7/1943	3	0
Insurance Commissioner	Eugene A. Conway	6/22/1932	2/19/1940	7	8
Insurance Commissioner	John D. Saint	9/8/1930	5/1/1932	1	8
Insurance Commissioner	James J. Bailey	9/30/1916	12/1/1929	13	3
Insurance Commissioner	William E. Millsaps	9/21/1915	9/29/1916	1	0
Acting Deputy Insurance Commissioner	Richard Flower	3/10/1915	4/1/1915	0	1
Secretary of State/Ins. Commissioner	Alvin E. Hebert <i>(Died March 9, 1915)</i>	7/23/1912	3/9/1915	2	8
Deputy Insurance Commissioner	E. J. O’Brien	5/1/1911	5/1/1912	1	0
Deputy Insurance Commissioner	Edward Everett	1/1/1911	5/1/1911	0	4
Assistant Secretary of State/Ins. Commissioner	Eugene J. McGivney	9/29/1903	9/30/1910	7	0
Secretary of State/Ins. Commissioner	<i>No Record in NAIC Proceedings</i>	9/13/1898	9/25/1902	4	0
Deputy Insurance Commissioner	Edward Newman	1897	1898	1	
Deputy Insurance Commissioner	John J. McCann	1896	1897	0	
Deputy Insurance Commissioner	John T. Michel	1896	1896	0	
Deputy Insurance Commissioner	W. B. Spencer	10/1/1895	1896	1	
Deputy Insurance Commissioner	George Spencer	10/1/1894	10/1/1895	1	0
Deputy Insurance Commissioner	W. B. Spencer	10/1/1891	10/1/1894	3	0
Deputy Insurance Commissioner	L. F. Mason	10/1/1889	10/1/1891	2	0
Secretary of State	Simeon Toby	8/6/1888	10/1/1891	3	2
Deputy Insurance Commissioner	Oscar Orroyo	10/1/1885	10/1/1889	4	0
Deputy Insurance Commissioner	William A. Strong	9/1/1878	9/25/1884	6	0
Secretary of State	<i>No Record in NAIC Proceedings</i>	4/16/1872	8/27/1878	6	4
Secretary of State	Richard Gaines	10/18/1871	4/15/1872	0	6
Secretary of State	George E. Bovee	5/24/1871	10/18/1871	0	5

<b>MAINE—Appointed; 5-Year Term</b>					
Acting Insurance Superintendent	Timothy N. Schott	4/1/2022		incumbent	
Insurance Superintendent	Eric A. Cioppa*	9/27/2011	3/31/2022	10	6
Acting Insurance Superintendent	Eric A. Cioppa*	6/1/2011	9/27/2011	0	3
Insurance Superintendent	Mila Kofman	3/1/2008	5/31/2011	3	2
Acting Insurance Superintendent	Eric A. Cioppa*	1/14/2007	2/28/2008	1	1

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## NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>MAINE—Continued</b>					
Insurance Superintendent	Alessandro A. 'Al' Iuppa*	2/4/1998	1/13/2007	8	11
Acting Insurance Superintendent	Alessandro A. 'Al' Iuppa*	8/30/1997	2/4/1998	0	6
Insurance Superintendent	Brian K. Atchinson*	5/20/1992	8/29/1997	5	3
Acting Insurance Superintendent	Richard Johnson	10/22/1991	5/19/1992	0	7
Acting Insurance Superintendent	Jeri E. Brown	9/1/1991	10/21/1991	0	1
Insurance Superintendent	Joseph A. 'Joe' Edwards	6/1/1987	9/1/1991	4	3
Acting Insurance Superintendent	Everard B. Stevens	11/10/1986	6/1/1987	0	7
Insurance Superintendent	Theodore T. 'Ted' Briggs	5/21/1979	11/10/1986	7	6
Insurance Superintendent	Frank M. Hogerty, Jr.	10/3/1973	5/20/1979	5	7
Insurance Commissioner	Frank M. Hogerty, Jr.	11/15/1967	10/3/1973	5	11
Acting Insurance Commissioner	Harold E. Trahey	6/2/1967	11/15/1967	0	5
Insurance Commissioner	George F. Mahoney (Died June 1, 1967)	6/18/1951	6/1/1967	16	0
Insurance Commissioner	David B. Soule	6/12/1947	6/18/1951	4	0
Insurance Commissioner	Alfred W. Perkins	1/14/1946	3/5/1947	1	2
Acting Insurance Commissioner	Guy R. Whitten (Alfred W. Perkins on leave of absence for military service)	1/13/1944	1/13/1946	2	0
Insurance Commissioner	Alfred W. Perkins	5/1/1942	1/12/1944	1	8
Insurance Commissioner	Pearce J. Francis (Died Feb. 13, 1942)	12/30/1940	2/13/1942	1	2
Insurance Commissioner	C. Waldo Lovejoy	3/23/1937	11/12/1940	3	8
Insurance Commissioner	Wilbur D. Spencer	5/3/1923	3/22/1937	13	10
Acting Insurance Commissioner	Leon W. Helson	11/26/1922	5/2/1923	0	6
Insurance Commissioner	G. Waldon Smith	4/24/1918	11/25/1922	4	7
Acting Insurance Commissioner	Ivan E. Lang	1/1/1918	4/24/1918	0	3
Insurance Commissioner	Erastus J. Carter	2/1/1915	1/1/1918	2	11
Insurance Commissioner	J. Wallace Blunt	7/1/1913	2/1/1915	1	7
Insurance Commissioner	Andrew P. Havey	12/9/1911	7/1/1913	1	7
Insurance Commissioner	Beecher Putnam	1/1/1909	12/9/1911	2	11
Insurance Commissioner	Stephen W. Carr*	12/26/1893	1/1/1909	15	0
Insurance Commissioner	Joseph O. Smith	1/1/1885	12/26/1893	9	0
Insurance Commissioner	Frank E. Nye	9/1/1884	11/20/1884	0	2
Insurance Commissioner	Oramandal Smith	4/1/1883	9/1/1884	1	5
Insurance Commissioner	Joseph B. Peaks	3/1/1880	4/1/1883	3	1
Insurance Commissioner	William Philbrick	5/5/1879	3/1/1880	0	10
Insurance Commissioner	Joshua Nye	4/26/1873	5/5/1879	6	0
Insurance Commissioner	Albert W. Paine	5/24/1871	4/26/1873	1	11

<b>MARYLAND—Appointed, at the Pleasure of the Governor; 4-Year Term</b>					
Insurance Commissioner	Kathleen A. Birrane	5/18/2020		incumbent	
Insurance Commissioner	Alfred W. 'Al' Redmer, Jr.	1/22/2015	5/15/2020	5	4
Insurance Commissioner	Therese M. Goldsmith	6/13/2011	1/21/2015	3	7
Acting Insurance Commissioner	Elizabeth 'Beth' Sammis	1/1/2010	6/13/2011	1	5
Insurance Commissioner	Ralph S. Tyler III	9/1/2007	1/1/2010	2	4
Interim Insurance Commissioner	Peggy J. Watson	6/1/2007	9/1/2007	0	3
Insurance Commissioner	R. Steven 'Steve' Orr	1/1/2006	5/31/2007	1	4
Acting Insurance Commissioner	James V. 'Jim' McMahan	10/1/2005	1/1/2006	0	3
Insurance Commissioner	Alfred W. 'Al' Redmer, Jr.	6/1/2003	10/1/2005	2	4
Insurance Commissioner	Steven B. 'Steve' Larsen	6/16/1997	6/1/2003	6	0

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**NAIC MEMBER TENURE LIST**

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>MARYLAND—Continued</b>					
Acting Insurance Commissioner	Charles B. Kelly III	5/1/1997	6/1/1997	0	1
Insurance Commissioner	Dwight K. Bartlett III	5/1/1993	5/1/1997	4	0
Insurance Commissioner	John A. Donaho	5/1/1989	5/1/1993	4	0
Insurance Commissioner	E. Susan Kellogg	7/1/1988	5/1/1989	0	10
Acting Insurance Commissioner	Martha Roach	1/1/1988	7/1/1988	0	6
Insurance Commissioner	Edward J. Muhl*	7/1/1982	1/1/1988	5	6
Insurance Commissioner	Edward J. Birrane, Jr.	7/1/1976	7/1/1982	5	0
Insurance Commissioner	Thomas J. Hatem	7/16/1970	7/1/1976	6	0
Insurance Commissioner	Newton I. Steers, Jr.	5/15/1967	7/15/1970	3	2
Insurance Commissioner	Norman Polovoy	12/16/1966	5/15/1967	0	5
Insurance Commissioner	Francis B. 'Bill' Burch	7/15/1965	12/16/1966	1	5
Insurance Commissioner	F. Douglass Sears	5/4/1959	6/24/1965	6	2
Insurance Commissioner	Charles S. Jackson	12/17/1952	5/4/1959	6	5
Acting Insurance Commissioner	John H. Coppage	8/18/1952	12/17/1952	0	4
Insurance Commissioner	Harvey M. Chesney <i>(Died Aug. 17, 1952)</i>	5/8/1951	8/17/1952	1	3
Insurance Commissioner	Claude M. Hanley	5/1/1947	5/8/1951	4	0
Insurance Commissioner	Lawrence E. Ensor	9/1/1943	5/1/1947	3	8
Insurance Commissioner	John B. Gontrum	5/1/1939	9/1/1943	4	4
Insurance Commissioner	Wesley S. Hanna	5/1/1935	5/1/1939	4	0
Insurance Commissioner	William C. Walsh	5/1/1931	5/1/1935	4	0
Insurance Commissioner	Harrison Rider	3/1/1929	5/1/1931	2	2
Insurance Commissioner	Carville D. Benson <i>(Died Feb. 8, 1929)</i>	8/1/1924	2/8/1929	4	6
Insurance Commissioner	Harvey L. Cooper	9/1/1922	8/1/1924	1	11
Insurance Commissioner	Thomas J. Keating	4/1/1919	9/1/1922	3	5
Insurance Commissioner	William Mason Shehan	2/1/1912	3/1/1919	7	1
Insurance Commissioner	Emerson C. Harrington	11/9/1910	1/31/1912	1	2
Insurance Commissioner	Benjamin F. Crouse* <i>(Died Nov. 8, 1910)</i>	12/1/1905	11/8/1910	4	11
Insurance Commissioner	Frank I. Duncan	1/10/1905	10/31/1905	0	10
Insurance Commissioner	Lloyd Wilkinson	9/1/1900	1/9/1905	4	4
Insurance Commissioner	F. Albert Kurtz	3/13/1896	9/1/1900	4	0
Insurance Commissioner	Thomas B. Townsend	12/18/1895	3/13/1896	0	3
Insurance Commissioner	I. Freeman Rasin	1/7/1893	12/14/1895	2	11
Insurance Commissioner	J. Frederick C. Talbott	10/1/1889	1/7/1893	3	3
Insurance Commissioner	Jesse K. Hines <i>(Died Sept. 20, 1889)</i>	2/1/1877	9/20/1889	12	7
Insurance Commissioner	John M. Miller	4/29/1876	1/31/1877	0	9
Insurance Commissioner	<i>Position Vacant</i>	1/31/1876	4/29/1876	0	3
Insurance Commissioner	Charles A. Wailes <i>(Died Jan. 31, 1876)</i>	1/1/1872	1/31/1876	4	1
Chief Clerk of the Treasury and Superintendent of Insurance	Charles A. Wailes <i>(Died Jan. 31, 1876)</i>	5/24/1871	1/1/1872	0	7
<b>MASSACHUSETTS—Appointed, at the Discretion of the Governor</b>					
Insurance Commissioner	Gary D. Anderson	10/31/2017		incumbent	
Acting Insurance Commissioner	Gary D. Anderson	2/23/2017	10/31/2017	0	8
Insurance Commissioner	Daniel R. Judson	4/1/2015	2/23/2017	1	10
Acting Insurance Commissioner	Gary D. Anderson	12/1/2014	4/1/2015	0	4

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## NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>MASSACHUSETTS—Continued</b>					
Insurance Commissioner	Joseph G. Murphy	2/8/2010	12/1/2014	4	10
Acting Insurance Commissioner	Joseph G. Murphy	9/1/2009	2/8/2010	0	5
Insurance Commissioner	Nonnie S. Burnes (Died Aug. 14, 2021)	2/1/2007	9/1/2009	2	7
Acting Insurance Commissioner	Joseph G. Murphy	1/1/2007	2/1/2007	0	1
Insurance Commissioner	Julianne M. 'Julie' Bowler	4/2/2002	1/1/2007	4	9
Insurance Commissioner	Linda L. Ruthardt	8/1/1993	4/2/2002	8	8
Insurance Commissioner	Kay Doughty	7/1/1991	6/30/1993	1	11
Acting Insurance Commissioner	Susan Scott	1/1/1991	7/1/1991	0	6
Insurance Commissioner	Timothy H. Gailey	7/1/1989	1/1/1991	1	6
Insurance Commissioner	Roger M. Singer	7/16/1987	7/1/1989	2	0
Insurance Commissioner	Peter Hiam	4/1/1983	7/16/1987	4	3
Insurance Commissioner	Michael J. Sabbagh	6/1/1979	4/1/1983	3	10
Insurance Commissioner	John G. Ryan	11/1/1971	6/1/1979	7	7
Insurance Commissioner	C. Eugene Farnam	12/1/1962	11/1/1971	8	11
Insurance Commissioner	Otis M. Whitney	1/1/1959	12/1/1962	3	11
Insurance Commissioner	Joseph A. Humphreys	1/1/1954	12/31/1958	4	11
Insurance Commissioner	Edmund S. Cogswell	1/1/1953	12/31/1953	0	11
Insurance Commissioner	Dennis E. Sullivan	1/1/1951	12/31/1952	1	11
Insurance Commissioner	Charles F. J. Harrington*	4/1/1938	12/31/1950	12	8
Insurance Commissioner	Francis J. DeCelles	4/1/1935	4/1/1938	3	0
Insurance Commissioner	Merton L. Brown	12/1/1928	4/1/1935	6	4
Acting Insurance Commissioner	Arthur E. Linnell	9/1/1928	12/1/1928	0	3
Insurance Commissioner	Wesley E. Monk	6/1/1923	9/1/1928	5	3
Insurance Commissioner	Clarence W. Hobbs	3/1/1920	6/1/1923	3	3
Acting Insurance Commissioner	Clarence W. Hobbs	9/1/1919	3/1/1920	0	6
Insurance Commissioner	Frank H. Hardison*	11/1/1907	9/1/1919	11	10
Insurance Commissioner	Frederick L. 'Fred' Cutting*	9/30/1897	11/1/1907	10	1
Insurance Commissioner	George S. Merrill*	9/1/1887	9/30/1897	10	1
Insurance Commissioner	John K. Tarbox* (Died May 28, 1887)	4/21/1883	5/28/1887	4	1
Insurance Commissioner	Julius L. Clarke*	5/24/1871	2/14/1883	12	4
<b>MICHIGAN—Appointed, at the Pleasure of the Governor; 4-Year Term</b>					
Director, Department of Insurance and Financial Services (DIFS)	Anita G. Fox	1/14/2019		incumbent	
Acting Director, DIFS	Judith A. 'Judy' Weaver	12/28/2018	1/14/2019	0	1
Director, DIFS	Patrick M. McPharlin	5/18/2015	12/28/2018	3	7
Director, DIFS	Annette E. Flood	11/1/2013	5/18/2015	1	6
Director, DIFS	R. Kevin Clinton	3/18/2013	11/1/2013	0	7
Commissioner, Office of Financial and Insurance Regulation (OFIR)	R. Kevin Clinton	4/16/2011	3/17/2013	1	11
Commissioner, OFIR	Kenneth 'Ken' Ross	4/6/2008	4/15/2011	3	0
Commissioner, Office of Financial and Insurance Services (OFIS)	Kenneth 'Ken' Ross	2/22/2008	4/5/2008	0	2
Acting Commissioner, OFIS	Kenneth 'Ken' Ross	11/1/2007	2/21/2008	0	3
Commissioner, OFIS	Linda A. Watters	4/11/2003	10/31/2007	4	6
Acting Commissioner, OFIS	Ronald C. Jones, Jr.	2/1/2003	4/11/2003	0	2
Commissioner, OFIS	Frank M. Fitzgerald	4/3/2000	2/1/2003	2	10
Commissioner of Insurance	Frank M. Fitzgerald	1/1/1999	4/2/2000	1	3

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**NAIC MEMBER TENURE LIST**

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>MICHIGAN—Continued</b>					
Commissioner of Insurance	E. L. Cox	5/4/1998	1/1/1999	0	8
Acting Commissioner of Insurance	Dominic A. D’Annunzio	8/11/1997	5/4/1998	0	9
Commissioner of Insurance	D. Joseph Olson	4/4/1995	8/11/1997	2	4
Acting Commissioner of Insurance	Patrick M. McQueen	1/1/1995	4/4/1995	0	3
Commissioner of Insurance	David J. Dykhouse	4/1/1991	1/1/1995	3	9
Acting Commissioner of Insurance	Dominic A. D’Annunzio	1/1/1991	4/1/1991	0	3
Acting Commissioner of Insurance	Dhiraj N. Shah	10/3/1988	1/1/1991	2	3
Commissioner of Insurance	Herman W. Coleman	9/1/1985	10/3/1988	3	1
Commissioner of Insurance	Nancy A. Baerwaldt	11/1/1980	9/1/1985	4	10
Acting Commissioner of Insurance	Elbert C. Mackey	6/1/1980	11/1/1980	0	5
Commissioner of Insurance	Richard A. Hemmings	12/1/1979	6/1/1980	0	6
Acting Commissioner of Insurance	Jean K. Carlson	1/1/1979	12/1/1979	0	11
Commissioner of Insurance	Thomas C. Jones	12/1/1975	1/1/1979	3	1
Commissioner of Insurance	Daniel J. Demlow	12/1/1973	12/1/1975	2	0
Commissioner of Insurance	Russell E. Van Hooser*	1/27/1969	12/1/1973	4	10
Commissioner of Insurance	David J. Dykhouse	12/1/1966	1/27/1969	2	2
Acting Commissioner of Insurance	John W. Wickstrom	1/1/1966	12/1/1966	0	11
Commissioner of Insurance	Allen L. Mayerson	12/1/1963	1/1/1966	2	1
Commissioner of Insurance	Sherwood Colburn	1/1/1962	12/1/1963	1	11
Commissioner of Insurance	Frank Blackford	1/1/1959	1/1/1962	3	0
Commissioner of Insurance	Joseph A. Navarre*	1/1/1951	1/1/1959	8	0
Commissioner of Insurance	David A. Forbes*	2/16/1943	1/1/1951	7	11
Acting Commissioner of Insurance	Horace B. Corell	1/2/1943	2/16/1943	0	1
Commissioner of Insurance	Eugene P. Berry	1/6/1941	12/31/1942	2	0
Commissioner of Insurance	John G. Emery	4/1/1939	1/6/1941	1	9
Commissioner of Insurance	Charles E. Gauss	1/1/1937	4/1/1939	2	3
Commissioner of Insurance	John C. Ketcham	1/1/1935	1/1/1937	2	0
Commissioner of Insurance	Charles E. Gauss	2/19/1933	1/1/1935	1	11
Commissioner of Insurance	Charles L. Livingston*	1/12/1927	2/19/1933	6	1
Commissioner of Insurance	Leonard T. Hands	5/18/1921	1/12/1927	5	8
Commissioner of Insurance	Frank H. Ellsworth*	7/1/1917	4/30/1921	3	10
Commissioner of Insurance	John T. Winship	7/1/1913	7/1/1917	4	0
Commissioner of Insurance	Calvin A. ‘Puss’ Palmer*	2/1/1911	7/1/1913	2	5
Commissioner of Insurance	Marion O. Rowland	11/15/1910	2/1/1911	0	3
Commissioner of Insurance	James V. Barry*	1/1/1901	11/15/1910	9	10
Commissioner of Insurance	Harry H. Stevens	7/1/1899	1/1/1901	1	6
Commissioner of Insurance	Milo D. Campbell	7/1/1897	7/1/1899	2	0
Commissioner of Insurance	Theron F. Giddings	7/1/1893	7/1/1897	4	0
Commissioner of Insurance	William E. Magill	7/1/1891	7/1/1893	2	0
Commissioner of Insurance	Henry S. Raymond	1/1/1885	7/1/1891	6	6
Commissioner of Insurance	Eugene Pringle	3/1/1883	1/1/1885	1	10
Commissioner of Insurance	Samuel H. Row*	5/24/1871	3/1/1883	11	10

<b>MINNESOTA—Appointed, at the Pleasure of the Governor; Confirmed by the Senate</b>					
Commissioner of Commerce	Grace Arnold <i>(Reappointed Nov. 16, 2022; Confirmed Feb. 16, 2023)</i>	4/15/2021		incumbent	
Temporary Cmsr. of Commerce	Grace Arnold	9/11/2020	4/15/2021	0	7
Commissioner of Commerce	Steve Kelley	1/7/2019	9/11/2020	1	8
Commissioner of Commerce	Jessica Looman	11/17/2017	1/7/2019	1	2

\* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

## NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>MINNESOTA—Continued</b>					
Commissioner of Commerce	Michael J. 'Mike' Rothman	1/12/2011	11/17/2017	6	10
Commissioner of Commerce	Glenn Wilson, Jr.	1/6/2003	1/12/2011	8	0
Commissioner of Commerce	James C. 'Jim' Bernstein	7/31/2000	1/6/2003	2	6
Acting Commissioner of Commerce	James C. 'Jim' Bernstein	2/24/2000	7/31/2000	0	5
Commissioner of Commerce	Steve Minn	8/16/1999	2/24/2000	0	6
Acting Commissioner of Commerce	Gary LaVasseur	8/6/1999	8/16/1999	0	1
Commissioner of Commerce	David M. Jennings	1/4/1999	8/6/1999	0	7
Commissioner of Commerce	David B. 'Dave' Gruenes	12/26/1995	1/4/1999	3	0
Commissioner of Commerce	James E. 'Jim' Ulland	9/1/1993	12/26/1995	2	4
Commissioner of Commerce	<i>Position Vacant</i>	8/1/1993	9/1/1993	0	1
Commissioner of Commerce	Bert J. McKasy	1/14/1991	8/1/1993	2	7
Acting Commissioner of Commerce	James Miller	1/7/1991	1/14/1991	0	1
Commissioner of Commerce	Thomas H. 'Tom' Borman	1/9/1990	1/7/1991	1	0
Commissioner of Commerce	Michael A. Hatch	7/1/1983	1/9/1990	6	6
Commissioner of Insurance	Reynaud L. Harp	1/3/1983	7/1/1983	0	6
Acting Commissioner of Insurance	Thomas L. O'Malley	7/1/1982	1/3/1983	0	6
Commissioner of Insurance	Michael D. 'Mike' Markman	3/5/1979	7/1/1982	3	4
Commissioner of Insurance	Berton W. Heaton	4/6/1971	3/5/1979	7	11
Acting Commissioner of Insurance	Alfred O. Anderson	8/1/1970	4/6/1971	0	8
Commissioner of Insurance	Thomas C. Hunt	7/15/1967	7/31/1970	3	0
Acting Commissioner of Insurance	L. Edwin Wang	3/13/1967	7/15/1967	0	4
Acting Commissioner of Insurance	Joseph 'Joe' Haveson	11/4/1965	3/9/1967	1	5
Commissioner of Insurance	Cyrus E. Magnusson*	4/15/1959	11/4/1965	6	7
Commissioner of Insurance	Cyril C. Sheehan	2/16/1953	4/15/1959	6	2
Commissioner of Insurance	A. Herbert Nelson	5/15/1951	2/15/1953	1	9
Commissioner of Insurance	Armand W. Harris	12/1/1947	5/15/1951	3	5
Commissioner of Insurance	Newell R. Johnson*	2/1/1941	12/1/1947	6	10
Commissioner of Insurance	Frank Yetka	3/1/1935	2/1/1941	5	11
Commissioner of Insurance	Garfield W. Brown*	10/15/1928	2/29/1935	6	5
Commissioner of Insurance	George W. Wells, Jr.	6/1/1922	10/15/1928	6	4
Commissioner of Insurance	Gustaf Lindquist	7/1/1920	6/1/1922	1	11
Commissioner of Insurance	John B. Sanborn	1/7/1919	7/1/1920	1	6
Commissioner of Insurance	C. Louis Weeks	9/3/1918	1/7/1919	0	4
Commissioner of Insurance	John B. Sanborn	1/7/1917	9/3/1918	1	8
Commissioner of Insurance	Samuel D. Works	1/13/1915	1/7/1917	2	0
Commissioner of Insurance	Ira C. Peterson	1/3/1915	1/13/1915	0	1
Commissioner of Insurance	Jacob A. O. Preus	1/3/1911	1/3/1915	4	0
Commissioner of Insurance	John A. Hartigan*	8/1/1907	1/3/1911	3	5
Commissioner of Insurance	Thomas D. O'Brien	1/12/1905	8/1/1907	2	7
Commissioner of Insurance	Elmer H. Dearth*	1/23/1901	1/12/1905	3	11
Commissioner of Insurance	John A. O'Shaughnessy*	2/27/1899	1/23/1901	2	0
Commissioner of Insurance	Elmer H. Dearth*	1/8/1897	2/27/1899	2	1
Acting Commissioner of Insurance	David C. Lightbourn	6/19/1896	1/8/1897	0	7
Commissioner of Insurance	Christopher H. Smith (Died June 18, 1896)	1/5/1891	6/18/1896	5	6
Commissioner of Insurance	Calvin P. Bailey	1/22/1889	1/5/1891	2	0
Commissioner of Insurance	Charles Shandrew	1/6/1887	1/22/1889	2	0
Commissioner of Insurance	Andrew R. McGill*	12/15/1873	1/6/1887	13	1
Commissioner of Insurance	Pennock Pusey	3/1/1872	12/15/1873	1	9

\* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

**NAIC MEMBER TENURE LIST**

<b>STATE/MEMBER TITLE</b>	<b>MEMBER NAME</b>	<b>BEG. DATE</b>	<b>END DATE</b>	<b>YRS. SERVED</b>	<b>MOS. SERVED</b>
<b>MISSISSIPPI—Elected; 4-Year Term</b>					
Commissioner of Insurance	Michael J. ‘Mike’ Chaney <i>(Elected Nov. 6, 2007; Re-elected Nov. 8, 2011; Re-elected Nov. 3, 2015; Re-elected Nov. 5, 2019)</i>	1/1/2008		incumbent	
Commissioner of Insurance	George Dale	1/1/1976	1/1/2008	32	0
Commissioner of Insurance	Evelyn Gandy	1/1/1972	1/1/1976	4	0
Commissioner of Insurance	Walter D. Davis	6/1/1952	1/1/1972	19	7
Commissioner of Insurance	Jesse L. White	2/2/1944	6/1/1952	8	4
Commissioner of Insurance	John Sharp Williams III* <i>(Died Jan. 29, 1944)</i>	1/1/1936	1/29/1944	8	1
Commissioner of Insurance	James H. Johnson	6/18/1935	1/1/1936	0	7
Commissioner of Insurance	George D. Riley <i>(Died June 18, 1935)</i>	1/18/1932	6/18/1935	3	5
Commissioner of Insurance	Ben S. Lowry	1/16/1928	1/18/1932	4	0
Commissioner of Insurance	Thomas M. Henry	1/18/1908	1/16/1928	20	0
Commissioner of Insurance	William Q. Cole	1/18/1904	1/18/1908	4	0
Auditor of Public Accounts/Cmsr. of Insurance	William Q. Cole	3/5/1902	1/18/1904	1	10
Auditor of Public Accounts	William Q. Cole	1/15/1900	3/5/1902	2	2
Auditor of Public Accounts	William D. Holder	1/20/1896	1/15/1900	4	0
Auditor of Public Accounts	W. W. Stone	1/1/1886	1/20/1896	10	0
Auditor of Public Accounts	Sylvester Gwin	1/1/1878	1/1/1886	6	4
Auditor of Public Accounts	William H. Gibbs	1/1/1874	1/1/1876	2	0
Auditor of Public Accounts	Henry Musgrove	5/24/1871	1/1/1874	3	8

<b>MISSOURI—Appointed, at the Pleasure of the Governor; Confirmed by the Senate</b>					
Director of Insurance	Chlora Lindley-Myers	4/13/2017		incumbent	
Acting Director of Insurance	Chlora Lindley-Myers	3/6/2017	4/13/2017	0	1
Acting Director of Insurance	John F. Rehagen	2/7/2017	3/6/2017	0	1
Director of Insurance	John M. Huff*	2/6/2009	2/6/2017	8	0
Acting Director of Insurance	Kip Stetzler	1/10/2009	2/5/2009	0	1
Acting Director of Insurance	Linda Bohrer	6/1/2008	1/1/2009	0	7
Director of Insurance	Douglas M. ‘Doug’ Ommen	1/2/2007	6/1/2008	1	5
Director of Insurance	W. Dale Finke	1/10/2005	1/2/2007	2	0
Director of Insurance	Scott B. Lakin	3/15/2001	1/10/2005	3	10
Director of Insurance	Keith Wenzel	5/10/1999	3/15/2001	1	10
Acting Director of Insurance	A. W. McPherson	10/31/1998	5/10/1999	0	7
Director of Insurance	Jay Angoff	2/16/1993	10/30/1998	5	8
Director of Insurance	Lewis E. Melahn	7/3/1989	2/11/1993	3	7
Acting Director of Insurance	Larry C. Call	5/24/1989	7/1/1989	0	2
Director of Insurance	William A. Bennett	2/28/1989	5/19/1989	0	3
Acting Director of Insurance	Larry C. Call	10/3/1988	2/27/1989	0	4
Director of Insurance	Lewis R. Crist	1/6/1986	10/1/1988	2	9
Acting Director of Insurance	Mary Hall	9/30/1985	1/5/1986	0	4
Director of Insurance	C. Donald Ainsworth	2/18/1981	9/27/1985	4	7
Acting Director of Insurance	William Arthur Jones	9/1/1980	2/17/1981	0	5
Director of Insurance	Richard J. Fredrick	6/1/1979	8/30/1980	1	3
Director of Insurance	Jerry B. Buxton	6/1/1977	5/31/1979	2	0
Superintendent of Insurance	Henry W. Edmiston	6/25/1975	5/31/1977	1	11

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## NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>MISSOURI—Continued</b>					
Acting Superintendent of Insurance	John Webb	6/1/1975	6/25/1975	0	1
Superintendent of Insurance	Edward G. Farmer, Jr.	4/1/1973	5/31/1975	2	2
Superintendent of Insurance	James P. Dalton	11/1/1972	3/31/1973	0	5
Superintendent of Insurance	William Y. 'Bill' McCaskill	5/22/1969	10/31/1972	3	5
Superintendent of Insurance	Robert D. Scharz	1/11/1965	5/21/1969	4	4
Superintendent of Insurance	Ralph H. Duggins	9/6/1963	1/11/1965	2	2
Superintendent of Insurance	Jack L. Clay	12/8/1961	9/6/1963	1	9
Acting Superintendent of Insurance	Jack L. Clay	11/15/1961	12/8/1961	0	1
Superintendent of Insurance	C. Lawrence Leggett*	11/25/1949	11/15/1961	12	0
Superintendent of Insurance	Owen G. Jackson	11/15/1945	11/24/1949	4	0
Superintendent of Insurance	Edward L. Scheufler	9/29/1941	10/15/1945	4	1
Superintendent of Insurance	Ray B. Lucas	1/10/1939	9/29/1941	2	8
Acting Superintendent of Insurance	F. P. Sizer	1/3/1939	1/9/1939	0	1
Superintendent of Insurance	George A. S. Robertson (Died Jan. 2, 1939)	7/1/1937	1/2/1939	1	6
Superintendent of Insurance	Robert Emmett O'Malley	7/1/1933	7/1/1937	4	0
Superintendent of Insurance	Joseph B. Thompson	3/1/1929	7/1/1933	4	4
Superintendent of Insurance	Ben C. Hyde	10/1/1921	3/1/1929	7	5
Superintendent of Insurance	Alfred L. Harty*	5/1/1918	10/1/1921	3	5
Acting Superintendent of Insurance	Claud L. Clark	3/5/1918	5/1/1918	0	2
Superintendent of Insurance	Walter K. Chorn	9/1/1915	3/5/1918	2	6
Superintendent of Insurance	Charles G. Revelle	3/1/1913	9/1/1915	2	6
Superintendent of Insurance	Frank Blake	11/1/1909	3/1/1913	3	4
Superintendent of Insurance	John Kennish	3/1/1909	11/1/1909	0	8
Superintendent of Insurance	W. D. Vandiver	4/1/1905	3/1/1909	3	11
Superintendent of Insurance	Robert G. Yates	11/1/1902	4/1/1905	2	5
Superintendent of Insurance	Edward E. Yates	6/1/1902	11/1/1902	0	5
Superintendent of Insurance	Thomas H. Wagner	8/1/1901	6/1/1902	0	10
Superintendent of Insurance	Edward T. Orear*	3/1/1897	8/1/1901	4	5
Superintendent of Insurance	James R. Waddill*	3/1/1893	3/1/1897	4	0
Superintendent of Insurance	Christopher P. Ellerbe*	3/1/1889	3/1/1893	4	0
Superintendent of Insurance	Alfred Carr	3/1/1885	3/1/1889	4	0
Superintendent of Insurance	John F. Williams	3/1/1881	3/1/1885	4	0
Superintendent of Insurance	William S. Relfe	3/1/1877	3/1/1881	4	0
Superintendent of Insurance	Celsus Price	7/1/1875	3/1/1877	1	8
Superintendent of Insurance	Francis P. Blair, Jr.	10/1/1873	7/1/1875	1	9
Superintendent of Insurance	William Selby	3/1/1873	10/1/1873	0	7
Superintendent of Insurance	Miles Sells	6/1/1872	3/1/1873	0	9
Superintendent of Insurance	Wyllis King	5/24/1871	6/1/1872	1	1
<b>MONTANA—Elected; 4-Year Term</b>					
Cmsr. of Securities and Insurance / State Auditor	Troy Downing (Elected Nov. 3, 2020)	1/4/2021		incumbent	
Cmsr. of Securities and Insurance / State Auditor	Matthew M. 'Matt' Rosendale (Elected Nov. 8, 2016)	1/2/2017	1/3/2021	4	0
Cmsr. of Securities and Insurance / State Auditor	Monica J. Lindeen* (Elected Nov. 4, 2008; Re-elected Nov. 6, 2012)	1/5/2009	1/2/2017	8	0

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**NAIC MEMBER TENURE LIST**

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>MONTANA—Continued</b>					
Cmsr. of Securities and Insurance / State Auditor	John Morrison <i>(Elected Nov. 7, 2000; Re-elected Nov. 2, 2004)</i>	1/1/2001	1/5/2009	8	0
Cmsr. of Insurance/State Auditor	Mark D. O’Keefe <i>(Elected Nov. 3, 1992; Re-elected Nov. 5, 1996)</i>	1/4/1993	1/1/2001	8	0
Cmsr. of Insurance/State Auditor	Andrea M. ‘Andy’ Bennett <i>(Elected Nov. 6, 1984 Re-elected Nov. 8, 1988)</i>	1/7/1985	1/4/1993	8	0
Cmsr. of Insurance/State Auditor	Elmer V. ‘Sonny’ Omholt	5/21/1962	1/7/1985	22	8
Cmsr. of Insurance/State Auditor	John J. Holmes <i>(Died May 12, 1962)</i>	1/3/1933	5/12/1962	29	4
Cmsr. of Insurance/State Auditor	George P. Porter	1/6/1919	1/3/1933	14	0
Cmsr. of Insurance/State Auditor	Rufus G. Poland	6/28/1917	1/6/1919	1	7
Cmsr. of Insurance/State Auditor	William Keating <i>(Died June 23, 1917)</i>	1/6/1913	6/23/1917	4	5
Cmsr. of Insurance/State Auditor	Charles M. McCoy	12/15/1911	1/6/1913	1	1
Cmsr. of Insurance/State Auditor	Henry R. Cunningham	1/1/1905	12/14/1911	6	11
State Auditor	James H. Calderhead	1/7/1901	1/1/1905	4	0
State Auditor	Thomas W. Poindexter, Jr.	1/4/1897	1/7/1901	4	0
State Auditor	Andrew B. Cook	1/2/1893	1/4/1897	4	0
State Auditor	Edwin A. Kenney	6/15/1892	1/2/1893	3	2
<b>NEBRASKA—Appointed, at the Pleasure of the Governor</b>					
Director of Insurance	Eric Dunning <i>(Appointed April 19, 2021; Reappointed Jan. 5, 2023)</i>	4/19/2021		incumbent	
Director of Insurance	Bruce R. Ramge	11/15/2010	4/18/2021	10	5
Acting Director of Insurance	Bruce R. Ramge	10/30/2010	11/15/2010	0	1
Director of Insurance	Ann M. Frohman	11/28/2007	10/30/2010	2	11
Acting Director of Insurance	Ann M. Frohman	10/10/2007	11/28/2007	0	1
Director of Insurance	L. Timothy ‘Tim’ Wagner <i>(Died Oct. 9, 2007)</i>	1/7/1999	10/9/2007	8	9
Director of Insurance	Timothy J. Hall	1/3/1998	1/7/1999	1	0
Director of Insurance	Robert G. Lange	3/1/1995	1/3/1998	2	10
Acting Director of Insurance	Robert G. Lange	2/1/1994	3/1/1995	1	1
Director of Insurance	William H. ‘Bill’ McCartney*	3/2/1987	2/1/1994	6	11
Director of Insurance	Michael J. Dugan	3/1/1983	3/2/1987	4	0
Director of Insurance	Walter D. Weaver	2/1/1979	3/1/1983	4	1
Director of Insurance	M. Berri Balka	1/1/1977	2/1/1979	1	1
Director of Insurance	E. Benjamin ‘Ben’ Nelson	8/15/1975	12/31/1976	1	4
Director of Insurance	James M. Jackson	7/7/1972	8/15/1975	3	1
Director of Insurance	Samuel ‘Sam’ Van Pelt	1/7/1971	7/7/1972	1	6
Director of Insurance	Benjamin C. ‘Ben’ Neff, Jr.	7/1/1967	1/7/1971	3	6
Acting Director of Insurance	Benjamin C. ‘Ben’ Neff, Jr.	1/28/1967	7/1/1967	0	6
Director of Insurance	Frank J. Barrett*	1/5/1961	1/5/1967	6	0
Director of Insurance	William E. Grubbs	1/8/1959	1/5/1961	2	0
Director of Insurance	John H. Binning	7/1/1957	1/8/1959	1	6
Director of Insurance	Thomas R. ‘Tom’ Pansing	1/8/1953	7/1/1957	5	6
Director of Insurance	Loren H. Laughlin	1/1/1952	12/31/1952	1	0
Director of Insurance	Bernard R. Stone	1/9/1947	12/31/1951	6	0

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## NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>NEBRASKA—Continued</b>					
Director of Insurance	Donald R. 'Don' Hodder	7/1/1946	1/9/1947	0	6
Director of Insurance	Stanley A. Matzke	6/15/1945	7/1/1946	1	0
Director of Insurance	Cecil C. Frazier	1/9/1941	6/15/1945	4	5
Director of Insurance	Charles Smrha	9/9/1935	1/9/1941	5	4
Acting Director of Insurance	John S. Logan	8/5/1935	9/9/1935	0	1
Director of Insurance	Conn W. Moose	1/3/1935	8/5/1935	0	7
Director of Insurance	Robert E. Lee 'Lee' Herdman	4/1/1933	1/3/1935	1	9
Commissioner of Insurance	Robert E. Lee 'Lee' Herdman	6/1/1931	4/1/1933	1	10
Acting Commissioner of Insurance	Joseph L. Kizer	1/3/1931	6/1/1931	0	5
Commissioner of Insurance	Lloyd C. Dort	10/16/1929	1/3/1931	1	3
Acting Commissioner of Insurance	Joseph L. Kizer	2/1/1929	10/16/1929	0	8
Commissioner of Insurance	Charles B. Anderson	1/3/1929	2/1/1929	0	1
Commissioner of Insurance	John R. Dumont	4/10/1925	1/3/1929	3	9
Acting Chief, Bureau of Insurance	Mary A. Fairchild	1/4/1923	4/10/1925	2	3
Chief, Bureau of Insurance	W. Bruce Young	8/23/1919	1/4/1923	3	4
Secretary of Insurance Board /Insurance Commissioner	William B. Eastham	7/23/1915	8/23/1919	4	1
Secretary of Insurance Board /Insurance Commissioner	Lawson G. Brian	7/22/1913	7/23/1915	2	0
State Auditor	William B. Howard	1/9/1913	7/22/1913	0	6
State Auditor	Silas R. Barton	1/7/1909	1/9/1913	4	0
State Auditor	Edward M. Searle, Jr.	1/5/1905	1/7/1909	4	0
State Auditor	Charles E. Weston	1/3/1901	1/5/1905	4	0
State Auditor	John F. Cornell	1/7/1897	1/3/1901	4	0
State Auditor	Eugene Moore	1/13/1893	1/7/1897	4	0
State Auditor	Thomas H. Benton	1/3/1889	1/13/1893	4	0
State Auditor	Heman A. Babcock	1/8/1885	1/3/1889	4	0
State Auditor	John Wallich	11/12/1880	1/8/1885	4	2
State Auditor	Frederick W. Liedtke	1/9/1879	11/11/1880	1	10
State Auditor	Jefferson B. Weston	1/13/1873	1/9/1879	6	0
State Auditor	John Gillespie	5/24/1871	1/13/1873	1	8
<b>NEVADA—Appointed, at the Pleasure of the Director of the Department of Business and Industry</b>					
Insurance Commissioner	Scott J. Kipper	2/27/2023		incumbent	
Interim Insurance Commissioner	Nick Stosic	1/6/2023	2/26/2023	0	1
Insurance Commissioner	<i>Position Vacant</i>	12/31/2022	1/5/2023	0	1
Insurance Commissioner	Barbara D. Richardson	3/7/2016	12/30/2022	6	9
Acting Insurance Commissioner	Amy L. Parks	7/7/2015	3/7/2016	0	8
Insurance Commissioner	Scott J. Kipper	10/24/2011	7/2/2015	3	9
Acting Insurance Commissioner	Amy L. Parks	8/12/2011	10/24/2011	0	2
Insurance Commissioner	Brett J. Barratt	7/7/2010	7/1/2011	1	0
Insurance Commissioner	Scott J. Kipper	12/29/2008	6/30/2010	1	6
Acting Insurance Commissioner	Betty Baker	9/1/2008	12/29/2008	0	3
Insurance Commissioner	Alice Molasky-Arman	1/6/1995	9/1/2008	13	8
Insurance Commissioner	Teresa 'Terry' Froncek Rankin	9/6/1991	12/1/1994	3	3
Acting Insurance Commissioner	Teresa 'Terry' Froncek Rankin	2/1/1991	9/6/1991	0	7
Insurance Commissioner	Alessandro A. 'Al' Iuppa*	1/1/1990	2/1/1991	1	1
Insurance Commissioner	David A. Gates*	7/6/1984	1/1/1990	5	6
Insurance Commissioner	Kevin Sullivan	1/3/1983	7/6/1984	1	6
Insurance Commissioner	Patsy Redmond	5/12/1981	1/3/1983	1	8

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**NAIC MEMBER TENURE LIST**

<b>STATE/MEMBER TITLE</b>	<b>MEMBER NAME</b>	<b>BEG. DATE</b>	<b>END DATE</b>	<b>YRS. SERVED</b>	<b>MOS. SERVED</b>
<b>NEVADA—Continued</b>					
Insurance Commissioner	Donald W. ‘Don’ Heath	1/1/1979	5/12/1981	2	4
Insurance Commissioner	James L. ‘Jim’ Wadhams	6/1/1978	1/1/1979	0	7
Insurance Commissioner	Richard L. ‘Dick’ Rottman*	3/11/1971	6/1/1978	7	3
Insurance Commissioner	Louis T. Mastos	6/1/1965	3/11/1970	5	9
Insurance Commissioner	Paul A. Hammel* <i>(Died April 21, 1965)</i>	4/1/1951	4/21/1965	14	1
Deputy Controller	Paul A. Hammel* <i>(Died April 21, 1965)</i>	1/1/1951	4/1/1951	0	3
State Comptroller	Jerome P. ‘Jerry’ Donovan	12/1/1947	1/1/1951	3	5
State Comptroller	Henry C. Schmidt	1/8/1935	12/1/1947	12	11
State Comptroller	Edward C. Peterson	1/3/1927	1/8/1935	8	0
State Comptroller	George A. Cole	1/1/1915	1/1/1927	12	0
State Comptroller	Jacob Eggers	1/1/1907	1/1/1915	8	0
State Comptroller	Samuel P. Davis	1/1/1899	1/1/1907	8	0
State Comptroller	C. A. LaGrave	1/1/1895	1/1/1899	4	0
State Comptroller	Robert L. Horton	1/1/1891	1/1/1895	4	0
State Comptroller	James F. Hallock	1/1/1879	1/1/1891	12	0
State Comptroller	William W. Hobart	10/18/1871	1/1/1879	7	3

<b>NEW HAMPSHIRE—Appointed, 5-Year Term; Nominated by the Governor; Approved by the Executive Council</b>					
Insurance Commissioner	Christopher R. ‘Chris’ Nicolopoulos	2/19/2020		incumbent	
Acting Insurance Commissioner	Alexander K. ‘Alex’ Feldvebel	1/1/2020	2/19/2020	0	1
Insurance Commissioner	John Elias	6/11/2018	12/31/2019	1	6
Insurance Commissioner	Roger A. Sevigny*	8/13/2003	6/9/2018	14	10
Insurance Commissioner	Paula T. Rogers	5/12/1999	8/12/2003	4	3
Insurance Commissioner	Charles N. ‘Charlie’ Blossom	8/1/1996	5/7/1999	2	9
Insurance Commissioner	Sylvio L. Dupuis	1/1/1994	8/1/1996	2	5
Insurance Commissioner	Louis E. Bergeron	7/28/1983	12/31/1993	10	5
Insurance Commissioner	Francis E. ‘Frank’ Whaland	3/31/1976	7/28/1983	7	4
Acting Insurance Commissioner	Leo W. Fraser, Jr.	4/11/1975	3/31/1976	1	0
Insurance Commissioner	Francis E. ‘Frank’ Whaland	6/13/1973	4/11/1975	1	10
Insurance Commissioner	John A. Durkin	7/2/1968	6/13/1973	4	11
Insurance Commissioner	Donald ‘Don’ Knowlton*	6/9/1943	7/2/1968	25	1
Acting Insurance Commissioner	Simon M. Sheldon	4/30/1943	6/9/1943	0	1
Insurance Commissioner	Arthur J. Rouillard	9/17/1937	4/30/1943	5	7
Insurance Commissioner	John E. Sullivan <i>(Died Sept. 6, 1937)</i>	6/16/1931	9/6/1937	6	3
Acting Insurance Commissioner	William N. Johnston	9/26/1930	6/16/1931	0	9
Insurance Commissioner	John E. Sullivan	5/17/1923	9/26/1930	7	4
Insurance Commissioner	John J. Donahue <i>(Died May 8, 1923)</i>	4/2/1919	5/8/1923	4	1
Insurance Commissioner	Rufus N. Elwell <i>(Died Feb. 9, 1919)</i>	11/21/1917	2/9/1919	1	3
Insurance Commissioner	Robert J. Merrill	1/13/1915	11/21/1917	2	10
Insurance Commissioner	Joseph Warren	12/31/1914	1/13/1915	0	1
Insurance Commissioner	Robert J. Merrill	11/23/1911	12/31/1914	3	1
Insurance Commissioner	George H. Adams*	9/25/1905	11/18/1911	6	2
Insurance Commissioner	John C. Linehan* <i>(Died Sept. 19, 1905)</i>	9/25/1890	9/19/1905	15	0
Insurance Commissioner	Henry H. Huse	3/14/1888	9/7/1890	2	6

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**NAIC MEMBER TENURE LIST**

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<b>NEW HAMPSHIRE—Continued</b>					
Insurance Commissioner	Oliver Pillsbury* (Died Feb. 21, 1888)	5/24/1871	2/21/1888	16	9
<b>NEW JERSEY—Appointed, at the Pleasure of the Governor</b>					
Cmsr. of Banking and Insurance	Marlene Caride	6/27/2018		incumbent	
Acting Cmsr. of Banking and Ins.	Marlene Caride	1/16/2018	6/27/2018	0	5
Commissioner Designee	Marlene Caride	12/20/2017	1/15/2018	0	1
Cmsr. of Banking and Insurance	Richard J. Badolato	6/21/2016	12/19/2017	1	6
Acting Cmsr. of Banking and Ins.	Richard J. Badolato	8/1/2015	6/21/2016	0	10
Acting Cmsr. of Banking and Ins.	Peter L. Hartt	7/1/2015	8/1/2015	0	1
Cmsr. of Banking and Insurance	Kenneth E. Kobylowski	12/20/2012	6/30/2015	2	6
Acting Cmsr. of Banking and Ins.	Kenneth E. Kobylowski	2/11/2012	12/20/2012	0	10
Cmsr. of Banking and Insurance	Thomas B. 'Tom' Considine	2/1/2010	2/11/2012	2	0
Acting Cmsr. of Banking and Ins.	William Radar	1/1/2010	2/1/2010	0	1
Cmsr. of Banking and Insurance	Neil N. Jasey	7/17/2009	1/1/2010	0	6
Cmsr. of Banking and Insurance	Steven M. Goldman	3/20/2006	7/17/2009	3	4
Acting Cmsr. of Banking and Ins.	Donald Bryan	3/1/2005	3/20/2006	1	0
Cmsr. of Banking and Insurance	Holly C. Bakke	2/4/2002	3/1/2005	3	1
Acting Cmsr. of Banking and Ins.	Donald Bryan	10/15/2001	2/4/2002	0	4
Cmsr. of Banking and Insurance	Karen L. Suter	6/29/2000	10/15/2001	1	4
Acting Cmsr. of Banking and Ins.	Karen L. Suter	1/18/2000	6/29/2000	0	5
Cmsr. of Banking and Insurance	Jaynee LaVecchia	9/1/1998	1/18/2000	1	4
Acting Cmsr. of Banking and Ins.	Jaynee LaVecchia	8/24/1998	9/1/1998	0	1
Cmsr. of Banking and Insurance	Elizabeth 'Lisa' Randall	10/1/1995	8/24/1998	2	10
Acting Insurance Commissioner	Anita B. Kartalopoulos	9/14/1995	10/1/1995	0	1
Insurance Commissioner	Andrew J. 'Drew' Karpinski	5/1/1994	9/14/1995	1	4
Acting Insurance Commissioner	Andrew J. 'Drew' Karpinski	3/4/1994	5/1/1994	0	2
Insurance Commissioner	Samuel F. Fortunato	4/1/1990	3/1/1994	3	11
Acting Insurance Commissioner	Jasper Jackson	1/1/1990	4/1/1990	0	3
Insurance Commissioner	Kenneth D. Merin	5/1/1986	1/1/1990	3	8
Insurance Commissioner	Hazel Frank Gluck	3/1/1985	5/1/1986	1	2
Acting Insurance Commissioner	Jasper Jackson	1/1/1985	3/1/1985	0	2
Insurance Commissioner	Kenneth D. Merin	10/1/1984	1/1/1985	0	3
Acting Insurance Commissioner	Kenneth D. Merin	4/1/1984	10/1/1984	0	6
Insurance Commissioner	Joseph F. Murphy	2/1/1982	4/1/1984	2	2
Acting Insurance Commissioner	John G. Foley	1/1/1982	2/1/1982	0	1
Insurance Commissioner	James J. Sheeran	1/1/1974	1/1/1982	8	0
Insurance Commissioner	Richard C. McDonough	2/14/1972	1/1/1974	1	11
Insurance Commissioner	Robert L. Clifford	1/1/1970	2/14/1972	2	1
Cmsr. of Banking and Insurance	Horace J. Bryant	3/1/1969	1/1/1970	0	10
Cmsr. of Banking and Insurance	Charles R. Howell*	2/1/1955	3/1/1969	14	1
Acting Cmsr. of Banking and Ins.	Jerome B. McKenna	10/1/1954	2/1/1955	0	4
Cmsr. of Banking and Insurance	Warren N. Gaffney	5/1/1950	10/1/1954	4	5
Acting Cmsr. of Banking and Ins.	Christopher A. Gough	1/1/1949	5/1/1950	1	4
Cmsr. of Banking and Insurance	John J. Dickerson	7/1/1948	1/1/1949	0	6
Acting Cmsr. of Banking and Ins.	Christopher A. Gough	5/1/1948	7/1/1948	0	2
Cmsr. of Banking and Insurance	Lawrence B. Carey	2/1/1945	5/1/1948	3	3
Cmsr. of Banking and Insurance	Eugene E. Agger	1/1/1942	2/1/1945	3	1
Cmsr. of Banking and Insurance	Louis A. Reilly	3/1/1938	1/1/1942	3	10
Cmsr. of Banking and Insurance	Carl K. Withers	4/1/1935	3/1/1938	2	11

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<b>NEW JERSEY—Continued</b>					
Cmsr. of Banking and Insurance	William H. Kelly	2/1/1932	4/1/1935	3	2
Cmsr. of Banking and Insurance	Frank H. Smith	2/1/1929	2/1/1932	3	0
Cmsr. of Banking and Insurance	Edward E. Maxson	2/28/1923	2/1/1929	6	0
Cmsr. of Banking and Insurance	William E. Tuttle, Jr. <i>(Died Feb. 11, 1923)</i>	1/1/1921	2/11/1923	2	1
Cmsr. of Banking and Insurance	Frank H. Smith	12/1/1917	1/1/1921	3	1
Cmsr. of Banking and Insurance	George M. La Monte	11/1/1912	12/1/1917	5	1
Cmsr. of Banking and Insurance	Henry J. Ford	4/1/1912	11/1/1912	0	7
Cmsr. of Banking and Insurance	Vivian M. Lewis	4/1/1909	4/1/1912	3	0
Cmsr. of Banking and Insurance	David O. Watkins	4/1/1903	4/1/1909	6	0
Cmsr. of Banking and Insurance	William Bettle	3/1/1897	3/31/1903	6	0
Cmsr. of Banking and Insurance	George W. Wurts	10/1/1896	3/1/1897	0	5
Cmsr. of Banking and Insurance	George S. Duryea	6/1/1891	10/1/1896	5	4
Cmsr. of Banking and Insurance	George B. M. Harvey	4/1/1891	6/1/1891	0	2
Cmsr. of Banking and Insurance	<i>No Record in Proceedings</i> <i>(Represented by Actuary David P. Fackler)</i>	9/20/1881	8/20/1890	8	11
Secretary of State	Henry C. Kelsey	5/24/1871	4/1/1881	9	11

<b>NEW MEXICO—Appointed, by the Insurance Nominating Committee; 4-Year Term</b>					
Interim Superintendent of Insurance	Jennifer A. Catechis	1/21/2023		incumbent	
Superintendent of Insurance	Russell Toal	1/1/2020	1/20/2023	3	0
Superintendent of Insurance	John G. Franchini	7/27/2010	12/31/2019	9	5
Acting Superintendent of Insurance	Johnny L. Montoya	6/15/2010	7/27/2010	0	1
Interim Superintendent of Insurance	Craig Dunbar	5/24/2010	6/15/2010	0	1
Interim Superintendent of Insurance	Thomas R. ‘Tom’ Rushton	5/4/2010	5/24/2010	0	1
Superintendent of Insurance	Morris J. ‘Mo’ Chavez	10/1/2006	5/4/2010	3	7
Acting Superintendent of Insurance	Thomas R. ‘Tom’ Rushton	6/14/2006	10/1/2006	0	4
Superintendent of Insurance	Eric P. Serna	2/20/2001	6/14/2006	5	4
Superintendent of Insurance	Donald J. ‘Don’ Letherer	10/4/1999	1/31/2001	1	3
Acting Superintendent of Insurance	Michael C. Batte	1/1/1999	10/4/1999	0	9
Superintendent of Insurance	Christopher P. ‘Chris’ Krahling	6/1/1995	12/11/1998	3	6
Acting Superintendent of Insurance	Thomas R. ‘Tom’ Rushton	4/28/1995	6/1/1995	0	1
Superintendent of Insurance	Fabian Chavez	4/18/1988	4/28/1995	7	0
Superintendent of Insurance	Vicente B. Jasso	8/1/1981	4/18/1988	6	8
Superintendent of Insurance	Manuel A. Garcia, Jr.	6/11/1978	8/1/1981	3	2
Superintendent of Insurance	Kenneth C. Moore	6/1/1976	6/11/1978	3	0
Superintendent of Insurance	Ralph F. Apodaca	10/15/1976	6/11/1978	1	8
Superintendent of Insurance	George A. Biel	8/20/1939	10/15/1976	37	2
Superintendent of Insurance	Eliseo Gonzales	2/15/1935	3/1/1935	0	1
Superintendent of Insurance	Alfonso Aguilar	1/6/1933	2/15/1935	2	1
Superintendent of Insurance	Max Fernandez	1/5/1931	1/6/1933	2	0
Superintendent of Insurance	J. H. Vaughn	2/1/1928	1/5/1931	2	11
Superintendent of Insurance	H. A. Delgado	3/20/1925	2/1/1928	2	11
Bank Examiner of State	L. B. Gregg	3/3/1921	3/20/1925	4	0
Superintendent of Insurance and Corporation Commission	Remijio Mirabel	3/6/1919	3/3/1921	2	0
Superintendent of Insurance and Corporation Commission	Cleofas Romero	3/15/1917	3/6/1919	2	0
Superintendent of Insurance	Jacobo Chavez	3/19/1907	3/15/1917	10	0

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<b>NEW MEXICO—Continued</b>					
Superintendent of Insurance	John H. Sloan	1/19/1906	3/19/1907	1	2
Superintendent of Insurance	Pedro Perea <i>(Died Jan. 11, 1906)</i>	3/1/1905	1/11/1906	0	10
Territorial Auditor	William G. Sargent	4/1/1901	3/1/1905	3	11
Territorial Auditor	Luis M. Ortiz	3/14/1899	4/1/1901	2	0
Territorial Auditor	Marcelino Garcia	2/21/1895	3/14/1899	4	0
Territorial Auditor	Demetrio Perez	3/18/1891	2/21/1895	4	0
Territorial Auditor	Trinidad Alarid	8/15/1888	3/18/1891	2	7
<b>NEW YORK—Appointed, at the Pleasure of the Governor</b>					
Superintendent of Financial Services	Adrienne A. Harris	1/25/2022		incumbent	
Acting Superintendent of Fin. Svcs.	Adrienne A. Harris	9/13/2021	1/25/2022	0	4
Acting Superintendent of Fin. Svcs.	Shirin Emami	8/25/2021	9/12/2021	0	1
Superintendent of Financial Services	Linda A. Lacewell	6/21/2019	8/24/2021	2	2
Acting Superintendent of Fin. Svcs.	Linda A. Lacewell	2/4/2019	6/20/2019	0	4
Superintendent of Financial Services	Maria T. Vullo	6/15/2016	2/1/2019	2	8
Acting Superintendent of Fin. Svcs.	Maria T. Vullo	2/22/2016	6/15/2016	0	4
Acting Superintendent of Fin. Svcs.	Shirin Emami	12/1/2015	2/22/2016	0	2
Acting Superintendent of Fin. Svcs.	Anthony J. Albanese	6/18/2015	11/30/2015	0	5
Superintendent of Financial Services	Benjamin M. Lawskey	10/3/2011	6/17/2015	3	8
Superintendent of Insurance	James J. Wrynn	9/11/2009	10/3/2011	2	1
Acting Superintendent of Insurance	James J. Wrynn	8/20/2009	9/11/2009	0	1
Acting Superintendent of Insurance	Kermitt J. Brooks	7/4/2009	8/19/2009	0	1
Superintendent of Insurance	Eric R. Dinallo	4/18/2007	7/3/2009	2	3
Acting Superintendent of Insurance	Eric R. Dinallo	1/29/2007	4/17/2007	0	3
Acting Superintendent of Insurance	Louis W. 'Lou' Pietroluongo	1/1/2007	1/28/2007	0	1
Superintendent of Insurance	Howard D. Mills III	5/18/2005	12/31/2006	1	7
Acting Superintendent of Insurance	Howard D. Mills III	1/18/2005	5/17/2005	0	4
Superintendent of Insurance	Gregory V. 'Greg' Serio	5/9/2001	1/18/2005	3	9
Acting Superintendent of Insurance	Gregory V. 'Greg' Serio	4/5/2001	5/9/2001	0	1
Superintendent of Insurance	Neil D. Levin <i>(Died Sept. 11, 2001)</i>	4/7/1997	4/5/2001	4	0
Acting Superintendent of Insurance	Gregory V. 'Greg' Serio	12/29/1996	4/7/1997	0	4
Superintendent of Insurance	Edward J. Muhl*	2/12/1995	12/29/1996	1	10
Superintendent of Insurance	Salvatore R. Curiale	6/30/1990	12/31/1994	4	6
Acting Superintendent of Insurance	Wendy E. Cooper	1/27/1990	6/29/1990	0	5
Superintendent of Insurance	James P. Corcoran	3/8/1983	1/26/1990	6	10
Superintendent of Insurance	Albert B. Lewis	1/5/1978	3/7/1983	5	2
Acting Superintendent of Insurance	John F. Lennon	7/21/1977	1/4/1978	0	6
Superintendent of Insurance	Thomas A. Harnett	6/24/1975	7/20/1977	2	1
Acting Superintendent of Insurance	John P. Gemma	4/11/1975	6/23/1975	0	2
Superintendent of Insurance	Lawrence W. Keepnews	3/18/1975	4/11/1975	0	1
Acting Superintendent of Insurance	Lawrence O. Monin	3/10/1975	3/18/1975	0	1
Superintendent of Insurance	Benjamin R. Schenck	1/1/1971	3/10/1975	4	2
Superintendent of Insurance	Richard E. 'Dick' Stewart*	1/1/1967	12/31/1970	3	11
Superintendent of Insurance	Henry Root Stern, Jr.	1/28/1964	12/31/1966	2	11
Acting Superintendent of Insurance	Samuel C. Cantor	10/3/1963	1/27/1964	0	3
Superintendent of Insurance	Thomas Thacher	1/27/1959	10/2/1963	4	9
Superintendent of Insurance	Julius S. Wikler	3/17/1958	1/26/1959	0	10
Superintendent of Insurance	Leffert Holz	2/3/1955	3/15/1958	3	1

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STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>NEW YORK—Continued</b>					
Acting Superintendent of Insurance	Adelbert G. Straub, Jr.	2/1/1955	2/3/1955	0	1
Superintendent of Insurance	Alfred J. Bohlinger	7/1/1950	1/31/1955	4	6
Superintendent of Insurance	Robert E. Dineen*	9/23/1943	6/30/1950	6	9
Acting Superintendent of Insurance	Thomas J. Cullen	2/1/1943	9/22/1943	0	7
Superintendent of Insurance	Louis H. Pink	5/10/1935	1/31/1943	8	4
Superintendent of Insurance	George S. Van Schaick	3/5/1931	5/9/1935	4	2
Acting Superintendent of Insurance	Henry A. Thellusson	2/17/1931	3/4/1931	0	1
Acting Superintendent of Insurance	Thomas F. Behan	7/1/1930	2/16/1931	0	7
Superintendent of Insurance	Albert Conway	1/1/1929	6/30/1930	1	6
Superintendent of Insurance	James A. Beha	7/1/1924	1/1/1929	4	6
Superintendent of Insurance	Francis R. Stoddard, Jr.	12/1/1921	6/30/1924	2	6
Acting Superintendent of Insurance	Henry D. Appleton	11/1/1921	11/30/1921	0	1
Superintendent of Insurance	Jesse S. Phillips*	7/1/1915	10/31/1921	6	3
Superintendent of Insurance	Frank Hasbrouck	3/27/1914	6/30/1915	1	3
Superintendent of Insurance	William Temple Emmet	2/21/1912	3/26/1914	2	1
Superintendent of Insurance	William H. Hotchkiss	2/18/1909	2/18/1912	3	0
Acting Superintendent of Insurance	Henry D. Appleton	1/14/1909	2/17/1909	0	1
Superintendent of Insurance	Otto Kelsey	5/17/1906	1/13/1909	2	8
Superintendent of Insurance	Francis Hendricks	2/2/1900	5/16/1906	6	3
Superintendent of Insurance	Louis F. Payn	2/11/1897	2/1/1900	3	0
Superintendent of Insurance	James F. Pierce*	2/12/1891	2/10/1897	6	0
Superintendent of Insurance	Robert A. Maxwell	1/1/1886	2/11/1891	5	1
Superintendent of Insurance	John A. McCall, Jr.*	4/23/1883	12/31/1885	2	8
Superintendent of Insurance	Charles G. Fairman	4/27/1880	4/23/1883	3	0
Superintendent of Insurance	John F. Smyth	2/21/1877	4/26/1880	3	2
Acting Superintendent of Insurance	William Smyth	2/1/1876	2/20/1877	1	0
Superintendent of Insurance	Orlow W. Chapman*	11/29/1872	1/31/1876	3	2
Acting Superintendent of Insurance	George B. Church	5/13/1872	11/28/1872	0	6
Superintendent of Insurance	George W. Miller*	5/24/1871	5/12/1872	1	0
<b>NORTH CAROLINA—Elected; 4-Year Term</b>					
Commissioner of Insurance	Mike Causey (Elected Nov. 8, 2016; Re-elected Nov. 3, 2020)	1/1/2017		incumbent	
Commissioner of Insurance	G. Wayne Goodwin	1/10/2009	1/1/2017	8	0
Commissioner of Insurance	James E. 'Jim' Long*	1/5/1985	1/10/2009	24	0
Commissioner of Insurance	John Randolph Ingram	1/10/1973	1/5/1985	12	0
Commissioner of Insurance	Edwin S. Lanier	7/16/1962	1/10/1973	10	6
Commissioner of Insurance	Charles F. Gold	6/1/1953	7/16/1962	9	1
Commissioner of Insurance	Waldo C. Cheek	6/1/1949	6/1/1953	4	0
Commissioner of Insurance	William P. 'Bill' Hodges	9/1/1942	6/1/1949	6	9
Commissioner of Insurance	Daniel C. 'Dan' Boney*	11/15/1927	9/1/1942	14	10
Commissioner of Insurance	Stacey W. Wade	1/1/1921	11/15/1927	6	10
Commissioner of Insurance	James R. Young*	1/1/1899	1/1/1921	22	0
Secretary of State	Cyrus Thompson	1/1/1897	1/1/1899	2	0
Secretary of State	C. M. Cooke	8/1/1895	1/1/1897	1	5
Secretary of State	Octavius Coke	4/1/1891	8/1/1895	4	4
Secretary of State	William L. Saunders	1/1/1879	4/1/1891	12	3
Secretary of State	J. A. Englehard	1/1/1877	1/1/1879	2	0
Secretary of State	W. H. Howerton	1/1/1873	1/1/1877	4	0

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STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>NORTH CAROLINA—Continued</b>					
Secretary of State	<i>No Record in Proceedings</i> (Represented by Special Delegate William H. Finch)	10/1/1871	1/1/1873	1	3
<b>NORTH DAKOTA—Elected; 4-Year Term</b>					
Commissioner of Insurance	Jon Godfread (Elected Nov. 8, 2016; Re-elected Nov. 3, 2020)	1/3/2017		incumbent	
Commissioner of Insurance	Adam W. Hamm*	10/9/2007	1/3/2017	9	3
Acting Commissioner of Insurance	Rebecca Ternes	9/1/2007	10/9/2007	0	1
Commissioner of Insurance	James A. ‘Jim’ Poolman	1/1/2001	8/31/2007	6	8
Commissioner of Insurance	Glenn Pomeroy*	1/1/1993	1/1/2001	8	0
Commissioner of Insurance	Earl R. Pomeroy*	1/1/1985	1/1/1993	8	0
Commissioner of Insurance	Jorris O. Wigen	1/1/1981	1/1/1985	4	0
Commissioner of Insurance	Byron Knutson	1/1/1977	1/1/1981	4	0
Commissioner of Insurance	Jorris O. Wigen	1/1/1969	1/1/1977	8	0
Commissioner of Insurance	Karsten O. Nygaard	1/1/1965	1/1/1969	4	0
Commissioner of Insurance	Frank Albers	1/1/1963	1/1/1965	2	0
Commissioner of Insurance	Alfred J. Jensen	1/1/1951	1/1/1963	12	0
Commissioner of Insurance	Otto G. Krueger	9/7/1945	1/1/1951	5	4
Commissioner of Insurance	Oscar E. Erickson (Died Aug. 15, 1945)	1/11/1937	8/15/1945	8	7
Commissioner of Insurance	Harold L. Hopton	1/7/1935	1/11/1937	2	0
Commissioner of Insurance	Sveinung A. Olsness	1/2/1917	1/7/1935	18	0
Commissioner of Insurance	Walter C. Taylor	1/1/1911	1/2/1917	6	0
Commissioner of Insurance	Ernest C. Cooper	1/1/1905	12/31/1910	6	0
Commissioner of Insurance	Ferdinand ‘Ferd’ Leutz	1/1/1901	12/31/1904	4	0
Commissioner of Insurance	George W. Harrison	1/3/1899	12/31/1900	2	0
Commissioner of Insurance	Frederick B. ‘Fred’ Fancher	1/7/1895	1/3/1899	4	0
Commissioner of Insurance	James ‘Jim’ Cudhie	1/3/1893	1/7/1895	2	0
Commissioner of Insurance	A. L. Carey	11/4/1889	1/3/1893	3	2
Territorial Auditor	John C. McManima	9/4/1889	11/4/1889	0	2
<b>NORTHERN MARIANA ISLANDS—Appointed, Concurrent with Current Governor</b>					
Acting Secretary of Commerce	Joseph Rios Jr.	2/1/2023		incumbent	
Secretary of Commerce	Edward M. Deleon Guerrero	7/8/2021	2/1/2023	1	7
Acting Secretary of Commerce	Edward M. Deleon Guerrero	3/28/2021	7/8/2021	0	4
Secretary of Commerce	Mark O. Rabauliman	3/6/2015	3/26/2021	6	0
Acting Secretary of Commerce	Mark O. Rabauliman	9/9/2014	3/6/2015	0	6
Secretary of Commerce	Sixto K. Igisomar	1/24/2012	9/9/2014	2	8
Acting Secretary of Commerce	Sixto K. Igisomar	10/8/2010	1/24/2012	1	3
Secretary of Commerce	Michael J. Ada	9/18/2008	10/8/2010	2	1
Acting Secretary of Commerce	Michael J. Ada	8/15/2008	9/18/2008	0	1
Secretary of Commerce	James A. Santos	5/8/2006	8/15/2008	2	3
Acting Secretary of Commerce	James A. Santos	1/9/2006	5/8/2006	0	4
Secretary of Commerce	Andrew S. Salas	1/1/2006	1/9/2006	3	0

\* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

**NAIC MEMBER TENURE LIST**

<b>STATE/MEMBER TITLE</b>	<b>MEMBER NAME</b>	<b>BEG. DATE</b>	<b>END DATE</b>	<b>YRS. SERVED</b>	<b>MOS. SERVED</b>
<b>OHIO—Appointed, at the Pleasure of the Governor; Confirmed by the Senate</b>					
Director of Insurance	Judith L. ‘Judi’ French	2/8/2021		incumbent	
Interim Director of Insurance	Tynesia Dorsey	8/24/2020	2/7/2021	0	6
Director of Insurance	Jillian E. Froment	3/31/2017	8/24/2020	3	5
Lt. Governor/Director of Insurance	Mary Taylor	1/10/2011	3/31/2017	6	2
Director of Insurance	Mary Jo Hudson	1/8/2007	1/10/2011	4	0
Director of Insurance	Ann H. Womer Benjamin	1/6/2003	1/8/2007	4	0
Interim Director of Insurance	Holly Saelens	11/29/2002	1/6/2003	0	2
Director of Insurance	J. Lee Covington II	5/7/1999	11/29/2002	3	7
Interim Director of Insurance	Alan F. Berliner	4/1/1999	5/7/1999	0	1
Interim Director of Insurance	David S. Meyer	1/11/1999	4/1/1999	0	3
Director of Insurance	Harold T. Duryee	3/1/1991	1/11/1999	7	10
Acting Director of Insurance	Dana Rudmose	1/14/1991	3/1/1991	0	2
Director of Insurance	George Fabe	2/4/1983	1/14/1991	7	11
Director of Insurance	Robert H. Katz	8/31/1982	2/4/1983	0	5
Director of Insurance	Robert L. Ratchford, Jr.	12/31/1979	8/31/1982	2	8
Director of Insurance	Harry V. Jump	1/13/1975	12/31/1979	4	11
Director of Insurance	Kenneth E. ‘Ken’ DeShetler	1/11/1971	1/13/1975	4	0
Director of Insurance	Fred B. Smith	2/4/1969	1/11/1971	1	11
Director of Insurance	Eugene P. Brown (Died Jan. 27, 1969)	3/1/1968	1/27/1969	0	10
Superintendent of Insurance	William R. Morris	1/14/1963	3/1/1968	5	2
Superintendent of Insurance	Robert L. Mullins	12/1/1961	1/14/1963	1	1
Acting Superintendent of Insurance	Robert L. Mullins	10/1/1961	12/1/1961	0	2
Superintendent of Insurance	Edward A. ‘Ted’ Stowell	1/12/1959	10/1/1961	2	9
Superintendent of Insurance	Arthur I. ‘Art’ Vorys	1/16/1957	1/12/1959	2	0
Superintendent of Insurance	August ‘Augie’ Pryatel	7/2/1955	1/16/1957	1	6
Superintendent of Insurance	Walter A. Robinson	1/10/1949	7/2/1955	6	6
Superintendent of Insurance	W. Lee Shield	1/13/1947	1/10/1949	2	0
Superintendent of Insurance	Walter Dressel	1/15/1945	1/13/1947	2	0
Superintendent of Insurance	J. Roth Crabbe	3/1/1943	1/15/1945	1	10
Superintendent of Insurance	John A. Lloyd	1/16/1939	3/1/1943	4	2
Superintendent of Insurance	Robert L. Bowen	1/14/1935	1/16/1939	4	0
Superintendent of Insurance	Charles T. Warner	2/1/1931	1/14/1935	3	11
Superintendent of Insurance	Charles S. Younger	1/14/1929	1/31/1931	2	0
Superintendent of Insurance	William A. Doody	12/15/1928	1/14/1929	0	1
Superintendent of Insurance	William C. Safford	4/15/1927	12/15/1928	1	8
Superintendent of Insurance	Harry L. Conn*	2/1/1925	4/15/1927	2	2
Superintendent of Insurance	Emmett L. Savage	6/25/1924	2/1/1925	0	8
Superintendent of Insurance	Harry L. Conn*	1/12/1923	6/25/1924	1	5
Superintendent of Insurance	Bert W. Gearheart	1/25/1921	1/12/1923	2	0
Superintendent of Insurance	Robert T. Crew	7/1/1920	1/25/1921	0	6
Superintendent of Insurance	William H. Tomlinson	6/1/1917	7/1/1920	3	1
Superintendent of Insurance	Frank Taggart	2/11/1915	6/1/1917	2	4
Superintendent of Insurance	Price Russell	11/7/1914	2/11/1915	0	3
Superintendent of Insurance	Robert M. Small	4/18/1914	11/7/1914	0	7
Acting Superintendent of Insurance	Robert M. Small	2/9/1914	4/18/1914	0	2
Superintendent of Insurance	Edmond H. Moore	5/18/1911	2/9/1914	2	9
Superintendent of Insurance	Charles C. Lemert	12/16/1907	4/30/1911	3	5
Superintendent of Insurance	Arthur I. ‘Jake’ Vorys*	6/3/1900	12/16/1907	7	6
Superintendent of Insurance	William S. Matthews	6/3/1896	6/3/1900	4	0

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**NAIC MEMBER TENURE LIST**

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>OHIO—Continued</b>					
Superintendent of Insurance	William M. Hahn*	6/3/1893	6/3/1896	3	0
Superintendent of Insurance	William H. Kinder	6/3/1890	6/3/1893	3	0
Superintendent of Insurance	Samuel E. Kemp	6/3/1887	6/3/1890	3	0
Superintendent of Insurance	Henry J. Reinmund	6/2/1884	6/3/1887	3	0
Superintendent of Insurance	Charles H. Moore	6/2/1881	6/2/1884	3	0
Superintendent of Insurance	Joseph F. Wright	6/2/1878	6/2/1881	3	0
Superintendent of Insurance	William D. Hill	6/2/1875	6/2/1878	3	0
Superintendent of Insurance	William F. Church	6/2/1872	6/2/1875	3	0
Auditor of State	James Williams	1/8/1872	6/2/1872	0	5
Auditor of State	James H. Godman	5/24/1871	1/8/1872	0	8
<b>OKLAHOMA—Elected; 4-Year Term</b>					
Insurance Commissioner	Glen Mulready <i>(Elected Nov. 6, 2018; Re-elected Nov. 8, 2022)</i>	1/14/2019		incumbent	
Insurance Commissioner	John D. Doak	1/10/2011	1/14/2019	8	0
Insurance Commissioner	Kim Holland	1/24/2005	1/10/2011	6	0
Insurance Commissioner	<i>Position Vacant</i>	9/24/2004	1/1/2005	0	3
Insurance Commissioner	Carroll Fisher	1/1/1999	9/24/2004	5	9
Insurance Commissioner	John P. Crawford	1/1/1995	1/1/1999	4	0
Insurance Commissioner	Catherine J. ‘Cathy’ Weatherford	10/1/1991	1/1/1995	3	3
Insurance Commissioner	Gerald Grimes	1/1/1975	10/1/1991	16	9
Insurance Commissioner	Joe B. Hunt	1/1/1955	1/1/1975	20	0
Insurance Commissioner	Robert L. Birdwell	6/1/1954	1/1/1955	0	7
Insurance Commissioner	Donald F. Dickey	7/21/1946	6/1/1954	7	11
Insurance Commissioner	Jess G. Read* <i>(Died July 20, 1946)</i>	1/6/1924	7/20/1946	22	6
Insurance Commissioner	E. W. Hardin	2/1/1921	1/6/1924	2	11
Insurance Commissioner	A. L. Welch	4/28/1913	2/1/1921	7	10
Insurance Commissioner	Perry A. Ballard	1/9/1911	4/28/1913	2	3
Insurance Commissioner	Milas Lasater	12/3/1909	1/9/1911	1	1
Insurance Commissioner	T. J. McComb	11/1/1907	12/3/1909	2	1
Territorial Secretary	Charles H. Filson	1/1/1906	11/1/1907	1	10
Territorial Secretary	William Grimes	5/1/1901	1/1/1906	4	8
Territorial Secretary	William M. Jenkins	6/1/1897	5/1/1901	3	11
Territorial Secretary	Thomas J. Lowe	9/1/1893	6/1/1897	3	9
Territorial Secretary	Robert Martin	5/1/1890	9/1/1893	3	4
<b>OREGON—Appointed, Indefinite</b>					
Director, Department of Consumer and Business Services (DCBS) / Insurance Commissioner	Andrew R. Stolfi	4/7/2020		incumbent	
Insurance Commissioner	Andrew R. Stolfi	2/1/2018	4/7/2020	2	2
Acting Director, DCBS / Insurance Commissioner	Cameron Smith	12/21/2017	1/31/2018	0	2
Acting Director, DCBS / Insurance Commissioner	Jean Straight	9/1/2017	12/20/2017	0	3
Insurance Commissioner / Chief Actuary	Laura N. Cali Robison	7/15/2013	8/31/2017	4	1
Insurance Commissioner	Louis D. Savage	5/1/2012	7/15/2013	1	2
Acting Insurance Commissioner	Louis D. Savage	11/1/2011	5/1/2012	0	6

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**NAIC MEMBER TENURE LIST**

<b>STATE/MEMBER TITLE</b>	<b>MEMBER NAME</b>	<b>BEG. DATE</b>	<b>END DATE</b>	<b>YRS. SERVED</b>	<b>MOS. SERVED</b>
<b>OREGON—Continued</b>					
Insurance Administrator	Teresa D. Miller	7/8/2009	11/1/2011	2	4
Acting Insurance Administrator	Teresa D. Miller	10/1/2008	7/8/2009	0	9
Insurance Administrator	Scott J. Kipper	12/1/2007	10/1/2008	0	10
Acting Insurance Administrator	Carl Lundberg	7/1/2007	12/1/2007	0	5
Insurance Administrator (named NAIC member rep. by Dir. Neidig)	Joel S. Ario	12/1/2000	7/1/2007	7	3
Director, DCBS / Insurance Commissioners	Mary C. Neidig ( <i>exp. 1/1/2003</i> )	4/27/2000	12/1/2000	2	9
Acting Director, DCBS / Insurance Commissioners	Mary C. Neidig	3/1/2000	4/27/2000	0	1
Acting Director, DCBS / Insurance Commissioners	Deborah Lincoln	3/1/2000	3/1/2000	0	1
Acting Director, DCBS / Insurance Commissioners	Mike Greenfield	7/1/1998	3/1/2000	1	8
Acting Director, DCBS / Insurance Commissioners	Deborah Lincoln	3/1/1998	7/1/1998	0	4
Acting Director, DCBS / Insurance Commissioners	Kerry Barnett	12/1/1993	12/31/1997	4	0
Acting Insurance Commissioner	Geoff Guilfooy	10/1/1993	12/1/1993	0	2
Insurance Commissioner	Gary Weeks	3/1/1991	10/1/1993	2	7
Acting Insurance Commissioner	Geoff Guilfooy	1/1/1991	3/1/1991	0	2
Insurance Commissioner	Theodore R. Kulongoski	1/1/1987	1/1/1991	4	0
Insurance Commissioner	Josephine M. 'Jo' Driscoll*	12/1/1981	1/1/1987	5	1
Insurance Commissioner	Wilfred W. Fritz	2/1/1978	12/1/1981	3	10
Insurance Commissioner	Lester L. Rawls*	8/1/1972	12/31/1977	5	4
Acting Insurance Commissioner	F. Frank Howatt	4/1/1972	8/1/1972	0	4
Insurance Commissioner	Cornelius C. Bateson	12/1/1969	4/1/1972	2	4
Insurance Commissioner	James R. Faulstich	1/1/1967	12/1/1969	2	11
Insurance Commissioner	Walter G. Korlann	11/1/1961	1/1/1967	5	2
Insurance Commissioner	V. Dean Musser	1/1/1959	11/1/1961	2	10
Insurance Commissioner	Hugh H. Earle	7/1/1957	1/1/1959	1	6
Insurance Commissioner	Robert B. Taylor*	7/1/1949	6/30/1957	7	11
Insurance Commissioner	Seth B. Thompson*	6/1/1940	6/30/1949	9	0
Insurance Commissioner	Hugh H. Earle	7/1/1935	6/1/1939	3	11
Insurance Commissioner	Alva H. Averill	6/1/1931	12/1/1934	3	6
Insurance Commissioner	Clare A. Lee	2/1/1927	12/1/1930	3	10
Insurance Commissioner	Will Moore	8/1/1923	10/1/1926	3	2
Insurance Commissioner	A. C. Barbour	9/1/1920	9/1/1921	1	0
Insurance Commissioner	Harvey W. Wells	9/1/1915	9/1/1919	4	0
Insurance Commissioner	John W. Ferguson	7/1/1912	9/1/1915	3	2
Insurance Commissioner	Samuel A. Kozer	8/1/1911	7/1/1912	0	11
Insurance Superintendent	Samuel A. Kozer	8/24/1909	8/1/1911	2	0

<b>PENNSYLVANIA—Appointed, by the Governor with the Advice and Consent of the Senate</b>					
Acting Insurance Commissioner	Michael M. 'Mike' Humphreys	2/26/2022		incumbent	
Insurance Commissioner	Jessica K. Altman	3/20/2018	2/25/2022	3	11
Acting Insurance Commissioner	Jessica K. Altman	8/19/2017	3/20/2018	0	7
Insurance Commissioner	Teresa D. Miller	6/3/2015	8/18/2017	2	2
Acting Insurance Commissioner	Teresa D. Miller	1/21/2015	6/3/2015	0	5
Insurance Commissioner	Michael F. 'Mike' Consedine	4/26/2011	1/20/2015	3	9

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**NAIC MEMBER TENURE LIST**

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>PENNSYLVANIA—Continued</b>					
Acting Insurance Commissioner	Michael F. ‘Mike’ Consedine	1/19/2011	4/26/2011	0	3
Acting Insurance Commissioner	Robert L. Pratter	8/30/2010	1/18/2011	0	5
Insurance Commissioner	Joel S. Ario	7/3/2008	8/29/2010	2	1
Acting Insurance Commissioner	Joel S. Ario	7/2/2007	7/3/2008	1	0
Acting Insurance Commissioner	Randolph R. ‘Randy’ Rohrbaugh	2/20/2007	7/1/2007	0	5
Insurance Commissioner	M. Diane Koken*	8/27/1997	2/19/2007	9	6
Acting Insurance Commissioner	Gregory S. Martino	6/30/1997	8/27/1997	0	2
Insurance Commissioner	Linda S. Kaiser	1/30/1995	6/30/1997	2	5
Insurance Commissioner	Cynthia M. Maleski	4/7/1992	1/30/1995	2	10
Acting Insurance Commissioner	Ronald Chronister	2/28/1992	4/7/1992	0	2
Insurance Commissioner	Constance B. Foster	1/20/1987	2/28/1992	5	1
Insurance Commissioner	George F. Grode	7/23/1985	1/20/1987	1	6
Acting Insurance Commissioner	William R. Muir, Jr.	5/1/1984	7/23/1985	1	3
Acting Insurance Commissioner	Anthony A. Geyelin	9/26/1983	5/1/1984	0	7
Insurance Commissioner	Michael L. Browne	7/24/1980	9/26/1983	3	2
Acting Insurance Commissioner	James R. Farley	5/21/1980	7/24/1980	0	2
Insurance Commissioner	Harvey Bartle III	2/23/1979	5/20/1980	1	3
Acting Insurance Commissioner	John J. Sheehy	1/2/1979	2/23/1979	0	2
Insurance Commissioner	William J. Sheppard	4/30/1974	1/1/1979	4	9
Insurance Commissioner	Herbert S. Denenberg	1/25/1971	4/30/1974	3	3
Insurance Commissioner	George F. Reed	9/11/1969	1/25/1971	1	4
Insurance Commissioner	David O. Maxwell	1/17/1967	9/11/1969	2	8
Insurance Commissioner	Audrey R. Kelly	1/15/1963	1/17/1967	4	0
Insurance Commissioner	Theodore S. Gutowicz	7/16/1962	1/15/1963	0	6
Insurance Commissioner	Francis R. Smith	1/18/1955	7/16/1962	7	6
Insurance Commissioner	Artemas C. Leslie	4/8/1950	1/18/1955	4	9
Insurance Commissioner	James F. Malone, Jr.	1/21/1947	4/8/1950	3	3
Insurance Commissioner	Gregg L. Neel	1/10/1943	1/21/1947	4	0
Insurance Commissioner	Ralph H. Alexander	11/5/1942	1/10/1943	0	2
Acting Insurance Commissioner	Ralph H. Alexander	7/23/1942	11/5/1942	0	4
Insurance Commissioner	Matthew H. Taggart <i>(Died July 23, 1942)</i>	1/17/1939	7/23/1942	3	6
Insurance Commissioner	Owen B. Hunt	1/15/1935	1/17/1939	4	0
Acting Insurance Commissioner	Charles H. Groff	2/5/1934	1/15/1935	0	11
Insurance Commissioner	Charles F. Armstrong <i>(Died Feb. 4, 1934)</i>	1/20/1931	2/4/1934	3	1
Insurance Commissioner	Matthew H. Taggart	4/18/1927	1/20/1931	3	9
Insurance Commissioner	Einar Barford	8/16/1926	4/18/1927	0	8
Insurance Commissioner	Samuel W. McCulloch	6/15/1923	8/16/1926	3	2
Insurance Commissioner	Thomas B. Donaldson	5/6/1919	6/15/1923	3	1
Insurance Commissioner	Charles A. Ambler	9/10/1917	5/6/1919	1	8
Insurance Commissioner	J. Denny O’Neil	6/23/1916	9/6/1917	1	3
Acting Insurance Commissioner	Samuel W. McCulloch	3/31/1916	6/23/1916	0	3
Insurance Commissioner	Charles Johnson	11/15/1911	3/30/1916	4	4
Insurance Commissioner	Samuel W. McCulloch	12/23/1909	11/15/1911	1	11
Insurance Commissioner	David Martin	7/1/1905	12/23/1909	4	5
Insurance Commissioner	Israel W. Durham	1/18/1899	6/30/1905	6	5
Insurance Commissioner	James H. Lambert	1/15/1895	1/18/1899	4	0
Insurance Commissioner	George B. Luper*	5/21/1891	1/15/1895	3	8
Insurance Commissioner	John Montgomery Forster	5/5/1873	5/21/1891	8	0

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**NAIC MEMBER TENURE LIST**

<b>STATE/MEMBER TITLE</b>	<b>MEMBER NAME</b>	<b>BEG. DATE</b>	<b>END DATE</b>	<b>YRS. SERVED</b>	<b>MOS. SERVED</b>
<b>PENNSYLVANIA—Continued</b>					
Auditor General	Harrison Allen	12/2/1872	5/5/1873	0	5
Auditor General	John F. Hartranft	5/24/1871	12/2/1872	1	7
<b>PUERTO RICO—Appointed, Indefinite</b>					
Commissioner of Insurance	Alexander S. Adams Vega	12/20/2021		incumbent	
Commissioner of Insurance	<i>Position Vacant</i>	11/25/2021	12/19/2021	0	1
Commissioner of Insurance	Mariano A. Mier Romeu	1/4/2021	11/24/2021	0	10
Commissioner of Insurance	Rafael Cestero-Lopategui	9/10/2020	1/4/2021	0	4
Acting Commissioner of Insurance	Rafael Cestero-Lopategui	1/23/2020	9/10/2020	0	8
Commissioner of Insurance	Javier Rivera Rios	1/17/2017	1/22/2020	3	0
Commissioner of Insurance	Ángela Weyne	1/2/2013	12/31/2016	3	11
Commissioner of Insurance	Ramón L. Cruz-Colón	1/4/2009	1/2/2013	4	0
Commissioner of Insurance	Dorelisse Juarbe Jiménez	1/7/2004	12/31/2008	4	11
Commissioner of Insurance	Fermín M. Contreras Gómez	3/15/2001	1/7/2004	2	10
Commissioner of Insurance	Juan Antonio Garcia	1/1/1993	3/15/2001	8	2
Commissioner of Insurance	Ralph J. Rexach Chandri	1/14/1992	12/31/1992	0	11
Commissioner of Insurance	Miguel A. Villafañe-Neriz	1/1/1989	1/14/1992	3	0
Commissioner of Insurance	Juan Antonio Garcia	1/4/1982	12/31/1988	6	11
Commissioner of Insurance	Rolando Cruz	1/13/1977	12/18/1981	4	11
Commissioner of Insurance	Manuel Juarbe	4/18/1975	12/31/1976	1	8
Commissioner of Insurance	Carlos R. Rios	7/2/1973	3/25/1975	1	8
Acting Commissioner of Insurance	Juan Antonio Garcia	12/31/1972	7/2/1973	0	6
Commissioner of Insurance	Pedro J. Fernández Badillo	4/17/1969	12/31/1972	3	8
Commissioner of Insurance	Julio R. Hernandez	11/1/1967	3/25/1969	1	5
Commissioner of Insurance	Jorge Soto Garcia	8/1/1964	9/30/1967	3	1
Commissioner of Insurance	Pablo J. Lopez Castro	8/1/1957	7/15/1964	7	0
Superintendent of Insurance	Mariano Nieves Hidalgo <i>(Died June 13, 1957)</i>	1/9/1953	6/13/1957	4	5
Superintendent of Insurance	Jorge Font Saldaña	6/1/1949	12/31/1952	2	7
Superintendent of Insurance	Lorenzo J. Noa	1/9/1943	4/6/1949	6	3
Superintendent of Insurance	Hector R. Ball	5/24/1933	12/31/1942	9	7
Superintendent of Insurance	Augusto R. Soltero	12/9/1930	5/23/1933	4	9
<b>RHODE ISLAND—Appointed, at the Discretion of the Director of Business Regulation</b>					
Superintendent of Insurance	Elizabeth ‘Beth’ Kelleher Dwyer	1/11/2016		incumbent	
Deputy Director/Insurance and Banking Superintendent	Joseph Torti III	12/16/2002	12/31/2015	13	0
Superintendent of Insurance	Alfonso E. ‘Al’ Mastrostefano	7/1/1994	12/16/2002	8	5
Superintendent of Insurance	Charles P. Kwolek, Jr.	11/19/1991	7/1/1994	3	8
Insurance Commissioner	Maurice C. Paradis	1/1/1991	11/19/1991	0	10
Insurance Commissioner	Robert J. Janes	10/30/1988	1/1/1991	2	2
Insurance Commissioner	Mark A. Pfeiffer	4/21/1986	10/30/1988	2	6
Insurance Commissioner	Clifton A. Moore	2/1/1985	4/21/1986	1	2
Insurance Commissioner	William F. Carroll	2/3/1984	2/1/1985	1	0
Insurance Commissioner	Thomas J. Caldarone, Jr.	1/16/1977	2/3/1984	6	1
Insurance Commissioner	Peter F. Mullaney	1/10/1969	1/16/1977	9	0
Insurance Commissioner	Ralph A. Petarca	6/30/1967	1/10/1969	2	6
Insurance Commissioner	Warren R. Campbell	1/1/1963	6/30/1967	4	6
Insurance Commissioner	Thomas J. Coyle	1/9/1961	1/1/1963	2	0
Insurance Commissioner	Hartley F. Roberts	1/20/1959	1/9/1961	2	0

\* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

**NAIC MEMBER TENURE LIST**

<b>STATE/MEMBER TITLE</b>	<b>MEMBER NAME</b>	<b>BEG. DATE</b>	<b>END DATE</b>	<b>YRS. SERVED</b>	<b>MOS. SERVED</b>
<b>RHODE ISLAND—Continued</b>					
Insurance Commissioner	George A. Bisson	2/11/1947	1/20/1959	11	11
Insurance Commissioner	J. Austin Carroll	7/1/1942	2/1/1947	4	7
Insurance Commissioner	Henri N. Morin	3/1/1939	7/1/1942	3	4
Chief, Division of Banking & Ins.	M. Joseph Cummings	3/4/1935	2/28/1939	4	0
Insurance Commissioner	Oscar L. Heltzen	12/29/1932	3/4/1935	2	2
Insurance Commissioner	Philip H. Wilbour	4/8/1929	12/9/1932	3	8
State Auditor/Ins. Commissioner	Philip H. Wilbour	2/1/1917	4/8/1929	12	2
State Auditor/Ins. Commissioner	Charles M. Arnold	12/23/1916	1/31/1917	0	1
State Auditor/Ins. Commissioner	Charles C. Gray <i>(Died Dec. 21, 1916)</i>	1/16/1899	12/21/1916	17	11
State Auditor/Ins. Commissioner	Albert C. Landers	5/27/1891	1/16/1899	7	7
State Auditor/Ins. Commissioner	Elisha W. Bucklin	5/28/1890	5/27/1891	1	0
State Auditor/Ins. Commissioner	William C. Townsend	5/30/1889	5/28/1890	1	0
State Auditor/Ins. Commissioner	Almon K. Goodwin	6/1/1888	5/30/1889	1	0
State Auditor/Ins. Commissioner	Elisha W. Bucklin	6/1/1887	6/1/1888	1	0
State Auditor/Ins. Commissioner	Samuel H. Cross	6/30/1882	6/1/1887	4	11
State Auditor/Ins. Commissioner	Joel M. Spencer	5/24/1871	6/30/1882	11	1
<b>SOUTH CAROLINA—Appointed, by the Governor upon the Advice and Consent of the Senate</b>					
Acting Director of Insurance	Michael Wise	4/16/2022		incumbent	
Director of Insurance	Raymond G. ‘Ray’ Farmer* <i>(Appointed Nov. 12, 2012; Confirmed Feb. 14, 2013; Reappointed Dec. 12, 2018)</i>	12/3/2012	4/15/2022	9	4
Acting Director of Insurance	Gwendolyn Fuller McGriff	12/29/2011	12/2/2012	1	0
Director of Insurance	David Black <i>(Appointed Jan. 20, 2011; Confirmed Feb. 3, 2011)</i>	2/1/2011	12/28/2011	0	10
Director of Insurance	Scott H. Richardson	2/15/2007	2/1/2011	4	0
Director of Insurance	Eleanor Kitzman	2/1/2005	2/15/2007	2	0
Co-Acting Director of Insurance	Gwendolyn Fuller & Tim Baker	8/1/2004	2/1/2005	0	6
Director of Insurance	Ernst N. ‘Ernie’ Csiszar*	1/26/1999	8/1/2004	5	7
Director of Insurance	Lee P. Jedziniak	7/1/1995	1/13/1999	3	6
Chief Insurance Commissioner	Susanne K. Murphy	3/1/1995	7/1/1995	0	4
Chief Insurance Commissioner	John G. Richards	3/7/1985	3/1/1995	10	0
Chief Insurance Commissioner	Rogers T. Smith	10/21/1981	3/7/1985	3	5
Acting Insurance Commissioner	Rogers T. Smith	9/3/1981	10/21/1981	0	1
Chief Insurance Commissioner	John W. ‘Jack’ Lindsay	7/1/1975	9/3/1981	6	2
Chief Insurance Commissioner	Howard B. Clark	1/14/1974	6/30/1975	1	5
Acting Insurance Commissioner	Glen E. Craig	12/1/1973	1/13/1974	0	1
Acting Insurance Commissioner	Lanville H. Mengedoht	1/1/1973	12/1/1973	0	11
Chief Insurance Commissioner	John W. ‘Jack’ Lindsay	3/2/1970	12/31/1972	2	9
Chief Insurance Commissioner	Leroy M. Brandt	7/1/1968	3/2/1970	1	8
Chief Insurance Commissioner	Charles W. Gambrell	2/17/1964	6/30/1968	4	4
Chief Insurance Commissioner	William F. Austin	7/1/1960	2/15/1964	3	7
Insurance Commissioner	R. Lee Kelly	8/5/1954	7/1/1960	5	11
Insurance Commissioner	D. D. ‘Pat’ Murphy*	9/15/1948	8/4/1954	5	11
Insurance Commissioner	L. George Benjamin, Jr.	11/1/1945	9/15/1948	2	10
Insurance Commissioner	D. D. ‘Pat’ Murphy*	8/16/1944	11/1/1945	1	3
Insurance Commissioner	William Egleston	9/4/1942	8/16/1944	1	11

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**NAIC MEMBER TENURE LIST**

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>SOUTH CAROLINA—Continued</b>					
Insurance Commissioner	L. George Benjamin, Jr.	4/1/1942	9/4/1942	0	5
Insurance Commissioner	Samuel B. ‘Sam’ King	4/2/1928	4/1/1942	14	0
Insurance Commissioner	John J. McMahan	4/7/1921	4/2/1928	7	0
Insurance Commissioner	William A. McSwain	3/1/1918	4/7/1921	3	1
Insurance Commissioner	Fitz Hugh McMaster	3/4/1908	3/1/1918	10	0
Comptroller-General of State	Adolphus W. Jones	1/21/1903	3/4/1908	5	2
Comptroller-General of State	John P. Derham	1/26/1898	1/21/1903	5	0
Comptroller-General of State	Layfayette P. Epton	11/2/1897	1/26/1898	0	2
Comptroller-General of State	James W. Norton	11/26/1894	11/2/1897	3	0
Comptroller-General of State	William H. Ellerbe	11/21/1890	11/26/1894	4	0
Comptroller-General of State	John S. Verner	12/22/1887	11/21/1890	2	11
Comptroller-General of State	William E. Stoney	11/23/1882	12/22/1887	5	1
Comptroller-General of State	John Bratton	12/22/1880	11/23/1882	1	11
Comptroller-General of State	John C. Coit	11/30/1880	12/20/1880	0	1
Comptroller-General of State	Johnson Hagood	11/23/1876	11/30/1880	4	0
Comptroller-General of State	Thomas C. Dunn	3/23/1875	11/23/1876	1	8
Comptroller-General of State	Solomon L. Hoge	12/7/1872	3/23/1875	2	3
Comptroller-General of State	John L. Neagle	10/18/1871	12/7/1872	1	2

<b>SOUTH DAKOTA—Appointed, at the Pleasure of the Secretary of the Department of Labor and Regulation</b>					
Director of Insurance	Larry D. Deiter	1/8/2015		incumbent	
Interim Director of Insurance	Larry D. Deiter	12/1/2014	1/8/2015	0	1
Director of Insurance	Merle D. Scheiber	8/8/2005	12/1/2014	9	4
Director of Insurance	Gary L. Steuck	5/12/2003	7/31/2005	2	2
Acting Director of Insurance	Wendell Malsam	1/1/2003	5/12/2003	0	4
Director of Insurance	Darla L. Lyon	1/6/1992	1/1/2003	11	0
Acting Director of Insurance	Darla L. Lyon	10/1/1991	1/6/1992	0	3
Director of Insurance	Mary Jane Cleary	7/6/1987	10/1/1991	4	3
Director of Insurance	Susan L. Walker	8/30/1983	7/6/1987	3	11
Director of Insurance	Henry J. Lussem, Jr.	3/1/1980	8/30/1983	3	9
Director of Insurance	Lowell L. Knutson	1/1/1976	3/1/1980	4	2
Acting Director of Insurance	Donald D. Graham	6/30/1975	1/1/1976	0	7
Commissioner of Insurance	Ralph A. Nauman	7/1/1971	6/30/1975	4	0
Commissioner of Insurance	Warren E. Dirks	1/1/1967	7/1/1971	4	6
Acting Commissioner of Insurance	Warren E. Dirks	12/1/1966	1/1/1967	0	1
Commissioner of Insurance	J. R. Menning	6/30/1963	12/1/1966	3	6
Acting Commissioner of Insurance	D. E. Mitchell	6/1/1963	6/30/1963	0	0
Commissioner of Insurance	Robert A. Hurlbut	6/1/1961	6/1/1963	2	0
Commissioner of Insurance	Randolph Bagby	11/15/1960	6/1/1961	0	7
Commissioner of Insurance	William J. ‘Bill’ Dawson <i>(Died Nov. 15, 1960)</i>	6/1/1959	11/15/1960	1	5
Commissioner of Insurance	D. E. Mitchell	5/1/1956	6/1/1959	3	1
Commissioner of Insurance	George O. Burt	6/1/1952	5/1/1956	4	6
Commissioner of Insurance	D. E. Mitchell	6/1/1951	6/1/1952	1	0
Commissioner of Insurance	George O. Burt	1/2/1950	6/1/1951	1	5
Commissioner of Insurance	Waldemar A. Mueller	7/18/1944	1/2/1950	5	6
Commissioner of Insurance	George K. Burt <i>(Died May 23, 1944)</i>	3/1/1940	5/23/1944	4	3
Commissioner of Insurance	P. J. Dunn	7/1/1937	3/1/1940	2	8

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**NAIC MEMBER TENURE LIST**

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>SOUTH DAKOTA—Continued</b>					
Commissioner of Insurance	William J. 'Bill' Dawson <i>(Died Nov. 15, 1960)</i>	7/1/1933	7/1/1937	4	0
Commissioner of Insurance	Clyde R. Horswill	7/1/1931	7/1/1933	2	0
Commissioner of Insurance	Donald C. 'Don' Lewis	7/1/1927	7/1/1931	4	0
Commissioner of Insurance	G. H. Helgerson	7/1/1925	7/1/1927	2	0
Commissioner of Insurance	William N. Van Camp	3/1/1917	7/1/1925	8	4
Commissioner of Insurance	M. Harry O'Brien	10/1/1915	3/1/1917	1	5
Commissioner of Insurance	Otto K. Stablein	9/1/1913	10/1/1915	2	1
Commissioner of Insurance	Orville S. Basford	9/1/1907	9/1/1913	6	0
Commissioner of Insurance	Len U. Doty	10/1/1906	9/1/1907	0	11
Commissioner of Insurance	John C. Perkins	9/1/1903	10/1/1906	3	1
Commissioner of Insurance	Howard C. Shober	9/1/1901	9/1/1903	2	0
Commissioner of Insurance	F. G. King	9/1/1899	9/1/1901	2	0
Commissioner of Insurance	L. C. Campbell	9/30/1898	9/1/1899	1	0
Commissioner of Insurance	Thomas H. Ayers	9/1/1898	9/30/1898	0	1
Commissioner of Insurance	J. H. Kipp	9/1/1897	9/1/1898	1	0
Commissioner of Insurance	H. E. Mayhew	1/1/1897	9/1/1897	0	8
Auditor of State	J. E. Hipple	1/1/1893	1/1/1897	4	0
Auditor of State	L. C. Taylor	11/2/1889	1/1/1893	3	2
Territorial Auditor	John C. McManima	9/4/1889	11/2/1889	0	2

<b>TENNESSEE—Appointed, at the Discretion of the Governor</b>					
Cmsr. of Commerce and Insurance	Carter Lawrence	11/12/2020		incumbent	
Cmsr. of Commerce and Insurance	Hodgen Mainda	10/1/2019	11/12/2020	1	1
Interim Cmsr. of Commerce & Ins.	Carter Lawrence	6/15/2019	9/30/2019	0	3
Cmsr. of Commerce and Insurance	Julie Mix McPeak*	1/12/2011	6/14/2019	8	5
Cmsr. of Commerce and Insurance	Leslie A. Newman	1/1/2007	1/12/2011	4	0
Cmsr. of Commerce and Insurance	Paula A. Flowers	1/18/2003	1/1/2007	4	0
Cmsr. of Commerce and Insurance	Anne B. Pope	11/1/1999	1/1/2003	3	2
Cmsr. of Commerce and Insurance	Douglas M. 'Doug' Sizemore	1/21/1995	10/31/1999	4	10
Cmsr. of Commerce and Insurance	Allan S. Curtis	4/1/1994	1/21/1995	0	9
Cmsr. of Commerce and Insurance	Elaine A. McReynolds	1/17/1987	4/1/1994	7	3
Cmsr. of Commerce and Insurance	William H. Inman	4/1/1986	1/17/1987	0	9
Commissioner of Insurance	John C. Neff	1/20/1979	4/1/1986	7	3
Commissioner of Insurance	Millard V. Oakley	1/18/1975	1/20/1979	4	0
Commissioner of Insurance	Richard F. Keathley	1/1/1974	1/18/1975	1	0
Cmsr. of Insurance and Banking	Halbert L. Carter, Jr.	1/25/1971	12/31/1973	2	11
Cmsr. of Insurance and Banking	Milton P. Rice	9/5/1969	1/25/1971	1	4
Cmsr. of Insurance and Banking	David M. Pack	1/16/1967	9/2/1969	1	8
Cmsr. of Insurance and Banking	Albert Williams	1/15/1963	1/16/1967	4	0
Cmsr. of Insurance and Banking	John R. Long, Jr.	1/19/1959	1/15/1963	4	0
Cmsr. of Insurance and Banking	Leon Gilbert	1/1/1959	1/19/1959	0	1
Cmsr. of Insurance and Banking	Arch E. Northington*	1/15/1953	12/23/1958	5	11
Cmsr. of Insurance and Banking	Robert L. Taylor	12/8/1952	1/15/1953	0	1
Cmsr. of Insurance and Banking	Malcolm O. Allen <i>(Died Nov. 27, 1952)</i>	1/17/1949	11/27/1952	3	10
Cmsr. of Insurance and Banking	James M. McCormack*	1/16/1939	1/17/1949	10	0
Cmsr. of Insurance and Banking	John W. Britton	1/10/1938	1/16/1939	1	0
Cmsr. of Insurance and Banking	James M. McCormack*	1/15/1937	1/10/1938	1	0
Cmsr. of Insurance and Banking	Joseph S. Tobin	1/17/1933	1/15/1937	4	0

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**NAIC MEMBER TENURE LIST**

<b>STATE/MEMBER TITLE</b>	<b>MEMBER NAME</b>	<b>BEG. DATE</b>	<b>END DATE</b>	<b>YRS. SERVED</b>	<b>MOS. SERVED</b>
<b>TENNESSEE—Continued</b>					
Cmsr. of Insurance and Banking	Joseph I. Reece	7/14/1931	1/17/1933	1	6
Cmsr. of Insurance and Banking	Albert S. Caldwell*	2/1/1923	7/14/1931	8	5
Insurance Commissioner	Earl N. Rogers	7/1/1921	2/1/1923	1	8
Insurance Commissioner	Robert L. Carden	1/17/1921	6/30/1921	0	5
Acting Insurance Commissioner	Thomas E. Miles	12/1/1920	1/17/1921	0	1
Insurance Commissioner	Leslie K. Arrington	7/7/1917	12/1/1920	3	5
Insurance Commissioner	William F. Dunbar	6/1/1915	7/1/1917	2	1
Insurance Commissioner	J. Will Taylor	3/1/1913	6/1/1915	2	3
State Treasurer/Ins. Commissioner	G. Thomas ‘Tom’ Taylor	2/20/1911	3/1/1913	2	1
State Treasurer/Ins. Commissioner	Reau E. Folk*	2/16/1901	2/20/1911	10	0
State Treasurer/Ins. Commissioner	Edward B. Craig	1/26/1893	2/16/1901	8	1
State Treasurer/Ins. Commissioner	Mansfield F. ‘Manse’ House	2/11/1889	1/26/1893	3	11
State Treasurer/Ins. Commissioner	Atha Thomas	10/26/1886	2/11/1889	2	4
State Treasurer/Ins. Commissioner	James W. Thomas (Died Oct. 25, 1886)	2/3/1885	10/25/1886	1	8
State Treasurer/Ins. Commissioner	Atha Thomas	1/17/1883	2/3/1885	2	1
State Treasurer/Ins. Commissioner	Marshall T. Polk	2/8/1877	1/17/1883	5	11
State Treasurer/Ins. Commissioner	William L. Morrow	5/24/1871	2/8/1877	5	9

<b>TEXAS—Appointed; 2-Year Term</b>					
Insurance Commissioner	Cassie Brown	9/8/2021		incumbent	
Chief Deputy Commissioner	J. Douglas ‘Doug’ Slape	10/1/2020	9/8/2021	0	11
Insurance Commissioner	Kent Sullivan	9/21/2017	9/30/2020	3	0
Insurance Commissioner	<i>Position Vacant</i>	4/13/2017	9/21/2017	0	5
Insurance Commissioner	David C. Mattax (Died April 13, 2017)	1/13/2015	4/13/2017	2	3
Insurance Commissioner	Julia Rathgeber	5/27/2013	1/13/2015	1	8
Insurance Commissioner	Eleanor Kitzman	8/15/2011	5/27/2013	1	9
Insurance Commissioner	Michael ‘Mike’ Geeslin	6/7/2005	8/15/2011	6	2
Insurance Commissioner	José Montemayor	2/1/1999	6/7/2005	6	4
Interim Insurance Commissioner	José Montemayor	1/11/1999	2/1/1999	0	1
Insurance Commissioner	Elton L. Bomer	2/2/1995	1/10/1999	3	11
Interim Insurance Commissioner	Rebecca Lightsey	12/11/1994	1/27/1995	0	1
Insurance Commissioner	J. Robert ‘Bob’ Hunter	11/3/1993	12/11/1994	1	1
Interim Commissioner of Insurance	Edna Ramon Butts	9/1/1993	11/1/1993	0	2
Insurance Commissioner	Georgia D. Flint	3/1/1992	8/31/1993	1	6
Acting Insurance Commissioner	Georgia D. Flint	11/4/1992	3/1/1992	0	4
Insurance Commissioner	Philip W. ‘Phil’ Barnes	1/8/1991	11/4/1991	0	10
Insurance Commissioner	A. W. ‘Woody’ Pogue	12/19/1988	11/1/1990	1	11
Acting Insurance Commissioner	A. W. ‘Woody’ Pogue	11/4/1988	12/19/1988	0	1
Insurance Commissioner	Doyce R. Lee	8/6/1985	11/4/1988	3	4
Insurance Commissioner	Tom Bond	9/24/1982	8/6/1985	2	11
Insurance Commissioner	E. J. Voorhis, Jr.	6/29/1977	9/24/1982	5	3
Insurance Commissioner	Joseph D. ‘Joe’ Hawkins	8/1/1975	6/29/1977	1	11
Acting Insurance Commissioner	Thomas I. ‘Tom’ McFarling	5/13/1975	8/1/1975	0	2
Insurance Commissioner	Don B. Odum	1/1/1974	5/13/1975	1	4
Insurance Commissioner	Clay Cotten	11/15/1965	1/1/1974	8	2
Insurance Commissioner	J. N. Nutt	9/1/1963	11/1/1965	2	2
Insurance Commissioner	William A. Harrison	8/5/1957	9/1/1963	6	1
Acting Insurance Commissioner	William A. Harrison	6/21/1957	8/5/1957	0	2

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## NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>TEXAS—Continued</b>					
Commissioner of Life Insurance/Chairman of Board	John Osorio	1/1/1957	6/1/1957	0	5
Commissioner of Life Insurance/Chairman of Board	J. Byron Saunders	1/30/1956	1/1/1957	0	11
Commissioner of Life Insurance/Chairman of the Board	Garland A. 'Chink' Smith	10/6/1953	1/30/1956	2	4
Commissioner of Life Insurance/Chairman of the Board	George B. Butler (Died Sept. 28, 1953)	2/11/1945	9/28/1953	8	8
Commissioner of Life Insurance/Chairman of the Board	Omicron P. Lockhart	5/12/1941	2/1/1945	3	9
Commissioner of Life Insurance/Chairman of Board	Reuben Williams	1/2/1941	5/12/1941	0	4
Commissioner of Life Insurance/Chairman of the Board	Walter C. Woodward (Died Dec. 17, 1940)	3/6/1939	12/17/1940	1	9
Commissioner of Life Insurance/Chairman of the Board	R. L. Daniel	2/10/1933	3/1/1939	6	1
Commissioner of Life Insurance/Chairman of the Board	William A. Tarver	5/2/1929	2/10/1933	3	9
Commissioner of Life Insurance/Chairman of the Board	Robert B. Cousins, Jr.	9/1/1927	5/1/1929	1	8
Commissioner of Insurance	R. L. Daniel	10/1/1925	9/1/1927	1	11
Commissioner of Insurance	John M. Scott	8/21/1923	10/1/1925	2	1
Cmsr. of Insurance and Banking	James L. Chapman	9/1/1922	8/21/1923	1	0
Cmsr. of Insurance and Banking	Edward 'Ed' Hall	1/20/1921	9/1/1922	1	8
Cmsr. of Insurance and Banking	J. T. McMillan	8/1/1920	1/20/1921	0	5
Cmsr. of Insurance and Banking	John C. Chidsey	4/1/1920	8/1/1920	0	4
Cmsr. of Insurance and Banking	George Waverly Briggs	2/1/1919	4/1/1920	1	2
Cmsr. of Insurance and Banking	Charles O. Austin	8/31/1916	1/31/1919	2	5
Cmsr. of Insurance and Banking	John S. Patterson (Died Aug. 29, 1916)	1/20/1915	8/29/1916	1	7
Cmsr. of Insurance and Banking	William W. Collier	7/22/1913	1/20/1915	1	6
Cmsr. of Insurance and Banking	Bennett L. 'Ben' Gill	1/17/1911	7/10/1913	2	6
Cmsr. of Insurance and Banking	Frederick C. von Rosenberg	8/4/1910	1/6/1911	0	5
Cmsr. of Insurance and Banking	William E. Hawkins	2/1/1910	8/3/1910	0	6
Cmsr. of Insurance and Banking	Thomas B. Love	9/1/1907	1/31/1910	2	5
Commissioner of Agriculture, Insurance, Statistics and History	Robert T. Milner	8/1/1906	8/31/1907	1	1
Commissioner of Agriculture, Insurance, Statistics and History	William J. Clay	8/1/1901	8/1/1906	5	0
Commissioner of Agriculture, Insurance, Statistics and History	Jefferson Johnson	8/1/1897	8/1/1901	4	0
Commissioner of Agriculture, Insurance, Statistics and History	Archibald J. Rose	1/10/1895	8/1/1897	2	7
Commissioner of Agriculture, Insurance, Statistics and History	John E. Hollingsworth	5/15/1891	1/10/1895	3	8
Commissioner of Agriculture, Insurance, Statistics and History	Lafayette L. Foster	1/21/1887	5/5/1891	4	4
Commissioner of Agriculture, Insurance, Statistics and History	Hamilton P. Bee	12/30/1884	1/21/1887	2	1
Commissioner of Agriculture, Insurance, Statistics and History	Henry P. Brewster (Died Dec. 26, 1884)	1/31/1883	12/26/1884	1	11

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**NAIC MEMBER TENURE LIST**

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>TEXAS—Continued</b>					
Commissioner of Agriculture, Insurance, Statistics and History	Ashley W. Spaight	1/26/1881	1/31/1883	2	0
Commissioner of Agriculture, Insurance, Statistics and History	Valentine O. King	9/17/1879	1/26/1881	1	4

<b>UTAH—Appointed, at the Pleasure of the Governor; Confirmed by the Senate</b>					
Commissioner of Insurance	Jonathan T. 'Jon' Pike	2/4/2021		incumbent	
Acting Commissioner of Insurance	Jonathan T. 'Jon' Pike	1/5/2021	2/4/2021	0	1
Interim Commissioner of Insurance	Tanji J. Northrup	10/1/2020	1/5/2021	0	3
Commissioner of Insurance	Todd E. Kiser	12/20/2012	9/30/2020	7	9
Commissioner of Insurance	Neal T. Gooch	5/24/2010	12/20/2012	2	7
Acting Commissioner of Insurance	Neal T. Gooch	1/19/2010	5/24/2010	0	4
Commissioner of Insurance	D. Kent Michie	1/5/2005	1/19/2010	5	0
Commissioner of Insurance	Merwin U. Stewart	2/7/1997	12/31/2004	7	11
Commissioner of Insurance	Robert E. Wilcox	1/27/1993	2/7/1997	4	1
Commissioner of Insurance	Harold C. Yancey	7/1/1985	1/27/1993	7	7
Commissioner of Insurance	Roger C. Day* (Died July 18, 2019)	6/1/1977	7/1/1985	8	1
Commissioner of Insurance	Clifton N. Ottosen	2/1/1965	6/1/1977	12	4
Commissioner of Insurance	E. Virgil Norton	1/1/1961	1/30/1965	3	8
Commissioner of Insurance	Carl A. Hulbert	6/1/1958	12/31/1960	2	7
Commissioner of Insurance	Albert E. 'Buck' Buckwell	3/15/1957	6/1/1958	1	3
Commissioner of Insurance	Walter M. Jones	9/11/1953	3/15/1957	3	6
Commissioner of Insurance	Lewis M. Terry	5/1/1949	9/11/1953	4	4
Acting Commissioner of Insurance	H. J. Timmerman	3/16/1949	5/1/1949	0	2
Commissioner of Insurance	Oscar W. Carlson	9/12/1941	3/16/1949	7	6
Acting Commissioner of Insurance	Clifton N. Ottosen	3/15/1941	9/12/1941	0	6
Commissioner of Insurance	C. Clarence Nelson*	4/1/1937	3/15/1941	4	0
Commissioner of Insurance	Elias A. Smith, Jr.	4/1/1933	4/1/1937	4	0
Commissioner of Insurance	John G. McQuarrie	3/13/1925	4/1/1933	8	1
Commissioner of Insurance	John W. Walker	4/1/1921	3/13/1925	3	11
Commissioner of Insurance	Rulon S. Wells	3/15/1917	4/1/1921	4	1
Commissioner of Insurance	John James	7/10/1914	3/15/1917	2	8
Commissioner of Insurance	Willard Done	10/10/1910	7/10/1914	3	9
Commissioner of Insurance	George B. Squires (Died Sept. 30, 1910)	4/8/1909	9/30/1910	1	6
Secretary of State	Charles S. Tingey	1/2/1905	4/3/1909	4	3
Secretary of State	James T. Hammond	1/6/1896	1/2/1905	9	0
Secretary of Territory	Elijah Sells	5/16/1889	5/6/1893	4	0
Secretary of Territory	William C. Hall	4/6/1887	5/16/1889	2	1
Secretary of Territory	Arthur L. Thomas	9/1/1884	4/6/1887	2	7

<b>VERMONT—Appointed, Biennially by the Governor with the Advice and Consent of the Senate</b>					
Commissioner, Department of Financial Regulation (DFR)	Kevin Gaffney	7/8/2022		incumbent	
Interim Commissioner, DFR	Kevin Gaffney	5/17/2022	7/8/2022	0	2
Commissioner, DFR	Michael S. 'Mike' Pieciak (Reappointed Dec. 22, 2016; Reappointed March 1, 2019)	7/5/2016	5/16/2022	5	10
Commissioner, DFR	Susan L. Donegan	1/10/2013	6/30/2016	3	5
Commissioner, DFR	Stephen W. 'Steve' Kimbell	4/4/2012	1/9/2013	0	9

\* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

**NAIC MEMBER TENURE LIST**

<b>STATE/MEMBER TITLE</b>	<b>MEMBER NAME</b>	<b>BEG. DATE</b>	<b>END DATE</b>	<b>YRS. SERVED</b>	<b>MOS. SERVED</b>
<b>VERMONT—Continued</b>					
Commissioner, Department of Banking, Insurance, Securities, & Health Care Administration (BISHCA)	Stephen W. ‘Steve’ Kimbell	1/7/2011	4/3/2012	1	3
Commissioner, BISHCA	Michael F. ‘Mike’ Bertrand	6/18/2010	1/6/2011	0	7
Commissioner, BISHCA	Paulette J. Thabault	1/22/2007	6/18/2010	3	5
Commissioner, BISHCA	John P. Crowley	1/9/2003	1/5/2007	4	0
Commissioner, BISHCA	Elizabeth R. ‘Betsy’ Costle	8/17/1992	1/9/2003	10	5
Commissioner of Banking and Insurance	Jeffery P. Johnson	1/13/1990	8/14/1992	2	7
Commissioner of Banking and Insurance	Gretchen Babcock	7/10/1987	1/13/1990	2	6
Commissioner of Banking and Insurance	Thomas P. Menson	3/30/1986	7/1/1987	1	3
Commissioner of Banking and Insurance	David T. Bard	1/23/1985	3/7/1986	1	2
Commissioner of Banking and Insurance	George A. Chaffee	3/24/1980	11/16/1984	4	8
Commissioner of Banking and Insurance	Stewart M. Ledbetter	2/16/1977	2/22/1980	3	0
Acting Cmsr. of Banking and Insurance	Jean B. Baldwin	6/23/1976	2/16/1977	0	8
Commissioner of Banking and Insurance	James A. Guest	7/16/1973	6/23/1976	2	11
Acting Cmsr. of Banking and Insurance	Eugene R. Lemke	1/3/1973	7/16/1973	0	6
Commissioner of Banking and Insurance	Charles F. Black	1/9/1969	1/3/1973	4	0
Commissioner of Banking and Insurance	James H. Hunt	7/20/1965	1/8/1969	3	6
Commissioner of Banking and Insurance	Robert E. Cummings, Jr.	6/7/1963	7/19/1965	2	1
Commissioner of Banking and Insurance	Albert D. Pingree	3/1/1961	6/7/1963	2	3
Commissioner of Banking and Insurance	Alexander H. Miller	3/1/1951	2/28/1961	10	0
Acting Cmsr. of Banking and Insurance	Albert D. Pingree	11/15/1950	3/1/1951	0	4
Commissioner of Banking and Insurance	Donald A. Hemenway	12/1/1947	11/15/1950	2	11
Commissioner of Banking and Insurance	Charles E. Burns	7/1/1943	12/1/1947	4	5
Acting Cmsr. of Banking and Insurance	Albert D. Pingree	4/29/1943	7/1/1943	0	2
Commissioner of Banking and Insurance	Reginald T. Cole	2/1/1941	4/29/1943	2	3
Commissioner of Banking and Insurance	Donald A. Hemenway	2/1/1937	2/1/1941	4	0
Commissioner of Banking and Insurance	George B. Carpenter	8/12/1935	2/1/1937	1	6
Commissioner of Banking and Insurance	L. Douglas Meredith	8/1/1934	8/12/1935	1	0
Commissioner of Banking and Insurance	George H.V. Allen	5/1/1934	8/1/1934	0	3
Commissioner of Banking and Insurance	Robert C. Clark	4/15/1923	5/1/1934	11	1
Insurance Commissioner	Laurence A. Kelty	10/1/1922	4/15/1923	0	6
Insurance Commissioner	Joseph G. Brown*	4/11/1917	10/1/1922	5	6
Secretary of State State Treasurer	Guy W. Bailey Walter F. Scott	10/1/1915	4/11/1917	1	6
Secretary of State State Treasurer	Guy W. Bailey Edward H. Deavitt	10/1/1908	10/1/1915	7	0
Secretary of State State Treasurer	F. L. Fleetwood Edward H. Deavitt	10/1/1902	10/1/1908	6	0
Secretary of State State Treasurer	Fred A. Howland John L. Bacon*	10/1/1898	10/1/1902	4	0
Secretary of State State Treasurer	Chauncey W. Browell, Jr. Henry F. Field	10/1/1890	10/1/1898	8	0
Secretary of State State Treasurer	Charles W. Porter William H. Dubois	10/1/1884	10/1/1890	6	0
Secretary of State State Treasurer	George Nichols William H. Dubois	10/1/1882	10/1/1884	2	0
Secretary of State State Treasurer	George Nichols John B. Page	9/17/1873	10/1/1882	9	1

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## NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>U.S. VIRGIN ISLANDS—Elected; 4-Year Term</b>					
Lt. Governor/Ins. Commissioner	Tregenza A. Roach (Elected Nov. 20, 2018; Re-elected Nov. 8, 2022)	1/7/2019		incumbent	
Lt. Governor/Ins. Commissioner	Osbert E. Potter	1/5/2015	1/7/2019	3	11
Lt. Governor/Ins. Commissioner	Gregory R. Francis	1/1/2007	1/5/2015	8	0
Lt. Governor/Ins. Commissioner	Vargrave A. Richards	1/6/2003	1/1/2007	4	0
Lt. Governor/Ins. Commissioner	Gerard Luz James II	1/4/1999	1/6/2003	4	0
Lt. Governor/Ins. Commissioner	Kenneth E. Mapp	5/1/1998	1/4/1999	0	8
Director, Banking & Insurance	Gwendolyn 'Gwen' Hall Brady	5/1/1996	5/1/1998	2	0
Acting Director, Banking & Ins.	Gwendolyn 'Gwen' Hall Brady	3/4/1996	5/1/1996	0	2
Director, Banking & Insurance	Margery O. Resnick	6/1/1995	3/4/1996	0	9
Lt. Governor/Ins. Commissioner	Kenneth E. Mapp	2/12/1995	6/1/1995	0	4
Director, Banking & Insurance	Larry Diehl	1/2/1995	2/12/1995	1	1
Lt. Governor/Ins. Commissioner	Derek M. Hodge	1/5/1987	1/2/1995	8	0
Lt. Governor/Ins. Commissioner	Julio A. Brady	1/3/1983	1/5/1987	4	0
Lt. Governor/Ins. Commissioner	Henry A. Millan	4/10/1978	1/3/1983	4	9
Lt. Governor/Ins. Commissioner	Position Vacant	1/3/1978	4/9/1978	0	3
Lt. Governor/Ins. Commissioner	Juan Francisco Luis	1/6/1975	1/2/1978	3	0
Lt. Governor/Ins. Commissioner	Athniel C. Ottley	4/5/1973	1/6/1975	1	9
Lt. Governor/Ins. Commissioner	Position Vacant	2/21/1973	4/4/1957	0	2
Lt. Governor/Ins. Commissioner	David E. Maas	10/1/1969	2/20/1973	2	8
Govt. Secretary/Ins. Commissioner	Cyril E. King	5/1/1961	9/30/1969	8	4
Govt. Secretary/Ins. Commissioner	Roy W. Bornn	9/25/1958	5/1/1961	2	8
Govt. Secretary/Ins. Commissioner	John D. Merwin	12/23/1957	9/25/1958	0	9
Govt. Secretary/Ins. Commissioner	Position Vacant	5/31/1957	12/23/1957	0	7
Govt. Secretary/Ins. Commissioner	Charles K. Claunch	4/9/1954	5/31/1957	3	1
Government Secretary	Daniel W. Ambrose	8/1/1952	4/9/1954	1	7
<b>VIRGINIA—Appointed, at the Pleasure of the State Corporation Commission</b>					
Commissioner of Insurance	Scott A. White	1/1/2018		incumbent	
Commissioner of Insurance	Jacqueline K. Cunningham	1/1/2011	12/31/2017	6	11
Commissioner of Insurance	Alfred W. 'Al' Gross	8/1/1996	1/1/2011	14	5
Acting Commissioner of Insurance	Alfred W. 'Al' Gross	5/1/1996	8/1/1996	0	3
Commissioner of Insurance	Steven T. Foster*	2/9/1987	4/30/1996	9	2
Commissioner of Insurance	James M. Thomson	12/1/1981	2/1/1987	5	2
Commissioner of Insurance	James W. Newman, Jr.	3/1/1979	12/1/1981	2	9
Acting Commissioner of Insurance	James W. Newman, Jr.	12/1/1978	3/1/1979	0	3
Commissioner of Insurance	John G. Day	6/1/1975	12/1/1978	2	6
Commissioner of Insurance	Everette S. Francis	7/1/1969	6/1/1975	5	11
Commissioner of Insurance	T. Nelson Parker*	6/1/1956	7/1/1969	13	1
Commissioner of Insurance	George A. Bowles* (Died June 1, 1956)	4/14/1932	6/1/1956	24	2
Cmsr. of Insurance and Banking	Myron E. Bristow	1/15/1930	4/14/1932	2	3
Cmsr. of Insurance and Banking	T. McCall Frazier	11/6/1929	1/17/1930	0	3
Cmsr. of Insurance and Banking	Joseph L. Button*	3/1/1928	10/15/1929	1	7
Commissioner of Insurance	Joseph L. Button*	7/1/1906	3/1/1928	21	8
Auditor of Public Accounts	Morton Marye	9/4/1889	7/1/1906	16	10
Auditor of Public Accounts	Research Proceedings	1884	1889	5	
Auditor of Public Accounts	S. B. Allen	11/7/1882	1884	2	
Auditor of Public Accounts	John E. Massey	1879	11/7/1882	3	

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**NAIC MEMBER TENURE LIST**

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>VIRGINIA—Continued</b>					
Auditor of Public Accounts	<i>Research Proceedings</i>	4/1/1872	1879	7	
Special Delegate for Auditor	Edward M. Alfriend	10/18/1871	4/1/1872	0	6
<b>WASHINGTON—Elected; 4-Year Term</b>					
Insurance Commissioner	Mike Kreidler <i>(Elected Nov. 7, 2000; Re-elected Nov. 2, 2004; Re-elected Nov. 4, 2008; Re-elected Nov. 6, 2012; Re-elected Nov. 8, 2016; Re-Elected Nov. 3, 2020)</i>	1/10/2001		incumbent	
Insurance Commissioner	Deborah M. Senn	1/13/1993	1/10/2001	8	0
Insurance Commissioner	Richard G. ‘Dick’ Marquardt	1/12/1977	1/13/1993	16	0
Insurance Commissioner	Karl V. Herrmann	1/15/1969	1/12/1977	8	0
Insurance Commissioner	Lee I. Kueckelhan*	1/1/1961	1/15/1969	8	0
Insurance Commissioner	William A. Sullivan*	1/11/1933	1/1/1961	28	0
Insurance Commissioner	Herbert O. Fishback*	1/13/1913	1/11/1933	20	0
Insurance Commissioner	John H. Schively	1/1/1909	1/13/1913	4	0
Secretary of State	Sam H. Nichols	1/1/1901	1/1/1909	8	0
Secretary of State	Will D. Jenkins	1/1/1897	1/1/1901	4	0
Secretary of State	James H. Price	1/1/1893	1/1/1897	4	0
Secretary of State	Allen Weir	6/26/1890	1/1/1893	2	7
<b>WEST VIRGINIA—Appointed, at the Pleasure of the Governor</b>					
Insurance Commissioner	Allan L. McVey	9/22/2021		incumbent	
Insurance Commissioner	James A. Dodrill	3/4/2019	9/20/2021	2	6
Acting Insurance Commissioner	Erin K. Hunter	1/25/2019	3/1/2019	0	2
Insurance Commissioner	Allan L. McVey	4/1/2017	1/23/2019	1	10
Acting Insurance Commissioner	Andrew R. Pauley	2/1/2017	3/31/2017	0	2
Insurance Commissioner	Michael D. Riley	1/9/2012	1/31/2017	5	0
Acting Insurance Commissioner	Michael D. Riley	7/1/2011	1/8/2012	0	6
Insurance Commissioner	Jane L. Cline*	1/15/2001	6/30/2011	10	5
Insurance Commissioner	Hanley C. Clark	1/18/1989	1/15/2001	12	0
Acting Insurance Commissioner	Hanley C. Clark	7/1/1988	1/17/1989	0	6
Insurance Commissioner	Fred E. Wright	2/21/1985	6/30/1988	3	4
Insurance Commissioner	Richard G. Shaw	1/17/1977	1/11/1985	8	0
Insurance Commissioner	Donald W. Brown	1/16/1975	1/14/1977	2	0
Insurance Commissioner	Samuel H. Weese	1/31/1969	1/16/1975	6	0
Insurance Commissioner	Robert J. Shipman	10/1/1968	1/30/1969	1	4
Insurance Commissioner	Frank R. Montgomery	1/16/1966	9/30/1968	2	8
Insurance Commissioner	Harlan Justice	9/4/1962	1/15/1966	3	4
Insurance Commissioner	Virginia Mae Brown	5/17/1961	9/3/1962	1	4
Insurance Commissioner	Hugh N. Mills	1/16/1961	5/16/1961	0	4
Insurance Commissioner	C. Judson Pearson	2/7/1958	1/15/1961	2	11
Insurance Commissioner	Harold E. Neeley	7/1/1957	2/5/1958	0	7
Insurance Commissioner	Louis Miller, Jr.	10/1/1956	6/30/1957	0	9
Insurance Commissioner	Thomas J. Gillooly	7/1/1953	9/30/1956	3	3
Insurance Commissioner	Hugh N. Mills	7/1/1952	6/30/1953	1	0
Insurance Commissioner	Robert A. Crichton	5/1/1949	6/30/1952	3	2
Insurance Commissioner	David S. Butler	7/1/1947	4/30/1949	1	10

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**NAIC MEMBER TENURE LIST**

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>WEST VIRGINIA—Continued</b>					
State Auditor	Edgar B. Sims	3/4/1933	7/1/1947	14	4
State Auditor	Edgar C. Lawson	3/4/1929	3/4/1933	4	0
State Auditor	Samuel T. ‘Sam’ Mallison	3/18/1927	3/4/1929	2	0
State Auditor	John C. Bond	3/4/1921	3/15/1927	6	0
State Auditor	John S. Darst*	3/4/1909	3/4/1921	12	0
State Auditor	Arnold C. Sherr	3/4/1901	3/4/1909	8	0
State Auditor	Latelle M. LaFollette	3/4/1897	3/4/1901	4	0
State Auditor	Isaac V. Johnson	3/4/1893	3/4/1897	4	0
State Auditor	Patrick F. Duffy	9/30/1891	3/4/1893	8	0
<b>WISCONSIN—Appointed, at the Pleasure of the Governor</b>					
Insurance Commissioner	Nathan Houdek	1/2/2022		incumbent	
Interim Commissioner	Nathan Houdek	12/18/2021	1/2/2022	0	1
Insurance Commissioner	Mark V. Afable	1/22/2019	12/17/2021	2	11
Insurance Commissioner	Theodore K. ‘Ted’ Nickel*	1/3/2011	1/7/2019	8	0
Insurance Commissioner	Sean Dilweg	1/1/2007	1/3/2011	4	0
Insurance Commissioner	Jorge Gomez	2/17/2003	12/18/2006	3	10
Acting Insurance Commissioner	Randy Blumer	1/7/2003	2/16/2003	0	1
Insurance Commissioner	Connie L. O’Connell	1/4/1999	1/6/2003	4	0
Acting Insurance Commissioner	Randy Blumer	1/6/1998	1/2/1999	1	0
Insurance Commissioner	Josephine W. ‘Jo’ Musser*	3/8/1993	1/2/1998	4	10
Insurance Commissioner	<i>Position Vacant</i>	1/1/1993	3/7/1993	0	2
Insurance Commissioner	Robert D. Haase	4/28/1987	12/31/1992	5	8
Insurance Commissioner	Thomas P. Fox	3/1/1983	4/27/1987	4	2
Insurance Commissioner	Ann J. Haney	8/1/1982	2/28/1983	0	7
Insurance Commissioner	Susan M. Mitchell	3/19/1979	7/31/1982	3	4
Insurance Commissioner	Harold R. Wilde, Jr.	4/8/1975	3/18/1979	3	11
Insurance Commissioner	Stanley C. DuRose, Jr.	10/1/1969	4/8/1975	5	6
Insurance Commissioner	Robert D. Haase	9/15/1965	9/7/1969	4	0
Insurance Commissioner	Charles L. Manson	7/2/1959	9/15/1965	6	2
Insurance Commissioner	Paul J. Rogan	11/1/1955	7/2/1959	3	8
Insurance Commissioner	Alfred Van DeZande	7/15/1955	11/1/1955	0	4
Insurance Commissioner	John R. Lange	12/1/1948	6/15/1955	6	6
Insurance Commissioner	John L. Sonderegger	10/1/1948	12/1/1948	0	2
Insurance Commissioner	Morvin Duel	10/1/1939	8/8/1948	8	10
Insurance Commissioner	Harry J. Mortensen	7/1/1931	10/1/1939	8	2
Insurance Commissioner	Milton A. Freedy	1/10/1927	7/1/1931	4	5
Insurance Commissioner	Olaf H. Johnson	6/2/1926	1/10/1927	0	7
Insurance Commissioner	W. Stanley Smith	7/17/1923	6/2/1926	2	11
Insurance Commissioner	Platt Whitman*	4/10/1919	7/17/1923	4	3
Insurance Commissioner	Michael J. ‘Mike’ Cleary*	7/1/1915	4/10/1919	3	9
Insurance Commissioner	Herman L. Ekern	1/2/1911	7/1/1915	4	6
Insurance Commissioner	George E. Beedle	1/7/1907	1/2/1911	4	0
Insurance Commissioner	Zeno M. Host	1/5/1903	1/1/1907	4	0
Insurance Commissioner	Emil Giljohann	10/15/1898	1/5/1903	4	3
Insurance Commissioner	William A. Fricke	1/7/1895	10/15/1898	3	9
Insurance Commissioner	Wilbur M. Root	1/5/1891	1/7/1895	4	0
Insurance Commissioner	Philip Cheek, Jr.*	1/3/1887	1/5/1891	4	0
Insurance Commissioner	Philip L. Spooner, Jr.	4/1/1878	1/3/1887	8	9
Secretary of State	Hans B. Warner	1/7/1878	4/1/1878	3	0

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## NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
<b>WISCONSIN—Continued</b>					
Secretary of State	Peter Doyle	1/5/1874	1/7/1878	4	0
Secretary of State	Llewelyn Breese*	5/24/1871	1/5/1874	2	8
<b>WYOMING—Appointed, at the Pleasure of the Governor</b>					
Insurance Commissioner	Jeffrey P. 'Jeff' Rude	9/19/2019		incumbent	
Interim Insurance Commissioner	Jeffrey P. 'Jeff' Rude	6/19/2019	9/19/2019	0	3
Insurance Commissioner	Paul Thomas 'Tom' Glause	1/3/2015	6/19/2019	4	5
Insurance Commissioner	Thomas C. 'Tom' Hirsig	4/16/2012	12/31/2014	2	8
Insurance Commissioner	Kenneth G. 'Ken' Vines	2/21/2003	4/16/2012	9	2
Acting Insurance Commissioner	Kenneth G. 'Ken' Vines	10/16/2002	2/21/2003	0	4
Insurance Commissioner	John P. McBride	5/7/1992	10/1/2002	10	5
Acting Insurance Commissioner	John P. McBride	10/1/1991	5/7/1992	0	7
Insurance Commissioner	Kenneth Erickson	2/1/1990	10/1/1991	1	8
Acting Insurance Commissioner	Ralph Thomas	12/1/1989	2/1/1990	0	2
Insurance Commissioner	Gordon W. Taylor, Jr.	7/1/1986	12/1/1989	3	5
Acting Insurance Commissioner	Monroe D. Lauer	3/1/1986	7/1/1986	0	4
Insurance Commissioner	Robert W. Schrader	6/1/1984	3/1/1986	1	9
Insurance Commissioner	John T. Langdon	1/1/1975	6/1/1984	9	5
Insurance Commissioner	Ben S. Murphy	1/1/1971	1/1/1975	4	0
Insurance Commissioner	Vincent J. Horn, Jr.	6/1/1970	1/1/1971	0	7
Insurance Commissioner	William G. Walton	6/1/1967	6/1/1970	3	0
Insurance Commissioner	Mark Duncan	6/1/1963	6/1/1967	4	0
Insurance Commissioner	Gilbert A.D. Hart	5/1/1960	6/1/1963	3	1
Insurance Commissioner	Robert Adams	3/1/1959	5/1/1960	1	2
Insurance Commissioner	Ford S. Taft	3/1/1951	3/1/1959	8	0
Insurance Commissioner	Rodney Barrus	3/18/1945	3/1/1951	6	0
Insurance Commissioner	Alex MacDonald	2/1/1939	3/18/1945	6	1
Insurance Commissioner	Arthur J. Ham	3/1/1935	2/1/1939	3	11
Insurance Commissioner	Theodore Thulemeyer	2/13/1929	3/1/1935	6	1
Insurance Commissioner	Lyle E. Jay	6/6/1927	2/13/1929	1	8
Insurance Commissioner	John M. Fairfield (Died May 21, 1927)	3/1/1927	5/21/1927	0	2
Insurance Commissioner	Harry A. Loucks	3/1/1923	3/1/1927	4	0
Insurance Commissioner	Donald M. Forsyth	11/8/1920	3/1/1923	2	4
Insurance Commissioner	Robert B. Forsyth	3/1/1919	11/8/1920	1	8
State Auditor	Robert B. Forsyth	1/2/1911	3/1/1919	8	2
State Auditor	LeRoy Grant	1/2/1899	1/2/1911	12	0
State Auditor	William O. Owen	1/7/1895	1/2/1899	4	0
State Auditor	Charles W. Burdick	11/9/1890	1/7/1895	4	2
State Auditor	Mortimer N. Grant	7/10/1890	11/8/1890	0	4
Territorial Auditor	Mortimer N. Grant	3/8/1888	7/10/1890	2	4
Insurance Commissioner	Joseph B. Adams	4/1/1884	3/8/1888	3	11
Territorial Auditor	Jesse Knight	4/1/1882	3/31/1884	1	11
Territorial Auditor	John H. Nason	1/4/1880	3/31/1882	2	2
Territorial Auditor	James France	12/13/1877	1/4/1880	2	1

Updated: 03/21/2023

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\* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

## NAIC MEETING RECORD

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

<u>Mtg</u>	<u>Date</u>	<u>Meeting Site</u>	<u>President</u>	<u>Vice-President</u>	<u>Secretary / Secretary-Treasurer</u>
1	5/24–6/2/1871	New York, NY	George W. Miller, NY	Llewelyn Breese, WI	Henry S. Olcott, NY
2	10/18–30/1871	New York, NY	George W. Miller, NY	Llewelyn Breese, WI	Henry S. Olcott, NY
3	10/--/1872	New York, NY	George W. Miller, NY	Llewelyn Breese, WI	Henry S. Olcott, NY
4	9/17–20/1873	Boston, MA	Llewelyn Breese, WI	John W. Foard, CA	Oliver Pillsbury, NH
5	9/2–5/1874	Detroit, MI	Orlow W. Chapman, NY	Samuel H. Row, MI	Oliver Pillsbury, NH
6	9/20–25/1875	New York, NY	Orlow W. Chapman, NY	Samuel H. Row, MI	Oliver Pillsbury, NH
7	9/19–21/1876	Harrisburg, PA	Samuel H. Row, MI	Oliver Pillsbury, NH	Stephen H. Rhodes, MA
8	9/18/1877	St. Paul, MN	Samuel H. Row, MI	Oliver Pillsbury, NH	Stephen H. Rhodes, MA
9	8/27/1878	Providence, RI	Oliver Pillsbury, NH	Andrew R. McGill, MN	Orrin T. Welch, KS
10	9/17/1879	St. Louis, MO	Oliver Pillsbury, NH	Andrew R. McGill, MN	Orrin T. Welch, KS
11	9/10/1880	Chicago, IL	Andrew R. McGill, MN	Julius L. Clarke, MA	Orrin T. Welch, KS
12	9/20–21/1881	Detroit, MI	Julius L. Clarke, MA	Philip L. Spooner, WI	Orrin T. Welch, KS
13	10/4–5/1882	Niagara Falls, NY	Julius L. Clarke, MA	John A. McCall Jr., NY	Orrin T. Welch, KS
14	9/26–27/1883	Columbus, OH	Oliver Pillsbury, NH	Charles P. Swigert, IL	John W. Brooks, CT
15	9/24–25/1884	Chicago, IL	John A. McCall Jr., NY	Charles H. Moore, OH	Charles P. Swigert, IL
16	9/23–24/1885	Chicago, IL	John A. McCall Jr., NY	Eugene Pringle, MI	Charles P. Swigert, IL
17	9/22–23/1886	St. Paul, MN	Charles P. Swigert, IL	Henry J. Reinmund, OH	Charles Shandrew, MN
18	9/21–22/1887	Niagara Falls, NY	Oliver Pillsbury, NH <sup>1</sup>	Samuel H. Cross, RI <sup>1</sup>	Jacob A. McEwen, OH <sup>1</sup>
19	8/15–16/1888	Madison, WI	Philip Cheek Jr., WI	Orsamus R. Fyler, CT	Jacob A. McEwen, OH
20	9/4–5/1889	Denver, CO	Orsamus R. Fyler, CT	Samuel E. Kemp, OH	George B. Luper, PA
21	8/20–21/1890	Cleveland, OH	George S. Merrill, MA	Samuel E. Kemp, OH	George B. Luper, PA
22	9/30–10/2/1891	St. Louis, MO	Christopher P. Ellerbe, MO	George B. Luper, PA	John J. Brinkerhoff, IL <sup>2</sup>
23	6/15–16/1892	St. Paul, MN	George B. Luper, PA	William H. Kinder, OH	John J. Brinkerhoff, IL
24	9/12–13/1893	Chicago, IL	John C. Linehan, NH	Christopher H. Smith, MN	John J. Brinkerhoff, IL
25	9/5–6/1894	Alexandria Bay, NY	James F. Pierce, NY	Bradford K. Durfee, IL	John J. Brinkerhoff, IL
26	9/17–18/1895	Mackinac Island, MI	Bradford K. Durfee, IL	William M. Hahn, OH	Frederick L. ‘Fred’ Cutting, MA
27	9/22–23/1896	Philadelphia, PA	James R. Waddill, MO <sup>3</sup>	Stephen W. Carr, ME <sup>3</sup>	Frederick L. ‘Fred’ Cutting, MA
28	9/7–8/1897	Old Point Comfort, VA	Stephen W. Carr, ME <sup>4</sup>	Stephen W. Carr, ME <sup>4</sup>	John J. Brinkerhoff, IL <sup>5</sup>
29	9/1898	Milwaukee, WI	Stephen W. Carr, ME	William A. Fricke, WI	John J. Brinkerhoff, IL <sup>6</sup>
30	9/1899	Detroit, MI	Edward T. Orear, MO <sup>7</sup>	Milo D. Campbell, MI	John J. Brinkerhoff, IL
31	9/1900	Hartford, CT	Edward T. Orear, MO	W. S. Matthews, OH	John J. Brinkerhoff, IL
32	9/1901	Buffalo, NY	William H. Hart, IN <sup>8</sup>	Edwin L. Scofield, CT	John J. Brinkerhoff, IL
33	9/1902	Columbus, OH	William H. Hart, IN	Fred A. Howland, VT	John J. Brinkerhoff, IL
34	9/1903	Baltimore, MD	Arthur I. Vorys, OH	John L. Bacon, VT	John J. Brinkerhoff, IL
35	9/1904	Indianapolis, IN	John L. Bacon, VT	James V. Barry, MI	John J. Brinkerhoff, IL
36	9/1905	Bretton Woods, NH	Frederick L. ‘Fred’ Cutting, MA	James V. Barry, MI	John J. Brinkerhoff, IL
37	10/1906	Washington, DC	James V. Barry, MI	Theron Upson, CT	John J. Brinkerhoff, IL
38	9/1907	Richmond, VA	George H. Adams, NH	Reau E. Folk, TN	John J. Brinkerhoff, IL
39	8/1908	Detroit, MI	Reau E. Folk, TN	Beryl F. Carroll, IA	John J. Brinkerhoff, IL
40	8/1909	Colorado Springs, CO	Benjamin F. Crouse, MD	Fred W. Potter, IL	John A. Hartigan, MN
41	9/1910	Mobile, AL	John A. Hartigan, MN	Eugene J. McGivney, LA	Harry R. Cunningham, MT
42	8/1911	Milwaukee, WI	Joseph L. Button, VA	Theodore H. Macdonald, CT <sup>9</sup>	Harry R. Cunningham, MT
43	7/1912	Spokane, WA	Fred W. Potter, IL	Frank H. Hardison, MA	Fitz Hugh McMaster, SC <sup>10</sup>
44	7/1913	Burlington, VT	Frank H. Hardison, MA	1st James R. Young, NC	Fitz Hugh McMaster, SC
45	9/1914	Asheville, NC	James R. Young, NC	2nd Willard Done, UT	Fitz Hugh McMaster, SC
46	9/1915	Del Monte, CA	John S. Darst, WV	1st Willard Done, UT <sup>11</sup>	Fitz Hugh McMaster, SC
47	9/1916	Richmond, VA	Burton Mansfield, CT	2nd John S. Darst, WV	Fitz Hugh McMaster, SC
48	8/1917	St. Paul, MN	Burton Mansfield, CT	1st Burton Mansfield, CT	Fitz Hugh McMaster, SC
49	9/1918	Denver, CO	Jesse S. Phillips, NY	2nd John T. Winship, MI	Fitz Hugh McMaster, SC
50	9/1919	Hartford, CT	Michael J. ‘Mike’ Cleary, WI <sup>12</sup>	1st John T. Winship, MI	Fitz Hugh McMaster, SC
51	9/1920	Beverly Hills, CA	Claude W. Fairchild, CO	2nd Emory H. English, IA	Joseph L. Button, VA <sup>13</sup>
			Joseph G. Brown, VT	1st Robert J. Merrill, NH <sup>12</sup>	Joseph L. Button, VA
				2nd Walter K. Chorn, MO <sup>12</sup>	Joseph L. Button, VA
				1st Joseph G. Brown, VT	Joseph L. Button, VA
				2nd Frank H. Ellsworth, MI	Joseph L. Button, VA
				1st Frank H. Ellsworth, MI	Joseph L. Button, VA
				2nd Alfred L. Harty, MO <sup>14</sup>	Joseph L. Button, VA

<u>Mtg</u>	<u>Date</u>	<u>Meeting Site</u>	<u>President</u>	<u>Vice-President</u>	<u>Secretary / Secretary-Treasurer</u>
52	9/1921	Louisville, KY	Alfred L. Harty, MO <sup>15</sup>	1st Thomas B. Donaldson, PA <sup>15</sup> 2nd Platt Whitman, WI <sup>15</sup>	Joseph L. Button, VA
53	9/1922	Swampscott, MA	Thomas B. Donaldson, PA	1st Platt Whitman, WI 2nd H. O. Fishback, WA	Joseph L. Button, VA
54	8/1923	Minneapolis, MN	Herbert O. Fishback, WA <sup>16</sup>	1st. John C. Luning, FL <sup>16</sup> 2nd John C. Luning, FL <sup>16</sup>	Joseph L. Button, VA
55	7/1924	Seattle, WA	Herbert O. Fishback, WA	1st John C. Luning, FL 2nd Samuel W. McCulloch, PA	Joseph L. Button, VA
56	9/1925	San Antonio, TX	John C. Luning, FL	1st Samuel W. McCulloch, PA 2nd Bruce T. Bullion, AR	Joseph L. Button, VA
57	11/1926	Los Angeles, CA	Harry L. Conn, OH <sup>17</sup>	1st T. M. Henry, MA 2nd Thomas M. Baldwin, Jr., DC	Joseph L. Button, VA
58	9/1927	Cincinnati, OH	Albert S. Caldwell, TN <sup>18</sup>	1st James A. Beha, NY <sup>18</sup> 2nd Charles R. Detrick, CA	Joseph L. Button, VA
59	9/1928	Rapid City, SD	Albert S. Caldwell, TN	1st Charles R. Detrick, CA 2nd James A. Beha, NY	Joseph L. Button, VA
60	9/1929	Toronto, Canada	Howard P. Dunham, CT <sup>19</sup>	1st Clarence C. Wysong, IN <sup>19</sup> 2nd Jess G. Read, OK <sup>19</sup>	Joseph L. Button, VA
61	9/1930	Hartford, CT	Howard P. Dunham, CT	1st Clarence C. Wysong, IN 2nd Jess G. Read, OK	Albert S. Caldwell, TN <sup>20</sup>
62	9/1931	Portland, OR	Jess G. Read, OK <sup>21</sup>	1st Charles D. Livingston, MI <sup>21</sup> 2nd William A. Tarver, TX <sup>21</sup>	Albert S. Caldwell, TN
63	10/1932	Dallas, TX	Charles D. Livingston, MI	1st William A. Tarver, TX 2nd Garfield W. Brown, MN	Jess G. Read, OK
64	6/1933	Chicago, IL	Garfield W. Brown, MN <sup>22</sup>	1st Daniel C. 'Dan' Boney, NC <sup>22</sup> 2nd George S. Van Schaick, NY <sup>22</sup>	Jess G. Read, OK
65	12/1934	St. Petersburg, FL	Garfield W. Brown, MN	1st Daniel C. 'Dan' Boney, NC 2nd George S. Van-Schaick, NY	Jess G. Read, OK
66	7/1935	Seattle, WA	Daniel C. 'Dan' Boney, NC	1st George S. Van-Schaick, NY <sup>23</sup> 2nd Merton L. Brown, MA <sup>23</sup>	Jess G. Read, OK
67	6/1936	St. Paul, MN	William A. Sullivan, WA	1st Ernest Palmer, IL 2nd George A. Bowles, VA	Jess G. Read, OK
68	6/1937	Philadelphia, PA	Ernest Palmer, IL	George A. Bowles, VA	Jess G. Read, OK
69	6/1938	Quebec, Canada	George A. Bowles, VA	Samuel L. Carpenter, Jr., CA	Jess G. Read, OK
70	6/1939	San Francisco, CA	Frank N. Julian, AL	Arthur J. Ham, WY	Jess G. Read, OK
71	6/1940	Hartford, CT	C. Clarence Nelson, UT	John C. Blackall, CT <sup>24</sup>	Jess G. Read, OK
72	6/1941	Detroit, MI	John C. Blackall, CT	Charles F. Hobbs, KS	Jess G. Read, OK
73	6/1942	Denver, CO	Charles F. Hobbs, KS	John Sharp Williams III, MS	Jess G. Read, OK
74	6/1943	Boston, MA	John Sharp Williams III, MS	Charles F. J. Harrington, MA	Jess G. Read, OK
75	6/1944	Chicago, IL	Charles F. J. Harrington, MA	Newell R. Johnson, MN	Jess G. Read, OK
76	6/1945	St. Paul, MN	Newell R. Johnson, MN	James M. McCormack, TN	Jess G. Read, OK
77	6/1946	Portland, OR	James M. McCormack, TN	Robert E. Dineen, NY <sup>25</sup>	Jess G. Read, OK
78	6/1947	Atlantic City, NJ	Robert E. Dineen, NY	Seth B. Thompson, OR	Nellis P. Parkinson, IL <sup>26</sup>
79	6/1948	Philadelphia, PA	Seth B. Thompson, OR	J. Edwin Larson, FL	William P. Hodges, NC
80	6/1949	Seattle, WA	J. Edwin Larson, FL	David A. Forbes, MI	George A. Bowles, VA
81	6/1950	Quebec, Canada	David A. Forbes, MI	W. Ellery Allyn, CT	George A. Bowles, VA
82	6/1951	Swampscott, MA	W. Ellery Allyn, CT	Frank Sullivan, KS	George A. Bowles, VA
83	6/1952	Chicago, IL	Frank Sullivan, KS	Wade O. Martin Jr., LA	George A. Bowles, VA
Reg.	12/1952	New York, NY	Wade O. Martin Jr., LA	D. D. 'Pat' Murphy, SC	George A. Bowles, VA
84	6/1953	San Francisco, CA	Wade O. Martin Jr., LA	D. D. 'Pat' Murphy, SC	George A. Bowles, VA
Reg.	11/1953	Miami Beach, FL	D. D. 'Pat' Murphy, SC	Donald Knowlton, NH <sup>27</sup>	George A. Bowles, VA
85	6/1954	Detroit, MI	D. D. 'Pat' Murphy, SC	Donald Knowlton, NH	George A. Bowles, VA
Reg.	11/1954	New York, NY	Donald Knowlton, NH	C. Lawrence Leggett, MO	George A. Bowles, VA
86	5/1955	Los Angeles, CA	Donald Knowlton, NH	C. Lawrence Leggett, MO	George A. Bowles, VA
Reg.	11/1955	New York, NY	C. Lawrence Leggett, MO	Robert B. Taylor, OR	George A. Bowles, VA
87	5/1956	St. Louis, MO	C. Lawrence Leggett, MO	Robert B. Taylor, OR	George A. Bowles, VA
Reg.	12/1956	Miami Beach, FL	Robert B. Taylor, OR	Joseph A. Navarre, MI	Paul A. Hammel, NV <sup>28</sup>
88	6/1957	Atlantic City, NJ	Robert B. Taylor, OR	Joseph A. Navarre, MI	Paul A. Hammel, NV
Reg.	12/1957	New York, NY	Joseph A. Navarre, MI	Arch E. Northington, TN	J. Edwin Larson, FL
89	6/1958	Chicago, IL	Joseph A. Navarre, MI	Arch E. Northington, TN	J. Edwin Larson, FL
Reg.	12/1958	New Orleans, LA	Arch E. Northington, TN	Paul A. Hammel, NY	J. Edwin Larson, FL
90	6/1959	Boston, MA	Paul A. Hammel, NV <sup>29</sup>	Sam N. Beery, CO <sup>29</sup>	J. Edwin Larson, FL
Reg.	11/1959	Miami Beach, FL	Paul A. Hammel, NV	Sam N. Beery, CO	Alfred N. Premo, CT

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91	5/1960	San Francisco, CA	Paul A. Hammel, NV	Sam N. Beery, CO	Alfred N. Premo, CT
Reg.	11/1960	New York, NY	Sam N. Beery, CO	T. Nelson Parker, VA	Alfred N. Premo, CT
92	6/1961	Philadelphia, PA	Sam N. Beery, CO	T. Nelson Parker, VA	Alfred N. Premo, CT
Reg.	12/1961	Dallas, TX	T. Nelson Parker, VA	Rufus D. Hayes, LA	Harvey G. Combs, AR
93	6/1962	Montreal, Canada	T. Nelson Parker, VA	Rufus D. Hayes, LA	Harvey G. Combs, AR
Reg.	12/1962	Chicago, IL	Rufus D. Hayes, LA	Joseph S. Gerber, IL	Harvey G. Combs, AR
94	6/1963	Seattle, WA	Rufus D. Hayes, LA	Joseph S. Gerber, IL <sup>30</sup>	Harvey G. Combs, AR
Reg.	12/1963	Phoenix, AZ	Lee I. Kueckelhan, WA	Cyrus E. Magnusson, MN	Ralph F. Apodaca, NM
95	6/1964	Minneapolis, MN	Lee I. Kueckelhan, WA	Cyrus E. Magnusson, MN	Ralph F. Apodaca, NM
Reg.	11/1964	Las Vegas, NV	Cyrus E. Magnusson, MN	William E. Timmons, IA	Ralph F. Apodaca, NM
96	6/1965	New York, NY	Cyrus E. Magnusson, MN	William E. Timmons, IA	Ralph F. Apodaca, NM
Reg.	11/1965	Miami Beach, FL	William E. Timmons, IA	Frank J. Barrett, NE	Ralph F. Apodaca, NM
97	6/1966	Richmond, VA	William E. Timmons, IA	Frank J. Barrett, NE	Ralph F. Apodaca, NM
Reg.	12/1966	Dallas, TX	Frank J. Barrett, NE	James L. Bentley, GA	Ralph F. Apodaca, NM
98	6/1967	Boston, MA	Frank J. Barrett, NE	James L. Bentley, GA	Ralph F. Apodaca, NM
Reg.	12/1967	Honolulu, HI	James L. Bentley, GA	Charles R. Howell, NJ	Ralph F. Apodaca, NM
99	6/1968	Portland, OR	James L. Bentley, GA	Charles R. Howell, NJ	Ralph F. Apodaca, NM
Reg.	12/1968	Los Angeles, CA	Charles R. Howell, NJ <sup>31</sup>	Ned Price, TX	Ralph F. Apodaca, NM
100	6/1969	Philadelphia, PA	Ned Price, TX	Richard E. 'Dick' Stewart, NY	Ralph F. Apodaca, NM
Reg.	12/1969	New Orleans, LA	Ned Price, TX	Richard E. 'Dick' Stewart, NY	Ralph F. Apodaca, NM
101	6/1970	Cleveland, OH	Ned Price, TX	Richard E. 'Dick' Stewart, NY	Ralph F. Apodaca, NM
Reg.	12/1970	Chicago, IL	Richard E. 'Dick' Stewart, NY <sup>32</sup>	Lorne R. Worthington, IA	Ralph F. Apodaca, NM
102	6/1971	New York, NY	Lorne Worthington, IA	Richards D. 'Dick' Barger, CA	Ralph F. Apodaca, NM
Reg.	11/1971	Miami Beach, FL	Richards D. 'Dick' Barger, CA	Russell E. Van Hooser, MI	Ralph F. Apodaca, NM
103	6/1972	Denver, CO	Richards D. 'Dick' Barger, CA	Russell E. Van Hooser, MI	Ralph F. Apodaca, NM
Reg.	12/1972	Atlanta, GA	Russell E. Van Hooser, MI	W. Fletcher Bell, KS	Ralph F. Apodaca, NM
104	6/1973	Washington, DC	Russell E. Van Hooser, MI	W. Fletcher Bell, KS	Ralph F. Apodaca, NM
Reg.	12/1973	Las Vegas, NV	W. Fletcher Bell, KS	Johnnie L. Caldwell, GA	Ralph F. Apodaca, NM
105	6/1974	San Francisco, CA	W. Fletcher Bell, KS	Johnnie L. Caldwell, GA	Ralph F. Apodaca, NM
Reg.	12/1974	Mexico City, Mexico	Johnnie L. Caldwell, GA <sup>33</sup>	Kenneth E. 'Ken' DeShetler, OH <sup>34</sup>	Ralph F. Apodaca, NM
106	6/1975	Seattle, WA	William H. Huff III, IA <sup>34</sup>	Richard L. 'Dick' Rottman, NV	Ralph F. Apodaca, NM
Reg.	12/1975	San Juan, PR	William H. Huff III, IA	Richard L. 'Dick' Rottman, NV	Ralph F. Apodaca, NM
107	6/1976	New Orleans, LA	Richard L. 'Dick' Rottman, NV	Lester L. Rawls, OR	Ralph F. Apodaca, NM
Reg.	12/1976	Phoenix, AZ	Richard L. 'Dick' Rottman, NV	Lester L. Rawls, OR	Ralph F. Apodaca, NM
108	6/1977	Minneapolis, MN	Lester L. Rawls, OR	Harold B. McGuffey, KY	Elmer V. Omholt, MT
Reg.	12/1977	Miami Beach, FL	Lester L. Rawls, OR	Harold B. McGuffey, KY	Elmer V. Omholt, MT
109	6/1978	Washington, DC	Harold B. McGuffey, KY	H. Peter 'Pete' Hudson, IN	Elmer V. Omholt, MT
Reg.	12/1978	Las Vegas, NV	Harold B. McGuffey, KY	H. Peter 'Pete' Hudson, IN	Elmer V. Omholt, MT
110	6/1979	Chicago, IL	H. Peter 'Pete' Hudson, IN	Wesley J. Kinder, CA	Elmer V. Omholt, MT
Reg.	12/1979	Los Angeles, CA	H. Peter 'Pete' Hudson, IN <sup>35</sup>	Wesley J. Kinder, CA	Elmer V. Omholt, MT
111	6/1980	Denver, CO	Wesley J. Kinder, CA	William H. L. Woodyard III, AR	Elmer V. Omholt, MT
Reg.	11/1980	New York, NY	Wesley J. Kinder, CA	William H. L. Woodyard III, AR	Elmer V. Omholt, MT
112	6/1981	Detroit, MI	William H. L. Woodyard, AR	John W. Lindsay, SC <sup>36</sup>	Elmer V. Omholt, MT
Reg.	12/1981	New Orleans, LA	William H. L. Woodyard, AR	Johnnie L. Caldwell, GA <sup>36</sup>	Elmer V. Omholt, MT
113	6/1982	Philadelphia, PA	Lyndon L. Olson Jr., TX	Roger C. Day, UT	Elmer V. Omholt, MT
Zone	9/1982	Nashville, TN	Lyndon L. Olson Jr., TX	Roger C. Day, UT	Elmer V. Omholt, MT
114	11/1982	Dallas, TX	Lyndon L. Olson Jr., TX	Roger C. Day, UT	Elmer V. Omholt, MT
Zone	3/1983	Baltimore, MD	Roger C. Day, UT	William D. 'Bill' Gunter, FL	Elmer V. Omholt, MT
115	6/1983	St. Louis, MO	Roger C. Day, UT	William D. 'Bill' Gunter, FL	Elmer V. Omholt, MT
Zone	9/1983	Tampa, FL	Roger C. Day, UT	William D. 'Bill' Gunter, FL	Elmer V. Omholt, MT
116	12/1983	San Diego, CA	Roger C. Day, UT	William D. 'Bill' Gunter, FL	Elmer V. Omholt, MT
Zone	3/1984	Portland, OR	William D. 'Bill' Gunter, FL	Bruce W. Foudree, IA	Elmer V. Omholt, MT
117	6/1984	New Orleans, LA	William D. 'Bill' Gunter, FL	Bruce W. Foudree, IA	Elmer V. Omholt, MT
Zone	9/1984	Omaha, NE	William D. 'Bill' Gunter, FL	Bruce W. Foudree, IA	Elmer V. Omholt, MT
118	12/1984	Washington, DC	William D. 'Bill' Gunter, FL	Bruce W. Foudree, IA	Elmer V. Omholt, MT
Zone	3/1985	Williamsburg, VA	Bruce W. Foudree, IA	Josephine M. Driscoll, OR	Elmer V. Omholt, MT
119	6/1985	Kansas City, MO	Bruce W. Foudree, IA	Josephine M. Driscoll, OR	Elmer V. Omholt, MT
Zone	9/1985	Syracuse, NY	Bruce W. Foudree, IA	Josephine M. Driscoll, OR	Elmer V. Omholt, MT
120	12/1985	Reno, NV	Bruce W. Foudree, IA	Josephine M. Driscoll, OR	Elmer V. Omholt, MT
Zone	3/1986	San Francisco, CA	Josephine M. 'Jo' Driscoll, OR	Edward J. Muhl, MD	W. Fletcher Bell, KS
121	6/1986	Boston, MA	Josephine M. 'Jo' Driscoll, OR	Edward J. Muhl, MD	W. Fletcher Bell, KS
Zone	9/1986	Des Moines, IA	Josephine M. 'Jo' Driscoll, OR	Edward J. Muhl, MD	W. Fletcher Bell, KS
122	12/1986	Orlando, FL	Josephine M. 'Jo' Driscoll, OR	Edward J. Muhl, MD	W. Fletcher Bell, KS
Zone	4/1987	Lexington, KY	Edward J. Muhl, MD	John E. Washburn, IL	W. Fletcher Bell, KS
123	6/1987	Chicago, IL	Edward J. Muhl, MD	John E. Washburn, IL	W. Fletcher Bell, KS
Zone	9/1987	Pittsburgh, PA	Edward J. Muhl, MD	John E. Washburn, IL	W. Fletcher Bell, KS

<u>Mtg</u>	<u>Date</u>	<u>Meeting Site</u>	<u>President</u>	<u>Vice-President</u>	<u>Secretary / Secretary-Treasurer</u>
124	12/1987	Phoenix, AZ	Edward J. Muhl, MD	John E. Washburn, IL	W. Fletcher Bell, KS
Zone	3/1988	Santa Fe, NM	John E. Washburn, IL	David A. Gates, NV	W. Fletcher Bell, KS
125	6/1988	New York, NY	John E. Washburn, IL	David A. Gates, NV	W. Fletcher Bell, KS
Zone	9/1988	Mackinac Island, MI	John E. Washburn, IL	David A. Gates, NV	W. Fletcher Bell, KS
126	12/1988	New Orleans, LA	John E. Washburn, IL	David A. Gates, NV	W. Fletcher Bell, KS
Zone	3/1989	Little Rock, AR	David A. Gates, NV	Earl R. Pomeroy, ND	W. Fletcher Bell, KS
127	6/1989	Cincinnati, OH	David A. Gates, NV	Earl R. Pomeroy, ND	W. Fletcher Bell, KS
Zone	9/1989	Wilmington, DE	David A. Gates, NV	Earl R. Pomeroy, ND	W. Fletcher Bell, KS
128	12/1989	Las Vegas, NV	David A. Gates, NV	Earl R. Pomeroy, ND	W. Fletcher Bell, KS
Zone	3/1990	Salt Lake City, UT	Earl R. Pomeroy, ND	James E. 'Jim' Long, NC	W. Fletcher Bell, KS
129	6/1990	Baltimore, MD	Earl R. Pomeroy, ND	James E. 'Jim' Long, NC	W. Fletcher Bell, KS
Zone	9/1990	Kansas City, MO	Earl R. Pomeroy, ND	James E. 'Jim' Long, NC	W. Fletcher Bell, KS
130	12/1990	Louisville, KY	Earl R. Pomeroy, ND	James E. 'Jim' Long, NC	W. Fletcher Bell, KS
Zone	4/1991	Charleston, WV	James E. 'Jim' Long, NC	William H. 'Bill' McCartney, NE	Robin Campaniano, HI
131	6/1991	Indianapolis, IN	James E. 'Jim' Long, NC	William H. 'Bill' McCartney, NE	Robin Campaniano, HI
Zone	9/1991	Pittsburgh, PA	James E. 'Jim' Long, NC	William H. 'Bill' McCartney, NE	Robin Campaniano, HI
132	12/1991	Houston, TX	James E. 'Jim' Long, NC	William H. 'Bill' McCartney, NE	Robin Campaniano, HI
Zone	3/1992	Seattle, WA	William H. 'Bill' McCartney, NE	Steven T. Foster, VA	David J. Walsh, AK
133	6/1992	Washington, DC	William H. 'Bill' McCartney, NE	Steven T. Foster, VA	David J. Walsh, AK
Zone	9/1992	Cincinnati, OH	William H. 'Bill' McCartney, NE	Steven T. Foster, VA	David J. Walsh, AK
134	12/1992	Atlanta, GA	William H. 'Bill' McCartney, NE	Steven T. Foster, VA	David J. Walsh, AK
Zone	3/1993	Nashville, TN	Steven T. Foster, VA	David J. Walsh, AK	David J. Lyons, IA
135	6/1993	Chicago, IL	Steven T. Foster, VA	David J. Walsh, AK	David J. Lyons, IA
136	9/1993	Boston, MA	Steven T. Foster, VA	David J. Walsh, AK	David J. Lyons, IA
137	12/1993	Honolulu, HI	Steven T. Foster, VA	David J. Walsh, AK	David J. Lyons, IA
138	3/1994	Denver, CO	David J. Walsh, AK	David J. Lyons, IA	Catherine J. Weatherford, OK
139	6/1994	Baltimore, MD	David J. Walsh, AK	David J. Lyons, IA <sup>37</sup>	Catherine J. Weatherford, OK
140	9/1994	Minneapolis, MN	David J. Walsh, AK	Lee Douglass, AR <sup>37</sup>	Catherine J. Weatherford, OK
141	12/1994	New Orleans, LA	David J. Walsh, AK	Lee Douglass, AR	Catherine J. Weatherford, OK
142	3/1995	Miami, FL	Lee Douglass, AR	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI
143	6/1995	St. Louis, MO	Lee Douglass, AR	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI
144	9/1995	Philadelphia, PA	Lee Douglass, AR	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI
145	12/1995	San Antonio, TX	Lee Douglass, AR	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI
146	3/1996	Detroit, MI	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND
147	6/1996	New York, NY	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND
148	9/1996	Anchorage, AK	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND
149	12/1996	Atlanta, GA	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND
150	3/1997	Orlando, FL	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND	George M. Reider Jr., CT
151	6/1997	Chicago, IL	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND	George M. Reider Jr., CT
152	9/1997	Washington, DC	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND	George M. Reider Jr., CT
153	12/1997	Seattle, WA	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND	George M. Reider Jr., CT
154	3/1998	Salt Lake City, UT	Glenn Pomeroy, ND	George M. Reider Jr., CT	George Nichols, III, KY
155	6/1998	Boston, MA	Glenn Pomeroy, ND	George M. Reider Jr., CT	George Nichols, III, KY
156	9/1998	New York, NY	Glenn Pomeroy, ND	George M. Reider Jr., CT	George Nichols, III, KY
157	12/1998	Orlando, FL	Glenn Pomeroy, ND	George M. Reider Jr., CT	George Nichols, III, KY
158	3/1999	Washington, DC	George M. Reider Jr., CT	George Nichols, III, KY	Kathleen Sebelius, KS
159	6/1999	Kansas City, MO	George M. Reider Jr., CT	George Nichols, III, KY	Kathleen Sebelius, KS
160	10/1999	Atlanta, GA	George M. Reider Jr., CT	George Nichols, III, KY	Kathleen Sebelius, KS
161	12/1999	San Francisco, CA	George M. Reider Jr., CT	George Nichols, III, KY	Kathleen Sebelius, KS
162	3/2000	Chicago, IL	George Nichols, III, KY	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA
163	6/2000	Orlando, FL	George Nichols, III, KY	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA
164	9/2000	Dallas, TX	George Nichols, III, KY	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA
165	12/2000	Boston, MA	George Nichols, III, KY	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA
166	3/2001	Nashville, TN	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR
167	6/2001	New Orleans, LA	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR
N/A	9/2001	Mtg. canceled <sup>38</sup>	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR
168	12/2001	Chicago, IL	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR
169	3/2002	Reno, NV	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR	Ernst N. 'Ernie' Csiszar, SC
170	6/2002	Philadelphia, PA	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR	Ernst N. 'Ernie' Csiszar, SC
171	9/2002	New Orleans, LA	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR	Ernst N. 'Ernie' Csiszar, SC
172	12/2002	San Diego, CA	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR	Ernst N. 'Ernie' Csiszar, SC
173	3/2003	Atlanta, GA	J. Michael 'Mike' Pickens, AR	Ernst N. 'Ernie' Csiszar, SC	James A. 'Jim' Poolman, ND
174	6/2003	New York, NY	J. Michael 'Mike' Pickens, AR	Ernst N. 'Ernie' Csiszar, SC	James A. 'Jim' Poolman, ND
175	9/2003	Chicago, IL	J. Michael 'Mike' Pickens, AR	Ernst N. 'Ernie' Csiszar, SC	James A. 'Jim' Poolman, ND
176	12/2003	Anaheim, CA	J. Michael 'Mike' Pickens, AR	Ernst N. 'Ernie' Csiszar, SC	James A. 'Jim' Poolman, ND
177	3/2004	New York, NY	Ernst N. 'Ernie' Csiszar, SC	James A. 'Jim' Poolman, ND	Joel S. Ario, OR



<u>Mtg</u>	<u>Date</u>	<u>Meeting Site</u>	<u>President</u>	<u>Vice-President</u>	<u>Secretary / Secretary-Treasurer</u>
178	6/2004	San Francisco, CA	Ernst N. 'Ernie' Csiszar, SC <sup>39</sup>	James A. 'Jim' Poolman, ND	Joel S. Ario, OR
179	9/2004	Anchorage, AK	M. Diane Koken, PA <sup>39</sup>	Joel S. Ario, OR <sup>39</sup>	Alessandro A. 'Al' Iuppa, ME <sup>39</sup>
180	12/2004	New Orleans, LA <sup>40</sup>	M. Diane Koken, PA	Joel Ario, OR	Alessandro A. 'Al' Iuppa, ME

<u>Mtg</u>	<u>Date</u>	<u>Meeting Site</u>	<u>President</u>	<u>President-Elect</u>	<u>Vice President</u>	<u>Secretary-Treasurer</u>
181	3/2005	Salt Lake City, UT	M. Diane Koken, PA	Alessandro A. 'Al' Iuppa, ME	Joel S. Ario, OR	Sandra K. 'Sandy' Praeger, KS
182	6/2005	Boston, MA	M. Diane Koken, PA	Alessandro A. 'Al' Iuppa, ME	Joel S. Ario, OR	Sandra K. 'Sandy' Praeger, KS
N/A	9/2005	Mtg. canceled <sup>41</sup>	M. Diane Koken, PA	Alessandro A. 'Al' Iuppa, ME	Joel S. Ario, OR	Sandra K. 'Sandy' Praeger, KS
183	12/3–6/2005	Chicago, IL	M. Diane Koken, PA	Alessandro A. 'Al' Iuppa, ME	Joel S. Ario, OR	Sandra K. 'Sandy' Praeger, KS
184	3/4–7/2006	Orlando, FL	Alessandro A. 'Al' Iuppa, ME	Walter A. Bell, AL	Sandra K. 'Sandy' Praeger, KS	Eric P. Serna, NM <sup>42</sup>
185	6/10–13/2006	Washington, DC	Alessandro A. 'Al' Iuppa, ME	Walter A. Bell, AL	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH <sup>42</sup>
186	9/9–12/2006	St. Louis, MO	Alessandro A. 'Al' Iuppa, ME	Walter A. Bell, AL	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH
187	12/9–12/2006	San Antonio, TX	Alessandro A. 'Al' Iuppa, ME	Walter A. Bell, AL	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH
188	3/10–13/2007	New York, NY	Walter A. Bell, AL	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH	Jane L. Cline, WV
189	6/1–4/2007	San Francisco, CA	Walter A. Bell, AL	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH	Jane L. Cline, WV
190	9/29–10/1/2007	Washington, DC	Walter A. Bell, AL	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH	Jane L. Cline, WV
191	12/2–4/2007	Houston, TX	Walter A. Bell, AL	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH	Jane L. Cline, WV
192	3/29–31/2008	Orlando, FL	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH	Jane L. Cline, WV	Susan E. Voss, IA
193	5/31–6/2/2008	San Francisco, CA	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH	Jane L. Cline, WV	Susan E. Voss, IA
194	9/22–24/2008	National Harbor, MD	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH	Jane L. Cline, WV	Susan E. Voss, IA
195	12/5–8/2008	Grapevine, TX	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH	Jane L. Cline, WV	Susan E. Voss, IA
196	3/15–18/2009	San Diego, CA	Roger A. Sevigny, NH	Jane L. Cline, WV	Susan E. Voss, IA	Kevin M. McCarty, FL
197	6/13–15/2009	Minneapolis, MN	Roger A. Sevigny, NH	Jane L. Cline, WV	Susan E. Voss, IA	Kevin M. McCarty, FL
198	9/21–24/2009	National Harbor, MD	Roger A. Sevigny, NH	Jane L. Cline, WV	Susan E. Voss, IA	Kevin M. McCarty, FL
199	12/5–8/2009	San Francisco, CA	Roger A. Sevigny, NH	Jane L. Cline, WV	Susan E. Voss, IA	Kevin M. McCarty, FL
200	3/25–28/2010	Denver, CO	Jane L. Cline, WV	Susan E. Voss, IA	Kevin M. McCarty, FL	Kim Holland, OK
201	8/14–17/2010	Seattle, WA	Jane L. Cline, WV	Susan E. Voss, IA	Kevin M. McCarty, FL	Kim Holland, OK
202	10/18–21/2010	Orlando, FL	Jane L. Cline, WV	Susan E. Voss, IA	Kevin M. McCarty, FL	Kim Holland, OK
203	3/26–29/2011	Austin, TX	Susan E. Voss, IA	Kevin M. McCarty, FL	James J. Donelon, LA	Michael T. McRaith, IL <sup>43</sup>
N/A	8/2011	Mtg. canceled <sup>44</sup>	Susan E. Voss, IA	Kevin M. McCarty, FL	James J. Donelon, LA	Adam Hamm, ND <sup>43</sup>
204	11/3–6/2011	Washington, DC	Susan E. Voss, IA	Kevin M. McCarty, FL	James J. Donelon, LA	Adam Hamm, ND
205	3/3–6/2012	New Orleans, LA	Kevin M. McCarty, FL	James J. Donelon, LA	Adam Hamm, ND	Monica J. Lindeen, MT
206	8/11–14/2012	Atlanta, GA	Kevin M. McCarty, FL	James J. Donelon, LA	Adam Hamm, ND	Monica J. Lindeen, MT
207	11/29–12/2/2012	National Harbor, MD	Kevin M. McCarty, FL	James J. Donelon, LA	Adam Hamm, ND	Monica J. Lindeen, MT
208	4/6–9/2013	Houston, TX	James J. Donelon, LA	Adam Hamm, ND	Monica J. Lindeen, MT	Michael F. Consedine, PA
209	8/24–27/2013	Indianapolis, IN	James J. Donelon, LA	Adam Hamm, ND	Monica J. Lindeen, MT	Michael F. Consedine, PA
210	12/15–18/2013	Washington, DC	James J. Donelon, LA	Adam Hamm, ND	Monica J. Lindeen, MT	Michael F. Consedine, PA
211	3/29–4/1/2014	Orlando, FL	Adam Hamm, ND	Monica J. Lindeen, MT	Michael F. Consedine, PA	Sharon P. Clark, KY
212	8/16–19/2014	Louisville, KY	Adam Hamm, ND	Monica J. Lindeen, MT	Michael F. Consedine, PA	Sharon P. Clark, KY
213	11/16–19/2014	Washington, DC	Adam Hamm, ND	Monica J. Lindeen, MT	Michael F. Consedine, PA <sup>45</sup>	Sharon P. Clark, KY
214	3/28–31/2015	Phoenix, AZ	Monica J. Lindeen, MT	John M. Huff, MO <sup>45</sup>	Sharon P. Clark, KY	Theodore K. 'Ted' Nickel, WI
215	8/15–18/2015	Chicago, IL	Monica J. Lindeen, MT	John M. Huff, MO	Sharon P. Clark, KY	Theodore K. 'Ted' Nickel, WI
216	11/19–22/2015	National Harbor, MD	Monica J. Lindeen, MT	John M. Huff, MO	Sharon P. Clark, KY <sup>46</sup>	Theodore K. 'Ted' Nickel, WI
217	4/3–6/2016	New Orleans, LA	John M. Huff, MO	Theodore K. 'Ted' Nickel, WI <sup>46</sup>	Julie Mix McPeak, TN <sup>46</sup>	Eric A. Cioppa, ME <sup>46</sup>
218	8/26–29/2016	San Diego, CA	John M. Huff, MO	Theodore K. 'Ted' Nickel, WI	Julie Mix McPeak, TN	Eric A. Cioppa, ME
219	12/10–13/2016	Miami, FL	John M. Huff, MO	Theodore K. 'Ted' Nickel, WI	Julie Mix McPeak, TN	Eric A. Cioppa, ME
220	4/8–11/2017	Denver, CO	Theodore K. 'Ted' Nickel, WI	Julie Mix McPeak, TN	Eric A. Cioppa, ME	David C. Mattax, TX <sup>47</sup>
221	8/6–9/2017	Philadelphia, PA	Theodore K. 'Ted' Nickel, WI	Julie Mix McPeak, TN	Eric A. Cioppa, ME	Raymond G. Farmer, SC <sup>47</sup>
222	12/2–4/2017	Honolulu, HI	Theodore K. 'Ted' Nickel, WI	Julie Mix McPeak, TN	Eric A. Cioppa, ME	Raymond G. Farmer, SC
223	3/24–27/2018	Milwaukee, WI	Julie Mix McPeak, TN	Eric A. Cioppa, ME	Raymond G. Farmer, SC	Gordon I. Ito, HI
224	8/4–7/2018	Boston, MA	Julie Mix McPeak, TN	Eric A. Cioppa, ME	Raymond G. Farmer, SC	Gordon I. Ito, HI
225	11/15–18/2018	San Francisco, CA	Julie Mix McPeak, TN	Eric A. Cioppa, ME	Raymond G. Farmer, SC	Gordon I. Ito, HI <sup>48</sup>
226	4/6–9/2019	Orlando, FL	Eric A. Cioppa, ME	Raymond G. Farmer, SC	David Altmaier, FL <sup>48</sup>	Dean L. Cameron, ID
227	8/3–6/2019	New York, NY	Eric A. Cioppa, ME	Raymond G. Farmer, SC	David Altmaier, FL	Dean L. Cameron, ID
228	12/7–10/2019	Austin, TX	Eric A. Cioppa, ME	Raymond G. Farmer, SC	David Altmaier, FL	Dean L. Cameron, ID
N/A	3/2020	Mtg. canceled <sup>49</sup>	Raymond G. Farmer, SC	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO
229	7/27–8/14/2020	Virtual meeting <sup>50</sup>	Raymond G. Farmer, SC	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO
230	12/3–9/2020	Virtual meeting <sup>51</sup>	Raymond G. Farmer, SC	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO
231	4/7–14/2021	Virtual meeting <sup>52</sup>	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO	Andrew N. Mais, CT
232	8/13–17/2021	Columbus, OH <sup>53</sup>	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO	Andrew N. Mais, CT
233	12/13–16/2021	San Diego, CA <sup>54</sup>	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO	Andrew N. Mais, CT
234	4/4–8/2022	Kansas City, MO	Dean L. Cameron, ID	Chlora Lindley-Myers, MO	Andrew N. Mais, CT	Jon Godfread, ND
235	8/9–13/2022	Portland, OR	Dean L. Cameron, ID	Chlora Lindley-Myers, MO	Andrew N. Mais, CT	Jon Godfread, ND
236	12/12–16/2022	Tampa, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO	Andrew N. Mais, CT	Jon Godfread, ND
237	3/21–25/2023	Louisville, KY	Chlora Lindley-Myers, MO	Andrew N. Mais, CT	Jon Godfread, ND	Scott A. White, VA

1. Sept. 23, 1886: John K. Tarbox (MA) was elected President for the 1887 Convention; Samuel H. Cross (RI) was elected Vice-President; and Robert B. Brinkerhoff (Ohio chief clerk) was elected Secretary. Commissioner Tarbox died May 28, 1887. Auditor Cross was out of office effective June 1, 1887. Mr. Brinkerhoff was out of office effective June 3, 1887. Oliver Pillsbury (NH) was chosen to preside over the 1887 Convention. It is unknown who acted as Vice-President. Jacob A. McEwen (Ohio chief clerk) was chosen to act as Secretary.
2. Aug. 21, 1890: Charles B. Allan (Nebraska deputy auditor) was elected Secretary for the 1891 Convention; however, he resigned before the Convention assembled. Sept. 30, 1891: John J. Brinkerhoff (Illinois actuary) was elected Secretary for the 1891 Convention.

3. Sept. 18, 1895: William M. Hahn (OH) was elected President for the 1896 Convention and James R. Waddill (MO) was elected Vice-President; however, Superintendent Hahn was out of office effective June 3, 1886. Sept. 22, 1896: Superintendent Waddill was elected President for the 1896 Convention and Stephen W. Carr (ME) was chosen to act as Vice-President.
4. Sept. 23, 1896: James R. Waddill (MO) was elected President for the 1897 Convention and Stephen W. Carr (ME) was elected Vice-President; however, Mr. Waddill was out of office effective March 1, 1897. Sept. 7, 1897: Commissioner Carr was elected President for the 1897 Convention. It is unknown who acted as Vice-President.
5. Sept. 23, 1896: Frederick L. 'Fred' Cutting (MA) was elected Secretary for the 1897 Convention; however, he was out of office at the date of the Convention. Sept. 7, 1897: John J. Brinkerhoff (Illinois actuary) was elected Secretary for the 1897 Convention.
6. Sept. 7, 1897: Frederick L. 'Fred' Cutting (MA) was elected Secretary for the 1898 Convention; however, he declined the offer. Sept. 13, 1898: John J. Brinkerhoff (Illinois actuary) was elected Secretary for the 1898 Convention.
7. Sept. 15, 1898: Elmer H. Dearth (MN) was elected President for the 1899 Convention; however, he was out of office at the date of the Convention. Sept. 5, 1899: Edward T. Orear (MO) was elected President for the 1899 Convention.
8. Sept. 20, 1900: John A. O'Shaughnessy (MN) was elected President for the 1901 Convention; however, he was out of office at the date of the Convention. September 1901: William H. Hart (IN) was elected President for the 1901 Convention.
9. Sept. 29, 1910: Theodore H. Macdonald (CT) was elected Vice-President for the 1911 Convention; however, he was out of office at the date of the Convention. It is unknown who acted as Vice-President.
10. Aug. 25, 1911: Harry R. Cunningham (MT) was elected Secretary for the 1912 Convention; however, he resigned before the Convention assembled. March 1912: Fitz Hugh McMaster (SC) was elected Secretary for the 1912 Convention.
11. Aug. 1, 1913: Willard Done (UT) was elected First Vice-President for the 1914 Convention; however, he resigned before the Convention assembled. It is unknown who acted as First Vice-President.
12. Aug. 31, 1917: Emory H. English (IA) was elected President for the 1918 Convention; Robert J. Merrill (NH) was elected First Vice-President; and Michael J. Cleary (WI) was elected Second Vice-President. November 1917: Mr. Merrill resigned as First Vice-President. Dec. 6, 1917: Mr. Cleary was elected First Vice-President for the 1918 Convention and Walter K. Chorn (MO) was elected Second Vice-President. Jan. 1, 1918: Mr. English resigned as President and Mr. Cleary was elected President for the 1918 Convention by the Executive (EX) Committee. It is unknown who acted as First Vice-President.
13. Aug. 31, 1917: Fitz Hugh McMaster (SC) was elected Secretary for the 1918 Convention; however, he resigned before the Convention assembled. Dec. 6, 1917: Joseph L. Button (VA) was elected Secretary for the 1918 Convention.
14. Sept. 12, 1919: John B. Sanborn (MN) was elected Second Vice-President for the 1920 Convention; however, he resigned before the Convention assembled. June 1920: Alfred L. Harty (MO) was chosen to act as Second Vice-President for the 1920 Convention.
15. Sept. 3, 1920: Frank H. Ellsworth (MI) was elected President for the 1921 Convention; Alfred L. Harty (MO) was elected First Vice-President; and Thomas B. Donaldson (PA) was elected Second Vice-President. Commissioner Ellsworth resigned effective April 30, 1921, as NAIC President and Michigan Insurance Commissioner. June 27, 1921: Superintendent Harty was elected President for the 1921 Convention by the Executive (EX) Committee; Commissioner Donaldson was elected First Vice-President; and Platt Whitman (WI) was elected Second Vice-President.
16. Sept. 8, 1922: Platt Whitman (WI) was elected President for the 1923 Convention; Herbert O. Fishback (WA) was elected First Vice-President; and John C. Luning (FL) was elected Second Vice-President. July 1, 1923: Commissioner Whitman resigned as President; Commissioner Fishback was elected President for the 1923 Convention by the Executive (EX) Committee; and Mr. Luning was elected First Vice-President by the Executive (EX) Committee. It is unknown who acted as Second Vice-President.
17. Sept. 18, 1925: William R. C. Kendrick (IA) was elected President for the 1926 Convention. January 1926: Commissioner Kendrick resigned as NAIC President and Harry L. Conn (OH) was elected President for the 1926 Convention. Commissioner Kendrick remained as Iowa Insurance Commissioner until March 1, 1926.

18. Nov. 19, 1926: Harry L. Conn (OH) was elected President for the 1927 Convention and Albert S. Caldwell (TN) was elected First Vice-President. April 15, 1927: Superintendent Conn resigned as NAIC President and Ohio Insurance Superintendent. May 3, 1927: Commissioner Caldwell was elected President for the 1927 Convention and James A. Beha (NY) was elected First Vice-President.
19. Sept. 26, 1928: Charles R. Detrick (CA) was elected President for the 1929 Convention; James A. Beha (NY) was elected First Vice-President; and Howard P. Dunham (CT) was elected Second Vice-President. Jan. 1, 1929: Superintendent Beha resigned as NAIC First Vice-President and New York Insurance Superintendent. Commissioner Dunham was elected First Vice-President for the 1929 Convention. April 24, 1929: Commissioner Detrick resigned as NAIC President and California Insurance Commissioner. Commissioner Dunham was elected President for the 1929 Convention; Clarence C. Wysong (IN) was elected First Vice-President; and Jess G. Read (OK) was elected Second Vice-President.
20. Sept. 19, 1929: Joseph L. Button (VA) was elected Secretary for the 1930 Convention; however, he resigned effective Oct. 15, 1929, as NAIC Secretary and Virginia Commissioner of Insurance and Banking. Dec. 10, 1929: Albert S. Caldwell (TN) was elected Secretary for the 1930 Convention.
21. Sept. 9, 1930: Clarence C. Wysong (IN) was elected President for the 1931 Convention; Jess G. Read (OK) was elected First Vice-President; and Clare A. Lee (OR) was elected Second Vice-President. January 1931: Commissioner Wysong resigned effective Jan. 1, 1931, as NAIC President and Indiana Insurance Commissioner; Commissioner Lee was no longer serving as Second Vice-President; and Commissioner Read was elected President by the Executive (EX) Committee for the 1931 Convention. June 17, 1931: Charles D. Livingston (MI) was elected First Vice-President by the Executive (EX) Committee for the 1931 Convention and William A. Tarver (TX) was elected Second Vice-President by the Executive (EX) Committee.
22. Oct. 20, 1932: William A. Tarver (TX) was elected President for the 1933 Convention; Garfield W. Brown (MN) was elected First Vice-President; and Daniel C. 'Dan' Boney (NC) was elected Second Vice-President. Commissioner Tarver resigned effective Feb. 10, 1933, as NAIC President and Texas Life Insurance Commissioner. Commissioner Brown was elected President for the 1933 Convention; Commissioner Boney was chosen to act as First Vice-President and George S. Van Schaick (NY) was chosen to act as Second Vice-President.
23. July 1935: It is unclear why no one acted as First Vice-President or Second Vice-President for the 1935 Convention.
24. June 23, 1939: J. Balch Moor (DC) was elected Vice-President; however, he died July 22, 1939, before the 1940 Convention assembled. John C. Blackall (CT) was elected Vice-President by the Executive (EX) Committee to fill the unexpired term.
25. June 6, 1945: Edward L. Scheufler (MO) was elected Vice-President for the 1946 Convention; however, he resigned effective Oct. 15, 1945, as NAIC Vice-President and Missouri Insurance Superintendent. Dec. 3, 1945: Robert E. Dineen (NY) was elected Vice-President by the Executive (EX) Committee for the 1946 Convention.
26. June 11, 1946: Jess G. Read (OK) was elected Secretary for the 1947 Convention; however, he died July 20, 1946. Sept. 4, 1946: Nellis P. Parkinson (IL) was elected Secretary by the Executive (EX) Committee to fill the unexpired term.
27. June 1953: George B. Butler (TX) was elected Vice-President; however, he died Sept. 28, 1953. It is unknown who acted as Vice-President for the November 1953 Convention. Nov. 30, 1953: Donald Knowlton (NH) was elected Vice-President by the Executive (EX) Committee to fill the unexpired term.
28. May 1956: George A. Bowles (VA) was elected Secretary; however, he died June 1, 1956. Paul A. Hammel (NV) was elected Secretary to fill the unexpired term.
29. June 1958: Arch E. Northington (TN) was elected President; however, he resigned effective Dec. 23, 1958, as NAIC President and Tennessee Insurance Commissioner. January 1959: Paul A. Hammel (NV) was elected President and Sam N. Beery (CO) was elected Vice-President by the Executive (EX) Committee to fill the unexpired term.
30. June 1962: Joseph S. Gerber (IL) was elected Vice-President; however, he resigned effective Jan. 29, 1963, as NAIC Vice-President and Illinois Insurance Director. The office of Vice-President was vacant for the June 1963 Convention.
31. June 1968: Charles R. Howell (NJ) was elected President; however, he resigned effective Feb. 28, 1969, as NAIC President and New Jersey Commissioner of Banking and Insurance. Ned Price (TX) was elected by the Executive (EX) Committee to fill the unexpired term.

32. June 1970: Richard E. ‘Dick’ Stewart (NY) was elected President; however, he resigned as NAIC President effective Dec. 17, 1970, and as New York Insurance Superintendent effective Dec. 31, 1970. Dec. 17, 1970: Lorne R. Worthington (IA) was elected by Plenary to fill the unexpired term.
33. A constitutional amendment moved NAIC officer elections from June to December (commencing December 1974), President Johnnie L. Caldwell (GA) served a six-month term.
34. Kenneth E. ‘Ken’ DeShetler (OH) was elected President; however, he resigned effective Jan. 13, 1975, as NAIC President and Ohio Insurance Director. William H. Huff, III (IA) was elected by the Executive (EX) Committee to fill the unexpired term.
35. H. Peter ‘Pete’ Hudson (IN) was elected President; however, he resigned as NAIC President and Indiana Insurance Commissioner effective Nov. 15, 1979. It is unknown who presided over the December 1979 Convention.
36. John W. Lindsay resigned effective Sept. 3, 1981, as NAIC Vice-President and South Carolina Insurance Commissioner. Johnnie L. Caldwell (GA) was elected by the Executive (EX) Committee to fill the unexpired term.
37. David J. Lyons resigned effective June 17, 1994, as NAIC Vice President but remained as Iowa Insurance Commissioner until July 31, 1994. A special interim Plenary election was held June 12, 1994: Arkansas Insurance Commissioner Lee Douglass was elected Vice President to serve June 17, 1994, to Dec. 31, 1994.
38. September 2001: NAIC members unanimously agreed that the 2001 Fall National Meeting should be canceled in the wake of the tragic events that occurred Sept. 11, 2001. The meeting had been scheduled for Sept. 22–25, 2001, at the Marriott and Westin Copley Place hotels in Boston, Massachusetts.
39. Ernst N. ‘Ernie’ Csiszar resigned effective Aug. 18, 2004, as NAIC President and South Carolina Director of Insurance. Approximately two weeks later, James A. ‘Jim’ Poolman resigned as NAIC Vice President but remained as North Dakota Insurance Commissioner. A special interim Plenary election was held Sept. 13, 2004, during the Fall National Meeting in Anchorage, Alaska: Pennsylvania Insurance Commissioner M. Diane Koken was elected President; Oregon Insurance Administrator Joel S. Ario was elected Vice President; and Maine Insurance Superintendent Alessandro A. ‘Al’ Iuppa was elected Secretary-Treasurer to serve from Sept. 13, 2004, to Dec. 31, 2004.
40. December 2004: NAIC members voted at its 2004 Winter National Meeting to adopt amendments to the NAIC Bylaws, which included the creation of a President-Elect position as an NAIC officer.
41. September 2005: NAIC members agreed to cancel the 2005 Fall National Meeting due to the devastation caused by Hurricane Katrina on Aug. 29, 2005. The meeting had been scheduled for Sept. 10–13, 2005, at the Sheraton hotel in New Orleans, Louisiana.
42. Eric P. Serna resigned effective June 14, 2006, as NAIC Secretary-Treasurer and New Mexico Superintendent of Insurance. A special Plenary interim election was held during the 2006 Summer National Meeting: New Hampshire Insurance Commissioner Roger A. Seigny was elected Secretary-Treasurer to serve from June 14, 2006, to Dec. 31, 2006.
43. Michael T. McRaith resigned effective May 31, 2011, as NAIC Secretary-Treasurer and Illinois Director of Insurance. A special Plenary interim election was held via conference call May 16, 2011: North Dakota Insurance Commissioner Adam Hamm was elected Secretary-Treasurer to serve from May 31, 2011, to Dec. 31, 2011.
44. Aug. 25, 2011: NAIC members agreed to cancel its 2011 Summer National Meeting so members could assist consumers in disaster situations caused by Hurricane Irene. The meeting had been scheduled for Aug. 29–Sept. 1, 2011, at the Marriott Philadelphia Downtown in Philadelphia, Pennsylvania.
45. Michael F. ‘Mike’ Consedine resigned effective Jan. 20, 2015, as NAIC President-Elect and Pennsylvania Insurance Commissioner. A special Plenary interim election was held via conference call Feb. 8, 2015: Missouri Insurance Director John M. Huff was elected President-Elect to serve from Feb. 8, 2015, to Dec. 31, 2015.
46. Sharon P. Clark resigned effective Jan. 11, 2016, as NAIC President-Elect and Kentucky Insurance Commissioner. A special Plenary interim election was held in Bonita Springs, Florida, on Feb. 7, 2016: Wisconsin Insurance Commissioner Theodore K. ‘Ted’ Nickel was elected President-Elect; Tennessee Insurance Commissioner Julie Mix McPeak was elected Vice President; and Maine Insurance Superintendent Eric A. Cioppa was elected Secretary-Treasurer to serve from Feb. 7, 2016, to Dec. 31, 2017.

47. David C. Mattax, NAIC Secretary-Treasurer and Texas Insurance Commissioner, died in office April 13, 2017. A special Plenary interim election was held via conference call on May 12, 2017: South Carolina Insurance Director Raymond G. Farmer was elected Secretary-Treasurer to serve from May 12, 2017, to Dec. 31, 2017.
48. Gordon I. Ito resigned effective Dec. 31, 2018, as NAIC Vice President and Hawaii Insurance Commissioner. A special Plenary interim election was held in La Quinta, California, on Feb. 4, 2019: Florida Insurance Commissioner David Altmaier was elected Vice President to serve from Feb. 4, 2019, to Dec. 31, 2019.
49. March 11, 2020: Due to concerns about the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership— decided to hold the 2020 Spring National Meeting in a virtual format. However, on March 23, 2020, the NAIC officers decided to suspend holding any further sessions of the virtual Spring National Meeting to allow NAIC members and staff more time to focus on the health emergency. The meeting had been scheduled for March 21–24, 2020, at the Phoenix Convention Center and the Sheraton Grand and Hyatt Regency hotels in Phoenix, Arizona.
50. June 10, 2020: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2020 Summer National Meeting in a virtual format. The meeting had been scheduled for Aug. 8–11, 2020, at the Minneapolis Convention Center and the Hilton and Hyatt Regency hotels in Minneapolis, Minnesota.
51. Sept. 21, 2020: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2020 Fall National Meeting in a virtual format. The meeting had been scheduled for Nov. 14–17, 2020, at the JW Marriott hotel in Indianapolis, Indiana.
52. Feb. 24, 2021: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2021 Spring National Meeting in a virtual format. The meeting had been scheduled for April 10–13, 2021, at the Gaylord Texan Hotel and Convention Center in Grapevine, Texas.
53. June 1, 2021: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2021 Summer National Meeting in a hybrid format. In-person meetings took place for NAIC members and interested parties as capacity allowed. Meetings were live-streamed for participants who attended virtually.
54. Oct. 27, 2021: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2021 Fall National Meeting in a hybrid format. In-person meetings took place for NAIC members and interested parties as capacity allowed. Meetings were live-streamed for participants who attended virtually.

*Updated: 3/21/2023*

[https://naiconline.sharepoint.com/teams/MemberServicesExecutive/Shared/Meeting\\_Officer\\_Record.docx](https://naiconline.sharepoint.com/teams/MemberServicesExecutive/Shared/Meeting_Officer_Record.docx)

Documents/Commissioner/Meeting\_Officer\_Record/08-

## NAIC MODEL LAWS, REGULATIONS AND GUIDELINES

The following is a listing of NAIC model laws, regulations, and guidelines referenced in the *Proceedings* of the 2023 Spring National Meeting.

*Actuarial Opinion and Memorandum Regulation (#822)*

2-4, 2-18, 3-6, 5-22, 5-74, 5-75, 5-99, 5-100, 5-101, 10-3

*After Market Parts Model Regulation (#891)*

13-6

*Annuity Disclosure Model Regulation (#245)*

3-44

*Coordination of Benefits Model Regulation (#120)*

6-50, 6-71, 6-72

*Credit for Reinsurance Model Law (#785)*

9-24, 9-25, 9-676, 9-687, 10-18, 10-21

*Credit for Reinsurance Model Regulation (#786)*

10-21

*Disclosure of Material Transactions Model Act (#285)*

9-34

*Guidelines for Administration of Large Deductible Policies in Receivership (#1980)*

9-597, 9-646, 9-654, 9-655, 9-656, 9-657, 9-658, 9-659, 9-660

*Guidelines for Stay on Termination of Netting Agreements and Qualified Financial Contracts (#1556)*

9-602, 9-605

*Health Carrier Prescription Drug Benefit Management Model Act (#22)*

6-66

*Health Maintenance Organization Model Act (#430)*

3-44

*Insurance Consumer Privacy Protection Model Law (#674)*

2-2, 2-19, 3-3, 4-21, 12-4, 12-23, 12-24

*Insurance Data Security Model Law (#668)*

2-19, 12-14, 12-16, 12-17, 12-19, 12-25

*Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)*

2-18, 3-6, 3-44, 9-560, 9-565, 9-566, 10-2, 10-3

*Insurance Holding Company System Regulatory Act (#440)*

2-18, 3-6, 3-44, 9-74, 9-213, 9-560, 9-565, 9-566, 10-2

*Insurer Receivership Model Act (#555)*

9-558, 9-584, 9-588, 9-589, 9-592, 9-593, 9-594, 9-595, 9-601, 9-602, 9-603, 9-615, 9-617, 9-621, 9-622, 9-624, 9-625, 9-628, 9-629, 9-630, 9-631, 9-632, 9-633, 9-634, 9-635, 9-636, 9-637, 9-638, 9-639, 9-640, 9-641, 9-643, 9-644, 9-645, 9-646, 9-648, 9-649, 9-650, 9-651, 9-654, 9-655, 9-656, 9-657, 9-658, 9-659, 9-660, 9-661

*Investments of Insurers Model Act (Defined Limits Version) (#280)*

9-603, 10-21

*Life and Health Insurance Guaranty Association Model Act (#520)*

9-558, 9-594, 9-661

*Life and Health Reinsurance Agreements Model Regulation (#791)*

10-21

*Life Insurance Illustrations Model Regulation (#582)*

3-8, 3-11, 3-12, 3-13, 13-4, 13-5

*Long-Term Care Insurance Model Act (#640)*

6-72

*Long-Term Care Insurance Model Regulation (#641)*

6-72

*Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)*

2-2, 2-6, 3-3, 4-20, 6-45, 6-49, 6-50, 6-51, 6-52, 6-54

*Mortgage Guaranty Insurance Model Act (#630)*

2-2, 2-11, 2-12, 3-3, 3-6, 4-20, 9-1, 9-3, 9-5, 9-6, 9-8, 9-9, 9-11, 9-13, 9-15, 9-17, 9-18, 9-19, 9-21, 9-22, 9-23, 9-24, 9-25, 9-88

*NAIC Insurance Information and Privacy Protection Model Act (#670)*

5-15

*Nonadmitted Insurance Model Act (#870)*

2-2, 2-8, 2-9, 3-3, 3-4, 4-20, 4-21, 7-1, 7-2, 7-3, 7-17, 7-18, 7-20, 7-22, 7-24, 7-26, 7-28, 7-30, 7-32, 7-34, 7-36, 7-38, 7-40, 7-42, 7-155, 7-156, 7-157, 7-158, 7-159, 7-161, 7-163, 7-165, 7-167, 7-169, 7-171, 7-173, 7-175, 7-177, 7-179, 7-181, 7-183, 7-185, 7-186, 7-187

*Pet Insurance Model Act (#633)*

3-44

*Privacy of Consumer Financial and Health Information Regulation (#672)*

5-15

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

2-2, 2-17, 3-2, 3-3, 4-1, 4-2, 4-3, 4-9, 4-20, 9-534, 9-659, 9-660, 9-661

*Real Property Lender-Placed Insurance Model Act (#631)*

3-44



*Risk-Based Capital (RBC) for Insurers Model Act (#312)*

10-18, 10-21

*Standard Nonforfeiture Law for Individual Deferred Annuities (#805)*

3-4, 3-14, 3-15, 3-18, 3-44, 5-9

*Standard Valuation Law (#820)*

2-18, 3-6, 5-23, 5-44, 5-62, 5-99, 5-100, 9-514

*Suitability in Annuity Transactions Model Regulation (#275)*

3-44, 8-4

*Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170)*

4-20

*Term and Universal Life Insurance Reserve Financing Model Regulation (#787)*

2-17, 9-674, 9-676, 9-677

*Title Insurers Model Act (#628)*

2-9, 7-189, 7-190

*Unfair Trade Practices Act (#880)*

1-5, 2-2, 2-11, 3-2, 3-44, 4-1, 4-3, 4-11, 4-12, 5-10, 5-18, 8-3, 8-14, 9-18

*Variable Annuity Model Regulation (#250)*

3-14, 3-17

*NAIC 2023 Spring National Meeting  
Louisville, KY*

**OPENING SESSION**  
March 22, 2023

**CALL TO ORDER**

*Chlora Lindley-Myers, NAIC President*

The 237th session of the National Association of Insurance Commissioners (NAIC) will now come to order. Good afternoon. My name is Chlora Lindley-Myers, and I am the NAIC President and Director of the Missouri Department of Commerce and Insurance. It is my pleasure to open the 2023 NAIC Spring National Meeting.

Thank you to the NAIC Meetings team for all the planning that went into the experience we will have this week. I would like to thank Churchill Downs Bugler Steve Buttleman for playing the “Call to Post” and Kentucky Department of Insurance Investigator/Analyst Chris Woodyard for singing the National Anthem. What an inspiring way to kick off this meeting. Thank you!

**INTRODUCTION OF SPECIAL GUESTS**

*Chlora Lindley-Myers, NAIC President*

We are pleased to welcome our special guests: federal officials, state officials, and international regulators to our Spring National Meeting.

**INTRODUCTION OF HEAD TABLE**

*Chlora Lindley-Myers, NAIC President*

I am honored to introduce the members of our head table.

Honorable Sharon P. Clark, Meeting Host and Kentucky Insurance Commissioner  
Honorable James J. Donelon, NAIC Past President and Louisiana Insurance Commissioner  
Honorable Dean L. Cameron, NAIC Immediate Past President and Idaho Insurance Director  
Honorable Andrew N. Mais, NAIC President-Elect and Connecticut Insurance Commissioner  
Honorable Jon Godfread, NAIC Vice President and North Dakota Insurance Commissioner  
Honorable Scott A. White, NAIC Secretary-Treasurer and Virginia Insurance Commissioner  
Andrew J. Beal, NAIC Chief Operating Officer (COO) and Chief Legal Officer (CLO)  
Michael F. Consedine, NAIC Chief Executive Officer (CEO)

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

**INTRODUCTION OF NEW MEMBERS**

*Chlora Lindley-Myers, NAIC President*

I would also like to recognize our newest members in this short video. [New member video plays]

**INTRODUCTION OF HOST COMMISSIONER**

*Chlora Lindley-Myers, NAIC President*

Here to welcome us to the Blue Grass State is Kentucky’s Insurance Commissioner Sharon P. Clark, and I understand we will also have a special guest welcoming us. I love this Kentucky hospitality, but before we are officially welcomed, I want to share a few words about Commissioner Clark, someone whom I have had the pleasure of knowing for many years. Commissioner Clark is a veteran of the Kentucky state government. She was appointed commissioner of the Department of Insurance (DOI) on Jan. 6, 2020. She also served as commissioner of the DOI from July 2008 to January 2016, and she has the longest tenure as a Kentucky commissioner since the

DOI was established in May 1870. Commissioner Clark was the first director of the DOI's Consumer Protection and Education Division, a position she held for five years.

Under her leadership, the DOI hired its first ombudsman, added consumer education and outreach functions, and strengthened enforcement efforts by expanding the number of consumer complaint investigators. Commissioner Clark served as the chair of the Kentucky Health Benefit Exchange (KHBE) Advisory Board during its inaugural year and continues as a board member. She is a member of the Kentucky Group Health Insurance Board, and during her first tenure as Kentucky's insurance commissioner, she served as an officer at the NAIC and chair of the NAIC's Market Regulation and Consumer Affairs (D) Committee.

This year, Commissioner Clark serves on several committees, including serving as vice chair of the Financial Regulation Standards and Accreditation (F) Committee, vice chair of the Producer Licensing (D) Task Force, chair of the Regulatory Framework (B) Task Force, and a member of the of the National Insurance Producer Registry (NIPR) Board of Directors. I have known Commissioner Clark for a very long time. I can attest to her commitment and hard work for the Commonwealth of Kentucky. Thank you, Commissioner, for the work you do! You are a testament to the fact that a regulators' work is never done!

### **HOST COMMISSIONER REMARKS**

*Commissioner Sharon P. Clark*

Thank you, Madam President. I have enjoyed the chance to catch up with many of you already and welcome you to Louisville. For those I have not seen yet, I want to take the opportunity now to say thank you for joining us this week. I look forward to seeing you in the meetings and hallways, and hopefully outdoors! Our governor, Andy Beshear, unfortunately could not be with us to welcome you in person today, but we are grateful he could send a special video message. Prior to his election in 2019 as Kentucky's 63rd governor, Governor Beshear served as our state's 50th Attorney General. His family is no stranger to the governor's office, as he is the son of Kentucky's 61st governor, Steve Beshear. [Governor Beshear's video plays]

Thank you again to Governor Beshear. I want to echo the governor's comments in a couple ways.

First, while we have a lot of important work to do this week, I encourage you to take in as much of the "Derby City" as possible. Louisville contains so much of Kentucky's history and industry in one location, and it is the birthplace of notable names as diverse as Muhammad Ali, Hunter S. Thompson, and Mary Travers of "Peter, Paul and Mary." It has provided inspiration to F. Scott Fitzgerald, and at one point, it contributed 90% of the U.S.'s disco ball count—some of us remember John Travolta dancing in the movie "Saturday Night Fever." Perhaps Louisville is best known for the Kentucky Derby, and while the Derby itself is still a few weeks away, the Kentucky Derby Museum does a great job of providing the next best thing, immersing over 240,000 visitors each year in the experience and tradition of "the most exciting two minutes in sports." Baseball season is even closer, and for our baseball fans—NAIC staff, I am talking to you—you may want to check out the Louisville Slugger Museum & Factory. It is just down the street, and it is home to a 120-foot tall and 68,000-pound baseball bat. You can even order your own personalized Louisville Slugger.

In a few minutes, we will go our separate ways to different meetings, and in a few days, we will return to our homes. In this little piece of time and space where we are all together—regulators, industry, and interested parties—I want to echo Governor Beshear's remarks by saying thank you. To my fellow regulators, thank you for your encouragement, support, and assistance as Kentucky endured historic storms and devastation. Over the past several years, it has seemed that as one part of the state recovers, another gets hit in some way. I know Kentucky is far from alone in dealing with the effects of severe weather. This is not just our story. It seems like every week we hear of an insurance event that has tragically struck our country, but in our state-based system, we do not have to face these kinds of challenges on our own. We face them together. We see what the cameras show—the wreckage, the shattered lives—but our roles take us far beyond that. We are the hands that reach out to help pull

someone up; the ears that take their calls and give their grief and difficulties an outlet; the eyes that see life arise from the ashes and hope return when we help resolve their uncertainty, calm their fears, bring closure, and provide a new start. Our fellow citizens contact us when they are most in need, and we are there for them. As regulators, having each other's backs maximizes our ability to support our individual consumers and markets. None of us go through the same situation the same way, and our collective experiences and expertise better inform and influence our individual responses.

The world is not an easy place right now. In truth, it never has been. The work we do does not make it perfect, but it makes it far better. I hope that encourages you as much as it does me. To industry, thank you for your quick responses and flexibility as the claims poured in. Thank you for stepping up to the plate and standing alongside our departments. We tackle tragedy by working well together as a team. You may sell policies, but those plans are not just products. They secure a family's dreams, provide some certainty for our loved ones, or offer the only way to afford treatment and find relief for an illness. Consumers count on both of us, and we owe it to them to always keep them first. As I was thinking about what I wanted to say today, three words kept coming to mind: protection, trust, and faith.

Everything we do, whether as regulators or industry, should have consumers' protection foremost in mind, never forgetting the trust and faith they have in us and the trust and faith we must have in each other to honor our commitments to them. Madam President, I have known you for almost 25 years. I know your leadership. I know the consistent example and your "C.A.L.M." approach. Thank you for the opportunity to say a few words today.

#### **PRESIDENTIAL ADDRESS**

*Chlora Lindley-Myers, NAIC President*

It is my honor to welcome you to the NAIC Spring National Meeting. On behalf of my fellow commissioners and the NAIC staff, thank you for joining us. We hope you have a wonderful experience at this meeting as you learn, participate, and network with the other attendees.

For those who are joining us for the first time, let us have a special welcoming round of applause! Each one of us has had a "first" national meeting. Some of us may have been around long enough that it is hard to remember our first meeting, but we all learned the ropes because someone took the time to welcome us and show us how things work. Do not hesitate to reach out and ask questions; we are all glad you are here.

As we are welcoming newcomers to the NAIC, we must say good-bye to others from time to time. With great sadness, we share the news of the passing of Colin M. Hayashida, former Hawaii Insurance Commissioner. He passed away on Feb. 28, 2023, due to health issues. Colin's work for the Hawaii Insurance Division spanned over 20 years, including his service as commissioner from January 2019 to December 2022. He was an extraordinary person who made countless contributions to advance NAIC efforts, the insurance industry, and his community. Colin will be greatly missed, and our deepest sympathies are with Colin's family, friends, and colleagues at the Hawaii Insurance Division.

We also say good-bye, in another way, to NAIC Chief Executive Officer (CEO) Mike Consedine, who submitted his resignation and will be leaving us on April 30. Mike has done a wonderful job in his leadership of the NAIC, and we are grateful for his dedication to the success of this organization. He led us during the pandemic through strategic planning, as well as some of our most challenging international issues. I know his shoes will be hard to fill, but we wish him well as he looks at the next chapter in his career, one that will allow him to spend more time with his lovely family. On behalf of all of the NAIC family, thank you Mike!

I have been a part of the NAIC and attending national meetings for many, many, MANY years, and I am just as excited and passionate about the mission of the NAIC and the work of state insurance regulators now as I was when I started in the early 1980s. Our state-based regulatory system is vital to keeping consumers safe and our

industry thriving. I applaud the resiliency of the NAIC and the perseverance of our state insurance regulators. I appreciate the curiosity and actions of interested parties who want to know more and do more to improve access and protections for our consumers.

The amount of effort it takes to ensure the insurance market's solvency and stability and educate the public about insurance products is significant. Since the NAIC was founded in 1871, insurance company solvency and the protection of consumers have been the core of who we are and what we do. While we come from a variety of different political viewpoints, geographical regions, experiences, and perspectives, we all have common goals. In a world filled with global uncertainty, challenges, and divisions, our commitment to support one another fuels our progress, growth, and effectiveness.

Our list of challenges is growing every day and, frankly, every minute. The insurance landscape is changing at an accelerated pace. This means our work here is more important each time we meet, and our ability to focus and collaborate is critical.

As we look at the many goals we must address, it is good to know we have a guide to help us achieve those goals. Many of you may recall the NAIC's *State Ahead* strategic plan. I am happy to announce the next phase of *State Ahead*, called *State Connected*. *State Connected* is a three-year plan that builds on that foundational blueprint for the NAIC's future. *State Connected* was finalized in the fall of 2022, and it has six key strategic focus areas:

- **Member Connectivity**

An example of member connectivity is the new NAIC Connect app that encourages more member access and interaction.

- **Training, Expertise, and Technology**
- **Data and Analytics**
- **Consumer Education, Outreach, and Advocacy**

I believe this is one of our most important areas of responsibility. Our consumers need our help to become better informed, educated, and prepared to make better decisions.

- **Committee Governance and Management**
- **NAIC Operations**

The vision that *State Connected* represents is a combined vision, and it would not have been possible without the engagement and support of all NAIC members and NAIC staff. The plan was formulated over a two-year period involving countless sessions and discussions. Now, it is finally time to implement it, and we are excited! Consumers, market participants, and our fellow state insurance regulators are counting on us to continue building on that long legacy of excellence. For those of us now serving, we must carry this forward and demonstrate our commitment. For more information, I invite you to reference our *State Connected* strategy at [naic.org](http://naic.org).

Last month, we announced the NAIC's 2023 priorities, and you will be able to see the *State Connected* strategic plan woven into most of what we do. Although the priorities are familiar, we all agree that the six areas identified for 2023 should receive our attention and focus.

It should come as no surprise that a top priority continues to be **financial oversight and transparency**. While this is always a priority for the NAIC, it is even more important given the economic climate we are in right now.

We need to maintain our vigilance to ensure companies are not only able to remain solvent and pay their claims when times are good, but they are also making sound investment choices and safeguarding their ability to remain solvent when we have economic challenges and a prolonged low interest rate environment. Stability is essential and remains a high priority.

**Cybersecurity** continues to be a big concern worldwide. Data breaches have touched nearly every industry, and the demand for cyber insurance is growing. Globally, this is further affected by international issues such as the war in Ukraine, supply chain interruptions, and the volatility in banking and the insurance marketplace. How companies are managing their third-party risks is now something that is on our radar. The fact that companies outsource certain functions and services does not absolve them of their responsibility.

Beyond cybersecurity, other technological issues, such as artificial intelligence (AI), are being addressed by the new Innovation, Cybersecurity, and Technology (H) Committee. While AI itself can represent advancements in the industry, we must also be mindful of the potential pitfalls that come along with this automation.

We want to see product innovation, but we also need to protect a consumer against potential problems, such as predictive modeling, price algorithms, and AI, which may affect people of color or underrepresented groups. Ensuring that everyone who needs insurance can get insurance is an important issue for us. Ensuring that consumers understand and know what they are buying and what protections it affords is a priority for the NAIC when looking at the **marketing of insurance products**.

As people become even more concerned with their family budgets, they look for the best value or least expensive option to serve their needs. We want to protect those consumers from being exposed to plans that may be marketed in an unfair and deceptive manner. Amending our *Unfair Trade Practices Act* (#880) and ensuring we stay up to date on some of these deceptive practices will help us keep our consumers safe and our markets safe and stable.

Another priority on our list is a possible transition of the **long-term care (LTC)** strategy. We will continue working to resolve the inconsistent rate review practices among the state insurance departments and ensure that consistent regulatory oversight and reduced benefit options are available to our collective citizenry. Customers who have these products should get what they are paying for.

**Race and insurance** continues to be a priority for the NAIC. We must continue to focus on addressing race, diversity, and inclusion within the insurance sector. Our customers are varied, our products are varied, our services are varied, and we should meet that. This includes not only access to affordable products, but also practices within the insurance industry that may have the potential to disadvantage people of color or underrepresented groups. We need to look at that. We are taking major steps to ensure that the protection gap is closed and that we look at ways to make financial inclusion a priority. We will continue to work across the various committees to accomplish these goals, but it takes all of us to do that.

Last, but certainly not least, is **climate risk, natural catastrophe, and resiliency**. Every commissioner in every state has a list of natural disasters they are dealing with from droughts to flooding, tornadoes to hurricanes, wildfires to earthquakes. Our newsfeeds are full of an increasing number of natural catastrophes, and this makes the business of insurance even more complicated. This is not just a state problem or a U.S. problem; it is a global issue. We are continuing to look at ways to anticipate and plan for these events and reduce the negative impact on our consumers.

One of the key ways we can help consumers prepare is through education. The NAIC hopes to develop a consumer education campaign on the coverage gap to help build awareness about this issue and inform them of the NAIC's efforts to work on this problem on their behalf.

If you want more information about the NAIC's 2023 priorities, you can tune in to Season 5, Episode 2 of the NAIC's "The Regulators" podcast, where I talked about each of these in more detail.

As we look ahead to the rest of this week and all the important work that continues to be before us, I want to remind you again that this year is the year of CALM. I know I have already explained that this is a play on my initials, and in my first newsletter I outlined what each letter of CALM represents.

Now, I want to put one more layer of meaning on the word CALM. The dictionary would tell us that calm simply implies the absence of agitation or one who is composed or has clarity of judgment.

Calm will help guide us as we address the many issues ahead of us. The work we have before us is important and complex. We will not always agree on the solutions or the path forward, but I know we will work together to find the right path, pivot where we need to, and abandon what no longer works. We will be calm and collegial.

I have the utmost respect for the talent and knowledge represented by this body of state insurance regulators. I look forward to working with you this year and moving the ball forward for the consumers we serve.

I want to thank you for working with me and together with consumers and the varied industry we regulate to make products plentiful, meaningful, accessible and most of all fairly priced and available. Welcome to the NAIC Spring National Meeting.

**ADJOURNMENT**

*Chlora Lindley-Myers, NAIC President*

I look forward to the sessions and discussing the work of the NAIC. I encourage you to network, make note of ways you can support state insurance regulators and the mission of the NAIC. With that, I officially conclude this opening session of the 237th meeting of the NAIC.

Draft: 4/26/2023

**Synopsis of the NAIC Committee, Subcommittee, and Task Force Meetings  
2023 Spring National Meeting  
March 21–25, 2023**

TO: Members of the NAIC and Interested Parties

FROM: The Staff of the NAIC

Committee Action

NAIC staff have reviewed the committee, subcommittee, and task force reports and highlighted the actions taken by the committee groups during the 2023 Spring National Meeting. The purpose of this report is to provide NAIC members, state insurance regulators, and interested parties with a summary of these meeting reports.

**EXECUTIVE (EX) COMMITTEE AND PLENARY (Joint Session)**

March 25, 2023

1. Received the March 23 report of the Executive (EX) Committee. See the Committee listing for details.
2. Adopted by consent the committee, subcommittee, and task force minutes of the 2022 Fall National Meeting.
3. Received the report of the Life Insurance and Annuities (A) Committee. See the Committee listing for details.
4. Received the report of the Health Insurance and Managed Care (B) Committee. See the Committee listing for details.
5. Received the report of the Property and Casualty Insurance (C) Committee. See the Committee listing for details.
6. Received the report of the Market Regulation and Consumer Affairs (D) Committee. See the Committee listing for details.
7. Received the report of the Financial Condition (E) Committee. See the Committee listing for details.
8. Received the report of the Financial Regulation Standards and Accreditation (F) Committee. See the Committee listing for details.
9. Received the report of the International Insurance Relations (G) Committee. See the Committee listing for details.
10. Received the report of the Innovation, Cybersecurity, and Technology (H) Committee. See the Committee listing for details.
11. Adopted the revisions 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)*.
12. Adopted *Actuarial Guideline LIV—Nonforfeiture Requirements for Index-Linked Variable Annuity Products (AG 54)*.
13. Adopted the *Regulator Resources for Consumers on Personal Lines Pricing and Underwriting*.
14. Adopted the *Rate/Rule Filing Checklist*.
15. Received a report on the state implementation of NAIC-adopted model laws and regulations.

**EXECUTIVE (EX) COMMITTEE**

March 23, 2023

1. Adopted the report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, which met March 22 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) and paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance). During this meeting, the Committee and Subcommittee took the following action:
  - A. Appointed Andrew J. Beal (NAIC, Chief Operating Officer and Chief Legal Officer) as acting Chief Executive Officer (CEO).



- B. Approved the retention of a consultant to conduct an organizational review and succession planning exercise.
2. Adopted the report of the Executive (EX) Committee, which met Feb. 10 and Jan. 13 and took the following action:
  - A. Appointed Superintendent Elizabeth Kelleher Dwyer (RI) to serve on the International Association of Insurance Supervisors (IAIS) Executive Committee.
  - B. Appointed the following to serve as members on the Consumer Board of Trustees: Commissioner Andrew R. Stolfi, Chair (OR); Commissioner Alan McClain (AR); Director Dana Popish Severinghaus (IL); Commissioner Vicki Schmidt (KS); Commissioner Troy Downing (MT); and Acting Commissioner Michael Humphreys (PA).
  - C. Appointed Commissioner Glen Mulready (OK) to the National Insurance Producer Registry (NIPR) Board of Directors.
  - D. Approved the recommendation for the NAIC's Kansas City, MO, office space.
  - E. Adopted the Washington, DC, property site selection and fiscal impact statement.
  - F. Appointed the following as members of the NAIC 2023 Audit Committee: Connecticut, Kentucky, Maryland, Massachusetts, Missouri, Nebraska, New Jersey, North Dakota, Oregon, South Dakota, Tennessee, and Virginia.
  - G. Received an update from the Investment Committee.
  - H. Received updates on various operational matters.
3. Adopted the report of the Climate and Resiliency (EX) Task Force. See the Task Force listing for details.
4. Adopted the report of the Government Relations (EX) Leadership Council. See the Leadership Council listing for details.
5. Adopted the report of the Long-Term Care Insurance (EX) Task Force. See the Task Force listing for details.
6. Adopted the report of the Special (EX) Committee on Race and Insurance. See the Special Committee listing for details.
7. Adopted the Request for NAIC Model Law Development to amend the *Property and Casualty Insurance Guaranty Association Model Act* (#540).
8. Adopted the Request for NAIC Model Law Development to amend the *Unfair Trade Practices Act* (#880).
9. Received the 2022 Annual Report of the NAIC Designation Program Advisory Board activities.
10. Received a status report on the implementation of the *State Connected* strategic plan.
11. Received a status report on model law development efforts for amendments to: 1) the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171); 2) Model #540; 3) the *Mortgage Guaranty Insurance Model Act* (#630); 4) the *Nonadmitted Insurance Model Act* (#870); and 5) the *Insurance Consumer Privacy Protection Model Law* (#674).
12. Heard a report from NIPR.
13. Heard a report from the Interstate Insurance Product Regulation Commission (Compact).

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

March 24, 2023

1. Received updates from its workstreams:
  - A. The Pre-Disaster Mitigation Workstream will continue to be led by Director Barbara D. Richardson (AZ).
  - B. The Climate Risk Disclosure Workstream will continue to be led by Commissioner Andrew R. Stolfi (OR).
  - C. The Technology Workstream and Innovation Workstream will be combined into one Technology Workstream that will be led by Commissioner James J. Donelon (LA).
  - D. The Solvency Workstream will continue to be led by Commissioner Kathleen A. Birrane (MD). The Workstream met Feb. 1 in regulator-to-regulator session and took the following action:
    - i. Heard a presentation from the Federal Reserve on its recently exposed proposed climate scenario analysis exercise.
    - ii. Discussed members' initial view on the role of climate scenario analysis as a financial oversight tool for U.S. state insurance regulators.

2. Adopted its 2022 Fall National Meeting Minutes.
3. Heard a presentation from Public Safety Canada (PSC) on Canadian flood risk and proposed insurance solutions. The Task Force on Flood Insurance and Relocation explored viable solutions for insurance in high-risk areas and the consideration for the potential relocation of homes most at risk of repeat flooding. The summarization of its findings and the analysis of possible insurance solutions in Canada are found in the Task Force’s paper “Adapting to Rising Flood Risk: An Analysis of Insurance Solutions for Canada.” The paper identifies four flood insurance market obstacles, including uncertainty, market penetration, affordability, and moral hazard, and it identifies recommendations to combat those obstacles.
4. Heard a presentation from the Canadian Council of Insurance Regulators (CCIR) on consumer protection gaps and property-specific risk related to flood risk in Canada. The presentation highlighted recommendations that will be found in the March 2023 report, including identifying best practices for assessing and communicating natural catastrophe risk, training, and education for those selling flood insurance; innovation in products and incentives for consumer mitigation practices; and ensuring that consumers understand the insurance product they are being offered.
5. Heard an international update. The International Association of Insurance Supervisors (IAIS) held public consultations on an approach to address climate risk, and it continues work on scenario analysis and climate risk data. The Sustainable Insurance Forum (SIF) is addressing access and affordability issues.
6. Heard a federal update. The National Flood Insurance Program (NFIP) expires on Sept. 30. The U.S. Congress (Congress) held a hearing on encouraging greater flood insurance coverage in America. The U.S. Securities and Exchange Commission’s (SEC’s) climate risk disclosure rule is expected to be finalized in the next few months. The executive branch’s budget proposal contains funding for investment in clean energy and community resilience to natural disasters. The NAIC continues to support the Disaster Mitigation and Tax Parity Act.
7. Received an update from the Catastrophe Modeling Center of Excellence (COE). The COE is developing catastrophe model training; developing tools, such as the compendium of regulatory interaction and requirements regarding catastrophe models; and continuing to engage insurance departments, catastrophe modelers, and organizations focused on resilience initiatives.

### **Government Relations (EX) Leadership Council**

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

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

March 13, 2023 (in lieu of the Spring National Meeting)

1. Adopted its 2022 Fall National Meeting minutes.
2. Heard a report on industry trends and other updates. State insurance departments continue to monitor the impacts of cost-of-care inflation, shifts in care from facilities to home care, increases in home care daily costs and other factors. The Long-Term Care Actuarial (B) Working Group has requested comments on the information checklist for rate increase filings and the actuarial methodologies for rate review. If any changes to either the checklist or the methodologies are made as a result of the Working Group’s review, related changes will be referred to the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework).
3. Adopted proposed edits to the *Checklist for Premium Increase Communications*.

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

March 23, 2023

1. Adopted its 2022 Fall National Meeting minutes.
2. Received a status report from the Property/Casualty (P/C) Workstream.
3. Received a status report from the Life Workstream.
4. Received a status report from the Health Workstream.
5. Heard an update on the Member Diversity Leadership Forum.

**INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE**

See the Executive (EX) Committee listing for details.

**LIFE INSURANCE AND ANNUITIES (A) COMMITTEE**

March 23, 2023

1. Adopted its Feb. 24 minutes, which included the following action:
  - A. Adopted its 2022 Fall National Meeting minutes.
  - B. Adopted revisions 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).
  - C. Adopted *Actuarial Guideline LIV—Nonforfeiture Requirements for Index-Linked Variable Annuity Products* (AG 54).
2. Adopted the report of the Life Actuarial (A) Task Force. See the Task Force listing for details.
3. Adopted the report of the Accelerated Underwriting (A) Working Group, including its Feb. 22 minutes. During this meeting, the Working Group took the following action:
  - A. Exposed the draft regulatory guidance for accelerated underwriting (AU) in life insurance for a 45-day public comment period ending April 15.
  - B. Exposed the draft referral to the Market Conduct Examination Guidelines (D) Working Group for a 30-day public comment period ending March 24.
4. Heard a presentation from the American Council of Life Insurers (ACLI) and the Society of Actuaries (SOA) on the current state of life insurance.

**Life Actuarial (A) Task Force**

March 20–21, 2023

1. Adopted its March 2, Feb. 23, Feb. 2, and Jan. 26 minutes, which included the following action:
  - A. Exposed referrals received from the Valuation of Securities (E) Task Force.
  - B. Exposed a VM-20, Requirements for Principle-Based Reserves for Life Products/VM-21, Requirements for Principle-Based Reserves for Variable Annuities, Economic Scenario Generator Technical Drafting Group topics, timing, and decision points document.
  - C. Adopted amendment proposal form (APF) 2022-09, which addresses reporting issues in VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation.
  - D. Exposed APF 2023-04, which clarifies VM-31 reporting requirements that support company experience mortality rates.
  - E. Adopted its 2022 Fall National Meeting Minutes.
  - F. Exposed proposed charges for the Economic Scenarios (E/A) Subgroup.
  - G. Adopted APF 2022-10, which clarifies VM-20 requirements for universal life policies with non-material secondary guarantees.
  - H. Adopted APF 2023-02, which adds disclosure requirements to VM-31 to explain any reporting discrepancies between the annual statement and the principle-based reserving (PBR) actuarial report.
  - I. Exposed APF 2023-01, a non-substantive amendment to clarify the value of starting assets in VM-21.
  - J. Exposed APF 2023-03, which addresses a series of clean-up items in VM-20, VM-21, and VM-31.
  - K. Responded to a referral from the Financial Regulation Standards and Accreditation (F) Committee by conveying the Task Force’s recommendation to remove the *Actuarial Opinion and Memorandum Regulation* (#822) as an accreditation standard.
  - L. Adopted APF 2022-07, which clarifies a VM-20 net premium reserve (NPR) mortality adjustment.
  - M. Adopted APF 2022-08, which clarifies that companies only reporting VM-21 reserves determined using the alternative methodology are subject to limited governance requirements under VM-G, Appendix G – Corporate Governance Guidance for Principle-Based Reserves.

2. Adopted the reports of the Longevity Risk (E/A) Subgroup, the Variable Annuities Capital and Reserve (E/A) Subgroup, the Indexed Universal Life (IUL) Illustration (A) Subgroup, and the Index-Linked Variable Annuity (A) Subgroup, which have not met this year.
3. Adopted the report of the Valuation Manual (VM)-22 (A) Subgroup, including its March 1 minutes. During this meeting, the Subgroup took the following action:
  - A. Heard an update on the VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, project plan.
  - B. Discussed the VM-22 exemption.
4. Heard a presentation on the impact of a rising interest rate environment.
5. Heard an update on the *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53) review plan.
6. Adopted the report of the Experience Reporting (A) Subgroup and heard an update on VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.
7. Exposed APF 2021-08, which would reduce the time lag in the VM-50/VM-51 mortality experience collection.
8. Heard a presentation on the VM-21/C3 Phase II economic scenario generator field test.
9. Exposed APF 2023-05, which revises hedge modeling language in the *Valuation Manual* to address index hedge crediting.
10. Heard an update from the American Academy of Actuaries (Academy) Life Practice Council.
11. Received an update on the activities of the Economic Scenario Generator Governance Drafting Group, the VM-20/VM-21 Economic Scenario Generator Technical Drafting Group, and the Standard Projection Amount Drafting Group.
12. Heard an update on the Society of Actuaries' (SOA's) research and education.
13. Heard an update from the Academy Council on Professionalism and Education.
14. Heard an update on mortality improvement.
15. Adopted APF 2023-03, which clarifies the VM-20 treatment of hedge modeling error and adds considerations to VM-20 regarding the assumed cost of borrowing and the treatment of risk factors other than interest and equities that are stochastically modeled.
16. Adopted APF 2023-01, which clarifies the value of starting assets in VM-21.

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

March 24, 2023

1. Discussed its 2023 activities.
2. Adopted its 2022 Fall National Meeting minutes.
3. Adopted the report of the Consumer Information (B) Subgroup, including its Feb. 2 minutes. During this meeting, the Subgroup took the following action:
  - A. Adopted its Jan. 31 minutes, which included the following action:
    - i. Discussed the results of a survey of states' consumer engagement activities.
  - B. Discussed its potential activities for 2023.
4. Adopted the report of the Health Innovations (B) Working Group, which met March 22 and took the following action:
  - A. Adopted its 2022 Fall National Meeting minutes.
  - B. Heard presentations from the Colorado Division of Insurance, the National Health Law Program (NHeLP), and America's Health Insurance Plans (AHIP) on work and recommendations related to essential health benefits (EHBs).
  - C. Discussed potential topics for future meetings, including telehealth services and adjustments to the premium load attributable to cost-sharing reductions.
5. Adopted the report of the Health Actuarial (B) Task Force. See the Task Force listing for details.
6. Adopted the report of the Regulatory Framework (B) Task Force. See the Task Force listing for details.
7. Adopted the report of the Senior Issues (B) Task Force. See the Task Force listing for details.

8. Heard a discussion on the Kaiser Family Foundation (KFF) issue brief, “Claims Denials and Appeals in ACA Marketplace Plans in 2021.” The presenters discussed what the data could mean and its limitations, whether the federal Centers for Medicare & Medicaid Services (CMS) use it as part of its regulatory oversight responsibilities, and its potential future uses.
9. Heard a discussion on a state “checklist” of actions related to the Medicaid unwinding process provided in the State Health and Value Strategies’ (SHVS’) issue brief, “Secrets to a Successful Unwinding: Actions State-Based Marketplaces and Insurance Departments Can Take to Improve Coverage Transitions.”
10. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on its recent activities.

### **Health Actuarial (B) Task Force**

March 21, 2023

1. Adopted its 2022 Fall National Meeting minutes.
2. Adopted the report of the Long-Term Care Actuarial (B) Working Group, including its Feb. 17 minutes. During this meeting, the Working Group took the following action:
  - A. Discussed disbanding the Long-Term Care Pricing (B) Subgroup and the Long-Term Care Valuation (B) Subgroup.
  - B. Exposed a request for comments on a proposal to revise the nationally coordinated long-term care insurance (LTCI) rate increase review checklist.
  - C. Exposed a request for comments on the Minnesota and Texas LTCI rate increase review methodologies.
  - D. Heard an update on LTCI valuation issues.
3. Disbanded the Long-Term Care Pricing (B) Subgroup and the Long-Term Care Valuation (B) Subgroup.
4. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on plan year 2024 federal Affordable Care Act (ACA) rate filing dates and procedures.
5. Heard a presentation from the Society of Actuaries (SOA) Research Institute on social, physical, and cultural determinants of health and their incorporation into actuarial data and workstreams.
6. Heard a presentation from the American Academy of Actuaries (Academy) Health Practice Council (HPC) on its key 2023 policy priorities of health equity, COVID-19 and other public health challenges, insurance coverage and benefit design, health care costs and quality, Medicare sustainability, long-term services and supports, financial reporting and solvency, and professionalism.
7. Heard an Academy professionalism update on the 2022 Actuarial Board for Counseling and Discipline (ABCD) report and revisions to various Actuarial Standards of Practice (ASOPs).

### **Regulatory Framework (B) Task Force**

March 22, 2023

1. Adopted its 2022 Fall National Meeting minutes.
2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its March 13, Feb. 27, and Feb. 13 minutes. During these meetings, the Subgroup took the following action:
  - A. Discussed the comments received on Section 8A—Supplementary and Short-Term Health Minimum Standards for Benefits of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).
  - B. Completed its review of Section 8A of Model #171.
  - C. Discussed the comments received on Section 7—Prohibited Policy Provisions of Model #171.
  - D. Discussed its upcoming work to review the remaining provisions in Model #171 in the following order:
    - i. The remainder of Section 8, including revisiting the proposed new subsection on short-term, limited-duration (STLD) plans to discuss the Feb. 24 comments received on that section.
    - ii. Section 7.
    - iii. Revisit Section 5—Definitions and Section 6—Policy Definitions to reconcile any inconsistencies that may have arisen after the Subgroup’s review of the substantive provisions of Model #171.
    - iv. Section 9—Required Disclosure Provisions.

3. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group. The Working Group has not met in open session since the 2022 Summer National Meeting, but it is continuing its work to update the NAIC chart on multiple employer welfare arrangements (MEWAs)/multiple employer trust (METs) and association plans and surveying the states regarding their stop-loss laws in relation to level-funded plans.
4. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, which plans to meet March 23 to hear a discussion of the *Wit v. United Behavioral Health* case, a potential landmark case setting a precedent for how care will be covered for individuals seeking treatment for mental health and addiction. The Working Group also met Feb. 24 and took the following action:
  - A. Adopted its 2022 Fall National Meeting minutes.
  - B. Discussed parity issues with health insurers.
5. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, which met March 22 and took the following action:
  - A. Adopted its 2022 Fall National Meeting minutes.
  - B. Received an update on the status of the pharmacy benefit manager (PBM) white paper.
  - C. Heard an update on PBM-related federal legislative and regulatory activities.
  - D. Heard an update on PBM-related litigation.
  - E. Heard a discussion on recently enacted state laws regulating PBMs and their business practices.
6. Heard an update from the Center on Health Insurance Reforms (CHIR) on its work on various projects of interest to the Task Force. In light of the upcoming end of the public health emergency (PHE) and the resulting Medicaid unwinding process, the CHIR recently released an issue brief, “Secrets to a Successful Unwinding: Actions State-Based Marketplaces and Insurance Departments Can Take to Improve Coverage Transitions.” The CHIR has taken on a few projects related to enrollment, including an analysis of state-based marketplace (SBM) outreach strategies for boosting health plan enrollment of the uninsured and the process of implementing the family glitch fix on the federal Affordable Care Act’s (ACA’s) marketplaces. The CHIR is also examining state activities, such as those occurring in Washington and Nevada, related to public option programs. The CHIR plans to continue monitoring these activities and new state public option legislation. The CHIR is examining what states are doing to improve coverage, and it recently released a few issue briefs highlighting state efforts in this area. The CHIR is continuing to monitor and analyze state action related to health equity. As part of this effort, the CHIR plans to publish a survey of SBMs’ language access and policy practices. The CHIR continues to monitor the implementation of the federal No Surprises Act (NSA), and it expects to issue publications on several issues related to the implementation process, including a one-year progress report. The CHIR recently launched a four-part series studying employer-sponsored insurance (ESI) and cost containment. The CHIR’s future work in this area includes investigating cost containment and outpatient facility fees. Another future CHIR project is a 50-state survey on state protections against medical debt.

### **Senior Issues (B) Task Force**

March 22, 2023

1. Adopted its 2022 Fall National Meeting minutes.
2. Discussed issues and topics for the Task Force to consider in 2023, including:
  - A. Medicare Advantage and whether the oversight should return to the states.
  - B. Possibly refreshing the 2017 long-term care insurance (LTCI) policy options document.
  - C. Preparing for any possible recommendations from the Long-Term Care Insurance (EX) Task Force.
  - D. Revisiting the conflict between Medicare and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) rules that has led to some confusion about which system and set of rules govern eligibility for coverage, as well as how the responsibility for the payment of health care benefits for eligible individuals is determined.
  - E. Possible further action on the conflict involving durable medical equipment (DME), Medicare Supplement (Medigap), and excess charges.

## PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

### March 24, 2023

1. Adopted its 2022 Fall National Meeting minutes.
2. Adopted the report of the Casualty Actuarial and Statistical (C) Task Force. See the Task Force listing for details.
3. Adopted the report of the Surplus Lines (C) Task Force. See the Task Force listing for details.
4. Adopted the report of the Title Insurance (C) Task Force. See the Task Force listing for details.
5. Adopted the report of the Workers' Compensation (C) Task Force. See the Task Force listing for details.
6. Adopted the report of the Cannabis Insurance (C) Working Group, which has not met this year.
7. Adopted the report of the Catastrophe Insurance (C) Working Group, which met March 21 in joint session with the NAIC/Federal Emergency Management Agency (FEMA) (C) Advisory Group and took the following action:
  - A. Adopted its 2022 Fall National Meeting minutes.
  - B. Heard an update on federal legislation. The National Flood Insurance Program (NFIP) has had 25 reauthorizations since 2017. Risk Rating 2.0, affordability, and the NFIP reauthorization are all being discussed. FEMA has experienced declines in reinsurance due to the hardening market.
  - C. Received an update on the *Catastrophe Modeling Primer* (Primer) progress. The drafting group has met several times, and it is making progress. Currently, several sections have been drafted, and the drafting group plans to meet following the Spring National Meeting to continue its work.
  - D. Heard updates regarding the activities of state and FEMA regional workshops. FEMA Region 1 will meet in Massachusetts May 22–23. The purpose of the meeting is to help departments of insurance (DOIs) form relationships with their FEMA partners. FEMA Region 2 and FEMA Region 3 will hold meetings later.
  - E. Heard a presentation from the Midland Radio Corporation on the National Oceanic and Atmospheric Administration (NOAA) Weather Radio (NWR). The presentation included the importance of using weather radios, as well as the availability of the radios through the FEMA Hazard Mitigation Grant Program (HMGP).
  - F. Held a panel discussion on homeowners deductible trends. There was a panelist representing consumers, a panelist representing insurers, and a panelist representing state insurance regulators. The panel discussed the types of deductibles trending, the importance of mitigation, and a policyholder's understanding of their homeowners insurance policy.
8. Adopted the report of the Terrorism Insurance Implementation (C) Working Group, which has not met this year.
9. Adopted the report of the Transparency and Readability of Consumer Information (C) Working Group, which met March 15 and took the following action:
  - A. Adopted its 2022 Fall National Meeting minutes.
10. Adopted revisions to the *Nonadmitted Insurance Model Act* (#870).
11. Heard presentations from the Nonprofits Insurance Alliance (NIA) and the National Association of Mutual Insurance Companies (NAMIC) on the availability and affordability of insurance coverage for nonprofit organizations.
12. Discussed the Committee's charge related to developing marketing intelligence data so state insurance regulators can better assess their markets. Heard presentations from Florida, Missouri, and the NAIC about prior data calls and how they helped state insurance regulators meet regulatory goals.

### **Casualty Actuarial and Statistical (C) Task Force**

#### March 7, 2023 (in lieu of the Spring National Meeting)

1. Adopted its Jan. 31, 2023; Jan. 27, 2023; Jan. 10, 2023; Jan. 3, 2023; Dec. 9, 2022; and 2022 Fall National Meeting minutes, which included the following action:
  - A. Exposed the generalized additive models (GAMs) appendix to the *Regulatory Review of Predictive Models* white paper for a 45-day public comment period ending Feb. 24.
  - B. Adopted the *2021 Competition Database Report* (Competition Report).
  - C. Adopted the *2019/2020 Auto Insurance Database Report* (Auto Report).

- D. Adopted the *2021 Report on Profitability by Line by State* (Profitability Report).
- E. Adopted the *2020 Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance Report* (Homeowners Report).
- 2. Adopted the report of the Actuarial Opinion (C) Working Group, including its Jan. 26 minutes. During this meeting, the Working Group took the following action:
  - A. Discussed 2022 instructions for the Statement of Actuarial Opinion (SAO). The Working Group agreed not to propose any substantive changes.
  - B. Discussed a referral from the Financial Analysis (E) Working Group about reserving models.
- 3. Adopted the report of the Statistical Data (C) Working Group, including its Feb. 23 minutes. During this meeting, the Working Group took the following action:
  - A. Adopted a proposal to create and release an *Auto Database Report Supplement for Average Premium Data* (Auto Supplement) annually in March, in addition to the Auto Report that is published at year-end.
  - B. Discussed proposed changes to NAIC statistical reports.
  - C. Discussed its 2023 work plan.
- 4. Adopted the GAMs appendix regarding the regulatory review of GAMs.
- 5. Eliminated the Expense Constant Supplement.
- 6. Discussed a communication plan for the adopted NAIC loss cost multiplier (LCM) forms.
- 7. Heard reports from the American Academy of Actuaries' (Academy's) Committee on Property and Liability Financial Reporting (COPLFR) and Casualty Practice Council (CPC), the Actuarial Board for Counseling and Discipline (ABCD), the Casualty Actuarial Society (CAS), and the Society of Actuaries (SOA) on their current activities and research efforts.

### **Surplus Lines (C) Task Force**

#### March 21, 2023

- 1. Adopted its 2022 Fall National Meeting minutes.
- 2. Adopted the report of the Surplus Lines (C) Working Group, which met March 9 in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to approve one insurer for admittance to the NAIC *Quarterly Listing of Alien Insurers*.
- 3. Adopted amendments to the *Nonadmitted Insurance Model Act* (#870), including a drafting note within Section 5D. Model #870 was modernized to align with the federal Nonadmitted and Reinsurance Reform Act (NRRRA) of 2010.

### **Title Insurance (C) Task Force**

#### March 23, 2023

- 1. Adopted its 2022 Fall National Meeting minutes.
- 2. Took a vote of consensus to postpone the review of the *Title Insurers Model Act* (#628), Section 15C pending the outcome of its consideration under the Model Law Review Initiative.
- 3. Heard an update on the information the Task Force requested from Voxtur following its presentation during the 2022 Fall National Meeting. On March 14, Voxtur told the Task Force chair and vice chair that it was discussing internally methods of sharing the requested information that requires confidentiality.
- 4. Heard a presentation from the American Land Title Association (ALTA) on new movements in the title alternative space. The information included United Wholesale Mortgage's (UWM's) alternative to the traditional lender title process and the Federal National Mortgage Association's (Fannie Mae's) pilot program on title insurance requirements.
- 5. Discussed adding additional questions to the *Survey of State Insurance Laws Regarding Title Data and Title Matters* before it is administered. The Task Force took a vote of consensus to add questions to the following sections: data reporting, policy rate and regulation, procedural regulation, and insurer-agent relationship. It also added a new category and questions for title opinion letters.



**Workers' Compensation (C) Task Force**March 6, 2023 (in lieu of the Spring National Meeting)

1. Adopted its 2022 Fall National Meeting minutes.
2. Heard a presentation from the International Association of Industrial Accident Boards and Commissions (IAIABC) on telework and how it is affecting workers' compensation.
3. Heard a presentation from the National Council of Compensation Insurance (NCCI) on presumptive workers' compensation benefits for firefighters and other first responders.

**MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE**March 24, 2023

1. Adopted its 2022 Fall National Meeting minutes.
2. Heard a presentation from Demotech and 4WARN on the emerging cyberthreat of technology-enabled claims instigation. The presentation reviewed the use of search engine optimization (SEO), as well as how public adjusters and plaintiff law firms create web content that results in their websites having the most favored ranking in response to consumer searches on Google and other internet search engines.
3. Adopted the report of the Antifraud (D) Task Force. See the Task Force listing for details.
4. Adopted the report of the Producer Licensing (D) Task Force, which has not met this year. The Task Force reported that:
  - A. NAIC staff are reviewing and summarizing the 17 comments received on the draft template on the 1033 waiver process.
  - B. Commissioner Trinidad Navarro (DE) will lead a new workstream on public adjusters for the Adjuster Licensing (D) Working Group.
5. Adopted the report of the Market Analysis Procedures (D) Working Group, which has not met this year. The Working Group reported that it plans to meet April 10 to discuss its 2023 charges.
6. Adopted the report of the Market Conduct Examination Guidelines (D) Working Group, which met March 15, Feb. 27, Feb. 7, and Feb. 1. During these meetings, the Working Group took the following action:
  - A. Discussed its 2023 charges.
  - B. Discussed topics continuing from last year, including a new travel insurance policy in-force standardized data request (SDR), a new travel insurance claims SDR, and revisions to Chapter 23—Conducting the Life and Annuity Examination of the *Market Regulation Handbook*.
7. Adopted the report of the Market Regulation Certification (D) Working Group, which met Feb. 27 and took the following action:
  - A. Adopted its Dec. 9, 2022, and 2022 Fall National Meeting minutes, which included the following action:
    - i. Adopted the Market Regulation Certification Program implementation plan.
  - B. Discussed its 2023 charges and goals.
  - C. Reviewed the pilot program suggested revisions to the Market Regulation Certification Program.
8. Adopted the report of the Speed to Market (D) Working Group, which has not met this year. The Working Group reported that:
  - A. It is continuing its work on the revisions to the *Product Filing Review Handbook*.
  - B. It will conduct its annual consideration of suggestions for the product coding matrices (PCMs) in June and July.

**Antifraud (D) Task Force**March 23, 2023

1. Adopted its 2022 Fall National Meeting minutes.
2. Discussed its 2023 charges and outlined its priorities. In addition to overseeing the work of the Improper Marketing of Health Insurance (D) Working Group and the Antifraud Technology (D) Working Group, the Task Force's priorities include the NAIC Producer Portal, the Antifraud Plan Repository, and the implementation of the Online Fraud Reporting System (OFRS) redesign.

3. Received the report of the Improper Marketing of Health Insurance (D) Working Group, which met March 23 and took the following action:
  - A. Discussed the *Unfair Trade Practices Act* (#880).
  - B. Discussed topics concerning the improper marketing of health insurance.
4. Received an update on the OFRS redesign. The Task Force discussed the completion of the OFRS redesign. The implementation process will include collaboration with the National Insurance Crime Bureau (NICB), the National Health Care Anti-Fraud Association (NHCAA), and state vendors.
5. Heard reports on antifraud activity from the Coalition Against Insurance Fraud (CAIF) and the NICB.

#### **Market Information Systems (D) Task Force**

The Market Information Systems (D) Task Force did not meet at the Spring National Meeting.

#### **Producer Licensing (D) Task Force**

The Producer Licensing (D) Task Force did not meet at the Spring National Meeting.

### **FINANCIAL CONDITION (E) COMMITTEE**

March 24, 2023

1. Adopted its 2022 Fall National Meeting minutes.
2. Adopted the report of the Accounting Practices and Procedures (E) Task Force. See the Task Force listing for details.
3. Adopted the report of the Capital Adequacy (E) Task Force. See the Task Force listing for details.
4. Adopted the report of the Financial Stability (E) Task Force. See the Task Force listing for details.
5. Adopted the report of the Receivership and Insolvency (E) Task Force. See the Task Force listing for details.
6. Adopted the report of the Reinsurance (E) Task Force. See the Task Force listing for details.
7. Adopted the report of the Valuation of Securities (E) Task Force. See the Task Force listing for details.
8. Adopted the report of the Mortgage Guaranty Insurance (E) Working Group, which met March 22 and took the following action:
  - A. Adopted its 2022 Fall National Meeting minutes.
  - B. Discussed comments received on the exposure draft of the *Mortgage Guaranty Insurance Model Act* (#630).
  - C. Discussed a proposed U.S. Securities and Exchange Commission (SEC) rule.
9. Adopted the report of the National Treatment and Coordination (E) Working Group, which met Feb. 14 and took the following action:
  - A. Adopted proposal 2022-03 (Domestic Corporate Amendment Application and Instructions).
  - B. Adopted proposal 2023-01 (Redomestication Form 2R).
10. Adopted the report of the Risk-Focused Surveillance (E) Working Group, which met March 23 and took the following action:
  - A. Discussed and exposed proposed changes to the NAIC's *Financial Analysis Handbook* and *Financial Condition Examiners Handbook* for a 45-day public comment period ending May 8. The proposed changes, developed by a drafting group consisting of state insurance regulators and industry representatives, are intended to provide additional guidance for state insurance regulators in reviewing service agreements put in place between insurers and their affiliates, particularly those that incorporate market-based reimbursement for services performed. In addition to requesting comments on the proposed handbook additions, the exposure also requests input on whether and how guidance on "cost-plus" reimbursement rates for affiliated service contracts should be developed and included in handbook guidance.
  - B. Discussed plans to conduct an all-state survey to collect data on financial analyst and examiner compensation for the purposes of adjusting the salary ranges included in NAIC handbooks.
  - C. Discussed plans for 2023 peer review training sessions, which include two financial sessions: 1) a financial examination session; and 2) an Own Risk and Solvency Assessment (ORSA)-focused session.

11. Received a referral from the Valuation of Securities (E) Task Force referral related to additional market and analytical information for bond investments.
12. Adopted action from the Valuation of Securities (E) Task Force that the Securities Valuation Office (SVO) would model collateralized loan obligations (CLOs) for NAIC designations.
13. Adopted a Request for NAIC Model Law Development extension from the Mortgage Guaranty Insurance (E) Working Group related to the *Mortgage Guaranty Insurance Model Act* (#630).
14. Agreed to merge the members and charges of the Restructuring Mechanisms (E) Subgroup into the Restructuring Mechanisms (E) Working Group.

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

#### March 23, 2023

1. Adopted its 2022 Fall National Meeting minutes.
2. Adopted the report of the Statutory Accounting Principles (E) Working Group, which met March 22 and took the following action:
  - A. Adopted its 2022 Fall National Meeting minutes.
  - B. Adopted Issue Paper No. 16X—*Derivatives and Hedging*, which historically documents new Statutory Accounting Principles (SAP) concept revisions to the documentation and assessment of hedge effectiveness, measurement method guidance for excluded components, and the modified incorporation of the U.S. generally accepted accounting principles (GAAP) portfolio layer method and the partial-term hedging method in *Statement of Statutory Accounting Principles (SSAP) No. 86—Derivatives*. (Ref #2017-33)
  - C. Adopted the following clarifications to statutory accounting guidance:
    - i. *SSAP No. 25—Affiliates and Other Related Parties*: Revisions clarify that any invested asset held by a reporting entity that is issued by, or includes the obligations of, an affiliated entity is an affiliated investment. (Ref #2022-15)
    - ii. *SSAP No. 34—Investment Income Due and Accrued*: Revisions add and data-capture additional disclosures. Directed NAIC staff to submit a corresponding blanks proposal to the Blanks (E) Working Group for year-end 2023. (Ref #2022-17)
    - iii. *SSAP No. 100R—Fair Value*: Revisions adopt, with modification, *Accounting Standards Update (ASU) 2022-03, Fair Value Measurement of Equity Securities Subject to Contractual Sales Restrictions*, with modification to reject the contractual sales restrictions disclosures. (Ref #2022-16)
    - iv. *SSAP No. 105R—Working Capital Finance Investments*: Rejects guidance from *ASU 2017-12, Derivatives and Hedging* and *ASU 2022-04, Disclosure of Supplier Finance Program Obligations*, as the disclosures are for borrowers, not insurance entity investors. (Ref #2022-18)
  - D. Exposed the following SAP clarifications to statutory accounting guidance for a public comment period ending June 9, except for agenda items 2023-03 and 2023-11EP, which have a public comment period ending May 5:
    - i. *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets* and *Issue Paper No. 16X—Updates to the Definition of a Liability*: Exposure includes revisions that defer to topic-specific SSAP guidance that varies from the liability definition. (Ref #2022-01)
    - ii. *SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve*: Exposure requests Working Group feedback and direction to NAIC staff regarding the direction and consideration of negative interest maintenance reserve (IMR). (Ref #2022-19)
    - iii. *SSAP No. 20—Nonadmitted Assets* and *SSAP No. 21R—Other Admitted Assets*: Exposed revisions clarify that pledged collateral must qualify as an admitted invested asset for a collateral loan to be admitted. The revisions require audits and the use of net equity value for valuation assessments when the pledged collateral is in the form of partnerships, limited liability companies (LLCs), or joint ventures. (Ref #2022-11)

- iv. *SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items*: Exposed revisions to SSAP No. 24 to clarify the rejection of *ASU 2021-10, Government Assistance*, and the incorporation of disclosures regarding government assistance. (Ref #2023-06)
  - v. *SSAP No. 43R—Loan-Backed and Structured Securities*: Exposed revisions to incorporate changes to add collateralized loan obligations (CLOs) to the financial modeling guidance and clarify that CLOs are not captured as legacy securities. (Ref #2023-02)
  - vi. *SSAP No. 104R—Share-Based Payments* and *SSAP No. 95—Nonmonetary Transactions*: Exposed revisions to adopt with modification *ASU 2019-08, Compensation—Stock Compensation (Topic 718) and Revenue from Contracts with Customers (Topic 606): Codification Improvements—Share-Based Consideration Payable to a Customer*. The revisions add guidance to include share-based consideration payable to customers. (Ref #2023-07)
  - vii. *Interpretation (INT) 03-02: Modification to an Existing Intercompany Pooling Arrangement*: Exposed the intent to nullify INT 03-02, as it is inconsistent with SSAP No. 25. (Ref #2022-12)
  - viii. *INT 20-01: ASU 2020-04 and 2021-01 – Reference Rate Reform*: Exposed revisions to revise the expiration date of INT 20-01 to Dec. 31, 2024. (Ref #2023-05)
  - ix. *Schedule D Reporting*: Exposed revisions to *SSAP No. 26R—Bonds*, *SSAP No. 21R*, *SSAP No. 43R*, and other affected SSAPs to refine guidance for the principles-based bond project. Directed NAIC staff to continue interim discussions with interested parties. (Ref #2019-21)
  - x. *Review Annual Statement Instructions for Accounting Guidance*: Exposed a proposed new project to review the annual and quarterly statement instructions to ensure that accounting guidance is reflected within the SSAPs. (Ref #2023-01)
  - xi. *C-2 Mortality Risk Note*: Exposed revisions to *SSAP No. 51R—Life Contracts*, *SSAP No. 59—Credit Life and Accident and Health Insurance Contracts*, and *SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance* providing new disclosures, which provide the net amount at risk detail needed to support updates to the life risk-based capital (RBC) C-2 mortality risk charges. This item was exposed with a shortened comment deadline of May 5. (Ref #2023-03)
  - xii. *Accounting Practices and Procedures Manual (AP&P Manual) Editorial Updates*: Exposed editorial revisions. This item was exposed with a shortened comment deadline of May 5. (Ref #2023-11EP)
  - xiii. *Appendix D—Nonapplicable GAAP Pronouncements*: The following U.S. GAAP standards were exposed with revisions to reject the following, as they are not applicable to statutory accounting:
    - a. *ASU 2019-07—Codification Updates to SEC Sections: Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10532, Disclosure Update and Simplification, and Nos. 33-10231 and 33-10442, Investment Company Reporting Modernization, and Miscellaneous Updates*. (Ref #2023-08)
    - b. *ASU 2020-09, Amendments to SEC Paragraphs Pursuant to SEC Release No. 33-10762—Debt (Topic 470)*. (Ref #2023-09)
    - c. *ASU 2022-05, Transition for Sold Contracts*, as not applicable for statutory accounting. (Ref #2023-10)
- E. Directed NAIC staff on the following items:
- i. *Tax Credits*: Directed NAIC staff to proceed with drafting revised accounting guidance and a related issue paper for both *SSAP No. 93—Low-Income Housing Tax Credit Property Investments* and *SSAP No. 94R—Transferable and Non-Transferable State Tax Credits*. Revisions will consider final Financial Accounting Standards Board (FASB) guidance on tax equity investments and interested party feedback. (Ref #2022-14)
  - ii. *Corporate Alternative Minimum Tax (CAMT)*: Directed NAIC staff to continue work with industry and Working Group members on developing guidance for the reporting of the CAMT for interim Working Group discussion. (Ref #2023-04)
- F. Received an update on the following items:
- i. Received a referral from the Valuation of Securities (E) Task Force to inquire about the NAIC Securities Valuation Office (SVO) obtaining the ability to calculate analytical information.

- ii. Announced that copyrighted portable document format (PDF) copies of the AP&P Manual will be made available through Account Manager upon purchase of the 2023 AP&P Bookshelf subscription.
  - iii. Received a request from the American Academy of Actuaries (Academy) for clarification on observed diversity across issuers regarding long-term care (LTC) asset adequacy testing (AAT) under *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51)*, *SSAP No. 54R—Individual and Group Accident and Health Contracts*, and *Appendix A-010, Minimum Reserve Standards for Individual and Group Accident and Health Insurance Contracts*.
  - iv. Received an update on international activity as discussed by the International Association of Insurance Supervisors (IAIS) Accounting and Auditing Working Group. This discussion noted that public consultations of Insurance Core Principle (ICP) 14: Valuation and ICP 17: Capital Adequacy are expected in July.
  - v. Received an update on U.S. GAAP exposures, noting that pending items will be addressed during the normal maintenance process.
3. Adopted the report of the Blanks (E) Working Group, which met March 7 and took the following action:
- A. Adopted its Nov. 17, 2022, minutes.
  - B. Adopted its editorial listing and the following proposals:
    - i. 2022-14BWG Modified – Modify Exhibit 1, Part 1 and 2, and Exhibit 8, Part 1 and 2, in the life and accident and health (A&H)/fraternal blank, to include the line of business detail reported on the Analysis of Operations by Lines of Business pages.
    - ii. 2022-15BWG – In the life, A&H/fraternal, and property/casualty (P/C) blanks, revise the language of the Schedule H, Part 5 to remove the 5% of premiums filing exemption (FE).
    - iii. 2022-16BWG – Remove Supplemental Health Care Exhibit Part 3 and Supplemental Health Care Exhibit’s Expense Allocation Report.
    - iv. 2022-18BWG – For the life and A&H/fraternal blank instructional corrections on the handling of Exchange Traded Funds (ETFs) and/or SVO-Identified Funds within the IMR and the asset valuation reserve (AVR).
    - v. 2022-20BWG – Modify the instructions and blanks for various health exhibits to change the order of the Vision and Dental lines of business to be consistent with all other statement types.
  - C. Re-exposed the following proposal for a 52-day public comment period ending April 28: 2022-17BWG – Add new disclosure paragraph for Note 8 – Derivative Instruments and illustration to new disclosure to be data-captured. Add electronic-only columns related to derivatives with excluded components to Schedule DB, Part A and Part B for both Section 1 and Section 2. Add new code column instructions for Schedule DB, Part A and B (SAPWG 2021- 20).
  - D. Exposed eight proposals for a 52-day public comment period ending April 28 and one proposal for a 115-day public comment period ending June 30.

### **Capital Adequacy (E) Task Force**

March 23, 2023

- 1. Adopted its Feb. 3, 2023; and 2022 Fall National Meeting minutes, which included the following action:
  - A. Adopted proposal 2022-12-CR (2022 U.S. and Non-U.S. Catastrophe Risk Event Lists).
- 2. Adopted the report of the Health Risk-Based Capital (E) Working Group, which met March 21 and took the following action:
  - A. Adopted its Feb. 7 minutes, which included the following action:
    - i. Adopted its 2022 Fall National Meeting minutes.
    - ii. Adopted proposal 2022-14-H (Trend Test Instructions), which the Working Group exposed for a 30-day public comment period ending Dec. 7, 2022.
    - iii. Referred the runoff company response letter to the Capital Adequacy (E) Task Force.
    - iv. Exposed proposal 2022-16-CA (Underwriting Risk Factors – Investment Income Adjustment) for a 30-day public comment period ending March 9.

- v. Received an update from the American Academy of Actuaries (Academy) on the H2 – Underwriting Risk Review project.
  - B. Adopted proposal 2022-15-H (XR008 Renumbering).
  - C. Referred proposal 2022-16-CA to the Task Force for a 30-day exposure for all lines of business.
  - D. Adopted its 2023 working agenda.
  - E. Exposed proposal 2023-01-CA (Stop Loss Instructions) for a 20-day public comment period ending April 10.
  - F. Discussed the stop loss data and factors.
  - G. Received an update on the Health Test Ad Hoc Group and the draft proposal with revisions to the health test language and general interrogatories.
  - H. Discussed the effect of the COVID-19 pandemic and pandemic risk on the health risk-based capital (RBC) formula.
  - I. Received an update on the H2 – Underwriting Risk Review project.
3. Adopted the report of the Life Risk-Based Capital (E) Working Group, which met March 22 and took the following action:
    - A. Adopted its Jan. 26, 2023, and 2022 Fall National Meeting minutes, which included the following action:
      - i. Exposed the Academy’s C2 Mortality Risk Work Group’s proposal for a 30-day public comment period ending March 1.
      - ii. Exposed proposed revisions to the CM6 and CM7 mortgage RBC factors and formula for a 45-day public comment period ending March 16.
      - iii. Exposed proposed revisions to remove the dual presentation of the trend test for a 15-day public comment period ending Feb. 14.
    - B. Discussed C-2 mortality risk.
    - C. Discussed its 2023 working agenda and priorities.
    - D. Discussed runoff companies.
  4. Adopted the report of the RBC Investment Risk and Evaluation (E) Working Group, which met March 23 and took the following action:
    - A. Adopted its Feb. 27, 2023, and 2022 Fall National Meeting minutes, which included the following action:
      - i. Discussed the Academy’s follow-up to its presentation on collateralized loan obligations (CLOs).
      - ii. Discussed comments received on the referral from the Valuation of Securities (E) Task Force.
      - iii. Discussed comments received on the potential structure change to address residual tranches.
    - B. Received updates from the Valuation of Securities (E) Task Force and the Statutory Accounting Principles (E) Working Group.
    - C. Continued its discussion of CLOs.
    - D. Discussed the residual tranche structure change.
    - E. Discussed its next steps.
  5. Adopted the report of the Property and Casualty Risk-Based Capital (E) Working Group, which met March 22 and took the following action:
    - A. Adopted its Jan. 30, 2023, and 2022 Fall National Meeting minutes, which included the following action:
      - i. Adopted proposal 2022-12-CR.
    - B. Adopted the report of the Catastrophe Risk (E) Subgroup, which met March 21 and took the following action:
      - i. Adopted its Jan. 30, 2023, and 2022 Fall National Meeting minutes, which included the following action:
        - a. Adopted proposal 2022-12-CR, which the Subgroup exposed for a seven-day public comment period ending Jan. 25.
      - ii. Discussed its working agenda.
      - iii. Received an update from the Catastrophe Model Technical Review Ad Hoc Group.
      - iv. Heard a presentation from Travelers on the climate overview and scenario analysis.
      - v. Discussed the wildfire peril impact analysis.

- C. Exposed proposal 2023-02-P (Underwriting Risk Line 1 Factors) for a 30-day public comment period ending April 21.
- D. Discussed annual statement proposal 2023-01BWG, which removes pet insurance from the inland marine line of business and adds new schedule P parts to pet insurance.
- 6. Adopted proposal 2022-09-CA (Revised Affiliated Investments Structure and Instructions), which the Task Force exposed for a 45-day public comment period ending Jan. 28.
- 7. Adopted proposal 2022-13-CA (Health Premiums and Underwriting Risk Premium References), which the Task Force exposed for a 45-day public comment period ending Jan. 28.
- 8. Adopted proposal 2022-14-H, which the Health Risk-Based Capital (E) Working Group exposed for a 30-day public comment period ending Dec. 6, 2022.
- 9. Adopted proposal 2022-15-H, which the Health Risk-Based Capital (E) Working Group exposed for a 30-day public comment period ending Feb. 28.
- 10. Adopted its working agenda.
- 11. Discussed the response from the Health Risk-Based Capital (E) Working Group regarding runoff companies.
- 12. Discussed two referrals from the Valuation of Securities (E) Task Force.
- 13. Discussed the current turmoil in the banking sector, including fallout and possible implications.
- 14. Discussed other matters brought before the Task Force, including: 1) the proposed revised proposal form; 2) health text exposure updates; and 3) the establishment of ad hoc groups to review or analyze current non-investment charges, missing risks, and modernizing asset concentration instructions.

#### **Examination Oversight (E) Task Force**

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

#### **Financial Stability (E) Task Force**

March 22, 2023 (joint session with the Macprudential (E) Working Group)

- 1. Adopted its 2022 Fall National Meeting minutes.
- 2. Heard an update on Financial Stability Oversight Council (FSOC) developments.
- 3. Received a Macprudential (E) Working Group update.
- 4. Received a Valuation Analysis (E) Working Group update.
- 5. Heard an international update, which included an update on the International Association of Insurance Supervisors (IAIS) Global Monitoring Exercise (GME). The GME includes the individual insurer monitoring (IIM) exercise and the sector-wide monitoring exercise with three more additional topics of interest: private equity (PE), climate, and cyber.

#### **Receivership and Insolvency (E) Task Force**

March 23, 2023

- 1. Adopted its 2022 Fall National Meeting minutes.
- 2. Adopted the report of the Receiver's Handbook (E) Subgroup, including its Dec. 21, 2022, minutes. During this meeting, the Subgroup took the following action:
  - A. Adopted its July 19, 2022, minutes. During this meeting, the Subgroup took the following action:
    - i. Adopted its Nov. 19, 2021, minutes.
    - ii. Adopted revised Chapters 1–2 of the *Receiver's Handbook for Insurance Insolvencies* (Receiver's Handbook).
    - iii. Exposed revised Chapters 3–5 of the Receiver's Handbook for a 30-day public comment period ending Aug. 19, 2022.
  - B. Adopted revised Chapters 3–5 of the Receiver's Handbook.
  - C. Exposed revised Chapters 6–7 of the Receiver's Handbook for a 45-day public comment period ending Feb. 6.

3. Adopted the report of the Receivership Law (E) Working Group. The drafting group that is reviewing comments received on amendments to the *Property and Casualty Insurance Guaranty Association Model Act (#540)* for restructuring mechanisms is making progress and plans to meet again in April.
4. Adopted the report of the Receivership Financial Analysis (E) Working Group. The Working Group met March 23 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss companies in receivership and related topics.
5. Heard an update on international resolution activities. The International Association of Insurance Supervisors (IAIS) released an application paper on policyholder protection schemes for public comment. Comments to be considered by the International Insurance Relations (G) Committee should be sent to NAIC staff by March 27.
6. Heard a presentation from the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) and the National Conference of Insurance Guaranty Funds (NCIGF) on a proposed tabletop receivership training session. Task Force members provided feedback on the session and possible participation.

### **Reinsurance (E) Task Force**

#### March 6, 2023 (in lieu of the Spring National Meeting)

1. Adopted its 2022 Fall National Meeting minutes.
2. Adopted the report of the Reinsurance Financial Analysis (E) Working Group, which met Jan. 31, 2023; Dec. 19, 2022; and Nov. 22, 2022, in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to approve several certified and reciprocal jurisdiction reinsurers for passporting.
3. Received a status report on the reinsurance activities of the Mutual Recognition of Jurisdictions (E) Working Group. The Working Group met Nov. 7, 2022, to reapprove the status of Bermuda, France, Germany, Ireland, Japan, Switzerland, and the United Kingdom (UK) as qualified jurisdictions and reapprove Bermuda, Japan, and Switzerland as reciprocal jurisdictions.
4. Received a status report on the states' implementation of the *Term and Universal Life Insurance Reserve Financing Model Regulation (#787)*. As of Feb. 22, 33 jurisdictions have adopted Model #787, with another three jurisdictions with action under consideration.

### **Risk Retention Group (E) Task Force**

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

### **Valuation of Securities (E) Task Force**

#### March 23, 2023

1. Adopted its Feb. 21, 2023, and 2022 Fall National Meeting minutes. During these meetings, the Task Force took the following action:
  - A. Adopted a *Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual)* amendment to update references to 5GI. The amendment had previously been exposed for a 60-day public comment period ending Feb. 13.
  - B. Adopted a P&P Manual amendment to add instructions for the financial modeling of collateralized loan obligations (CLOs). The amendment had previously been exposed for a 15-day public comment period ending Jan. 9.
  - C. Discussed proposed CLO modeling methodology (excluding scenarios and probabilities).
2. Received a report on the projects of the Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group.
3. Discussed an amendment to the P&P Manual to add instructions for structured equity and funds and deferred a decision on the amendment. The amendment had previously been exposed for a 60-day public comment



period ending Feb. 13. The Task Force directed staff to send a referral to the Statutory Accounting Principles (E) Working Group to request that it consider the definition of structured equity and funds in its residual guidance.

4. Discussed next steps for the CLO modeling project.
5. Discussed proposed questions for NAIC credit rating providers (CRPs) and requested that any recommendations be sent to Securities Valuation Office (SVO) staff.
6. Exposed a proposed P&P Manual amendment to update the Notice of Credit Deterioration for the List of Qualified U.S. Financial Institutions for a 15-day public comment period ending April 10, followed by an e-vote. The Task Force directed staff to also refer the amendment to the Reinsurance (E) Task Force.
7. Received the Annual Report from the SVO on year-end carry-over filings.
8. Received a report on projects of the Statutory Accounting Principles (E) Working Group.

## **FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE**

March 22, 2023

1. Adopted its 2022 Fall National Meeting minutes.
2. Adopted, immediately by reference, revisions made during 2022 to NAIC publications that are required for accreditation purposes (e.g., the *Accounting Practices and Procedures Manual* [AP&P Manual]) and were deemed insignificant.
3. Discussed comment letters received in response to the previously exposed 2020 revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). The revisions, which will be considered for adoption at the Summer National Meeting, are recommended for all states effective Jan. 1, 2026, and implement a group capital calculation (GCC) for the purpose of group solvency supervision and a liquidity stress test (LST) for macroprudential surveillance.
4. Voted to remove the *Actuarial Opinion and Memorandum Regulation* (#822) from the Part A: Laws and Regulations, #9. Liabilities and Reserves standard as a requirement for accreditation. The Life Actuarial (A) Task Force opined that it is no longer necessary for accreditation given that the *Standard Valuation Law* (#820) and VM-30, Actuarial Opinion and Memorandum Requirement contain a large degree of overlap with Model #822.

## **INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE**

March 22, 2023

1. Adopted its Feb. 3, 2023; Jan. 4, 2023; and 2022 Fall National Meeting minutes. During these meetings, the Committee took the following action:
  - A. Discussed NAIC comments on the International Association of Insurance Supervisors' (IAIS') public consultation on the review of its individual insurer monitoring (IIM) assessment methodology.
  - B. Discussed NAIC comments on the *IAIS' Issues Paper on Insurance Sector Operational Resilience*.
2. Heard an update on international activities related to addressing protection gaps. This included hearing from speakers from the American Property Casualty Insurance Association (APCIA) and the Reinsurance Association of America (RAA) on the recently released report, *Global Protection Gaps and Recommendations for Bridging Them* by the Global Federation of Insurance Associations (GFIA).
3. Heard an update on recent activities and priorities of the IAIS, including: 1) a review of recent committee meetings; 2) finalization of the criteria for the comparability assessment process for the aggregation method (AM); 3) continuing work at various IAIS forums and steering groups; and 4) the status of papers on operational resilience and policyholder protection schemes.
4. Heard an update on international activities, including: 1) workstreams of the European Union (EU)-U.S. Insurance Dialogue Project and its plans for 2023; 2) recent meetings, events, and speaking engagements with international insurance regulators; 3) the upcoming NAIC Spring 2023 International Fellows Program; 4) recent and upcoming meetings of the Organisation for Economic Co-operation and Development (OECD) Insurance

and Private Pensions Committee; and 5) upcoming plans of the Sustainable Insurance Forum (SIF) and its priorities.

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

March 22, 2023

1. Adopted its 2022 Fall National Meeting minutes.
2. Adopted the report of the Big Data and Artificial Intelligence (H) Working Group, which met March 22 and took the following action:
  - A. Adopted its 2022 Fall National Meeting minutes.
  - B. Received an update on the artificial intelligence (AI)/machine learning (ML) survey. The survey's purpose is to gain a better understanding of the industry's use of big data, AI/ML, and what governance and risk management controls are being put in place. Companies had until Dec. 15, 2022, to file their responses to the home survey. A public report on the home survey will be issued at the Summer National Meeting.
  - C. Received an update on the AI/ML life survey. The survey's purpose is to gain a better understanding of how life insurance companies are deploying AI/ML technologies in pricing and underwriting, marketing, and loss prevention. This survey will be issued to life insurance companies with more than \$250 million in premiums on all individual policies in 2021; term writers that have issued policies on more than 10,000 lives; or a specifically selected insurtech company. An informational letter regarding the survey is scheduled to be distributed by the end of March. A formal examination call letter will be issued at the end of April, and survey responses will be due by the end of May.
  - D. Discussed draft model and data regulatory questions, which insurance regulators may use to ask about models and data used by insurance companies. All comments submitted by the Feb. 13 deadline will be reviewed, and a revised draft will be circulated to the Working Group by the end of May.
3. Adopted the report of the Cybersecurity (H) Working Group, which met March 7 and took the following action:
  - A. Adopted its 2022 Fall National Meeting minutes.
  - B. Discussed its work plan for 2023.
  - C. Heard an overview of the U.S. Department of the Treasury's (Treasury Department's) report, *The Financial Services Sector's Adoption of Cloud Services*, which was released on Feb. 8.
  - D. Discussed a referral to the Information Technology (IT) Examination (E) Working Group to consider updating its cybersecurity-related guidance based on the Cybersecurity and Infrastructure Security Agency's (CISA's) cybersecurity performance goals.
  - E. Discussed the outline for the incident response plan, which builds on the *Insurance Data Security Model Law* (#668) and would aid the states in requesting information from insurers that have experienced a cybersecurity event.
4. Adopted the report of the E-Commerce (H) Working Group. The Working Group reported that it had exposed its state law surveys/framework for a public comment period ending March 23. The framework was developed based on survey work completed in 2022, which included questions on state laws, questions on actions taken in the wake of the COVID-19 pandemic, and a business impact survey.
5. Adopted the report of the Innovation in Technology and Regulation (H) Working Group. The Working Group reported that it plans to meet after the Spring National Meeting to begin implementing its work plan and setting timelines for its 2023 goals, which include the development of forums to discuss innovations within the industry and regulatory communities.
6. Adopted the report of the Privacy Protections (H) Working Group, which met March 21 and took the following action:
  - A. Adopted its 2022 Fall National Meeting minutes.
  - B. Heard an update on federal and state privacy legislation.
  - C. Discussed its updated 2023 work plan.
  - D. Received and discussed comments on the exposure draft of the new *Insurance Consumer Privacy Protection Model Law* (#674).

7. Received an update from the Collaboration Forum on Algorithmic Bias on the development of a model bulletin providing regulatory guidance regarding the use of big data/AI-driven decisional systems by insurers.
8. Heard a report on the proposed Colorado algorithm and predictive model governance regulation.
9. Heard a presentation on North Dakota’s use of blockchain methodology for data calls.

### **NAIC/CONSUMER LIAISON COMMITTEE**

March 21, 2023

1. Adopted its 2022 Fall National Meeting minutes.
2. Heard a presentation from the Rhode Island Parent Information Network (RIPIN), the American Cancer Society (ACS), and the Center on Health Insurance Reforms (CHIR) on the barriers to enrollment. This presentation is important to state insurance regulators and consumers because it explained the timing and reasons for the rewinding of Medicaid and what state insurance regulators could do to assist them.
3. Heard a presentation from Health Care For All (HCFA), the Leukemia & Lymphoma Society (LLS), Consumers’ Checkbook, and the HIV + Hepatitis Policy Institute on “Obstacles to Medically Necessary Care – Part 1: Delays and Red Tape Due to Prior Authorization.” In this presentation, the spotlight was about how difficult it is and how long it takes, especially for underserved communities, to get the prior authorizations needed for urgently needed care and how state insurance regulators could provide much-needed assistance.
4. Heard a presentation from the National Women’s Law Center (NWLC) and the National Health Law Program (NHeLP) on obstacles to medically necessary care. The presentation discussed the refusal of care and network adequacy, especially reproductive health services and pre-exposure prophylaxis (PrEP) for HIV from religiously affiliated providers in areas that are geographically bent toward facilities of this type. It was important for state insurance regulators to hear how challenging these situations are for consumers.
5. Heard a presentation from the Life Insurance Consumer Advocacy Center calling attention to the dilemma of current assumption policy illustrations for indexed universal life (IUL) and other life policies. This presentation is important to consumers, industry, and state insurance regulators because it draws focus to the effect of low investment rates and their long-term effects on life insurance policies.
6. Heard a presentation from the Center for Economic Justice (CEJ) on dark patterns in digital communications that addressed the perils of the insurance industry moving from paper to digital consumer interactions. This presentation is important to insurance consumers, industry, and state insurance regulators because it pointed to an issue that causes consumers to unwittingly share personal data that did not exist within a paper society but that is very much a concern in today’s digital society.
7. Heard a presentation from the Automotive Education & Policy Institute (AEPI) on aftermarket parts, noting that imitation parts are often not equal when it comes to consumer safety, protection, and the continuation of vehicle warranties. This presentation is important to insurance consumers and state insurance regulators because it identified the differences in manufacturing parts versus vehicle parts produced for use in repairs following accidents.

### **NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE**

March 24, 2023

1. Adopted its 2022 Fall National Meeting minutes.
2. Discussed the results of its member survey and its next steps for 2023. This is important to tribal insurance consumers, state insurance regulators, and industry because it will guide the agenda items for discussion and presentation throughout the entire year.
3. Heard a presentation from Blue Cross and Blue Shield of Oklahoma titled “ACA Risk Adjustment Treatment of Tribal Enrollees: Barriers to Tribal Member Enrollment and Investments in Tribal Health and Health Equity.” This presentation is important because it highlights the inequities of the federal Centers for Medicare & Medicaid Services (CMS) risk assessment process, especially relative to underserved tribal communities due to the lack of tribal investment opportunities.

**EXECUTIVE (EX) COMMITTEE AND PLENARY**

Executive (EX) Committee and Plenary March 25, 2023, Minutes ..... 3-2

    Adopted Revisions 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) (Attachment One) ..... 3-8

    Adopted *Actuarial Guideline LIV—Nonforfeiture Requirements for Index-Linked Variable Annuity Products* (AG 54) (Attachment Two) ..... 3-14

    Adopted the *Regulatory Resources for Consumers on Personal Lines Pricing and Underwriting* (Attachment Three) ..... 3-20

    Adopted the *Rate/Rule Filing Checklist* (Attachment Four)..... 3-41

    Report on States’ Implementation of NAIC-Adopted Model Laws and Regulations (Attachment Five) ..... 3-44

Draft: 4/10/23

Executive (EX) Committee and Plenary  
Louisville, Kentucky  
March 25, 2023

The Executive (EX) Committee and Plenary met in Louisville, KY, March 25, 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); Ricardo Lara represented by Lucy Wang (CA); Michael Conway represented by Peg Brown (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 represented by Holly Lambert (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); Troy Downing represented by Matt Eberhardt (MT); Mike Causey represented by Jackie Obusek (NC); Eric Dunning (NE); Scott Kipper (NV); Adrienne A. Harris (NY); Judith L. French (OH); Glen Mulready (OK); Elizabeth Kelleher Dwyer (RI); Michael Wise (SC); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence (TN); Cassie Brown represented by Jessica Barta (TX); Jon Pike (UT); Kevin Gaffney (VT); Mike Kreidler represented by Molly Nollette (WA); Nathan Houdek (WI); Allan L. McVey (WV); and Jeff Rude (WY).

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

Director Lindley-Myers reported that the Executive (EX) Committee met March 23. During this meeting, the Committee adopted the March 22 report from the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee and took the following action: 1) appointed Andrew J. Beal (NAIC, Chief Operating Officer and Chief Legal Officer) as acting Chief Executive Officer (CEO); and 2) approved the retention of a consultant to conduct an organizational review and succession planning exercise.

The Committee adopted its interim meeting report from Feb. 10 and Jan. 13 including the following action: 1) appointed Superintendent Dwyer to serve on the International Association of Insurance Supervisors (IAIS) Executive Committee; 2) appointed the following to serve as members on the Consumer Board of Trustees: Commissioner Andrew R. Stolfi, Chair (OR); Commissioner McClain; Director Severinghaus; Commissioner Schmidt; Commissioner Downing; and Acting Commissioner Michael Humphreys (PA); 3) appointed Commissioner Mulready to the National Insurance Producer Registry (NIPR) Board of Directors; 4) approved the recommendation for the NAIC's Kansas City, MO, office space; 5) adopted the Washington, DC, property site selection and fiscal impact statement; 6) appointed the following as members of the NAIC 2023 Audit Committee: Connecticut, Kentucky, Maryland, Massachusetts, Missouri, Nebraska, New Jersey, North Dakota, Oregon, South Dakota, Tennessee, and Virginia; 7) received an update from the Investment Committee; and 8) received updates on various operational matters.

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 approved Requests for NAIC Model Law Development to amend: 1) the *Property and Casualty Insurance Guaranty Association Model Act* (#540); and 2) the *Unfair Trade Practices Act* (#880).

The Committee also: 1) received the 2022 Annual Report of the NAIC Designation Program Advisory Board activities; and 2) received a status report on the implementation of *State Connected*.

The Committee received a status report on model law development efforts for amendments to: 1) the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171); 2) the *Property and Casualty Insurance Guaranty Association Model Act* (#540); 3) the *Mortgage Guaranty Insurance Model Act* (#630); 4) the *Nonadmitted Insurance Model Act* (#870); and 5) the *Insurance Consumer Privacy Protection Model Law* (#674).

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 2022 Fall National Meeting

Commissioner Godfread made a motion, seconded by Commissioner Mais, to adopt by consent the committee, subcommittee, and task force minutes of the 2022 Fall National Meeting. The motion passed unanimously.

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

Director French reported that the Life Insurance and Annuities (A) Committee met March 23. During this meeting, the Committee adopted its Feb. 24 minutes, which included the following action: 1) adopted its 2022 Fall National Meeting minutes; 2) adopted revisions 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); and 3) adopted *Actuarial Guideline LIV—Nonforfeiture Requirements for Index-Linked Variable Annuity Products* (AG 54).

The Committee adopted the report of the Accelerated Underwriting (A) Working Group, including its Feb. 22 minutes. During this meeting, the Working Group took the following action: 1) exposed the draft regulatory guidance for accelerated underwriting (AU) in life insurance for a 45-day public comment period ending April 15; and 2) exposed the draft referral to the Market Conduct Examination Guidelines (D) Working Group for a 30-day public comment period ending March 24.

The Committee also heard a presentation from the American Council of Life Insurers (ACLI) and the Society of Actuaries (SOA) on the current state of life insurance.

4. Adopted Revisions 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)

Director French reported that revisions to AG 49-A were adopted by the Life Insurance and Annuities (A) Committee on Feb. 24. These revisions, effective for policies sold on or after May 1, address an issue in indexed universal life (IUL) illustrations where some companies are illustrating non-benchmark indices in a more favorable manner than benchmark indices, particularly for products with uncapped volatility-controlled funds and a fixed bonus.

Director French made a motion, seconded by Commissioner Ommen, to adopt the revisions to AG 49-A (Attachment One). The motion passed unanimously.

5. Adopted Actuarial Guideline LIV—Nonforfeiture Requirements for Index-Linked Variable Annuity Products (AG 54)

Director French reported that the Life Insurance and Annuities (A) Committee adopted AG 54 during its Feb. 24 meeting. AG 54 provides principles outlining the conditions under which an index-linked variable annuity (ILVA) is

consistent with the definition of a variable annuity and exempt from the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805), and it specifies nonforfeiture requirements consistent with variable annuities.

The guideline promotes consistency while allowing for reasonable product variation, outlining that interim values should provide equitable treatment to the contract holder and the insurance company. AG 54 ensures that consumers will not only experience losses when indices go down, but they will realize gains when indices go up.

Director French made a motion, seconded by Commissioner Donelon, to adopt AG 54 (Attachment Two). The motion passed unanimously.

#### 6. 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 March 23. During this meeting, the Committee adopted its 2022 Fall National Meeting minutes.

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

The Committee heard a discussion on the Kaiser Family Foundation (KFF) issue brief, “Claims Denials and Appeals in ACA Marketplace Plans in 2021.” The presenters discussed what the data could mean and its limitations, whether the federal Centers for Medicare & Medicaid Services (CMS) use it as part of its regulatory oversight responsibilities, and its potential future uses.

The Committee also heard a discussion of a state “checklist” of actions related to the Medicaid unwinding process provided in the State Health and Value Strategies’ (SHVS’s) issue brief, “Secrets to a Successful Unwinding: Actions State-Based Marketplaces and Insurance Departments Can Take to Improve Coverage Transitions.”

The Committee heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on recent activities of interest to the Committee, including activities related to the Medicaid unwinding process as a result of the ending of the COVID-19 public health emergency (PHE), the implementation of the federal No Surprises Act (NSA), its new plan management certification modernization project, its health equity initiatives, and the soon to be finalized Notice of Benefit and Payment Parameters 2024 proposed rule.

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

Commissioner McClain reported that the Property and Casualty Insurance (C) Committee met March 24. During this meeting, the Committee adopted its 2022 Fall National Meeting minutes.

The Committee adopted the reports of its task forces and working groups: 1) the Casualty Actuarial and Statistical (C) Task Force; 2) the Surplus Lines (C) Task Force; 3) the Title Insurance (C) Task Force; 4) the Workers’ Compensation (C) Task Force; 5) the Cannabis Insurance (C) Working Group; 6) the Catastrophe Insurance (C) Working Group; 7) the Terrorism Insurance Implementation (C) Working Group; and 8) the Transparency and Readability of Consumer Information (C) Working Group.

The Committee adopted revisions to the *Nonadmitted Insurance Model Act* (#870). The revisions are intended to conform Model #870 to the federal Nonadmitted and Reinsurance Reform Act of 2010 (NRRRA), which was part of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act).

The Committee heard presentations from the Nonprofits Insurance Alliance (NIA) and the National Association of Mutual Insurance Companies (NAMIC) on the availability and affordability of insurance coverage for nonprofit organizations.

The Committee discussed its charge related to developing marketing intelligence data so state insurance regulators can better assess their markets.

#### 8. Adopted the *Regulatory Resources for Consumers on Personal Lines Pricing and Underwriting*

Commissioner McClain reported that the *Regulator Resources for Consumers on Personal Lines Pricing and Underwriting* was adopted by the Transparency and Readability of Consumer Information (C) Working Group on Nov. 15, 2022, and by the Property and Casualty (C) Committee on Dec. 15, 2022.

This document can be used by state departments of insurance (DOIs) to create consumer education bulletins, social media posts, and other consumer facing materials to help consumers better understand their home and auto insurance premiums.

Commissioner McClain made a motion, seconded by Commissioner Fowler, to adopt the *Regulatory Resources for Consumers on Personal Lines Pricing and Underwriting* (Attachment Three). The motion passed unanimously.

#### 9. Adopted the *Rate/Rule Filing Checklist*

Commissioner McClain reported that the Transparency and Readability of Consumer Information (C) Working Group adopted the *Rate/Rule Filing Checklist* on Nov. 15, 2022, and the Property and Casualty Insurance (C) Committee adopted it on Dec. 15, 2022. DOIs can use the checklist to ensure that their rate/rule filings include all necessary information.

The checklist is based on Kansas' *Rate/Rule Filing Checklist* with the inclusion of a question regarding whether an insurer uses a rating model.

Commissioner McClain made a motion, seconded by Director Cameron, to adopt the *Rate/Rule Filing Checklist* (Attachment Four). The motion passed unanimously.

#### 10. 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 March 24. During this meeting, the Committee adopted its 2022 Fall National Meeting minutes.

The Committee heard a presentation on the emerging cyberthreat of technology-enabled claims instigation, including the review of the use of search engine optimization (SEO).

The Committee adopted the reports of its task forces and working groups: 1) the Antifraud (D) Task Force; 2) the Market Information Systems (D) Task Force; 3) the Producer Licensing (D) Task Force; 4) the Advisory Organization (D) Working Group; 5) the Market Analysis Procedures (D) Working Group; 6) the Market Conduct Annual Statement Blanks (D) Working Group; 7) the Market Conduct Examination Guidelines (D) Working Group; 8) the Market Regulation Certification (D) Working Group; and 9) the Speed to Market (D) Working Group.

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

Superintendent Dwyer reported that the Financial Condition (E) Committee met March 24. During this meeting, the Committee: 1) adopted its 2022 Fall National Meeting minutes; 2) received a referral from the Valuation of Securities (E) Task Force related to additional market and analytical information for bond investments; 3) adopted action from the Valuation of Securities (E) Task Force directing that the Securities Valuation Office (SVO) model



collateralized loan obligations (CLOs) for NAIC designations; and 4) adopted an extension until the Summer National Meeting for revisions to the *Mortgage Guaranty Insurance Model Act* (#630).

The Committee adopted the reports of its task forces and working groups: 1) the Accounting Practices and Procedures (E) Task Force; 2) the Capital Adequacy (E) Task Force; 3) the Examination Oversight (E) Task Force; 4) the Financial Stability (E) Task Force; 5) the Receivership and Insolvency (E) Task Force; 6) the Reinsurance (E) Task Force; 7) the Valuation of Securities (E) Task Force; 8) the Mortgage Guaranty Insurance (E) Working Group; 9) the National Treatment and Coordination (E) Working Group; 10) and the Risk-Focused Surveillance (E) Working Group.

The Committee also agreed to merge the members and charges of the Restructuring Mechanisms (E) Subgroup into the Restructuring Mechanisms (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 with respect to those items. If no objections are received with respect to a particular item, the technical changes will be considered adopted by the NAIC membership and effective immediately.

## 12. 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 March 21 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 Nebraska, Virginia, and West Virginia.

The Committee met March 22. During this meeting, the Committee adopted its 2022 Fall National Meeting minutes and revisions to NAIC publications that are required for accreditation purposes (e.g., the *Accounting Practices and Procedures Manual* [AP&P Manual]) and were deemed insignificant.

The Committee discussed comment letters received in response to the previously exposed 2020 revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). The revisions, which will be considered for adoption at the Summer National Meeting, are recommended for all states effective Jan. 1, 2026, and implement a group capital calculation (GCC) for the purpose of group solvency supervision and a liquidity stress test (LST) for macroprudential surveillance.

The Committee voted to remove the *Actuarial Opinion and Memorandum Regulation* (#822) from the Part A: Laws and Regulations, #9 Liabilities and Reserves standard as a requirement for accreditation. The Life Actuarial (A) Task Force reported that the standard is no longer necessary for accreditation because the *Standard Valuation Law* (#820) and VM-30, Actuarial Opinion and Memorandum Requirements, overlap with Model #822.

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

Commissioner Anderson reported that the International Insurance Relations (G) Committee met March 22. During this meeting, the Committee adopted its Feb. 3, 2023; Jan. 4, 2023; and 2022 Fall National Meeting minutes.

The Committee heard an update on international activities related to protection gaps, including presentations from the American Property Casualty Insurance Association (APCIA) and the Reinsurance Association of America (RAA) on the recently released report, *Global Protection Gaps and Recommendations for Bridging Them* by the Global Federation of Insurance Associations (GFIA).

The Committee also heard an update on recent activities and priorities of the International Association of Insurance Supervisors (IAIS), including: 1) a review of recent committee meetings; 2) the finalization of the criteria for the comparability assessment process for the aggregation method (AM); 3) continuing work at various IAIS forums and steering groups; and 4) the status of papers on operational resilience and policyholder protection schemes.

The Committee heard an update on international activities, including: 1) workstreams of the European Union (EU)-U.S. Insurance Dialogue Project and its plans for 2023; 2) recent meetings, events, and speaking engagements with international insurance regulators; 3) the upcoming 2023 Spring International Fellows Program; 4) upcoming meetings of the Organisation for Economic Co-operation and Development (OECD) Insurance and Private Pensions Committee; and 5) upcoming plans of the Sustainable Insurance Forum (SIF).

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

Commissioner Birrane reported that the Innovation, Cybersecurity, and Technology (H) Committee met March 22 and adopted: 1) its 2022 Fall National Meeting minutes; and 2) the reports of its task forces and working groups.

The Committee received an update from the Collaboration Forum on Algorithmic Bias on the development of a model bulletin providing regulatory guidance regarding the use of big data/artificial intelligence (AI)-driven decisional systems by insurers.

The Committee also: 1) heard a report on the proposed Colorado Algorithm and Predictive Model Governance Regulation; and 2) heard a presentation on North Dakota's use of blockchain methodology for data calls.

#### 15. 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 the states' implementation of NAIC-adopted model laws and regulations (Attachment Five).

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

SharePoint/NAIC Support Staff Hub/Meetings

*Adopted by Life Actuarial (A) Task Force – Dec. 11, 2022*

*Adopted by Life Insurance and Annuities (A) Committee – Feb. 24, 2023*

### Actuarial Guideline XLIX-A

## THE APPLICATION OF THE LIFE ILLUSTRATIONS MODEL REGULATION TO POLICIES WITH INDEX-BASED INTEREST SOLD (On or After December 14, 2020)

### Background

The *Life Insurance Illustrations Model Regulation* (#582) was adopted by the NAIC in 1995. Since that time there has been continued evolution in product design, including the introduction of benefits that are tied to an index or indices. Although these policies are subject to Model #582, not all of their features are explicitly referenced in the model, resulting in a lack of uniform practice in its implementation. In the absence of uniform guidance, two illustrations that use the same index and crediting method often illustrated different credited rates. The lack of uniformity can be confusing to potential buyers and can cause uncertainty among illustration actuaries when certifying compliance with Model #582.

~~In 2019, the NAIC decided that illustrations of products with multipliers, cap buy-ups, and other enhancements that are linked to an index or indices should not illustrate better than products without such features. This new requirement is intended to apply to illustrations on policies sold on or after the effective date of this guideline while the existing requirements continue to apply for inforce illustrations on policies sold before the effective date of this guideline.~~

This guideline provides uniform guidance for policies with index-based interest. In particular, this guideline:

- (1) Provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale.
- (2) Limits the policy loan leverage shown in an illustration.
- (3) Requires additional consumer information (side-by-side illustration and additional disclosures) that will aid in consumer understanding.

### Text

#### 1. Effective Date

This Actuarial Guideline shall be effective for all new business and in force illustrations on policies sold on or after December 14, 2020.

#### 2. Scope

This Actuarial Guideline shall apply to any life insurance illustration that meets both (i) and (ii), below:

- i. The policy is subject to Model #582.
- ii. The policy offers Indexed Credits.

#### 3. Definitions

A. Alternate Scale: A scale of non-guaranteed elements currently being illustrated such that:

- i. The Annual Rate of Indexed Credits for each Index Account does not exceed the lesser of

## AG XLIX-A

## Appendix C

the maximum Annual Rate of Indexed Credits for the illustrated scale less 100 basis points and the credited rate for the Fixed Account. If the insurer does not offer a Fixed Account with the illustrated policy, the Annual Rate of Indexed Credits for each Index Account shall not exceed the average of the maximum Annual Rate of Indexed Credits for the illustrated scale and the guaranteed Annual Rate of Indexed Credits for that account. However, the Annual Rate of Indexed Credits for each Index Account shall never be less than the guaranteed Annual Rate of Indexed Credits for that account.

- ii. If the illustration includes a loan, the illustrated Policy Loan Interest Credited Rate shall not exceed the illustrated Policy Loan Interest Rate. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 4%.
  - iii. All other non-guaranteed elements are equal to the non-guaranteed elements for the illustrated scale.
- B. Annual Net Investment Earnings Rate: Gross portfolio annual earnings rate of the general account assets (excluding hedge assets for Indexed Credits), less provisions for investment expenses and default cost, allocated to support the policy. Charges of any kind cannot be used to increase the Annual Net Investment Earnings Rate.
- C. Annual Rate of Indexed Credits: The total annualized Indexed Credits expressed as a percentage of the account value used to determine the Indexed Credits.
- D. Benchmark Index Account: An Index Account with the following features:
- i. The interest calculation is based on the percent change in S&P 500<sup>®</sup> Index value only, over a one-year period using only the beginning and ending index values. (S&P 500<sup>®</sup> Index ticker: SPX)
  - ii. An annual cap is used in the interest calculation.
  - iii. The annual floor used in the interest calculation shall be 0%.
  - iv. The participation rate used in the interest calculation shall be 100%.
  - v. Interest is credited once per year.
  - vi. The Hedge Budget used to determine the cap in 3 (D) (ii) does not exceed the Annual Net Investment Earnings Rate. Charges of any kind cannot be used to increase the annual cap.
  - vii. There are no enhancements or similar features that provide additional Indexed Credits in excess of the interest provided by 3 (D) (i) through 3 (D) (v), including but not limited to experience refunds, multipliers, or bonuses.
  - viii. There are no limitations on the portion of account value allocated to the account.
  - ix. A single Benchmark Index Account will be determined for each policy. This can be either an Index Account offered with the illustrated policy or determined according to Section 4 (A) (ii) for purposes of complying with this guideline. A policy shall have no more than one Benchmark Index Account.

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## Appendix C

- E. Fixed Account: An account where there are no Indexed Credits.
- F. Hedge Budget: For each Index Account, the total annualized amount assumed to be used to generate the Indexed Credits of the account, expressed as a percent of the account value in the Index Account. This total annualized amount should be consistent with the hedging program of the company.
- G. Index Account: An account where some or all of the amounts credited are Indexed Credits.
- H. Indexed Credits: Any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy values that is linked to an index or indices. Amounts credited to the policy resulting from a floor greater than zero on an account with any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy values that is linked to an index or indices are included.
- I. Loan Balance: Any outstanding policy loan and loan interest, as defined in the policy.
- J. Policy Loan Interest Rate: The current annual interest rate as defined in the policy that is charged on any Loan Balance. This does not include any other policy charges.
- K. Policy Loan Interest Credited Rate: The annualized interest rate credited that applies to the portion of the account value backing the Loan Balance:
  - i. For the portion of the account value in the Fixed Account that is backing the Loan Balance, the Policy Loan Interest Credited Rate is the applicable annual interest crediting rate.
  - ii. For the portion of the account value in an Index Account that is backing the Loan Balance, the Policy Loan Interest Credited Rate is the Annual Rate of Indexed Credits, net of any applicable Supplemental Hedge Budget, for that account.
- L. Supplemental Hedge Budget: For each Index Account, the Hedge Budget minus the minimum of the Annual Net Investment Earnings Rate and the Hedge Budget that is used in the determination of the Benchmark Index Account. The Supplemental Hedge Budget will never be less than zero. This amount should be consistent with the hedging program of the company.

## 4. Illustrated Scale

The total Annual Rate of Indexed Credits for the illustrated scale for each Index Account shall be limited as follows:

- A. Calculate the geometric average annual credited rate for the Benchmark Index Account for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.
  - i. If the insurer offers a Benchmark Index Account with the illustrated policy, the illustration actuary shall use the current annual cap for the Benchmark Index Account in 4 (A).
  - ii. If the insurer does not offer a Benchmark Index Account with the illustrated policy, the illustration actuary shall use actuarial judgment to determine a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of the Benchmark Index Account, and shall use that cap in 4 (A).

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- B. For the Benchmark Index Account the Annual Rate of Indexed Credits shall not exceed the minimum of (i) and (ii):
- i. The arithmetic mean of the geometric average annual credited rates calculated in 4 (A).
  - ii. 145% of the Annual Net Investment Earnings Rate.
- C. For any other Index Account that is not the Benchmark Index Account in 3 (D), the Annual Rate of Indexed Credits illustrated as a percentage of the account value in the Index Account prior to the deduction of any charges used to fund a Supplemental Hedge Budget shall not exceed the minimum of (i) and (ii) for policies sold prior to May 1, 2023 and shall not exceed the minimum of (i), (ii), and (iii) for policies sold on or after May 1, 2023:
- i. The Annual Rate of Indexed Credits for the Benchmark Index Account calculated in 4 (B) plus the Supplemental Hedge Budget for the Index Account.
  - ii. The Annual Rate of Indexed Credits reflecting the fundamental characteristics of the Index Account and the appropriate relationship to the expected risk and return of the Benchmark Index Account. The illustration actuary shall use actuarial judgment to determine this value using lookback methodology consistent with 4 (A) and 4 (B) (i) where appropriate.
  - iii. The lesser of (1) and (2) multiplied by the Annual Rate of Index Credits for the Benchmark Index Account, calculated in 4 (B), divided by (2); plus, the Supplemental Hedge Budget for the Index Account:
    1. The Hedge Budget of the Index Account
    2. Hedge Budget of the Benchmark Index Account.
- D. For the purposes of compliance with Section 6 (C) of Model #582, the Supplemental Hedge Budget is subtracted from the Annual Rate of Indexed Credits before comparing to the earned interest rate underlying the disciplined current scale.

At the beginning of each calendar year, the insurer shall be allowed up to three (3) months to update the credited rate for each Index Account in accordance with 4 (B) and 4 (C).

## 5. Disciplined Current Scale

The earned interest rate for the disciplined current scale shall be limited as follows:

- A. If an insurer engages in a hedging program for Indexed Credits in an account, the assumed earned interest rate underlying the disciplined current scale for that account, inclusive of all general account assets, both hedge and non-hedge assets, that support the policy, net of default costs and investment expenses (including the amount spent to generate the Indexed Credits of the policy) shall not exceed the lesser of (i) and (ii):
- i. The Annual Net Investment Earnings Rate, plus 45% of the lesser of (1) and (2):
    1. Hedge Budget minus any annual floor, to the extent that the floor is supported by the Hedge Budget.

## AG XLIX-A

## Appendix C

2. The minimum of the Annual Net Investment Earnings Rate and the Hedge Budget that is used in the determination of the Benchmark Index Account.
- ii. The Annual Rate of Indexed Credits plus the Annual Net Investment Earnings Rate minus the Hedge Budget.

These rates should be adjusted for timing differences in the hedge cash flows to ensure that fixed interest is not earned on the Hedge Budget minus any annual floor, to the extent that the floor is supported by the Hedge Budget.

Guidance Note: The above approach does not stipulate any required methodology as long as it produces a consistent limit on the assumed earned interest rate underlying the disciplined current scale.

For a policy with multiple Index Accounts, a maximum rate in 5 (A) should be calculated for each account. All accounts, fixed and indexed, within a policy can be tested in aggregate.

- B. If an insurer does not engage in a hedging program for Indexed Credits, the assumed earned interest rate underlying the disciplined current scale shall not exceed the Annual Net Investment Earnings Rate.
- C. These experience limitations shall be included when testing for self-support and lapse-support under Model #582, accounting for all illustrated benefits including any illustrated benefits and bonuses that impact the policy's account value.

## 6. Policy Loans

If the illustration includes a loan, the illustrated Policy Loan Interest Credited Rate shall not exceed the illustrated Policy Loan Interest Rate by more than 50 basis points. For example, if the illustrated Policy Loan Interest Rate is 4.00%, the Policy Loan Interest Credited Rate shall not exceed 4.50%.

## 7. Additional Standards

The basic illustration shall also include the following:

- A. A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.
- B. A table showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).
- C. For each Index Account illustrated, a table showing actual historical index changes and corresponding hypothetical Indexed Credits using current index parameters for the most recent 20-year period.

**PROJECT HISTORY****2023 REVISIONS TO ACTUARIAL GUIDELINE XLIX-A—  
THE APPLICATION OF THE LIFE ILLUSTRATIONS MODEL  
REGULATION TO POLICIES WITH INDEX-BASED INTEREST SOLD  
(ON OR AFTER DECEMBER 14, 2020)****1. What issues was the project intended to address?**

After the 2020 adoption of *AG 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), state regulators developed concerns with some new product designs that illustrated more favorably than those based on a traditional capped Standard and Poor's 500 index (S&P 500). In particular, the revisions to AG 49-A intend to improve illustrations for indexed universal life (IUL) products with uncapped volatility-controlled funds and a fixed bonus.

**2. What states participated in drafting the model?**

The following states are currently members of the IUL Illustration (A) Subgroup of the Life Actuarial (A) Task Force: Minnesota (Chair), California, Connecticut, Illinois, Indiana, Iowa, Nebraska, New York, Ohio, Texas, Utah, and Virginia.

**3. What general procedure was followed in drafting the model? What efforts were made to assure that all interested parties were provided an opportunity to comment during the drafting process?**

To address the illustration issues, open meetings of the existing IUL Illustration (A) Subgroup were held to draft revisions to AG 49-A (see Table 1). The subgroup coordinated with all of the industry interested parties, including representatives from the American Council of Life Insurers and the American Academy of Actuaries. Notice of the open conference calls was posted to the NAIC's home page on the Internet and emailed to over 500 interested parties.

Table 1:

Meeting Date	Open/Regulator-only?
7/18/2022	Open
10/12/22	Open
11/9/22	Open

**4. What significant issues were raised during the drafting process, and how were those issues resolved?**

The key question the group faced was whether to address the issues with the illustrations of specific IUL product designs by revising AG 49-A or to more comprehensively address life insurance illustration issues by opening up the *Life Insurance Illustrations Model Regulation* (#582). The Task Force decided to move forward with a phased approach that would address the immediate issues impacting by revising AG 49-A, while continuing to consider larger changes to life insurance illustration regulations.

**5. What are the implications of this project for accreditation and codification?**

The Guideline should be handled in a manner that is consistent with the treatment of other guidelines.



*Adopted by Life Actuarial (A) Task Force – 12/11/2022*

*Adopted by Life Insurance and Annuities (A) Committee – 2/24/2023*

## Actuarial Guideline LIV

### Nonforfeiture Requirements for Index-Linked Variable Annuity Products

#### **Background**

**The purpose of this guideline is to specify the conditions under which an Index-Linked Variable Annuity (ILVA) is consistent with the definition of a variable annuity and exempt from Model 805 and specify nonforfeiture requirements consistent with variable annuities.**

A number of insurers have developed and are issuing annuity products with credits based on the performance of an index with caps on returns, participation rates, spreads or margins, or other crediting elements, that include a risk of negative index returns subject to limitations on the loss, such as a floor or a buffer. These products are not unitized and do not invest directly in the assets whose performance forms the basis for the credits.

There is no established terminology for these annuity products. These products go by several names, including structured annuities, registered index-linked annuities (RILA), or index-linked variable annuities, among others. This guideline refers to these products as index-linked variable annuities (ILVA).

Variable annuities are exempted from the scope of NAIC Model 805, *Standard Nonforfeiture Law for Individual Deferred Annuities*; however, NAIC Model 805 does not define the term "variable annuity".

NAIC Model 250, *Variable Annuity Model Regulation*, defines variable annuities as “contracts that provide for annuity benefits that vary according to the investment experience of a separate account.” Section 7B of NAIC Model 250 provides that "to the extent that a variable annuity contract provides benefits that do not vary in accordance with the investment performance of a separate account" the contract shall satisfy the requirements of the NAIC Model 805.

The application of the NAIC Model 250 to a traditional variable annuity with unitized values is straightforward. The unitized feature provides an automatic linkage between annuity values and the investment experience of a separate account. Daily values (market values of the separate account assets) are the basis of all the benefits, including surrender values.

The fact that ILVA accounts are not unitized means they do not have values determined directly by the market prices of the underlying assets. Therefore, this guideline sets forth principles and requirements for determining values, including death benefit, withdrawal amount, annuitization amount or surrender values, such that an ILVA is considered a variable annuity and thereby exempt from Model 805. An ILVA that does not comply with the principles and requirements of this guideline is not considered a variable annuity and therefore is subject to Model 805.

**Drafting Note:** This guideline interprets the term “variable annuity” for purposes of exemption from Model 805. It is not intended to modify the definition of a variable annuity under Model 250 or other Model Regulations.

#### **Scope**

This guideline applies to any index-linked annuity exempt from the NAIC Model 805 on the basis that it is a variable annuity and includes index-linked crediting features that are built into policies or contracts (with or without unitized subaccounts) or added to such by rider, endorsement, or amendment.

**Principles**

This guideline is based on the following principles:

1. Interim Values defined in the contract provide equity between the contract holder and the insurance company.
2. Interim Values are consistent with the value of the Hypothetical Portfolio over the Index Strategy Term.

**Definitions**

“Derivative Asset Proxy” means a package of hypothetical derivative assets established at the beginning of an Index Strategy Term that is designed to replicate credits provided by an Index Strategy at the end of an Index Strategy Term.

“Fixed Income Asset Proxy” is a hypothetical fixed income asset.

“Hypothetical Portfolio” means a hypothetical portfolio composed of a Fixed Income Asset Proxy and a Derivative Asset Proxy.

“Index” means a benchmark designed to track the performance of a defined portfolio of securities.

“Index Strategy” means a method used to determine index credits with specified index or indices and cap, buffer, participation rate, spread, margin or other index crediting elements.

“Index Strategy Base” means the notional amount used to determine index credits that does not change throughout the Index Strategy Term except for withdrawals, transfers, deposits, loans, and any explicit charges.

“Index Strategy Term” means the period of time from the term start date to the term end date over which an index changes and the index credit is determined.

“Interim Value” means the Strategy Value at any time other than the start date and end date of an Index Strategy Term.

“Strategy Value” means the value, attributable to an Index Strategy, used in determining values including death benefit, withdrawal amount, annuitization amount or surrender values.

“Trading Cost” means the additional cost of liquidating the derivative assets in the Derivative Asset Proxy or actual derivative assets supporting the Index Strategy that is not accounted for in the Derivative Asset Proxy calculation.

**Text**

The Index Strategy Base must equal the Strategy Value at the Index Strategy Term start date.

The Fixed Income Asset Proxy is assumed to be a hypothetical fixed income asset with a yield that results in

- i. At the beginning of the Index Strategy Term, the book value of the Fixed Income Asset Proxy equal to the Index Strategy Base less the Derivative Asset Proxy value; and
- ii. At the end of the Index Strategy Term, the book value of the Fixed Income Asset Proxy, assuming no change in yield, projected to equal the Index Strategy Base.

**Drafting Note:** The guideline defines the conditions under which an index-linked variable annuity is exempt from Model 805 on the basis that it is a variable annuity. A variable annuity provides daily values (analogous to Interim Values in this guideline) based on the market value of separate account assets. In order to more closely align an ILVA to a variable annuity Interim Values should be consistent with the market value of hypothetical assets supporting the ILVA (i.e. Hypothetical Portfolio). The market value of the assets may be determined by a fair value methodology or by applying an MVA to the book value. A state may want to consider whether including or

excluding an MVA is appropriate. In making a determination regarding whether including or excluding an MVA is appropriate and, if applicable, what an acceptable MVA formula is, the state should consider whether the Interim Values provide reasonable equity between the contract holder and the insurance company.

The value of the package of derivative assets is determinable daily. Assumptions used to determine the market value of the Derivative Asset Proxy including implied volatilities, risk-free rates, and dividend yields must be consistent with the observable market prices of derivative assets, whenever possible.

Interim Values must be materially consistent with the value of the Hypothetical Portfolio over the Index Strategy Term less a provision for the cost attributable to reasonably expected or actual Trading Costs at the time the Interim Value is calculated.

If a contract provides Interim Values determined using a methodology other than a Hypothetical Portfolio methodology as described in this guideline, the company must demonstrate that the contractually defined Interim Values will be materially consistent over the Index Strategy Term with the Interim Values that would be produced using the Hypothetical Portfolio methodology for each combination of Index Strategy and Index Strategy Term under a reasonable number of realistic economic scenarios that include index changes that test crediting constraints and recognize initial option pricing market conditions.

The company must provide an actuarial memorandum with each ILVA product filing that includes the following:

1. Actuarial certifications must be included with each ILVA product filing and must include the following:
  - a. Interim Values defined in the contract provide equity between the contract holder and the insurance company;
  - b. The assumptions used to determine the market value of the Derivative Asset Proxy including implied volatilities, risk-free rates, dividend yields, and other parameters required to value the derivatives are consistent with the observable market prices of derivative assets over the Index Strategy Term, whenever possible. Valuation techniques include the standard Black-Scholes method, Monte-Carlo Simulation techniques, and other market consistent option valuation techniques for more complex options;
  - c. The contractually defined Interim Values are materially consistent with the Interim Values that would be produced using the Hypothetical Portfolio methodology for each combination of Index Strategy and Index Strategy Term over the Index Strategy Term less a provision for the Trading Costs at the time the Interim Value is calculated; and
  - d. Any Trading Costs represent reasonably expected or actual costs at the time the Interim Value is calculated.
2. If the Interim Values are determined using a methodology other than the Hypothetical Portfolio methodology described in this guideline, the actuary shall describe the testing performed to verify that the values are materially consistent with the Hypothetical Portfolio methodology. The actuary should define any parameters or assumptions used in determining material consistency and provide a summary of the results of the testing.
3. Descriptions of
  - a. The value of the Fixed Income Asset Proxy;
  - b. The market value adjustment formula, if any;
  - c. The market value of the Derivative Asset Proxy including any Trading Costs; and
  - d. All formulas, methodologies and assumptions used to calculate these values for each Index Strategy and Index Strategy Term as well as the sources for all assumptions.

ILVA nonforfeiture benefits for Index Strategies subject to this guideline must comply with Section 7 of Model 250 not including Section 7.B with net investment return consistent with the requirements for determining Interim Values in this guideline.

**Effective Date**

The Guideline applies to all contracts (including associated riders, endorsements, or amendments) issued on or after July 1, 2024.

**PROJECT HISTORY****ACTUARIAL GUIDELINE LIV—  
NONFORFEITURE REQUIREMENTS FOR INDEX-LINKED  
VARIABLE ANNUITY PRODUCTS****1. What issues was the project intended to address?**

The purpose of the Guideline is stated as follows: “The purpose of this guideline is to specify the conditions under which an Index-Linked Variable Annuity (ILVA) is consistent with the definition of a variable annuity and exempt from Model 805 and specify nonforfeiture requirements consistent with variable annuities.”

**2. What states participated in drafting the model?**

The following states are currently members of the Index-Linked Variable Annuity (ILVA) (A) Subgroup of the Life Actuarial (A) Task Force: Ohio (Chair), Utah (Vice-Chair), California, Illinois, Indiana, Nebraska, New Jersey, New York, Texas, Virginia, and Washington.

**3. What general procedure was followed in drafting the model? What efforts were made to assure that all interested parties were provided an opportunity to comment during the drafting process?**

In response to the emergence of products commonly referred to as index-linked variable annuities, registered index-linked annuities, or other names, Pete Weber (OH) recommended that the Life Actuarial (A) Task Force form an ILVA (A) Subgroup to draft a standard that would define the minimum interim values for these products at a call of the Task Force on June 17, 2021. After approval of the formation of the ILVA (A) Subgroup from the Task Force and subsequent approval from the Life Insurance and Annuities (A) Committee and the NAIC’s Executive (EX) Committee and Plenary, open meetings of the subgroup began.

The work of the subgroup was coordinated with all industry interested parties. In addition to twelve open subgroup conference calls that were held over 2021 and 2022 (see Table 1) to develop a draft Actuarial Guideline, several updates were provided to the Life Actuarial (A) Task Force during open sessions. Notice of these conference calls was posted on the NAIC’s home page on the Internet and e-mailed to approximately 500 interested parties, including representatives of the American Council of Life Insurers, the Committee of Annuity Insurers, and the American Academy of Actuaries.

Table 1:

<b>Meeting Date</b>	<b>Open/Regulator-only?</b>
7/15/2021	Open
9/23/2021	Open
11/23/2021	Open
2/16/2022	Open
3/2/2022	Open
3/9/2022	Open
3/17/2022	Regulator-only
5/17/2022	Open
5/18/2022	Open
7/13/2022	Open
8/29/2022	Open
9/20/2022	Open
9/27/2022	Open

**4. What significant issues were raised during the drafting process, and how were those issues resolved?**

Two key questions emerged during the process of drafting the actuarial guideline:

1. Should the actuarial guideline allow companies to utilize market value adjustment term lengths other than the maturity of the Fixed Income Asset Proxy?
2. Should the actuarial guideline allow companies to continue to have the option to include or exclude a market value adjustment in their ILVA products?

There was concern that reaching a strong consensus on both of these items would be time consuming if not impossible. To address both issues and advance the actuarial guideline, revisions were made to remove specific requirements related to market value adjustments. In place of specific market value adjustment requirements, a drafting note was added that granted more flexibility to the states to be able to approve products that are consistent with the principles laid out in the actuarial guideline. In particular, the first principle of the actuarial guideline states that the interim values must provide equity between the contract holder and the insurance company. That principle should guide states in determining whether a market value adjustment is appropriate or not.

**5. What are the implications of this project for accreditation and codification?**

The Guideline should be handled in a manner that is consistent with the treatment of other guidelines.

*Adopted by Transparency and Consumer Readability (C) Working Group – Nov. 15, 2022*

*Adopted by Property and Casualty (C) Committee – Dec. 15, 2022*



*REGULATORY RESOURCES  
FOR CONSUMERS ON  
PERSONAL LINES PRICING  
AND UNDERWRITING*

# *AUTO SECTION*



## How Do Insurers Determine Your Auto Insurance Premium?

The way auto insurers determine how much you pay for insurance is constantly changing. The process starts with the information you provided on the application. The two parts of the process are *underwriting* and *rating*.

### How Do Insurers Underwrite?

The first part of the process is underwriting. Insurance companies underwrite to:

- know the risk of insuring an applicant.
- group the applicant with others who have similar risks.
- decide if they will insure the applicant.

To underwrite an auto insurance policy, insurance companies want information about certain factors that might affect how likely you are to have a loss that insurance covers. Some of these factors are beyond your control, such as age and gender. You have control over other factors an insurance company considers, including where your car is, how you use it, the make and model of your car, and your credit-based insurance score.

An underwriter uses information from your application as well as from other sources.

Insurance companies depend on the information in your policy application. The questions you're asked when you apply for insurance help the company know how likely you are to have a loss that insurance covers.

Insurance companies also get information from other sources. For example, some auto insurers get information about your credit history from credit bureaus. They also get information about your driving record from third parties, such as the Division of Motor Vehicles, and your history of filing auto insurance claims from insurance claims databases.

### How Do Insurers Rate Risk?

After underwriting, the next step is to rate your risk. The company sets a rate for each group of applicants who are similar risks.

A rating factor is a specific characteristic of a potential policyholder that an insurer uses to price auto insurance premiums. All else being equal, the less risky your rating factors are, the less you'll pay for insurance.

For more information about the rating factors many companies use, see *Factors Used to Rate Auto Insurance*.

### How Do Insurers Determine Auto Insurance Premiums?

Insurance companies use information about you, your vehicle, and your insurance coverage to decide whether to insure you and how much you'll pay for auto insurance. They'll get this information from you or from organizations. All this information is used to rate you as an insurance risk and affects how much you'll pay for insurance.

Some factors relate to the driver(s) and some to the type of vehicle you want to insure. Others are based on the amount and types of coverage you buy. There are discounts that could reduce the premium.

Insurance companies use various methods to rate your risk. Different insurance companies often charge you different amounts for the same or similar coverage.

Also, some states limit the factors an insurance company can use. States also have different requirements about how much insurance you buy, which affects your cost.

## General Information

Age, years of driving experience, gender, and marital status are factors insurance companies may use to determine how much you'll pay. The insurance company gets information about your driving record and accident history from a third party (such as the Division of Motor Vehicles). In some states, insurance companies can't consider certain factors, such as your gender or age.

If other drivers live with you, your insurance company will also look at their information to decide how much you'll pay.

## How You Use the Vehicle

Your insurance premium may vary based on whether you use your vehicle only for pleasure or drive it back and forth to work. Driving for pleasure means that you drive only occasionally. If you drive only for pleasure, you might pay less.

Most personal auto insurance policies won't pay for accidents if you use your car for business activities your policy doesn't cover, such as transporting people or delivering goods.

## Gender and Age

Some research shows that males have more accidents than females and younger drivers have more accidents than older and more experienced drivers. That's why young men are often charged more for insurance than young women. Inexperienced drivers may pay more regardless of age. Some states don't let insurance companies use gender as a factor when they rate insurance.

Insurance companies look at accident statistics for all age groups. What you pay for insurance may change as you get older.

Some states require insurance companies to give a discount to any primary driver who is older than 55 if they complete an approved accident prevention or defensive driving course the Division of Motor Vehicles approves.

## Location

It's important to tell your insurance company where you keep (or "garage") your vehicle. You may pay more or less based on where you live or keep your car. The insurance company may look at the weather and number of accidents and thefts in the area you live in.

## Other Risk Factors

Some insurance companies consider your job and education to decide how much to charge you. That's why an insurance company may ask what you do for a living and how much school you've completed.

In some states, married drivers might pay less for auto insurance. And homeowners might pay less than renters.

## Coverage History

When you apply for insurance, you may be asked about your previous insurance coverage. Most insurance companies charge you more if you've gone without insurance before.

You might need to give the name of your previous insurance companies and the dates you were insured. Insurance companies want to know if a company ever cancelled your insurance policy because you didn't pay. Your new insurance company also may ask about your traffic violations and claims history.

Some states limit insurance companies' use of prior insurance coverage as a factor when rating a policy.

## Driving Habits and History

Insurance companies look at your driving record and habits and those of anyone else on your policy or living with you. Your new insurance company might ask if you've had traffic tickets or been in an accident. Typically, your driving record for the past three to five years impacts what you pay. Drivers with a bad driving record have a greater chance of being in an accident and might pay more for their insurance.

Drive safely. Nothing affects your auto insurance premium more than how you drive. Insurance companies consider drivers who have caused car accidents to be a higher risk and might charge them more for insurance.

Although the company will get your driving record from a third party when you apply for a policy, it's important to be honest and truthful when you give the insurer information. Being honest will mean it's more likely that your quote will match what you'll actually pay for your insurance.

If your driving record has improved over the last few years, shop around to see if you can pay less with another insurance company.

## Vehicle Owners and Operators in Your Household

Some states may let you exclude a driver from your insurance policy. Others will not. An excluded driver is one that you ask your insurance company not to cover, usually because having them on your policy will increase what you'll pay. Talk with your agent or insurance company to find out if this is an option for you. Be aware that you have no insurance coverage for damage caused by an excluded driver driving your vehicle.

## Telematics

Telematics is in-car tracking technology that insurance companies use to monitor your car and your driving behaviors. Many insurance companies use telematics to learn how fast you drive, your braking behaviors, and the distance you drive. Telematics can work through a mobile app or a Bluetooth device that communicates with your car. The insurance company may use your driving behaviors and habits to determine how much to charge you. Telematics can also work directly with your car to record how it performs and how it's maintained.

### Usage-Based Premiums

Some insurance companies may use information about how you drive or how much you drive to decide how much you'll pay. Pay As You Drive and Pay-per-Mile policies are two examples of using telematics to determine premium.

**Pay As You Drive.** Pay As You Drive uses information from telematics about your driving habits to determine what you'll pay. Telematics can track braking and speeding, how often you drive, the time of day or night you drive, where you drive, and whether you use a cell phone while driving. You may be able to log on to the insurance company's website to see how your driving habits affect how much you pay.

**Pay-per-Mile.** Insurance companies base what you pay for insurance on an estimate of how much you drive. Some insurance companies charge a base rate and then add a "per-mile" fee to determine your premium. Insurance companies use a device installed in your car to track the number of miles you drive. If you work from home, use mass transit, or don't drive often this type of policy could save you money. Some companies let you have this type of policy without a tracking device but require you to send a photo of your odometer reading each month.

### Credit-Based Insurance Score

Insurance companies may use information about your credit history when they rate your policy. They use credit-based insurance scores which, like all credit-based scores, predict an outcome. Credit-based insurance scores predict the amount of a claim, the likelihood of filing a claim, or the likelihood a policyholder will stay with an insurer instead of shopping around.

Credit-based insurance scores, like other credit scores, are based on your credit payment history, your current debt, how much new credit you've applied for, and what types of credit you have. Some insurance companies combine credit information with traditional insurance information, such as claims history, to create hybrid credit-based insurance scores. In either case, a higher score indicates you'll likely pay less for insurance.

Some states restrict or even ban the use of credit-based insurance scoring. Each insurance company uses its own method to determine your score.

Before you apply for insurance, it's a good idea to get a copy of your credit report and make sure the information in it is correct. Bankruptcies, judgments, liens, late payments, and credit inquiries

may mean a lower credit-based insurance score. You can find information about how to get your credit report at <https://www.usa.gov/credit-reports>.

It's important to talk to your agent or insurance company if you've had extraordinary life circumstances, such as divorce, death of a family member, job loss, military deployment, or serious illness, that might affect your credit.

If you have a “freeze” on your credit to help prevent identity theft, an insurance company won't be able to see your credit report and you may pay more for your insurance. You can temporarily “unfreeze” your credit when you apply for insurance.

## Vehicle Specific Factors

The type of vehicle you drive affects the cost of your auto insurance. You'll pay more for cars that cost more to repair or replace or that are often stolen. For example, you'll pay more to insure higher-value cars and newer cars. Some examples are large SUVs or trucks, high-performance sports cars, and vehicles with special features such as all-wheel drive transmissions and hybrid engines.

## Auto Insurance Discounts

You may pay less for car insurance if you qualify for a discount. To make sure you get the discounts you qualify for, be sure to ask your agent what discounts the insurance company offers and how much you could save. When you compare the cost of insurance between different companies, compare the total cost after any discounts.

Here are some important things to consider:

- Discounts vary depending on the insurance company and the state where you live;
- Ask about discounts at every policy renewal; and
- If you get quotes from different insurance companies, be sure to ask each about discounts.

## General Discounts

Most insurance companies offer various types of discounts. Insurance companies might offer discounts if you use automated payments, pay your annual premium in one payment, or sign up for electronic billing.

Ask your agent or insurance company about discounts you can get.

## Continuous Coverage

Insurers may offer discounts if you keep a car continually insured and haven't had a gap in coverage.

## Group Memberships

Some insurance companies may offer a discount if you're a member of an organization, such as an alumni or professional association, a union, or other organization.

## Loyalty

Some insurance companies may offer discounts for:

- Renewing your policy for a certain number of years;
- Children who use the same company their parents use even after they move out.

## Multiple Vehicles

Most insurance companies offer a discount if you insure more than one car with them.

## Multiple Policies

Insurance companies may offer discounts if you have your auto and homeowners insurance with the same insurance company. This often is called bundling or home/auto packages.

## Driver-Specific Discounts

Insurance companies may look at information about each driver on the policy when they choose which discounts to give you.

## Claim Free

If you haven't filed any claims, insurance companies may offer a discount.

## Defensive Driver/Driver's Education

Many insurance companies offer discounts if you've completed a defensive driving or driver's education course. Discounts for driver education courses are targeted primarily at younger and older drivers.

## Good Student

Some insurance companies offer discounts to students who get good grades.

## Mileage

Driving fewer miles reduces the chance you'll be in an accident. Many insurance companies know this and offer discounts if you don't drive much. Some companies offer discounts to drivers who use carpools.

## Military

Some insurance companies offer a discount to active, retired, reserve, and honorably discharged members of the military (and often their family members). This discount isn't available in all states. Ask your insurance company if this discount is available to you.

They might also have a discount if you keep your car on base while you're deployed.

## Non-smoker/Non-drinker

Because smoking and drinking can increase the chances that you'll be in an accident, some insurance companies offer non-smoker and non-drinker discounts.

## Seat Belt Use

Using your seat belt may get you a discount.

## Vehicle Discounts

### Safety Devices.

Auto safety devices can reduce how much you'll pay because they help prevent accidents, vehicle damage, and injuries. This equipment includes:

- Adaptive Cruise Control
- Adaptive Headlights
- Air Bags
- Anti-Lock Brakes
- Automatic Braking
- Automatic Seat Belts
- Blind Spot Warning
- Daytime Running Lights
- Electronic Stability Control
- Forward Collision Warning
- Lane Departure Warning
- Passive Restraint

### Anti-Theft Discount

You'll also pay less if you have certain devices that reduce theft or vandalism. Some examples include:

- Active Disabling Device
- Audible Alarm
- Vehicle Recovery
- Vehicle Identification Number Etching

There are a lot of things to consider if you're trying to lower your auto insurance premiums. You'll find some great questions to ask your agent in [A Shopping Tool for Auto Insurance](#).

# *HOMEOWNERS SECTION*



## How Do Insurers Determine Your Homeowners Insurance Premium?

Insurance companies use information about you, your home, and your insurance coverage to decide whether to insure your home and how much you'll pay for homeowners insurance. They'll get this information from you and from organizations. All this information is linked to "factors" that affect how much you'll pay for insurance, or how the insurance company "rates" your insurance risk. Many of these factors are described below. Different insurance companies determine their risk of insuring you in different ways and charge different amounts for the same or similar coverage.

There may be discounts that reduce your premium.

### Factors Relating to You

#### Claims History and Loss History Reports

If you've filed homeowners insurance claims, or if a previous homeowner has filed claims for your home, you may pay more for insurance. Your history of filing claims will affect how much you pay for homeowners insurance, even if claim payments were low. Insurance companies use third-party data, including the Comprehensive Loss and Underwriting Exchange (CLUE) database to see, the number and types of claims you've filed in the last five to seven years. Different insurance companies treat claims information differently, so it's always a good idea to shop around.

#### Credit-Based Insurance Score

Insurance companies may use information about your credit history when they rate your policy. They use credit-based insurance scores which, like all credit-based scores, predict an outcome. Credit-based insurance scores predict the amount of a claim, the likelihood of filing a claim, or the likelihood a policyholder will stay with an insurer instead of shopping around.

Credit-based insurance scores, like other credit scores, are based on your credit payment history, your current debt, how much new credit you've applied for, and what types of credit you have. Some insurance companies combine credit information with traditional insurance information, such as claims history, to create hybrid credit-based insurance scores. In either case, a higher score indicates you'll likely pay less for insurance.

Some states restrict or even ban the use of credit-based insurance scoring. Each insurance company uses its own method to determine your score.

Before you apply for insurance, it's a good idea to get a copy of your credit report and make sure the information in it is correct. Bankruptcies, judgments, liens, late payments, and credit inquiries may mean a lower credit-based insurance score. You can find information about how to get your credit report at <https://www.usa.gov/credit-reports>.

It's important to talk to your agent or insurance company if you've had extraordinary life circumstances, such as divorce, death of a family member, job loss, military deployment, or serious illness, that might affect your credit.

If you have a “freeze” on your credit to help prevent identity theft, an insurance company won't be able to see your credit report and you may pay more for your insurance. You can temporarily “unfreeze” your credit when you apply for insurance.

## Pets

Some insurance companies consider some pets or breeds of pets aggressive. An aggressive pet increases the risk you may be legally responsible if someone makes a claim against you for a pet-related injury. Some insurance companies have their own list of pet breeds they won't cover, or that could increase your premium. Check with your agent or company if you own a pet.

## Smoking

Smoking increases the risk of a fire in your home. Insurance companies usually charge more if someone in your home smokes.

## Factors Relating to Your Policy

### Coverage History

Insurance companies look at your insurance history to see if you've had continuous coverage on your home. If you canceled a policy before you bought a new one (called a lapse) you may pay a higher premium on a new policy. You also could have had a lapse in coverage if:

- you didn't pay your bill on or before the due date or within the grace period; or
- you let your current policy end before you bought a new policy.

If you don't pay your bill on time, your insurance company could:

- cancel your policy and not cover a loss to your home; or
- refuse to continue your policy, which may leave you without homeowners insurance.

If you let your insurance coverage lapse and you have a mortgage, your lender may buy a policy and charge you for it. Your premium for a lender-placed policy will probably be higher and might not provide as much coverage for you.

### The Homeowners Insurance Coverage You Choose

Your insurance agent or company will help you decide what types and amounts of coverage you need. Your policy will specify the coverage for your home and personal belongings. It also may include *liability* coverage, which can pay if someone gets hurt on your property.

Your agent might suggest that you buy enough coverage to rebuild your house and replace your personal belongings. That's called replacement cost coverage. Another type of coverage is based on actual cash value.

- *Actual cash value* coverage pays the fair market value of property at the time of the loss. This value usually is the cost to repair or replace the property, less *depreciation*. (Depreciation is a deduction for the age of the property and wear and tear.) Actual cash value coverage pays you for your loss, but often doesn't pay enough to fully replace or repair the damage to your property.

Some policies provide only actual cash value coverage for roofs over a certain age or that are in poor condition. Be sure to find out what your policy covers.

- *Replacement cost* coverage pays the cost to repair or replace your damaged or destroyed property *without* a deduction for depreciation. Most policies cover your house for replacement cost. If you don't have replacement cost coverage, your insurance company might only pay actual cash value. The cost of building supplies might be higher now than when you bought your policy. Review your policy with your agent at renewal to be sure you have the best coverage you can afford.

Replacement cost and *market value* aren't the same. The market value of a home includes the price of your land and depends on the real estate market. For more information about these and other coverages, see the NAIC's [Homeowners Shopping Tool](#).

### The Deductible You Choose

A deductible is the money you pay out of pocket on a claim before the policy pays. The deductible applies to coverage for your home and personal property. You pay a deductible for each claim. Higher deductibles mean lower policy premiums. The premium for a policy with a \$1,000 deductible will be lower than the premium for the same policy with a \$500 deductible. In some areas, there are also catastrophe deductibles, which are either a dollar amount or a percentage of the value of the property.

A higher deductible can be a good way to save money on your premium. But be sure you can afford the deductible if you have a loss.

### The Risks Your Policy Covers

*Peril* is an insurance term for a specific risk or reason for a loss. An all-perils policy insures your property against all perils, except those the policy names as not covered. Flood and earthquake are often not covered.

A *named perils* policy covers your home and personal property only against a specific list of reasons for a loss. Your policy will list the types of losses that it covers. Common examples of covered losses include fire, theft, and vandalism. Named perils policies cover less than all perils policies and are less expensive.

Talk with your insurance company's representative or agent if you want coverage for floods or earthquakes. A homeowners policy doesn't cover either, so you'll need to buy extra coverage.

### Coverage You Add

To cover the full value of your possessions, you may need to add coverage to your homeowners policy. These additions may be called endorsements or riders and will increase your premium.

You may want to add coverage for:

- Antiques
- Computer Equipment
- Fine Art
- Firearms
- Jewelry

## Your Home's characteristics

### Your Home's Age and Condition

If you have an older home, your policy might be more expensive. Older homes might have outdated electrical and plumbing systems which might increase the risk of a loss. Older "historic" homes may require building materials that are hard to find. If you have an older home, you may need a special policy and probably will pay a higher premium.

Improvements to your home, such as replacing your roof; upgrading electrical, heating, or plumbing; or installing a security system, may lower your premium. You should tell your insurance agent or company about any upgrades you make to your home.

### The Size of Your Home

The size of your home affects what you pay for insurance. Larger homes normally cost more to insure because they cost more to rebuild or repair. Your agent or company might ask about your basement and what percent is finished.

### Your Home's Construction and Exterior Features

The material your home is made of affects how your home holds up against a natural disaster and perils like wind and fire. Homes made with concrete or solid brick exteriors are less likely to catch fire and are more stable during a storm.

Your home's roof is its main protection against hail, wind, fire, and other perils. The age, condition, material, and shape of your roof are all factors that determine your premium. Homes with newer roofs made of materials that are stable and fire-resistant usually cost less to insure.

Installing fire-resistant siding made of metal, fiber-cement shingles and clapboards, or masonry can help you pay less for your homeowners insurance, especially in fire-prone areas.

### Custom Features of the Home

If you have a wood-burning or pellet stove, you may pay more for insurance. If a licensed contractor installed your stove and it meets code requirements, your premium may be lower.

If your home is made from custom, designer, or luxury grade materials, such as high-end marble, luxury grade cabinets, and expensive lighting, or requires professional craftsmanship to rebuild, you may pay more for your insurance.

## Where You Live

Your home's location affects what you pay for homeowners insurance. If your area gets a lot of hurricanes, tornadoes, or wildfires, your insurance will cost more.

Insurance companies consider how far you live from a fire station when they calculate your premium. Living in a city or suburban area, by a body of water, or in an area with a lot of crime will increase your premium.

## Attractive Nuisances (For Example, A Swimming Pool) on Your Property

An *attractive nuisance* is a dangerous condition that may attract children to a homeowner's property. Examples are swimming pools, trampolines, and playground equipment. If you have an attractive nuisance you might want to increase your homeowners policy's liability insurance. You may be liable if someone is hurt using an attractive nuisance on your property (even if they don't have your permission and aren't using the item safely).

Your insurance company may require you to install an enclosure or fence around an attractive nuisance. Your policy might not cover items like diving boards or slides. Having an attractive nuisance on your property likely will increase your premium.

## Homeowners Insurance Discounts

Most insurance companies offer various types of discounts. You will pay less for homeowners insurance if you qualify for a discount. Ask your agent or the insurance company what discounts the company offers and how much you could save. When you compare the costs of different insurance policies, compare the total cost after discounts.

Here are some important things to know:

- Discounts vary depending on the insurance company and the state where you live. Some insurance companies may not offer discounts.
- Ask about discounts every year when you renew your policy.
- If you get quotes from different insurance companies, be sure to ask each about discounts you might qualify for.

## General Discounts

Most insurance companies offer various types of discounts. The discounts may be tied to how you pay for your policy, your personal characteristics, and/or your home.

### Advance Purchase

You might get an Advance Purchase Discount if you buy a policy before the renewal date. Insurance companies might give discounts if you give them seven to 10 days' notice before you switch to their company.

### Purchasing and Payment

Some insurance companies offer discounts if you pay for the full year of insurance in one payment, sign up for electronic billing, or are a new customer.

### Multiple Policies

Insurance companies might offer a discount if you have your auto and homeowners policies with the same insurance company. This is known as bundling.

### Discounts Specific to You and Your Policy

Discounts vary by insurance company. Some are not available in all states.

#### Claim Free

Insurance companies might offer a discount if you haven't filed any claims or haven't filed a claim for a certain number of years. Ask your insurance company if they offer this discount.

#### Prior Insurance

The prior insurance discount is for new policyholders. It's based on the number of years in a row that you had a policy with your previous insurance company.

#### Being Married or Widowed

Your insurance company may offer a discount if you're married or widowed. Ask your agent or insurance company about this discount.

#### Retirement Discount

Some insurance companies offer a discount to retired people. They tend to spend more time at home and will know about fires, water leaks, or burglaries at their homes.

#### Non-smoker Discount

Smoking at home may increase your fire risk, so some insurance companies offer a non-smoker discount.

### Group Memberships

#### Military

Some insurance companies offer a discount to active, retired, reserve, and honorably discharged members of the military (and often their family members). Ask your agent or insurance company if they offer this discount.

#### Associations

Some insurance companies offer a discount if you're a member of an organization, such as an alumni or professional association or a union.

#### Occupation

Some insurance companies offer a discount to people with certain jobs, such as first responders, teachers, and nurses.

### Loyalty (5-10 years or more)

Some insurance companies offer discounts if you:

- Renew your policy for a certain number of years
- No longer live with your parents, but buy a policy from the same insurance company

### Replacement Cost

If you insure your home for 100% of the cost to replace it, you might be eligible for a discount.

### Discounts Relating to Your Home

#### Age of Home

If your home is less than 10 years old, insurance companies may offer you a discount.

#### Construction Type

If your home is built from brick, stucco, metal, or concrete, you might be eligible for a discount.

#### New or Renovated Home Discount

If you bought a new or renovated home with upgraded electrical or plumbing, you may be eligible for a discount.

#### Roof Age Discount

Some insurance companies give a discount based on the age of your roof. If your home has a newer roof, or an impact-resistant roof, you might get a discount.

#### Accredited Builder Discount

If your home's builder is on the insurance company's "accredited builder" list, you might be eligible for a discount. This discount will probably only last for five years after your home is built.

#### Homeowners Association (HOA)

Some insurance companies offer a discount if you live in a neighborhood with an HOA.

#### Living in a Gated Community

Living in a gated community (with or without security patrols) offers an extra level of security and might make you eligible for a discount.

#### Fire and Safety Protection

Your insurance company may offer a discount if your home has qualifying fire or theft protection. Some of these include:

- Smoke Detectors
- Sprinkler System
- Fire Alarm
- Security Alarm
- Backup Generator
- Smart Technology to Alert You to Fires, Water Leaks, or Burglaries
- Deadbolt Locks

### Water Leak Detection

You might get a discount if you have a water leak detector or prevention system. Discounts depend on how advanced the detection system is, so ask your agent or insurance company.

### Mitigation Discounts

If you live in an area that has severe weather, your insurance company might give you a discount if you have storm shutters, reinforced doors, shatterproof glass, or other protections.

If you live in an area that is at risk for wildfires, you may get a discount if you take steps to mitigate damage. This includes using concrete or other fire-resistant materials for your home's structure and creating an area around your home that reduces fire risks.



## PROJECT HISTORY

### **Transparency and Readability of Consumer Information (C) Working Group's Regulatory Resources for Consumers on Personal Lines Pricing and Underwriting**

#### **1. Description of the project, issues addressed, etc.**

The purpose of the *Regulatory Resources for Consumers on Personal Lines Pricing and Underwriting* document is to provide state insurance regulators with information they can use in social media, bulletins, and other means of consumer information for which a department of insurance (DOI) might need to provide information to consumers regarding the pricing, rating, and underwriting of personal lines products.

The resources document includes information regarding both auto insurance and homeowners' insurance.

The auto insurance section includes information regarding how insurers: 1) underwrite; 2) rate risk; and 3) determine premiums for auto insurance products. The rating factors addressed in the document include: 1) how a vehicle is used; 2) an insured's gender and age; 3) the vehicle's location; 4) vehicle-specific factors; and 5) other risk factors. The document also affords information regarding a driver's coverage history, driving habits and history, and the vehicle owners and operators in a household.

The document additionally covers information regarding telematics and usage-based premiums, information regarding credit-based insurance scores, and vehicle-specific factors.

Furthermore, the document identifies information regarding auto insurance premium discounts, including general discounts like: 1) continuous coverage; 2) group memberships; 3) loyalty discounts; and 4) multiple vehicle and multiple policy discounts.

The document further identifies driver-specific discounts, including: 1) being claims-free; 2) taking defensive driving or driver's education courses; 3) good student discounts; 4) mileage discounts; 5) military discounts; 6) being a non-smoker/non-drinker; and 7) using a seat belt. Lastly, the document includes vehicle discounts for various safety devices and anti-theft discounts.

The document's homeowners insurance section discusses how insurers determine a premium using factors related to the homeowner, as well as discount information. General factors include items such as: 1) the homeowner's credit-based insurance score; 2) pets owned by the homeowner; and 3) whether someone in the homeowner's home smokes.

Factors concerning the homeowners policy include: 1) coverage history; 2) the coverage chosen; 3) the deductible chosen; 4) risks a policy covers; and 5) coverages added for valuable items.

Factors about a home's characteristics consist of: 1) the home's age and condition; 2) the home's size; 3) the home's construction and exterior features; 4) the home's custom features; 5) the home's location; and 6) whether there are attractive nuisances on the homeowner's property.

Discounts offered for a homeowners policy include general discounts, such as: 1) the advance purchase of a policy; 2) certain methods of purchasing and paying for insurance; and 3) whether the homeowner has multiple policies.

Discounts to a homeowners policy also include discounts specific to the homeowner and their policy, including: 1) being claims-free; 2) having prior insurance; 3) being married or widowed; 4) retirement discounts; and 5) non-

smoker discounts. Homeowners can also get discounts for things like: 1) having a group membership, such as belonging to the military or being a member of an association; 2) the homeowner's occupation; 3) loyalty discounts for having a policy for five to 10 years or more; and 4) insuring a home for replacement cost.

Discounts pertaining to the home may include: 1) the home's age; 2) the construction type; 3) whether the home is new or renovated; 4) roof age; 5) an accredited builder discount; 6) living in a gated community; 7) having qualifying fire or theft protection; 8) having water leak detection; and 9) mitigating the home for damage.

**2. Name of group responsible for drafting the model and states participating.**

The Transparency and Readability of Consumer Information (C) Working Group of the Property and Casualty Insurance (C) Committee was responsible for drafting the resource document and formed drafting groups to draft it. Participating states included: Alabama, the District of Columbia, Kansas, Maryland, Michigan, North Carolina, and Tennessee.

**3. Project authorized by what charge and date first given to the group.**

The project was authorized by the charge of the Transparency and Readability of Consumer Information (C) Working Group of the Property and Casualty Insurance (C) Committee to: "Consider drafting regulatory best practices that serve to inform consumers of the reasons for significant increases related to property/casualty (P/C) insurance products." The charge was given to the Working Group in 2021.

**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.**

In March 2021, the Transparency and Readability of Consumer Information (C) Working Group began discussing items to be included in a document meant to provide state insurance regulators with information about pricing, rating, and the underwriting of personal lines products. The document gives the state insurance regulator information that can be used in social media, bulletins, and other means of consumer education.

The Working Group formed drafting groups to work on each section of the document. The drafting groups met monthly to work on drafting the document. Interested parties from the American Property Casualty Insurance Association (APCIA) and the American Automobile Association (AAA) of Missouri also joined these meetings and provided feedback.

**5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers, and legislators was solicited).**

The drafting groups of the Transparency and Readability of Consumer Information (C) Working Group met regularly, and during its meetings, the Working Group heard comments and discussed suggested revisions from state insurance regulators and interested parties. Following the drafting of the document, the document was exposed on June 9, 2022, for a 14-day public comment period. Once comments were received, in early July, the drafting groups addressed these comments to put back before the Working Group. The changes made were editorial, mainly to increase the readability level. The Working Group adopted the regulatory document on Nov. 15, 2022. The Property and Casualty Insurance (C) Committee adopted the regulatory document during its Dec. 15, 2022, meeting at the 2022 Fall National Meeting.

**6. A discussion of the significant issues (items of some controversy raised during the due process and the group's response).**

There were no items of controversy raised during the due process.

**7. Any other important information (e.g., amending an accreditation standard).**

Not applicable.

Adopted by the Transparency and Readability of Consumer Information (C) Working Group, Nov. 15, 2022  
Adopted by the Property and Casualty Insurance (C) Committee, Dec. 15, 2022

Completed	N/A	<b>EXAMPLE RATE/RULE FILING CHECKLIST</b>	
<input type="checkbox"/>	<input type="checkbox"/>	1.	Please complete all check boxes on this form or your filing may be returned "Rejected," and a resubmission may be necessary.
<input type="checkbox"/>	<input type="checkbox"/>	2.	All rate information must be completed on the rate/rule tab without capping.
<input type="checkbox"/>	<input type="checkbox"/>	3.	All proposed rate/rule manual pages must be submitted under the rate/rule schedule tab for approval.
<input type="checkbox"/>	<input type="checkbox"/>	4.	Complete rate/rule manual with all proposed changes must be submitted under supporting documents tab as this will be marked informational only. A complete manual should consist of all corresponding rules for your optional forms, all rules corresponding to your rating factors, all rating factors, territory definitions and factors, and all proposed changes to rules and rates.
<input type="checkbox"/>	<input type="checkbox"/>	5.	Provide a histogram on an uncapped basis. If the filing contains more than one company, please provide a separate histogram for each company.
<input type="checkbox"/>	<input type="checkbox"/>	6.	Provide the characteristics of the insured(s) receiving the maximum rate increase. If the filing contains more than one company, please provide a separate histogram for each company.
<input type="checkbox"/>	<input type="checkbox"/>	7.	Provide the average dollar change, the maximum dollar change, and minimum dollar change on an uncapped basis. If the filing contains more than one company, please provide a separate histogram for each company.
<input type="checkbox"/>	<input type="checkbox"/>	8.	Please provide our department with a talking points sheet that will assist our consumer assistance division should we receive consumer complaints regarding the rate increase. This submission should provide detailed information that we can share with policyholders that will explain what it is causing this rate increase.
<input type="checkbox"/>	<input type="checkbox"/>	9.	Please provide us with the breakdown of the permissible loss ratio by coverage including: a. Taxes, licenses, and fees b. Total production expense c. Underwriting profit d. Any other fees that comprise the permissible loss ratio e. Permissible loss ratio
<input type="checkbox"/>	<input type="checkbox"/>	10.	Provide all support and justification exhibits for rate change including how you derived your overall indication, all support for proposed factor changes, etc.
<input type="checkbox"/>	<input type="checkbox"/>	11.	This checklist item is only required for Personal Auto rate filings: Provide the percentage breakdown of the rate impact. If the filing contains more than one company, please provide a separate histogram for each company.
<input type="checkbox"/>	<input type="checkbox"/>	12.	Rates developed using generalized linear modeling or other predictive modeling techniques must include a detailed narrative of the modeling process. This should include a description of the modeling data, variable selection process, data dictionary, model testing & validation, and any judgements made throughout the process.
<input type="checkbox"/>	<input type="checkbox"/>	13.	If a GLM (Generalized Linear Model) is currently in use, the company must include the SERFF tracking number of the original GLM filing.

## PROJECT HISTORY

### **Transparency and Readability of Consumer Information (C) Working Group's NAIC Rate/Rule Filing Checklist**

#### **1. Description of the project, issues addressed, etc.**

The purpose of the *NAIC Rate/Rule Filing Checklist* is to provide state insurance regulators with a checklist that insurers with a rate/rule filing can complete. It was determined that many states do not have a rate/rule filing checklist in place. Kansas and Connecticut both have checklists in place and have found them to be extremely helpful.

The checklist includes items insurers are required to complete for the filing to be accepted. For example: 1) all rate information must be completed on the rate/rule tab without capping; 2) all proposed rate/rule manual pages must be submitted under the rate/rule schedule tab for approval; 3) all proposed changes must be submitted under the supporting documents tab (will be marked informational only); 4) provide a histogram on an uncapped basis; 5) provide the characteristics of the insureds receiving the maximum rate increase; 6) provide the average dollar change, the maximum dollar change, and minimum dollar change on an uncapped basis; 7) provide the department of insurance (DOI) with a talking points sheet that will assist the consumer assistance division if a consumer complaint regarding a rate increase is made; 8) provide a breakdown of permissible loss ratio by coverage; 9) provide all support and justification exhibits for rate change; 10) the checklist is only required for personal auto rate filings; 11) rates developed using a generalized linear modeling (GLM) or other predictive modeling techniques must include a detailed narrative of the modeling process; and 12) if a GLM is currently in use, the company must include the System for Electronic Rates & Forms Filing (SERFF) tracking number of the original GLM filing.

The checklist is not a required document but will be available to states that do not have one in place and wish to implement it.

#### **2. Name of group responsible for drafting the model and states participating.**

The Transparency and Readability of Consumer Information (C) Working Group of the Property and Casualty Insurance (C) Committee was responsible for drafting the *NAIC Rate/Rule Filing Checklist*. A drafting group was formed to draft the checklist. Participating states included: Alabama, Kansas, Maryland, and Tennessee.

#### **3. Project authorized by what charge and date first given to the group.**

The project was authorized by the charge of the Transparency and Readability of Consumer Information (C) Working Group of the Property and Casualty Insurance (C) Committee to: "Consider drafting regulatory best practices that serve to inform consumers of the reasons for significant increases related to property/casualty (P/C) insurance products." The charge was given to the Working Group in 2021.

#### **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.**

In March 2021, the Transparency and Readability of Consumer Information (C) Working Group began discussing items to be included in the checklist. This checklist is based on a checklist that has been used in Kansas for several years.

The Working Group formed a drafting group to work on the rate/rule filing checklist. The drafting group met monthly via conference call to work on drafting the document.

**5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers, and legislators was solicited).**

The drafting group of the Transparency and Readability of Consumer Information (C) Working Group met regularly via conference call, during which the drafting group discussed suggested revisions in the *NAIC Rate/Rule Filing Checklist*. Following the drafting of the checklist, the Working Group exposed the checklist on June 9, 2022, for a 14-day public comment period. Interested parties were given the opportunity to participate in the calls, and there were no objections prior to the comment period. The drafting group received one comment from a trade organization. However, the Working Group agreed there was no need for changes to be made to the checklist, as it has been being used in Kansas for several years with no objections from insurers. The Transparency and Readability of Consumer Information (C) Working Group adopted the checklist on Nov. 15, 2022. The Property and Casualty Insurance (C) Committee adopted the checklist during its Dec. 15, 2022, meeting at the 2022 Fall National Meeting.

**6. A discussion of the significant issues (items of some controversy raised during the due process and the group's response).**

There were no items of controversy raised during the due process.

**7. Any other important information (e.g., amending an accreditation standard).**

Not applicable.



Date: 3/23/2023

## 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. Eight jurisdictions have enacted the 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. NAIC staff are not aware of any activity regarding this model.
- Amendments to the *Suitability in Annuity Transactions Model Regulation (#275)*—These revisions were adopted by the Executive (EX) Committee and Plenary during the February 13, 2020, conference call. 30 jurisdictions have enacted the revisions to the model.
- Amendments to the *Standard Nonforfeiture Law for Individual Deferred Annuities (#805)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. 22 jurisdictions have adopted the 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 the 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. 24 jurisdictions have adopted the 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. 12 jurisdictions have adopted the 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. One jurisdiction has adopted this model.

**EXECUTIVE (EX) COMMITTEE**

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Draft: 4/10/23

Executive (EX) Committee  
Louisville, Kentucky  
March 23, 2023

The Executive (EX) Committee met in Louisville, KY, March 23, 2023. The following Committee 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); Michael Conway (CO); Trinidad Navarro (DE); Doug Ommen (IA); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon (LA); Kathleen A. Birrane (MD); Anita G. Fox (MI); Carter Lawrence (TN); and Kevin Gaffney (VT). Also participating was: Elizabeth Kelleher Dwyer (RI).

1. Adopted the March 22 Report of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee

Director Lindley-Myers reported that the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee met March 22 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) and paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings.

During this meeting, the Committee and Subcommittee: 1) appointed Andrew J. Beal (NAIC, Chief Operating Officer and Chief Legal Officer) as acting Chief Executive Officer (CEO); and 2) approved the retention of a consultant to conduct an organizational review and succession planning exercise.

Commissioner Mais made a motion, seconded by Commissioner Godfread, to adopt the March 22 report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee. The motion passed unanimously.

2. Adopted its Feb.10 and Jan. 13 Interim Meeting Report

Commissioner Donelon made a motion, seconded by Director Cameron, to adopt the Executive (EX) Committee's Feb. 10 and Jan. 13 interim meeting report (Attachment One). The motion passed unanimously.

3. Adopted the Reports of its Task Forces

Director Wing-Heier made a motion, seconded by Commissioner Donelon, to adopt the reports of the: 1) Climate and Resiliency (EX) Task Force; 2) Government Relations (EX) Leadership Council; 3) Long-Term Care Insurance (EX) Task Force; and 4) Special (EX) Committee on Race and Insurance (Attachment Two). The motion passed unanimously.

4. Approved a Request for NAIC Model Law Development Regarding Model #540

Superintendent Dwyer reported that on Dec. 15, 2022, the Financial Condition (E) Committee approved a Request for NAIC Model Law Development to amend the *Property and Casualty Insurance Guaranty Association Model Act* (#540). The amendments will clarify guaranty fund coverage of cybersecurity insurance.

The National Conference of Insurance Guaranty Funds (NCIGF) developed and presented language to the Receivership and Insolvency (E) Task Force that they believe would address this issue. The NCIGF's proposed

language is drafted to provide each state's guaranty associations with the solvency tools needed to handle a cybersecurity insurance claim.

The Request for NAIC Model Law Development was exposed by the Task Force, and no comments were received. The Task Force is confident that these amendments can be adopted on the same timeline as another set of amendments to Model #540 currently being drafted, which clarify coverage for insurance business transfers (IBTs) and corporate divisions (CDs).

Commissioner Donelon made a motion, seconded by Commissioner Gaffney, to approve the Request for NAIC Model Law Development to amend Model #540 (Attachment Three). The motion passed unanimously.

#### 5. Approved a Request for NAIC Model Law Development Regarding Model #880

Commissioner Navarro reported that on Dec. 14, 2022, the Market Regulation and Consumer Affairs (D) Committee approved the Request for NAIC Model Law Development to amend the *Unfair Trade Practices Act* (#880). The request came from the Improper Marketing of Health Insurance (D) Working Group of the Antifraud (D) Task Force, which was charged with reviewing existing NAIC models and guidelines that address the use of lead generators for the sale of health insurance products to identify models and guidelines that need to be updated or developed to address current marketplace activities.

These amendments aim to provide state insurance regulators with the appropriate regulatory authority over health insurance lead generators and define prohibited practices of health insurance lead generators. The Working Group believes amending Model #880 is the best option to address this issue, but it will consider alternative courses of action during its discussions.

Commissioner Navarro made a motion, seconded by Commissioner Godfread, to approve the Request for NAIC Model Law Development to amend Model #880 (Attachment Four). The motion passed unanimously.

#### 6. Received the 2022 Annual Report of the NAIC Designation Program Advisory Board Activities

Commissioner Clark provided an update on the NAIC Designation Program Advisory Board's activities and 2022 achievements for the NAIC Insurance Regulator Professional Designation Program (Attachment Five). At year-end, enrollment totaled 3,373. State insurance regulators earned 1,969 professional insurance regulation designations.

Commissioner Clark noted that the Advisory Board met quarterly in 2022 to discuss policy recommendations, renewal credits, and the future of the program, and it began working with the Education & Training Department on a modernization project.

Commissioner Clark also reported some notable accomplishments in 2022, including implementing virtual proctoring across all designation exams and waiving renewals for active chief insurance regulators and deputy commissioners.

Commissioner Clark reported on the State Mentor Program, which liaises between state insurance departments and the NAIC's Education & Training Department to help disseminate information and assist with candidate questions. All but one jurisdiction currently have mentors. The Advisory Board is strategizing for the future of the program and how it can best serve members and state insurance regulators.

#### 7. Received a Status Report on the Implementation of *State Connected*

Director Lindley-Myers provided an update on *State Connected* implementation efforts. The NAIC has finalized the next iteration of the strategic plan, which builds on *State Ahead* initiatives and will position the NAIC as a “connected hub” for the membership.

#### 8. Received a Report on Model Law Development Efforts

Director Lindley-Myers presented a written report on the progress of ongoing model law development efforts (Attachment Six).

#### 9. Heard a Report from the NIPR Board of Directors

Director Deiter reported that the National Insurance Producer Registry (NIPR) Board of Directors met March 21. During this meeting, the Board accepted the 2022 independent financial audit conducted by RubinBrown, a professional service firm. The audit report is part of NIPR’s 2022 Annual Report released on March 21. The Annual Report highlights NIPR’s 2022 accomplishments, including processing 47 million credentialing and report transactions on behalf of state departments of insurance (DOIs), a year-over-year increase of 10%. NIPR had 8.1 million producer records in its database and \$67.4 million in revenue, representing a 9.3% increase from 2021. NIPR moved \$1.29 billion in state licensing fees from NIPR to DOIs, a 17.5% increase over last year. Through February, NIPR revenues are 6% over budget.

In 2022, NIPR completed several important initiatives that help fulfill its mission to provide cost-effective, streamlined, and uniform producer licensing services. NIPR added three states—Hawaii, Kansas, and Massachusetts—to major NIPR products. NIPR expanded the Contact Change Request (CCR) for Business Entities, which gives businesses the ability to change their contact information easily through *nipr.com*. CCR is available in 34 states. NIPR also achieved 97% first contact resolution by NIPR’s customer service team, which eliminates calls and questions to state departments of insurance (DOIs).

The NAIC and NIPR are holding a Training and Collaboration Summit, April 18–20, in Kansas City, MO. This summit is an opportunity for attendees to learn more about NAIC and NIPR products while sharing ideas and best practices with state insurance regulators from around the country.

#### 10. Heard a Report from the Compact

Commissioner Birrane reported that the Interstate Insurance Product Regulation Commission (Compact) met March 24. During this meeting, the Compact released its 2022 Annual Report, which provides a detailed account of the Compact’s activities and accomplishments in 2022.

The Compact also finalized Position Statement 1-2022, which addresses the issues raised by the Colorado Supreme Court’s 2020 decision in *Amica Life Insurance Company v. Wertz*. The question in that case was whether a company selling a Compact product with a two-year suicide clause provision could enforce that two-year clause given that for non-Compact products, the Colorado legislature adopted a one-year suicide clause provision. The Colorado Supreme Court concluded that the Colorado legislature could not delegate to the Compact the authority to adopt a standard, effective in Colorado, that was in direct conflict with a product standard adopted by the Colorado legislature.

The Compact adopted a Position Statement in 2022 and received support in the form of resolutions from the National Council of Insurance Legislators (NCOIL) and the National Conference of State Legislatures (NCSL). The Position Statement notes that the Colorado opinion is of concern to Compact members because of its potential

to undermine the premise of the Compact and because it is at odds with the understanding and intent of the Compacting States. The Compact's position is that the Colorado opinion is wrong because among other things, it ignores that the Compact received implied Congressional consent.

In December 2022, the Compact amended the suicide exclusion period in question across all life Uniform Standards, keeping the standard at two years but providing that if a state has a period of less than two years, the shorter period applies. This amendment becomes effective in April 2023. The Compact members agreed to give filers until early October 2023 to bring their previously approved Compact products into compliance with the amendment.

In 2022, the members also adopted a framework for expanding the use of Uniform Standards for non-employer groups. The Compacting States continue to exercise authority over the eligibility and approval of non-employer groups, but once authorized, the insurer can issue a Compact-approved product to the eligible group.

The Compact's Product Standards Committee is working on several projects, including developing standards for group whole products and index-linked variable annuities (ILVAs).

During its meeting, the Compact: 1) adopted two new Uniform Standards for disability income products; 2) adopted guidelines for Uniform Standards development; and 3) received reports from its committees.

Commissioner Birrane also noted that in 2022, the Compact officers launched the concept of Compact Roundtables to facilitate communication among officers, committee leaders, members, legislators, and Compact filers. The goal of the roundtables is to have open communication regarding the performance of the Compact and how it can better support the needs of member states.

There were two roundtables in 2022 in New York City, NY, and Omaha, NE. Discussion at the roundtables focused on how to balance uniformity with states' concerns, as well as how to keep up with the pace of product development.

After the Roundtables, an ad hoc committee of members from across Zones was established to evaluate the viability and appropriateness of ideas coming out of the Roundtables. The committee agreed to establish an Advisory Services Office and recommended creating a formal task force to develop proposals for these services.

The Compact officers will host another Compact Roundtable on May 17, the day before the International Insurance Forum.

In 2022, the Compact developed and distributed its first Value of Services report for members states. The report quantifies the benefits of being a Compacting State, showing the annual dollar value of services the Compact provides to each member.

Commissioner Birrane also reported that the Compact's financial position is strong. The Compact ended 2022 at 80% of budgeted revenues, or \$2,547,200, compared to a budget of \$3.2 million. This variance was partially offset by a reduction in Compact expenses, which came in at 88% or \$2,804,072, compared to a budget of \$3.1 million. The Compact ended 2022 with a net loss of \$256,872, compared to a net gain in 2021 of \$790,016. The Compact's year-end cash balance is \$1.8 million, and its net assets at year-end were \$533,144.

This volatility in revenue over the past two years tracks life companies' filing cycles, including new or amendatory filings needed to meet standards adopted by the Compact. For example, companies needed to file nonforfeiture updates by the end of 2021, which resulted in a record number of filings that year. No such imperative was in place for 2022, so filings were lower.

The Compact was within 3% of meeting its annual registration revenue budget in 2022, which is the revenue the Compact receives from companies for access to the Compact platform. In 2022, the Compact also collected and remitted \$2,750,000 in state filing fees to its members.

Through the end of February 2023, the Compact is meeting budgeted revenues and has a cash balance of a little over \$2 million. This positions the Compact to make its fourth annual repayment this month on the outstanding debt to the NAIC in the amount of \$275,000.

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

SharePoint/NAIC Support Staff Hub/Committees



## **EXECUTIVE (EX) COMMITTEE**

February 10, 2023 / January 13, 2023

### **Summary Report**

The Executive (EX) Committee met Feb. 10 and Jan. 13, 2023, in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During these meetings, the Committee:

1. Appointed Superintendent Elizabeth Kelleher Dwyer (RI) to serve on the International Association of Insurance Supervisors (IAIS) Executive Committee.
2. Appointed the following to serve as members on the Consumer Board of Trustees: Commissioner Andrew R. Stolfi (OR), Chair; Commissioner Alan McClain (AR); Director Dana Popish Severinghaus (IL); Commissioner Vicki Schmidt (KS); Commissioner Troy Downing (MT); and Commissioner Michael Humphreys (PA).
3. Appointed Commissioner Glen Mulready (OK) to the National Insurance Producer Registry (NIPR) Board of Directors.
4. Approved the recommendation for the NAIC's Kansas City, MO, office space.
5. Adopted the Washington, DC, property site selection and fiscal impact statement.
6. Appointed the following as members of the NAIC 2023 Audit Committee: Connecticut, Kentucky, Maryland, Massachusetts, Missouri, Nebraska, New Jersey, North Dakota, Oregon, South Dakota, Tennessee, and Virginia.
7. Received an update from the Investment Committee.
8. Received updates on various operational matters.



Draft: 3/22/23

## REPORT OF THE EXECUTIVE (EX) COMMITTEE TASK FORCES

**Climate and Resiliency (EX) Task Force**—The Climate and Resiliency (EX) Task Force will meet March 24 and anticipates the following action: 1) adopting its 2022 Fall National Meeting minutes; 2) hearing presentations from Canadian insurance regulators related to insuring flood risks; 3) hearing an update on private flood insurance data; 4) hearing an update from the Catastrophe Modeling Center of Excellence (COE); 5) receiving a federal update; and 6) receiving an international update.

**Government Relations (EX) Leadership Council**—The Government Relations (EX) Leadership Council did not meet at the Spring National Meeting. The Leadership Council meets weekly in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss federal legislative and regulatory developments affecting insurance regulation.

**Long-Term Care Insurance (EX) Task Force**—The Long-Term Care Insurance (EX) Task Force met March 13, in lieu of the Spring National Meeting, and took the following action: 1) adopted its 2022 Fall National Meeting minutes; 2) heard a report on industry trends and factors affecting reserve levels; and 3) adopted proposed amendments to the *Checklist for Premium Increase Communications*. The Task Force will also meet March 23 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individual) of the NAIC Policy Statement on Open Meetings.

**Special (EX) Committee on Race and Insurance**—The Special (EX) Committee on Race and Insurance will meet March 23 and anticipates the following action: 1) adopting its 2022 Fall National Meeting minutes; 2) receiving a status report from its workstreams; and 3) hearing an update on the Member Diversity Leadership Forum. At the end of last year, the Special Committee voted to disband Workstream One and Workstream Two (focused on diversity within the insurance industry, the insurance regulatory community, and the NAIC) and rename its remaining workstreams by product line—property/casualty (P/C), life, and health. The work of the Special Committee was discussed at the Commissioners' Conference, and Members focused on defining deliverables for the Workstreams, strategies to engage industry and consumers in the ongoing discussions, and data needs. Work planning for the year is ongoing, and meetings of each workstream will be scheduled shortly.

NAICSupportStaffHub/Member Meetings/Spring 2023/Cmte/Ex/Rpt of Task Forces/Att 2 TF CombinedRpt.docx

*Adopted by the Financial Condition (E) Committee, Dec. 15, 2022*

*Adopted by the Receivership and Insolvency (E) Task Force, 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](mailto: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.

- 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:**

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: Nov. 16, 2022

*Adopted by the Market Regulation and Consumer Affairs (D) Committee, Dec. 14, 2022*  
*Adopted by the Antifraud (D) Task Force, Nov. 16, 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:**

Market Regulation Consumer Affairs (D) Committee/Antifraud (D) Task Force/Improper Marketing of Health Insurance (D) Working Group

**2. NAIC staff support contact information:**

Market Regulation and Consumer Affairs (D) Committee – Tim Mullen  
Antifraud (D) Task Force – Greg Welker  
Improper Marketing of Health Insurance (D) Working Group – Greg Welker

**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.**

Proposed are amendments to the *Unfair Trade Practices Act* (#880):

- Section 2: Definitions
- Section 3: Unfair Trades Practices Prohibited
- Section 4: Unfair Trade Practices Defined

The Improper Marketing of Health Insurance (D) Working Group is charged to (1) coordinate with regulators, both on a state and federal level, to provide assistance monitoring the improper marketing of health plans and coordinate appropriate enforcement actions, as needed, with other NAIC Committees, Task Forces, and Working Groups; and (2) review existing NAIC Models and Guidelines that address the use of lead generators for sales of health insurance products and to identify models and guidelines that need to be updated or developed to address current marketplace activities.

In order to achieve this goal and provide regulation over lead generators, the Working Group is requesting the review the above-mentioned Model #880, Sections 2, 3, and 4.

Section 2: There is currently no definition for Health Insurance Lead Generator. This section will be amended to include a definition of Health Insurance Lead Generator.

Section 3: This section will be amended to prohibit a Health Insurance Lead Generator, as defined in Section 2, from engaging in an unfair trade practice.

Section 4: This section will be amended to define what marketing-related activity of Health Insurance Lead Generators are unfair trade practices. These amendments will provide states the means to regulate lead generators and gain a level of consumer protection that is not currently in place.

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: One of the initial efforts at developing state legislation in response to the McCarran-Ferguson Act of 1945 was the development of trade practices legislation and the adoption of the NAIC's Unfair Trade Practices Act in 1947. Health Insurance Lead Generators impact consumers in every jurisdiction. Insurance regulatory authority over Health Insurance Lead Generators and defining prohibited practices of Health Insurance Lead Generators need to be clarified.

- 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:

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:

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

No

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

No




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To: Members of the NAIC Executive Committee

From: Commissioner Sharon Clark, Kentucky Department of Insurance  
Chair, NAIC Insurance Regulator Professional Designation Program Advisory Board

Date: March 23, 2023

Subject: 2022 Annual Report of NAIC Designation Program Advisory Board Activities

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In October of 2006, the NAIC launched the Insurance Regulator Professional Designation Program (“Designation Program”), a formal credentialing program designed for regulators, by regulators to establish structured training and development paths for insurance department employees. In that same year, the Internal Administration (EX1) Subcommittee directed the program’s Advisory Board to present a brief annual report of program benchmarks and board activities. This memorandum, with its supplemental charts, sets forth an account of the program’s year in review.

#### **Program Enrollments**

We continued our outreach to states and have seen increased interest and enrollments across the board. In 2022, the Designation Program surpassed 3,300 enrollments, bringing the total number of enrollments since 2006 to 3,373.

By year-end, earned designation totals were as follows: 1,405 APIR designees, 534 PIR designees, 26 SPIR designees, and 4 IPIR designees.

#### **The Designation Program Mentoring Network**

States have been encouraged to appoint a “mentor” that can serve as a liaison between the Department and the NAIC’s Education & Training Department as a means of disseminating information about the program to interested regulators, and to assist candidates as they have questions. Most mentors have earned an NAIC Designation or are currently working toward one.

#### **Designation Program Advisory Board Meetings**

The Designation Program Advisory Board met quarterly throughout 2022 both in-person at NAIC National Meeting and via WebEx to discuss policy matters and other issues. Discussion items included modernizing the Designation Program and the delivery of courses, policy recommendations and promotion of the program to increase awareness and participation.

#### **2022 Accomplishments**

Significant accomplishments of 2022 include:

- Fully rolled out the new online proctoring service to eliminate the need for an in-person, department of insurance staff member to proctor exams.
- The Designation Program Advisory Board approved an automatic renewal policy for chief insurance regulators and deputy commissioners who hold an NAIC APIR, PIR, SPIR or IPIR designation. The Designation Advisory Board recognizes that the work of commissioners and deputy commissioners results in experiential learning which meets and exceeds the formal learning requirements to earn Designation Renewal Credits (DRCs).
- Increased designation renewal credit options to include insurance related college courses.

**About the Insurance Regulator Professional Designation Program Advisory Board**

The 2022 Advisory Board was composed of Laura Arp (NE Department of Insurance), Rachel Chester (RI Insurance Division), Eric Fletcher (ID Department of Insurance) and Scott Sanders (GA Department of Insurance).

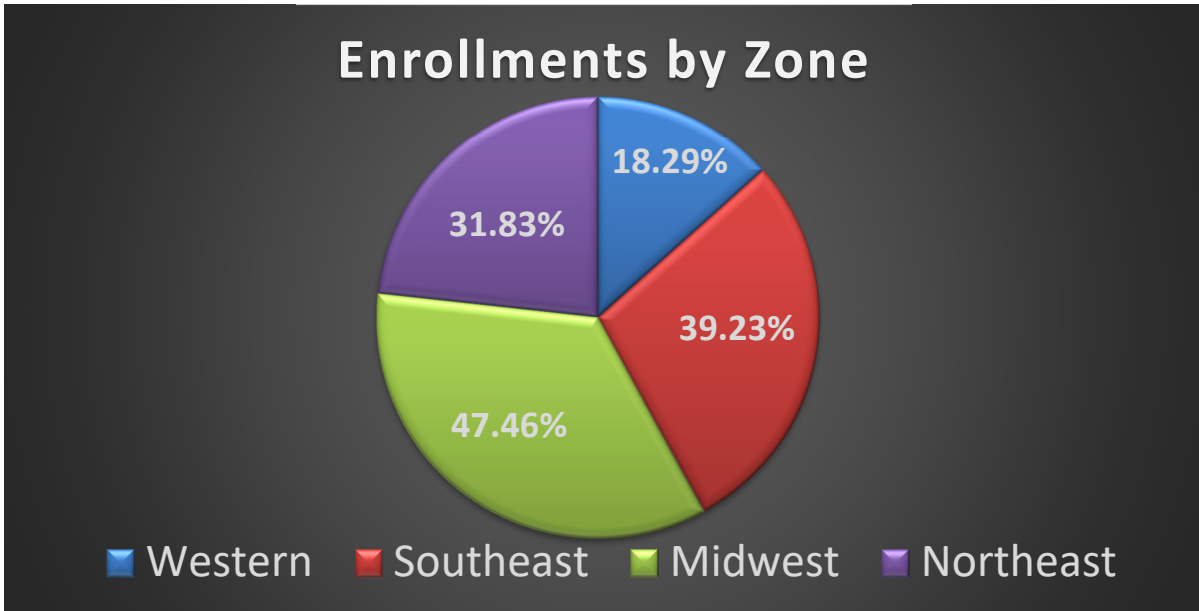
Kentucky Commissioner Sharon Clark chaired the 2022 Advisory Board.

In addition to overseeing Designation Program policy and advising NAIC Education Department staff on designation program policy administration, the board members work on outreach to regulators during NAIC Zone Meetings and other regulatory meetings. Additional information about the Designation Program can be found by visiting the NAIC website: [http://naic.org/education\\_designation.htm](http://naic.org/education_designation.htm)

**TOTAL ENROLLMENTS – 3,373**  
**Designation Participation by Zone**  
**As of December 31, 2022**

<b>Western Zone</b>	<b>Enrollments</b>	<b>Southeast Zone</b>	<b>Enrollments</b>
Alaska	24	Alabama	28
American Samoa	1	Arkansas	43
Arizona	46	Florida	257
California	82	Georgia	33
Colorado	21	Kentucky	65
Guam	1	Louisiana	80
Hawaii	53	Mississippi	34
Idaho	66	North Carolina	112
Montana	47	Puerto Rico	52
Nevada	90	South Carolina	73
New Mexico	59	Tennessee	100
N. Mariana Isle	0	Virgin Islands	12
Oregon	34	Virginia	103
Texas	37	West Virginia	90
Utah	109		
Washington	25		
Wyoming	26		
<b>Total</b>	<b>721</b>	<b>Total</b>	<b>1082</b>

<b>Midwest Zone</b>	<b>Enrollments</b>	<b>Northeast Zone</b>	<b>Enrollments</b>
Illinois	85	Connecticut	31
Indiana	45	Delaware	25
Iowa	83	District of Col	26
Kansas	54	Maine	28
Michigan	105	Maryland	59
Minnesota	57	Massachusetts	28
Missouri	47	New Hampshire	32
Nebraska	101	New Jersey	81
North Dakota	20	New York	222
Ohio	52	Pennsylvania	77
Oklahoma	131	Rhode Island	60
South Dakota	29	Vermont	60
Wisconsin	32		
<b>Total</b>	<b>841</b>	<b>Total</b>	<b>729</b>





State	Enrollments/State Participation*	EARNED DESIGNATIONS				% Completed
		APIR	PIR	SPIR	IPIR	
Alabama	28	9	2	1		42.86%
Alaska	24	4	3	1		33.33%
American Samoa	1					0.00%
Arizona	46	14	6			43.48%
Arkansas	43	17	10			62.79%
California	82	38	1			47.56%
Colorado	21	9	3	1		61.90%
Connecticut	31	10	6	1	1	58.06%
District of Columbia	26	8	4			46.15%
Delaware	25	11	3		1	60.00%
Florida	257	104	32	2		53.70%
Georgia	33	15	2			51.52%
Guam	1					0.00%
Hawaii	53	19	4			43.40%
Idaho	66	31	5			54.55%
Illinois	85	34	14			56.47%
Indiana	45	22	3			55.56%
Iowa	83	39	20			71.08%
Kansas	54	20	8	1		53.70%
Kentucky	65	27	13			61.54%
Louisiana	80	31	8	1		50.00%
Maine	28	8	5			46.43%
Maryland	59	29	6			59.32%
Massachusetts	28	8	3	1		42.86%
Michigan	105	46	28			70.48%
Minnesota	57	32	4			63.16%
Mississippi	34	10	1			32.35%
Missouri	47	15	2	1		38.30%
Montana	47	19	8	1		59.57%
Nebraska	101	56	11			66.34%
Nevada	90	26	16	1		47.78%
New Hampshire	32	12	4			50.00%
New Jersey	81	30	10	2		51.85%
New Mexico	59	13	3			27.12%

New York	222	105	48			68.92%
North Carolina	112	49	26	1		67.86%
North Dakota	20	8	2			50.00%
Northern Mariana Islands	0					
Ohio	52	22	10			61.54%
Oklahoma	131	49	29		1	60.31%
Oregon	34	13	7			58.82%
Pennsylvania	77	33	22			71.43%
Puerto Rico	52	24	2			50.00%
Rhode Island	60	28	8	2		63.33%
South Carolina	73	31	19			68.49%
South Dakota	29	13	4			58.62%
Tennessee	100	50	13	1		64.00%
Texas	37	15	8		1	64.86%
Utah	109	36	20	2		53.21%
Vermont	60	24	13	2		65.00%
Virginia	103	47	9	3		57.28%
Virgin Islands	12	3	2			41.67%
Washington	25	7	3			40.00%
West Virginia	90	34	14	1		54.44%
Wisconsin	32	10	3			40.63%
Wyoming	26	15	3			69.23%
<b>TOTALS</b>	<b>3373</b>	<b>1382</b>	<b>513</b>	<b>26</b>	<b>4</b>	<b>57.07%</b>

\* Enrollments = individuals enrolled in the Program within multiple levels (1 person may count multiple times, APIR, PIR, etc.)



Draft: 3/15/23

### Model Law Development Report

**Amendments to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)***—Amendments to Model #171 are required for consistency with the federal Affordable Care Act (ACA) and the revisions to its companion model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170)*. The Accident and Sickness Insurance Minimum Standards (B) Subgroup completed the revisions to Model #170 in late 2018, which the Executive (EX) Committee and Plenary adopted in February 2019. Therefore, they did not require approval of a Request for NAIC Model Law Development by the Executive (EX) Committee. Soon after completing its work on Model #170, the Subgroup began considering revisions to Model #171. The Subgroup met every two weeks until it lost one of its co-chairs in December 2019. After a long hiatus since late 2019 because of the loss of a co-chair and the COVID-19 pandemic, as well as other resource issues, the Subgroup resumed its meetings in June 2021. The Subgroup has been meeting on a regular basis to discuss the comments received on Model #171. During the last few months of 2022, the Subgroup’s discussions focused on Section 8—Supplementary and Short-Term Health Minimum Standards for Benefits. This section establishes minimum standards for benefits for the products subject to the model, including accident-only coverage, hospital indemnity or other fixed indemnity coverage, and disability income protection coverage. The revisions also include a new section establishing minimum benefits for short-term, limited-duration (STLD) plans. The Subgroup completed its discussions of Section 8 in December 2022, including developing a new subsection establishing minimum benefit standards for STLD plans. The Subgroup resumed its meetings in February and plans to continue meeting on a regular basis to continue its discussions and plans to work on the following Model #171 sections in this order: 1) the remainder of Section 8, including revisiting the proposed new subsection on STLD plans to discuss the Feb. 24 comments received on that section; 2) Section 7—Prohibited Policy Provisions; 3) revisit Section 5—Definitions and Section 6—Policy Definitions to reconcile any inconsistencies that may have arisen after the Subgroup’s review of the substantive provisions of Model #171; and 4) Section 9—Required Disclosure Provisions. The Subgroup hopes to finish its work to develop an initial draft of comments on Model #171 for public comment by the end of the year.

**Amendments to the *Property and Casualty Insurance Guaranty Association Model Act (#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 will address the continuity of guaranty fund coverage when a policy is transferred from one insurer to another. The Financial Condition (E) Committee approved this request on July 21, 2022. The Receivership Law (E) Working Group exposed draft revisions for a 30-day comment period ending Oct. 14, 2022. During the Working Group’s Nov. 7, 2022, meeting, it formed a drafting group to address comments received. The drafting group met Nov. 30, 2022, and March 6, 2023, to consider further revisions and will continue to meet as needed to finalize the Model #540 amendments.

**Amendments to the *Mortgage Guaranty Insurance Model Act (#630)***—The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #630 during the 2013 Summer National Meeting. The Mortgage Guaranty Insurance (E) Working Group has developed proposed changes to the model, which have been exposed for comment, and subsequent changes have been made to address the comments. A third exposure for a 15-day comment period ended on March 14, 2023, and the Working Group plans to discuss comments received during the Spring National Meeting. The Working Group received an extension from the Financial Condition (E) Committee until the 2023 Fall National Meeting.

**Amendments to the *Nonadmitted Insurance Model Act (#870)***—The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #870 during the 2021 Spring National

Meeting. The amendments will modernize the model and bring it into alignment with the federal Nonadmitted and Reinsurance Reform Act (NRRRA). The Surplus Lines (C) Task Force met May 23, 2022, to discuss amendments to Model #870 and expose Model #870 for a 60-day public comment period ending July 21, 2022. The Task Force met Oct. 17, 2022, to hear a summary of comments received on the draft exposure and actions taken by the drafting group to address the comments. The Task Force exposed Model #870 for a 30-day public comment period ending Nov. 17, 2022. The Task Force discussed the comments received on the draft exposure during an open meeting on Dec. 12, 2022. On Jan. 23, 2023, the Task Force exposed a draft of Model #870 for a 14-day public comment period. The Task Force and the Property and Casualty Insurance (C) Committee will consider adoption of Model #870 during the Spring National Meeting.

**New Model: *Insurance Consumer Privacy Protection Model Law***—During the 2022 Summer National Meeting, the Executive (EX) Committee approved a Request for NAIC Model Law Development for a new model that would replace existing models in order to enhance consumer protections and corresponding obligations of entities licensed by insurance departments to reflect the extensive innovations that have been made in communications and technology. The Privacy Protections (H) Working Group approved this request on Aug. 2. The drafting group met in regulator-to-regulator session on Aug. 31, Sept. 15, Sept. 29, Oct. 4, Oct. 13, Dec. 1, and Dec. 5. The drafting group also met with companies privately to discuss current consumer data practices on Nov. 17, Nov. 29, Nov. 30, Dec. 5, Dec. 6, and Dec. 8. The Working Group met in open session Dec. 12 to hear presentations from an industry and a consumer perspective on general market practices regarding the use of personal information during the insurance process followed by an open discussion of these insights.

The Working Group exposed its initial draft of the new model (Model #674) Feb. 1, 2023, for a 60-day public comment period ending April 3, 2023. The drafting group met in regulator-to-regulator session on Jan. 23 and March 15. The drafting group continued its meetings with companies privately to discuss current consumer data practices on Feb. 16, March 1, March 2, March 7, March 8, March 9, and March 14 with additional meetings scheduled for April 5, April 12, and April 13. The Working Group will discuss comments received and collaborate on workable language at the Spring National Meeting and Summer National Meeting; during open meetings every two weeks following the comment period; and at an in-person, two-day interim meeting in Kansas City, MO, in June.

**CLIMATE AND RESILIENCY (EX) TASK FORCE**

Climate and Resiliency (EX) Task Force March 24, 2023, Minutes ..... 4-23

Draft: 4/4/23

Climate and Resiliency (EX) Task Force  
Louisville, Kentucky  
March 24, 2023

The Climate and Resiliency (EX) Task Force met in Louisville, KY, March 24, 2023. The following Task Force members participated: Lori K. Wing-Heier, Co-Chair (AK); Ricardo Lara, Co-Chair (CA); James J. Donelon, Co-Vice Chair (LA); Mike Kreidler, Co-Vice Chair (WA); Mark Fowler (AL); Peni Itula Sapini Teo (AS); Barbara D. Richardson (AZ); Michael Conway represented by Peg Brown (CO); Andrew N. Mais represented by Wanchin Chou (CT); Trinidad Navarro represented by Susan Jennette (DE); Michael Yaworsky represented by Anoush Brangaccio (FL); Gordon I. Ito (HI); Doug Ommen (IA); Dana Popish Severinghaus (IL); Amy L. Beard represented by Patrick O'Connor (IN); Sharon P. Clark represented by Shawn Boggs (KY); Gary D. Anderson represented by Rachel M. Davison (MA); Kathleen A. Birrane (MD); Timothy N. Schott (ME); Anita G. Fox represented by Chad Arnold (MI); Chlora Lindley-Myers represented by Cynthia Amann (MO); Mike Chaney represented by Andy Case (MS); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Jackie Obusek (NC); Jon Godfread (ND); Eric Dunning (NE); Jennifer Catechis (NM); Scott Kipper represented by David Cassetty (NV); Adrienne A. Harris represented by John Finston (NY); Judith L. French (OH); Glen Mulready (OK); Andrew R. Stolfi represented by Alex Cheng (OR); Michael Humphreys represented by Michael McKenney (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); Michael Wise (SC); Scott A. White (VA); Kevin Gaffney (VT); Nathan Houdek represented by Sarah Smith (WI); and Jeff Rude (WY). Also participating were: Alan McClain (AR); Christian Citarella (NH); Tregenza A. Roach (VI); and Allan L. McVey (WV).

1. Received Updates from its Workstreams

Director Wing-Heier said the Pre-Disaster Mitigation Workstream will continue to be led by Director Richardson. She said the Climate Risk Disclosure Workstream will continue to be led by Commissioner Stolfi. She said the Technology Workstream and Innovation Workstream will be combined into one Technology Workstream that will be led by Commissioner Donelon. She said the Solvency Workstream will continue to be led by Commissioner Birrane.

Commissioner Birrane said in the first half of 2022, the Solvency Workstream developed and sent three referrals to three different Financial Condition (E) Committee working groups to propose specific enhancements to the existing financial solvency tools to more explicitly consider climate-related risks. She said the Workstream is reaching back out to those groups to see what the status is regarding their consideration of the referrals. She said the Workstream focused on climate scenario analysis in 2022, holding three public panels to discuss the topic. She said the first panel was held Oct. 12, 2022, and it provided a foundational education on climate scenario analysis, including what it is intended to accomplish and what data is needed to do the analysis effectively. She said the second panel was held Nov. 4, 2022, and it included presentations from international jurisdictions that have required the industry or a subset of the industry to participate in mandatory analytical risk evaluation exercises. She said the third panel was held Nov. 29, 2022, and it included presentations from a property/casualty (P/C) carrier and a life insurance carrier on how they utilize climate scenario analysis in their risk management and business strategy.

Commissioner Birrane said the Solvency Workstream is now tasked with understanding what role climate scenario analysis plays in the oversight of insurers in the U.S. She said on Feb. 1, the Workstream met in regulator-to-regulator session to: 1) receive a presentation from the Federal Reserve on its recently exposed proposed climate scenario analysis exercise; and 2) discuss members' initial view on the role of climate scenario analysis as a financial oversight tool for U.S. state insurance regulators.

Commissioner Birrane said the next steps for the Solvency Workstream include developing and sending out a survey to its members and interested state insurance regulators on whether the Workstream and the NAIC should look at the development and incorporation of any form of specific climate scenario analysis approach with regard to current oversight tools. She said the Solvency Workstream would also begin to look at stress testing. She said it would hold public meetings that would include education for state insurance regulators and others on climate stress testing, as well as hearing from international jurisdictions that are using climate stress tests.

## 2. Adopted its 2022 Fall National Meeting Minutes

Director Wing-Heier said the Task Force met Dec. 15, 2022.

Commissioner Kreidler made a motion, seconded by Commissioner Donelon, to adopt the Task Force's Dec. 15, 2022, minutes (*see NAIC Proceedings – Fall 2022, Climate and Resiliency (EX) Task Force*). The motion passed unanimously.

## 3. Heard a Presentation from PSC on Flood Risk

Matthew Godsoe (Public Safety Canada—PSC) said with the increase in frequency and severity of disaster events, the need to address flooding and other disasters has become an elevated priority within the Canadian government. He said a December 2021 mandate from the Canadian Prime Minister sets out provisions to take actions to help Canadians be prepared for and recover from the impact of floods in high-risk areas by creating a low-cost national flood insurance program to protect homeowners who are at high risk of flooding and do not have adequate insurance protection. He said this issue has to be addressed by the federal, provincial, and territorial governments working together.

Godsoe said flooding is Canada's most frequent and costly natural disaster, causing over \$1.5 billion in direct damage to homes each year. He said 94% of Canadians in high-risk areas remain unaware of their flood risk. He said most of the major cities in Canada are wholly or partially located in flood zones, and new unmitigated developments in these cities are the current number one driver of flood risk in Canada. He said financial and social hardships that occur because of disasters disproportionately affect vulnerable and marginalized populations. He said to date, almost all residential flood losses have been ineligible for insurance coverage; therefore, those losses had to be covered by provincial and territorial government disaster assistance programs.

Godsoe said the PSC created a Task Force on Flood Insurance and Relocation to explore viable solutions for insurance in high-risk areas and considerations for the potential relocation of homes most at risk of repeat flooding. He said the Task Force did not decide on an insurance or relocation solution, but it undertook research, costing, and analysis to inform future decision-making processes. He said this work concludes with its report titled *Adapting to Risking Flood Risk: An Analysis of Insurance Solutions for Canada*.

Godsoe said the Task Force created six public policy objectives to serve as a framework to later assess the viability of insurance arrangements. He said those objectives were: 1) provide adequate and predictable financial compensation for residents in high-risk areas; 2) incorporate risk-informed price signals and other levers that promote risk-appropriate land use, mitigation, and improved flood resiliency; 3) be affordable to residents of high-risk areas, with specific consideration for marginalized, vulnerable, and/or diverse populations; 4) provide coverage that is widely available for those at a higher risk across all regions; 5) maximize the participation of residents in high-risk areas; and 6) provide value for money for governments and taxpayers. He said the Task Force also focused on the need for targeted risk reduction activities through the mitigation and relocation for those in high-risk areas, which included household defenses, community flood mitigation, national support for risk reduction, and strategic relocation.

Godsoe said the Task Force studied international examples of how other countries were dealing with flood risk and other natural disasters. He said it referenced the work of Australia, France, the United Kingdom (UK), and the U.S. He said the Task Force put forth six potential insurance arrangements for analysis, and four were determined to be viable options in Canada. He said two of the arrangements were based on public-private pooling, and two arrangements were based on direct intervention in the insurance and reinsurance markets.

Godsoe said the report highlights four obstacles that Canada could potentially face based on the flood arrangements: 1) uncertainty; 2) market penetration; 3) affordability; and 4) moral hazard. He said the report also includes recommendations to overcome these obstacles.

Godsoe said the Canadian federal government will need to put forth its position based on the recommendations in the report. He said once that position has been determined, the PSC will go back to working with the provincial and territorial governments to implement one of the models.

#### 4. Heard a Presentation from the CCIR on Flood Risk

Lucas Neufeld (Canadian Council of Insurance Regulators—CCIR) said a CCIR working group released a paper in 2016 that focused on the impact of catastrophic floods and other perils on personal property insurance. He said with the increase in frequency and severity of these perils, the CCIR has released multiple reports that highlight findings on its research on these perils and property insurance. He said the common element in all of its reports is that there remain consumer protection gaps, which is the cost to rebuild plus additional living expenses, less insurance coverage. He said this includes both uninsured and underinsured consumers.

Neufeld said the CCIR has identified consumer awareness gaps, such as low awareness of one's property specific risk, low awareness of available insurance coverage options, low awareness of actual coverage purchased, and low awareness of what is and is not covered by provincial disaster financial assistance programs. He said these are limiting the uptake of flood coverage and potentially adding to the overall consumer protection gaps. He said industry is aware of the knowledge gaps and has created materials to address these gaps. He said there is still a disconnect between consumers having access to those materials and actual action to address and decrease the gaps. He said one example of this is that even though flood mapping is generally widely available, 80% of surveyed Canadians say they have not seen a flood map for the community they live in.

Neufeld said an important element of the work of the CCIR is to address property-specific risk. He said these include knowing the likelihood of flooding and the severity and frequency that could increase due to climate factors. He said structure and land-specific risks also need to be addressed, as these could potentially be mitigated due to personal or public action.

Neufeld said a forthcoming report from the CCIR working group highlights five recommendations: 1) identify and implement best practices for assessing and communicating property-specific natural catastrophe risk at the point of sale and renewal; 2) identify and implement best practices that insurers and intermediaries may use to communicate natural catastrophe related insurance options to customers; 3) take steps to ensure that consumers understand the insurance product they are being offered, including a simplified approach to summarizing coverage on the first page of the policy; 4) design innovative products and create incentives to encourage customers to act on personalized advice and product features; and 5) train and educate those selling insurance products to ensure that they understand the product's key features, including how it aligns with the customer's needs.

Director Wing-Heier asked if there will be a mandate for insurers and intermediaries to disclose the need for flood insurance. Rob O'Brien (CCIR) said in Canada, that decision would occur at a provincial or territorial level.



Director Richardson asked whether strategic relocation would kick in when there is no insurance available or because insurance is so expensive that current residents cannot afford it. Godsoe said some provinces provide dedicated relocation funding even if insurance has not been purchased, but the funding amount is capped and usually does not meet the market value of properties. He said with the future government decision on a national flood insurance arrangement, there may be a more consistent approach.

Commissioner Lara asked who is responsible for creating the flood maps. Godsoe said regulatory flood maps are developed by local governments, provinces, or territories. He said while most Canadian residents are covered by these flood maps, they only represent a small percentage of Canadian land mass. He said the PSC has been working with insurers to look at flood models to create maps in addition to the already created regulatory flood maps.

Chou asked how big the private flood insurance market is in Canada. O'Brien said in 2020, direct written premiums were about \$71 billion, but that is not broken out between auto and property coverage.

Chou asked who is working on the model validation in the PSC work. Godsoe said the Task Force is using a composite of private sector models that are overlaid on top of one another and calibrated against the regulatory flood maps. He said after a federal government decision, the PSC would come up with a Canadian model based on interventions from private catastrophe modeling firms that would provide a standard view to bring to the provinces and territories.

Aaron Brandenburg (NAIC) said the NAIC has collected private flood insurance data starting with premium and loss data from the NAIC Financial Annual Statement State Page. He said the NAIC issued a data call in 2020 to collect 2018 and 2019 data at a much more granular level, which led to the inclusion of a Private Flood Insurance Supplement in the Annual Statement. He said the data call and supplement collected data split out between commercial and residential, as well as data on a standalone, first dollar, excess, and endorsement basis. He said it also included data elements such as the number of policies, number of claims, and claims closed with payment. He said this data showed that in 2021, there were over 360,000 residential flood insurance policies, which was a 29% increase over the previous year. He said the 2022 NAIC Annual Statement State Page showed an increase of 21% in direct written premium for private flood.

## 5. Heard an International Update

Ryan Workman (NAIC) said the International Association of Insurance Supervisors (IAIS) launched one of three public consultations planned for the next year and a half looking at the initial approach of its work to address climate risk. He said the IAIS started off doing an assessment and review of existing insurance core principles (ICPs), which found the way those principles are drafted to accommodate climate risk and are applicable, but they also identified some areas where it might be helpful to provide additional supporting material on ways climate plays on in different contexts.

Workman said the IAIS has a workstream that is developing an application paper that is looking at climate issues as they relate to enterprise risk management (ERM) and macroprudential supervision.

Workman said the IAIS published a special topic edition of its *Global Insurance Market Report* (GIMAR) in 2021, which was a first attempt to look at doing a quantitative global study on the impact of climate change in the insurance sector. He said the current global monitoring exercise (GME) has seen the addition of data elements that would help the IAIS collect annual data on insurance sector risks, looking particularly at climate risks.

Workman said the Sustainable Insurance Forum (SIF) is continuing its work on net zero, which is identifying a potential role for insurance supervisors in the net zero transition. He said this group is looking at how to leverage

existing practices around the globe to address access and affordability issues. He said the group plans to meet in the second quarter of this year.

Workman said the (European Union) EU-U.S. dialog project has two workstreams focused on climate: 1) Climate Risk and Financial Oversight; and 2) Climate Risk and Resilience. He said the project is holding a public stakeholder event on June 16.

#### 6. Heard a Federal Update

Shana Oppenheim (NAIC) said the National Flood Insurance Program (NFIP) authorization is set to expire on Sept. 30. She said it has been reauthorized on a short-term basis 25 times since 2017. She said on March 10, the U.S. House of Representatives (House) Financial Services Subcommittee on Housing, Community Development, and Insurance, led by Chairman Warren Davidson (R-OH), held a hearing entitled “How Do We Encourage Greater Flood Insurance Coverage in America?” She said Republicans were focused on encouraging private flood uptake, especially in regions outside of flood zones. She said they also expressed interest in examining federal regulatory barriers to private flood insurance, consumer information, and public awareness. She said Democrats expressed an interest in bipartisan, long-term authorization and looking at the diversity, equity, and inclusion (DE&I) aspects of flood risk and insurance. She said U.S. Sen. John Kennedy (R-LA) has introduced bills to cap annual flood insurance premium increases and force the Federal Emergency Management Agency (FEMA) to explain price changes under Risk Rating 2.0. She said U.S. Rep. Blaine Luetkemeyer (R-MO) has introduced bills to require that FEMA purchase reinsurance to pay for flood losses and allow communities to develop alternative flood maps.

Oppenheim said the U.S. Securities and Exchange Commission’s (SEC’s) climate risk disclosure is expected to be finalized in the next few months. She said the chair, Gary Gensler (D-MD) may be signaling a departure from the International Sustainability Standards Board (ISSB) standards.

Oppenheim said the Federal Insurance Office (FIO) has not yet released the climate report that was expected at the end of 2022. She said in October 2022, the FIO published a notice and request for comment on a proposal to collect data from certain P/C insurers to assess the potential for major disruptions of the private insurance coverages in the U.S. market. She said the NAIC sent a letter expressing disappointment that the FIO did not engage state insurance regulators in a credible exercise to identify data elements gathered by either the regulatory community or industry that is indicative of climate risk. She said the NAIC letter expressed a willingness to work with the FIO on this issue.

Oppenheim said President Joe Biden’s budget plan calls for significant investments in clean energy and billions of dollars to help build community resilience to flood, wildfire, storms, extreme heat, and drought. She said the budget also calls for investment in green climate funds and loan guarantees; reasserting U.S. leadership in the Indo-Pacific region to finance energy, security, and infrastructure projects; and reducing reliance on volatile energy supplies.

Oppenheim said the NAIC continues to support the Disaster Mitigation and Tax Parity Act of 2021, which would ensure that state-based disaster mitigation grants receive the same federal tax exemption as federal mitigation grants.

Oppenheim said the NAIC is in dialogue with the Federal Deposit Insurance Corporation (FDIC) and the Federal Housing Finance Agency (FHFA) over concerns about coverage caps in the property insurance market in areas that are being affected by rising sea levels and increasing storms, floods, and wildfires.

## 7. Heard a Presentation from the NAIC Catastrophe Modeling COE

Jeff Czajkowski (NAIC) said the Catastrophe Modeling Center of Excellence (COE) is fully operational and staffed with catastrophe risk modeling experts and resilience subject matter experts (SMEs), and they are integrated and well aligned with the catastrophe modeling community. He said the COE has several regulator-oriented tools and training, and they are engaged with individual departments of insurance (DOIs) and a number of NAIC committees.

Czajkowski said the goal of the COE is to provide the same level of technical expertise and tools to state insurance departments that the industry has at their disposal. He said they are implementing that goal through their three pillars of activity: 1) vendor models; 2) education and tools; and 3) applied research. He said the central coordination for the provided tools is the CAT COE SharePoint site, which is available for state insurance regulator access. He said the COE has entered into agreements with seven catastrophe modelers, and their information is accessible on the SharePoint site.

Czajkowski said in terms of education and training, the COE is expected to debut its Catastrophe Modeling 101 training in the spring of 2023. He said it also has access to the International Society of Catastrophe Managers training. He said the COE provides virtual and in-person training for state insurance departments on peril-specific catastrophe models.

Jennifer Gardner (NAIC) said the COE is developing tools to work in conjunction with the provided training. She said the COE has developed peril model cards that provide high-level summaries of models. She said the COE is developing a compendium of legislative and regulatory actions relative to catastrophe models. She said the COE is using catastrophe models to develop risk assessments.

Gardner said the COE is combining market insights from NAIC data with different risk assessments to focus on resilience and mitigation efforts.

Gardner said the COE has been bringing members of state insurance departments to the Insurance Institute for Business and Home Safety (IBHS) facilities to highlight wildfire risks and severe convective storm risks.

Gardner said the COE had the opportunity to involve a couple of states in a panel discussion at the National Disaster Resilience Conference hosted by the Federal Alliance for Safe Homes Inc. (FLASH). She said the organization was initiated by the insurance industry, and it does advocacy and awareness campaigns around risk reduction, flood losses, building code awareness, and hazard preparedness. She said the COE also hosted several state insurance regulators at the Reinsurance Association of America (RAA) Catastrophe Risk Management conference, where they spoke about earthquake risk, insurance market stability, and state resiliency initiatives.

Gardner said the COE is working with the Colorado Division of Insurance to identify potential resources that could be developed by Catastrophe model vendors to support risk assessment and regulatory initiatives.

Gardner said the COE is continuing to engage with NAIC working groups on catastrophe and mitigation matters, as well as engaging in discussions on support tools needed to stand up a mitigation grant program.

Commissioner Donelon said he endorses the important work of the COE and the training for state DOIs, and he said he encourages state insurance regulators to learn about the tools and training available.

## 8. Discussed Other Matters

Dave Snyder (American Property Casualty Insurance Association—APCIA) said he wanted to offer a future presentation from the Global Federation of Insurance Associations (GFIA), which has produced a report on global

protection gaps and recommendations for bridging them. He said there is growing concern about political polarization that is leading to potentially undercutting diverse business models and time-tested regulation of the insurance markets by state insurance regulators.

Birny Birnbaum (Center for Economic Justice—CEJ) said there is a bill in the Texas legislature that would ban economic scenario generator (ESG) considerations, therefore banning climate risk consideration for state insurance regulators.

Amann said the Catastrophe Risk (C) Working Group is undergoing revisions to the Catastrophe Risk Primer, and it would invite participation from any states.

Having no further business, the Climate and Resiliency (EX) Task Force adjourned.

[SharePoint/NAIC Support Staff Hub/Committees/EX CMTE/CRTF/2023\\_Spring/CRTF\\_Minutes](#)

**GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL**

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

**LONG-TERM CARE INSURANCE (EX) TASK FORCE**

Long-Term Care Insurance (EX) Task Force March 13, 2023, Minutes..... 4-32  
    *Checklist for Premium Increase Communications* with Comments and Drafting Group Responses  
    (Attachment One)..... 4-34  
    *Checklist for Premium Increase Communications* (Attachment Two) ..... 4-48

Draft: 3/16/23

Long-Term Care Insurance (EX) Task Force  
Virtual Meeting (*in lieu of meeting at the 2023 Spring National Meeting*)  
March 13, 2023

The Long-Term Care Insurance (EX) Task Force met March 13, 2023. The following Task Force members participated: Michael Conway, Chair (CO); Andrew R. Stolfi, Vice Chair, represented by TK Keen (OR); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler (AL); Alan McClain represented by Jimmy Harris (AR); Barbara D. Richardson represented by Erin Klug (AZ); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Philip Barlow (DC); Trinidad Navarro (DE); Michael Yaworsky represented by Lilyan Zhang (FL); Gordon I. Ito (HI); Doug Ommen represented by Klete Geren (IA); Dean L. Cameron (ID); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon represented by Tom Travis (LA); Gary D. Anderson represented by Rachel M. Davison (MA); Timothy N. Schott (ME); Anita G. Fox represented by Rachel Davison (MI); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers (MO); Troy Downing represented by Mari Kindberg (MT); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning (NE); Jennifer Catechis represented by Anna Krylova (NM); Scott Kipper (NV); Judith L. French (OH); Michael Humphreys (PA); Elizabeth Kelleher Dwyer represented by Megan Mihara (RI); Larry D. Deiter (SD); Cassie Brown represented by R. Michael Markham (TX); Kevin Gaffney (VT); Scott A. White (VA); Mike Kreidler (WA); Nathan Houdek represented by Diane Dambach (WI); Allan L. McVey (WV); and Jeff Rude (WY).

1. Adopted its 2022 Fall National Meeting Minutes

Keen made a motion, seconded by Commissioner Clark, to adopt the Task Force's Nov. 30, 2022, minutes (*see NAIC Proceedings – Fall 2022, Long-Term Care Insurance (EX) Task Force*). The motion passed unanimously.

2. Heard a Report on Industry Trends and Other Updates

Andersen said coordinated efforts between states have resulted in the completion of targeted reviews of year ending 2021 reserve adequacy filings. Review of the 2022 annual filings will begin soon. The following are key industry trends that have been seen and that will be monitored going forward:

- Cost-of-care inflation trends lead to more maximum daily benefit being used than originally expected. There is consensus among companies selling long-term care insurance (LTCI) that home care costs have increased over the past five to six years. There will likely be long-term impacts from this issue.
- There is a shift in situs of care from facilities to home care. Varying reports indicate the reversal of that trend back to facilities.
- Home care daily costs are starting to catch up with the cost of facility care.
- There is an increase in incidents and the length of claims. COVID-19 had caused lower incidents and shorter claims. So far, the impact of COVID-19 is short-term. COVID-19 is not seen as having a long-term impact on the finances of the blocks of business.
- Pre-claim wellness initiatives have had some impact on claims. Wellness initiatives may involve being proactive or preventing falls, providing early cognitive tests, and providing care for the family caregiver. It is still uncertain if the investments in these wellness initiatives will be more than offset by cost reductions.
- Improvements in technology and medical and drug advancements have potential impacts on claim costs.

Andersen said the Long-Term Care Actuarial (B) Working Group met Feb. 17 and exposed: 1) the information checklist submitted with rate increase filings; and 2) the actuarial methodologies used to review older blocks of

business. Comments on both exposures are due April 24. If any changes are made to the checklist or the methodologies, similar changes will be proposed to the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework). Review of the checklist is likely to be completed in 2023. Review of the methodologies will likely conclude in 2024.

### 3. Adopted Proposed Edits to the Checklist for Premium Increase Communications

Commissioner Conway said proposed edits to the *Checklist for Premium Increase Communications* were exposed for a 30-day public comment period ending Feb. 3. Five comment letters were received. A drafting group of consumer representatives and regulators from California, Pennsylvania, Vermont, and Virginia reviewed the comments and recommended a few edits in response to the comments.

Jane Koenigsman (NAIC) summarized the comments and the drafting group's responses (Attachment One). Comments were received from Wayne Enstice (University of Cincinnati), Patrick Cantilo (Cantilo & Bennett), Robert Wake (ME), Jan Andrews (NC), and Molly Nollette (WA).

Koenigsman said the comments from Enstice did not appear to be related to consumer communication but rather the review of rate increases and reduced benefit options (RBOs). She said the drafting group recommended referring those comments to the Long-Term Care Actuarial (B) Working Group.

Commissioner Kreidler made a motion, seconded by Superintendent Schott, to refer the comments received from Enstice to the Long-Term Care Actuarial (B) Working Group. The motion passed unanimously.

Koenigsman said the drafting group proposed additional edits to address certain comments, including duplicative checklist items, the use of references to "example" RBOs in the revisions, rate guarantees, default options, and other clarifying changes.

Hamby made a motion, seconded by Commissioner Kreidler, to adopt the revised *Checklist for Premium Increase Communications* (Attachment Two). The motion passed unanimously.

Having no further business, the Long-Term Care Insurance (EX) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/EX CMTE/LTCITF/2023 Spring  
NM/minutes/LTCI(EX)TaskForce\_031323\_Minutes.docx



Comments and Drafting Group and Task Force responses shown in comment balloons.  
Edits since exposure are highlighted yellow.

### Checklist for Premium Increase Communications

#### AUTHORITY

The Long-Term Care Insurance Reduced Benefit Options (RBO) (EX) Subgroup **was** composed of regulators from 17 state insurance departments. It has been tasked with assisting the Long-Term Care Insurance (EX) Task Force in completing the following charge:

*Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.*

The Long-Term Care Insurance (EX) Task Force (Task Force) adopted the Long-Term Care Insurance RBO Communication Principles **and this** complementary checklist **Nov. 19, 2021. The checklist was amended March 13, 2023.**

**Deleted:** Adopted by the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup 11/19/21 ¶  
**Deleted:** i

#### INTRODUCTION

This checklist is intended to establish a consistent approach to drafting and reviewing Long-Term Care Insurance RBO policyholder communications. The checklist can be used as guidance and does not carry the weight of law or impose any legal liability.

State regulators who consider the checklist excessive, deficient, or not focused on issues specific to consumer experiences in their state are encouraged to modify the checklist to suit the needs of the Department.

Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion and complaints, improve the quality of consumer communications, and ensure that consumer communications:

- Read in a clear, logical, not overly complex manner.
- Present options **fairly** and without subtle coercion.
- Include appropriate referrals to external resources, definitions, disclosures, and visualization tools.

**Deleted:** The Long-Term Care Insurance RBO EX Subgroup has been charged with developing a  
**Deleted:** , that  
**Deleted:** The principles and checklist can be leveraged by state regulators and Long-Term Care Insurance insurers. ...

**Deleted:** or examples of options

**The Task Force RECOMMENDS** that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and **use the checklist** when reviewing filed Long-Term Care Insurance RBO Communications.

**Deleted:**

*Comments and Drafting Group and Task Force responses shown in comment balloons.  
Edits since exposure are highlighted yellow.*

**CALLS ON** all insurance companies to consider the checklist when developing reduced benefit option policyholder communications in the event of a rate increase.

Comments and Drafting Group and Task Force responses shown in comment balloons.  
Edits since exposure are highlighted yellow.

**Checklist for Premium Increase Communications**

<b>Insurer name:</b>	
<b>Date of filing:</b>	
<b>Product form:</b>	
<b>Tracking number(s) SERFF rate filing:</b>	
<b>Tracking number(s) SERFF form filing:</b>	

		SERFF FILING	Page Reference and Filing Notes
Yes	No	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Does the filing contain all required materials including: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (expected if communication refers policyholder to website for more information)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Has actuarial review of the rate increase been completed?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Will notice of the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Have all new innovative RBO options presented in the communication been clearly explained in the filing? Have they been vetted by policy and actuarial staff? (e.g., rate guarantees)

**Commented [A1]:** ME Comment: ME suggested various non-substantive spacing and formatting edits.

**Commented [A2R1]:** Drafting Group: Formatting will be addressed by NAIC staff before republishing on the website.

**Commented [A3]:** Patrick Cantillo Comment: Based on our experience with SHIP, I offer three comments.

- 1.Does the communication clearly describe the "default" option that will be given effect if the policyholder does not respond by the applicable deadline?
- 2.Does the communication include objective indicators by which the relative values of the options can be compared? Examples would include for each option:
  - 1.Premium,
  - 2.Maximum Policy Value (MPV),
  - 3.Maximum Daily Benefit (MDB) by site of care if different,
  - 4.Maximum Benefit Period,
  - 5.Elimination Period, and
  - 6.Inflation factor
- 3.Consideration should be given to "bang for the buck" value indicators for each option, such as:
  - 1.MPV/premium,

**Commented [A4R3]:** Drafting Group: Comment #1 is addressed with a new question in #44. The topics proposed in comments 2 & 3 had been previously discussed by the RBO Subgroup and due to opposition, were not included in the checklist. No further changes recommended.

**Deleted:**

Comments and Drafting Group and Task Force responses shown in comment balloons.  
Edits since exposure are highlighted yellow.

			Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deleted: Y
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Commented [A5]:</b> Wayne Enstice comment: Has the insurer taken steps internally to mitigate the severity of rate hikes (such as diverting funds across product lines)? Has the insurer guaranteed that a profit margin is not included in the rate hike filing? In Understanding Options-Presentation, include an option for a policy buyout.</p> <p><b>Commented [A6R5]:</b> Drafting Group: Comments are related to the review of the RBO rather than the consumer notice. Recommend referring this to the LTCI Actuarial WG.</p> <p>Task Force: Voted 03-13-2023 to refer Enstice's comments to the LTCI Actuarial (B) Working Group.</p> <p>Deleted:</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Yes	No	N/A	READABILITY AND ACCESSIBILITY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Do reviewers understand any variable information that appears in the communication?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Were state-specific or contract-specific pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when filed in addition to notification before effective date. PA posts filed rate increase details on their website.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. <u>Is the communication easy to follow? Does it flow logically? Does it display the essential information and/or the primary action first (followed by the nonessential information)? Is the primary message of the communication presented first and clearly worded?</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Are all technical insurance terms clearly explained in the communication?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Are all technical terms used consistently throughout the communication?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Is the communication in an easily readable font? For example: Is the type at least 11-point type?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Does the communication use headings to help the reader find information easily?

Comments and Drafting Group and Task Force responses shown in comment balloons.  
Edits since exposure are highlighted yellow.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?		<b>Deleted:</b> <b>Commented [A7]:</b> NC Comment: Item 15 would be better if no arbitrary examples are allowed, and the company provides exact options based on their policy and rate increase. We suggest removing the language in Item 15 that states "If the reduced benefit options are examples, is that clear?" and replacing it with "Only options pertaining to the policyholder should be illustrated with results specific to the rate increase and that individual."
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Are tables, charts, and other graphics easy to read and understand? (See question 18 for reference).		<b>Deleted:</b> Are
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Are the grade level and reading ease scores appropriate according to state readability standards?		<b>Deleted:</b> Are
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. <u>Is it clear which reduced benefit options are available to the policyholder?</u> <u>Are the reduced benefit options examples specific to the policyholder, is that clear?</u> <u>Are there side-by-side illustrations showing how the RBOs impact the policy benefits and premiums?</u>		<b>Commented [A8R7]:</b> Drafting Group: Exposed additions referencing "examples" were removed throughout the document.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Does the communication avoid diminished contrast features that may make it harder to read? Examples include: <ul style="list-style-type: none"> <li>• Use of Italics</li> <li>• Narrow margins (top and bottom less than 1.5 inches)</li> <li>• All caps (all bold is acceptable)</li> <li>• Difficult to read text (typefaces other than Sans Serif or Courier)</li> <li>• Different colors throughout</li> <li>• Small font</li> </ul> Reviewers should aim to review these communications in the size and contrast in which a consumer would see them; a print test may be beneficial.		<b>Commented [A9]:</b> WA Comment: Items 23 and 37 include a similar question. Can they be consolidated? <b>Commented [A10R9]:</b> Drafting Group: Edits were made to #23 to remove certain exposed additions. <b>Deleted:</b> clear and not misleading <b>Deleted:</b> For example: <b>Deleted:</b> of options compared with current benefits <b>Deleted:</b> include <b>Commented [A11]:</b> ME comment: Does that read [...][2] <b>Commented [A12R11]:</b> Drafting Group: No change [...][3] <b>Deleted:</b> fonts <b>Commented [A13]:</b> ME Comment: I like this. <b>Commented [A14R13]:</b> Drafting Group: No edits [...][4]

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Edits since exposure are highlighted yellow.

	17. If FAQs are included, are they succinct and easy to understand?		
Yes	No	N/A	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<p>18. Does the communication include notice that policyholders with disabilities and policyholders for whom English is not a first language can request ongoing accommodations that will enable them to read online and written materials and notices? For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or macular degeneration, deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity, and combinations of these.</p>		
<input type="checkbox"/>	<p>19. Does the communication <u>clearly indicate that its purpose is to inform the consumer of a rate increase and, if applicable, that they have options to reduce that increase?</u></p>		<p><b>Deleted:</b> answer what is happening <b>Commented [A15]:</b> WA Comment: Does every rate increase come with RBO? If not, this checklist needs to be clear. <b>Commented [A16R15]:</b> Drafting Group: Added "if applicable" to the sentence.</p>
<input type="checkbox"/>	<p>20. Does the communication answer why the consumer is receiving a rate increase <u>and when the rate increase will be effective?</u></p>		
<input type="checkbox"/>	<p>21. Does the communication reflect negatively on the Department of Insurance?</p>		
<input type="checkbox"/>	<p>22. <u>Does the communication accurately reflect the role of the Department of Insurance in approving rate increases?</u></p>		<p><b>Deleted:</b> Does the communication indicate when the rate increase will be effective?</p>

Comments and Drafting Group and Task Force responses shown in comment balloons.  
Edits since exposure are highlighted yellow.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>23. Does the communication clearly indicate the policyholder has options?                  Does the communication clearly indicate whether the RBOs listed are the policyholder's only options? <del>or if they are examples of options.</del> Can the insurer confirm policyholders will see only those illustrated options that are available to them (and not be shown options that are not available to them)? If the identified RBOs are examples, are they clearly described as such throughout the communication? If the identified RBOs are examples, does the communication clearly indicate how the policyholder can learn about other options?</p>		<p><b>Deleted:</b></p> <p><b>Commented [A17]:</b> NC Comment: Based upon the concern noted above in item 15, we suggest removing the language in Item 49 "or examples of options."</p> <p><b>Commented [A18R17]:</b> Drafting Group: Exposed additions referencing "examples" were removed throughout the document. #49 is combined with #23.</p> <p><b>Commented [A19]:</b> WA Comment: Proposed addition "Is there a guarantee period associated with the RBO option?"</p> <p><b>Commented [A20R19]:</b> Drafting Group: WA's Proposed sentence was not added to this question. Rate guarantees are associated with an RBO and would be included in the description of the option. Rate guarantee was added as an "e.g." to question #4.</p> <p><b>Deleted:</b></p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>24. Does the communication clearly indicate how the consumer may elect an option? Does the election documentation allow the consumer to clearly indicate his or her choice? Does the election form description of options match the description of options found earlier in the communication, such that consumers will not be confused looking at the election form?</p>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>25. Does the communication clearly explain that the consumer is not being singled out for the increase?</p>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Yes</b></p>	<p><b>Yes</b></p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>No</b></p>	<p><b>No</b></p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>N/A</b></p>	<p><b>N/A</b></p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>26. Does the communication remind consumers to reflect on the original reason they bought the policy?</p>		
			<p><b>Page Reference and Filing Notes</b></p>		

Comments and Drafting Group and Task Force responses shown in comment balloons.  
Edits since exposure are highlighted yellow.

Yes	No	N/A	CONSULTATION AND CONTACT INFORMATION	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Does the communication express an understanding of the difficulty of evaluating choices?	Deleted:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29. Are the options presented fairly? Options are <b>not</b> presented fairly if one option is emphasized, mentioned multiple times, or bolded when the other options are not.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30. Are words used that could influence a policyholder's decision, such as <i>must</i> or <i>avoid</i> ? For instance, consider demonstrating immediacy by using the word "now," and avoiding words like "must." Consider "manage an increase" instead of "avoid an increase."	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31. Is the insurer's consumer service number easy to find? Is it clear what hours and days consumer service is open? Regulators may consider testing the phone number to ensure it connects easily to live company representatives without long wait times. Regulators may want to determine if company representatives in other countries have sufficient language skills and speak without strong accents that might make them difficult for older people to understand. For example, test calls could be made to understand consumer experience.	<p><b>Commented [A21]:</b> NC Comment: The Department welcomes Items 18 and 31 and notes that companies typically do not currently offer further assistance in policyholder communications if English is not the first language or if there is a disability.</p> <p><b>Commented [A22R21]:</b> Drafting Group: No changes needed.</p> <p><b>Commented [A23]:</b> WA Comment: How do regulators determine this? Could this be subjective and varied one regulator from another?</p> <p><b>Commented [A24R23]:</b> Drafting Group: Example test calls was added.</p>



Comments and Drafting Group and Task Force responses shown in comment balloons.  
 Edits since exposure are highlighted yellow.

			Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32. Are website links accurate and functional?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial advisor, producer, state SHIP program (where applicable) with the state-specific name of the program or trusted family member?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34. Does the Insurer encourage consumers to consult the Department of Insurance?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35. Does the communication encourage consumers to consult with a tax advisor or someone who could advise as to the impact on eligibility for public benefits or tax consequences of any refunded amounts if the reduction options include a cash buy out or could cause loss of Partnership status?
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>UNDERSTANDING OPTIONS - PRESENTATION</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36. Does the communication have a clearly worded, descriptive title or subject line? For example: <b>Your Long-Term Care Premiums Are Increasing.</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37. Are the options included with the rate increase notification communication? Is it clear that the options are examples and if so, that the policyholder can ask for additional options?

Deleted: if

Comments and Drafting Group and Task Force responses shown in comment balloons.  
 Edits since exposure are highlighted yellow.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38. Are the number of options or <del>examples of options</del> presented reasonable? If there are more than 5, engage with insurer to understand what is being presented.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39. Is <u>it clear if the policyholder</u> has the right to reduce coverage at any time? Are the instructions about how to do that clear?	<b>Deleted:</b> e of a policyholder's choosing clear
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc. are they supplemental education materials or are they required sources to choose an option?	
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>UNDERSTANDING OPTIONS –                  PAST AND FUTURE RATE ACTIONS</b>	<b>Commented [A25]:</b> WA Comment: It appears this should be Future rather than Past Rate Actions. <b>Commented [A26R25]:</b> Drafting Group: added "And Future"
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41. Does the communication include a statement that premiums may increase in the future? Is it clear that any future increase will include RBOs? Is the plan for filing future rate increases disclosed and clear?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42. Does the communication include a 10-year nationwide rate increase history for this and similar forms?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43. Does the communication disclose the policy is guaranteed renewable and clearly explain guaranteed renewable?	
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>UNDERSTANDING OPTIONS –                  WINDOW OF TIME TO ACT</b>	<b>Page Reference and Filing Notes</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44. Does the communication indicate what the reader must do to elect an option and provide a deadline to do it? <u>Does the communication</u>	

Comments and Drafting Group and Task Force responses shown in comment balloons.  
Edits since exposure are highlighted yellow.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>indicate what happens if they do not elect an option? Is the deadline in compliance with state law regarding notification periods in advance of a rate increase? If there is no deadline, does the communication avoid creating a false sense of urgency to act?</u>		<b>Commented [A28R27]:</b> Drafting Group: Removed "reasonable period of time"
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45. If options are only available during the decision window, is that limitation clear to consumers?		<b>Deleted:</b> a reasonable period of time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46. Does the communication indicate what happens if the policyholder does not send payment? For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable?		<b>Deleted:</b>
<b>Yes</b>	<b>No</b>	<b>N/A</b>		<b>UNDERSTANDING OPTIONS – CURRENT BENEFITS</b>	<b>Page Reference and Filing Notes</b>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47. Does the communication include all the following applicable information? Current policy benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?		<b>Deleted:</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48. If current benefits have an inflation option, does the communication clearly explain the impact that changes to this inflation option may have on benefits now and in the future?		<b>Deleted:</b>
<b>Yes</b>	<b>No</b>	<b>N/A</b>		<b>UNDERSTANDING OPTIONS – PERSONAL DECISION</b>	<b>Page Reference and Filing Notes</b>	

Comments and Drafting Group and Task Force responses shown in comment balloons.  
Edits since exposure are highlighted yellow.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			Deleted: <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49. Does the communication prompt the policyholder to consider their personal situation, such as: current age, <u>gender</u> , health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for and cost of care?		Deleted: <input type="checkbox"/> Deleted: <input type="checkbox"/> Deleted: <input type="checkbox"/> Deleted: Can the insurer confirm policyholders will see only those options or examples of options that are available to them (and not be shown options that are not available to them) Deleted: ?
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>UNDERSTANDING OPTIONS – VALUE OF OPTIONS</b>	<b>Page Reference and Filing Notes</b>	<b>Commented [A31]:</b> ME Comments: I would like to see disclosure of the estimated actuarial value of each option alongside the monthly premium, but I suppose that's too much to ask. <b>Commented [A32R31]:</b> Drafting Group: This topic had been previously discussed by the RBO Subgroup and due to opposition, was not included in the checklist. No further changes recommended. Deleted: is
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	50. <u>Does</u> the narrative describing the Contingent Nonforfeiture (CNF) and other limited benefit options <u>make it</u> clear that there is a reduction in the current policy's LTC benefits? The narrative does not have to include the dollar value for CNF.		
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>UNDERSTANDING OPTIONS – IMPACT OF DECISION</b>	<b>Page Reference and Filing Notes</b>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51. Is there a prominent statement telling policyholders they can maintain their current benefits by paying the increased premium?		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	52. Do the options reflect the impact of removing or reducing the inflation option on the growth or reduction of future benefits?		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	53. <u>Is there a declarative statement about whether dropping or adjusting</u> inflation protection results in the loss of <u>some or all of the</u> accumulated benefit amount?		Deleted: f Deleted: , is that clearly explained

Comments and Drafting Group and Task Force responses shown in comment balloons.  
 Edits since exposure are highlighted yellow.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	54. For phased-in increases, <u>is</u> there a table with all <u>state approved</u> phase-in dates and premium amounts if no RBO is selected? Does the communication clearly state if RBO(s) are limited to only the first rate increase or will be available during each phase of the rate increase?	<p><b>Commented [A331]:</b> WA Comment: Proposed addition: "Are the increases pre-approved or will the increase for each phase be filed separately in the future?"</p> <p><b>Commented [A34R33]:</b> Drafting Group: Added "state approved" to address WA's comment</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	55. For phased-in increases, are there communications sent at least 45 days before each phase of the increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	56. Does the communication disclose that all reduction options require careful consideration and may not be equal in value?	
<u>Yes</u>	<u>No</u>	<u>N/A</u>	<b>UNDERSTANDING OPTIONS – OTHER</b>	<b>Page Reference and Filing Notes</b>
			57. Does the notice include a reminder to the policyholder to keep the notice or any other documents related to this policy with the policyholder's long-term care insurance policy? Does the notice encourage the policyholder to keep the policy and related documents in an easily accessible location ( <u>not</u> a safe deposit box) and inform the appropriate individuals about where the policy can be found?	
			58. Does the notice include a reminder that the policyholder can identify a third party to be notified if premiums aren't paid and information about how to make that <u>election</u> ?	<p><b>Commented [A351]:</b> ME Comment: Good Addition</p> <p><b>Commented [A36R35]:</b> Drafting Group: No edits needed.</p>

**Page 3: [1] Commented [A3] Author**

Patrick Cantillo Comment: Based on our experience with SHIP, I offer three comments.

1. Does the communication clearly describe the “default” option that will be given effect if the policyholder does not respond by the applicable deadline?
2. Does the communication include objective indicators by which the relative values of the options can be compared? Examples would include for each option:
  1. Premium,
  2. Maximum Policy Value (MPV),
  3. Maximum Daily Benefit (MDB) by site of care if different,
  4. Maximum Benefit Period,
  5. Elimination Period, and
  6. Inflation factor
3. Consideration should be given to “bang for the buck” value indicators for each option, such as:
  1. MPV/premium,
  2. Gross Premium Valuation/premium, and
  3. MDB/premium.

**Page 5: [2] Commented [A11] Author**

ME comment: Does that really stand out as the “most readable” serif typeface? And there are a lot of unreadable sans-serif options available.

**Page 5: [3] Commented [A12R11] Author**

Drafting Group: No change. Generically, a sans serif font (one without the decorative strokes) is considered easier to read than a serif font. Using a sans serif font is a common recommendation to improve readability.

**Page 5: [4] Commented [A14R13] Author**

Drafting Group: No edits necessary.



## Checklist for Premium Increase Communications

### AUTHORITY

The Long-Term Care Insurance Reduced Benefit Options (RBO) (EX) Subgroup was composed of regulators from 17 state insurance departments. Beginning in 2019, it has been tasked with assisting the Long-Term Care Insurance (EX) Task Force in completing the following charge:

*Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.*

The Long-Term Care Insurance (EX) Task Force (Task Force) adopted the Long-Term Care Insurance RBO Communication Principles and this complementary checklist Nov. 19, 2021. The checklist was amended March 13, 2023.

### INTRODUCTION

This checklist is intended to establish a consistent approach to drafting and reviewing Long-Term Care Insurance RBO policyholder communications. The checklist can be used as guidance and does not carry the weight of law or impose any legal liability.

State regulators who consider the checklist excessive, deficient, or not focused on issues specific to consumer experiences in their state are encouraged to modify the checklist to suit the needs of the Department.

Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion and complaints, improve the quality of consumer communications, and ensure that consumer communications:

- Read in a clear, logical, not overly complex manner.
- Present options fairly and without subtle coercion.
- Include appropriate referrals to external resources, definitions, disclosures, and visualization tools.



**The Task Force:**

- **RECOMMENDS** that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and use the checklist when reviewing filed Long-Term Care Insurance RBO Communications.
- **CALLS ON** all insurance companies to consider the checklist when developing reduced benefit option policyholder communications in the event of a rate increase.



### Checklist for Premium Increase Communications

<b>Insurer name:</b>	
<b>Date of filing:</b>	
<b>Product form:</b>	
<b>Tracking number(s) SERFF <i>rate</i> filing:</b>	
<b>Tracking number(s) SERFF <i>form</i> filing:</b>	

Yes	No	N/A	SERFF FILING	Page Reference and Filing Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Does the filing contain all required materials including: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (expected if communication refers policyholder to website for more information)?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Has actuarial review of the rate increase been completed?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Will notice of the rate action be mailed at least 45-days prior to the policyholder anniversary date (or billing date if state law allows)?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Have all new innovative RBO options presented in the communication been clearly explained in the filing? Have they been vetted by policy and actuarial staff? (e.g., rate guarantees)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Do reviewers understand any variable information that appears in the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Were state-specific or contract-specific pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when	

			filed in addition to notification before effective date. PA posts filed rate increase details on their website.	
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>READABILITY AND ACCESSIBILITY</b>	<b>Page Reference and Filing Notes</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Is the communication easy to follow? Does it flow logically? Does it display the essential information and/or the primary action first (followed by the nonessential information)? Is the primary message of the communication presented first and clearly worded?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Are all technical insurance terms clearly explained in the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Are all technical terms used consistently throughout the communication?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Is the communication in an easily readable font? For example: Is the type at least 11-point type?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Does the communication use headings to help the reader find information easily?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Are tables, charts, and other graphics easy to read and understand? (See question 18 for reference).	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Are the grade level and reading ease scores appropriate according to state readability standards?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Is it clear which reduced benefit options are available to the policyholder? Are there side-by-side illustrations showing how the RBOs impact the policy benefits and premiums?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Does the communication avoid diminished contrast features that may make it harder to read? Examples include: <ul style="list-style-type: none"> <li>• Use of Italics</li> </ul>	

			<ul style="list-style-type: none"> <li>• Narrow margins (top and bottom less than 1.5 inches)</li> <li>• All caps (all bold is acceptable)</li> <li>• Difficult to read text (typefaces other than Sans Serif or Courier)</li> <li>• Different colors throughout</li> <li>• Small font</li> </ul> <p>Reviewers should aim to review these communications in the size and contrast in which a consumer would see them; a print test may be beneficial.</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. If FAQs are included, are they succinct and easy to understand?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>18. Does the communication include notice that policyholders with disabilities and policyholders for whom English is not a first language can request ongoing accommodations that will enable them to read online and written materials and notices?</p> <p>For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or macular degeneration, deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity, and combinations of these.</p>	
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>IDENTIFICATION</b>	<b>Page Reference and Filing Notes</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Does the communication clearly indicate that its purpose is to inform the consumer of a rate increase and, if applicable, that they have options to reduce that increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Does the communication answer why the consumer is receiving a rate increase and when the rate increase will be effective?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Does the communication reflect negatively on the Department of Insurance?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. Does the communication accurately reflect the role of the Department of Insurance in approving rate increases?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. Does the communication clearly indicate the policyholder has options? Does the communication clearly indicate whether the RBOs listed are the policyholder's <i>only</i> options? Can the insurer confirm policyholders will see only those illustrated options that are available to them (and not be shown options that are not available to them)?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. Does the communication clearly indicate how the consumer may elect an option? Does the election documentation allow the consumer to clearly indicate his or her choice? Does the election form description of options match the description of options found earlier in the communication, such that consumers will not be confused looking at the election form?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. Does the communication clearly explain that the consumer is not being singled out for the increase?	
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>COMMUNICATION TOUCH AND TONE</b>	<b>Page Reference and Filing Notes</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. Does the communication remind consumers to reflect on the original reason they bought the policy?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Does the communication express an understanding of the difficulty of evaluating choices?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29. Are the options represented fairly? Options are <b>not</b> presented fairly If one option is	

			emphasized, mentioned multiple times, or bolded when the other options are not.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30. Are words used that could influence a policyholder’s decision, such as <i>must</i> or <i>avoid</i> ? For instance, consider demonstrating immediacy by using the word “now” and avoiding words like “must.” Consider “manage an increase” instead of “avoid an increase.”	
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>CONSULTATION AND CONTACT INFORMATION</b>	<b>Page Reference and Filing Notes</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31. Is the insurer’s consumer service number easy to find? Is it clear what hours and days consumer service is open? Regulators may consider testing the phone number to ensure it connects easily to live company representatives without long wait times. Regulators may want to determine if company representatives in other countries have sufficient language skills and speak without strong accents that might make them difficult for older people to understand. For example, test calls could be made to understand consumer experience.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32. Are website links accurate and functional?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33. Does the insurer encourage consumers to consult with multiple sources to include any of the following: Financial advisor, producer, state SHIP program (where applicable) with the state-specific name of the program or trusted family member?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34. Does the insurer encourage consumers to consult the Department of Insurance?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35. Does the communication encourage consumers to consult with a tax advisor or someone who could advise as to the impact on eligibility for public benefits or tax consequences of any refunded amounts	

			if the reduction options include a cash buy out or could cause loss of Partnership status?	
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>UNDERSTANDING OPTIONS - PRESENTATION</b>	<b>Page Reference and Filing Notes</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36. Does the communication have a clearly worded, descriptive title or subject line? For example: <b>Your Long-Term Care Premiums Are Increasing.</b>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38. Are the number of options presented reasonable? If there are more than 5, engage with insurer to understand what is being presented.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39. Is it clear if the policyholder has the right to reduce coverage at any time? Are the instructions about how to do that clear?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc. are they supplemental education materials or are they required sources to choose an option?	
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>UNDERSTANDING OPTIONS – PAST AND FUTURE RATE ACTIONS</b>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41. Does the communication include a statement that premiums may increase in the future? Is it clear that any future increase will include RBOs? Is the plan for filing future rate increases disclosed and clear?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42. Does the communication include a 10-year nationwide rate increase history for this and similar forms?	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43. Does the communication disclose the policy is guaranteed renewable and clearly explain guaranteed renewable?	
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT</b>	<b>Page Reference and Filing Notes</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44. Does the communication indicate what the reader must do to elect an option and provide a deadline to do it? Does the communication indicate what happens if they do not elect an option? Is the deadline in compliance with state law regarding notification periods in advance of a rate increase? If there is no deadline, does the communication avoid creating a false sense of urgency to act?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45. If options are only available during the decision window, is that limitation clear to consumers?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46. Does the communication indicate what happens if the policyholder does not send payment? For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable?	
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>UNDERSTANDING OPTIONS – CURRENT BENEFITS</b>	<b>Page Reference and Filing Notes</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47. Does the communication include all the following applicable information? Current policy benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48. If current benefits have an inflation option, does the communication clearly explain the impact that changes to this inflation option may have on benefits now and in the future?	
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>UNDERSTANDING OPTIONS – PERSONAL DECISION</b>	<b>Page Reference and Filing Notes</b>

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49. Does the communication prompt the policyholder to consider their personal situation, such as: current age, gender, health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for and cost of care?	
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>UNDERSTANDING OPTIONS – VALUE OF OPTIONS</b>	<b>Page Reference and Filing Notes</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	50. Does the narrative describing the Contingent Nonforfeiture (CNF) and other limited benefit options make it clear that there is a reduction in the current policy’s LTC benefits? The narrative does not have to include the dollar value for CNF.	
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>UNDERSTANDING OPTIONS – IMPACT OF DECISION</b>	<b>Page Reference and Filing Notes</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51. Is there a prominent statement telling policyholders they can maintain their current benefits by paying the increased premium?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	52. Do the options reflect the impact of removing or reducing the inflation option on the growth or reduction of future benefits?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	53. Is there a declarative statement about whether dropping or adjusting inflation protection results in the loss of some or all of the accumulated benefit amount?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	54. For phased-in increases: Is there a table with all state approved phase-in dates and premium amounts if no RBO is selected? Does the communication clearly state if RBO(s) are limited to only the first rate increase or will be available during each phase of the rate increase?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	55. For phased-in increases, are there communications sent at least 45 days before each phase of the increase?	



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	56. Does the communication disclose that all reduction options require careful consideration and may not be equal in value?	
<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>UNDERSTANDING OPTIONS – OTHER</b>	<b>Page Reference and Filing Notes</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	57. Does the notice include a reminder to the policyholder to keep the notice or any other documents related to this policy with the policyholder’s long-term care insurance policy? Does the notice encourage the policyholder to keep the policy and related documents in an easily accessible location ( <b>not</b> a safe deposit box) and inform the appropriate individuals about where the policy can be found?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	58. Does the notice include a reminder that the policyholder can identify a third party to be notified if premiums aren’t paid and information about how to make that election?	

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

Special (EX) Committee on Race and Insurance March 23, 2023, Minutes ..... 4-60

Draft: 4/10/23

Special (EX) Committee on Race and Insurance  
Louisville, Kentucky  
March 23, 2023

The Special (EX) Committee on Race and Insurance met in Louisville, KY, March 23, 2023. The following Special Committee members participated: Chlora Lindley-Myers, Co-Chair (MO); Andrew N. Mais, Co-Chair (CT); Jon Godfread, Co-Vice Chair (ND); Scott A. White, Co-Vice Chair (VA); Lori K. Wing-Heier (AK); Mark Fowler (AL); Alan McClain (AR); Peni Itula Sapini Teo (AS); Michael Conway (CO); Karima M. Woods (DC); Michael Yaworsky (FL); Doug Ommen (IA); Dean L. Cameron (ID); Dana Popish Severinghaus (IL); Amy L. Beard (IN); 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); Troy Downing (MT); Mike Causey (NC); Eric Dunning (NE); Marlene Caride (NJ); Jennifer Catechis (NM); Scott Kipper (NV); Judith L. French (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Michael Humphreys (PA); Alexander S. Adams Vega (PR); Elizabeth Kelleher Dwyer (RI); Michael Wise (SC); Larry D. Deiter (SD); Jon Pike (UT); Kevin Gaffney (VT); Mike Kreidler (WA); Nathan Houdek (WI); and Jeff Rude (WY).

1. Adopted its 2022 Fall National Meeting Minutes

Commissioner Godfread made a motion, seconded by Director Cameron, to adopt the Special Committee's Dec. 14, 2022, minutes (see *NAIC Proceedings – Fall 2022, Special (EX) Committee on Race and Insurance*). The motion passed unanimously.

2. Received a Status Report on the Property/Casualty (P/C) Workstream

Commissioner Gaffney reported that the Property/Casualty (P/C) Workstream continues its focus on engaging with the Collaboration Forum activities related to algorithmic bias. The work of the Collaboration Forum is critical as this Workstream looks more deeply at issues related to unfair discrimination. The education and framework within the Collaboration Forum related to algorithmic bias are necessary building blocks in evaluating issues of unfair discrimination.

The Workstream is building on this foundational work by looking at potential bias in marketing, access to insurance, underwriting, rating, and claims handling, including fraud detection. The Workstream is looking at the product life cycle, starting with marketing and access first.

The workstream recently met with several insurers in order to focus on marketing and advertising activities and to learn more about insurers' corporate governance principles and best practices. These discussions help to inform the Workstream's efforts looking at potential algorithmic bias and explore industry best practices. In addition to additional areas of the product life cycle, as previously discussed, the Workstream will likely have continued engagement with the industry in the marketing and advertising area related to the industry's general approach to diversity, equity, and inclusion (DE&I) issues both internally and externally.

3. Received a Status Report on the Life Workstream

Commissioner Woods reported that the Life Workstream met Nov. 2, 2022, and heard a panel presentation focusing on what agents and advisors are doing to increase diversity in marketing, distribution, and access to life insurance products.

In discussing 2023 plans for this Workstream, Commissioner Woods shared with Director French current DE&I initiatives at the District of Columbia Department of Insurance, Securities, and Banking. A new initiative the

Department is launching focuses on providing resources about life insurance, including when to purchase and how to purchase the right policy. The Department is partnering with local organizations, relevant government agencies, and industry on this new initiative. A Webex presentation on the District of Columbia Life Insurance Program is currently being planned for April 13, and a call notice will be distributed following the Spring National Meeting.

Commissioner Woods noted that even as the capabilities and focus of state insurance departments may differ, her hope is to provide helpful information and ideas for state insurance regulators as the Workstream continues to focus on marketing, distribution, and access to life insurance products in minority communities and the role that financial literacy plays.

#### 4. Received a Status Report on the Health Workstream

Commissioner Arnold provided an update on the continuation of the Health Workstream's work from 2022 and outlined what the Workstream plans to do this year.

Last year, the Health Workstream set out on a mission to identify and better understand the barriers to accessing and using health insurance that exist for systematically disadvantaged and historically underrepresented populations. In 2022, the Workstream held seven open meetings on two main focus areas: 1) provider network design and benefit structures; and 2) consumer engagement and education.

Four of the seven meetings focused on plan networks, providers, and benefits and innovative benefit design. From the early meetings, the Workstream learned that historically underserved communities face the greatest challenges in finding high-quality health care, often due to inadequate provider networks. Workstream members heard presentations on how state insurance regulators can require more inclusive networks from their carriers to promote better access to appropriate care and more equitable health outcomes.

Later meetings focused on health carriers' benefit design practices that limit access to care, such as burdensome cost sharing or utilization management protocols placed on high-value health care services or prescription drugs, especially for historically underserved communities. Workstream members heard presentations on the tools that are available to state insurance regulators that can serve to lower such barriers to care.

Commissioner Birrane reported that the other three meetings focused on consumer engagement and education. The Workstream heard presentations and discussions from community-based providers, state based exchange marketplaces, independent navigator programs, and advocates. These presentations covered the deployment of various strategies and techniques to identify and engage certain systematically disadvantaged and historically underserved and underrepresented populations to connect them to coverage. The presentations also addressed the continuity of assistance that certain enrollees require to better use their coverage and to ultimately retain their coverage.

The objective from the seven sessions was to take the information gathered and lessons learned from each presentation and develop a resource for state insurance regulators that presents potential tools and strategies to address and remove the barriers to accessing and using health insurance for historically disadvantaged populations at the community and micro-community level.

This deliverable is underway. Per the NAIC's strategic goals, the Health Workstream plans to make the information and materials that it captured on removing barriers to health insurance for historically disadvantaged communities available to the NAIC Membership in a SharePoint space similar to what the NAIC has developed for Climate Risk and Resiliency and International Engagement. The thought is that a SharePoint site would be a living resource for state insurance regulators, and content and other tools will continue to be added to the site. This site

could also serve as a platform for discussion and conversations related to health equity, among other things. The plan is to launch the site this year, starting with last year's information and grow from there.

In addition to that deliverable, the Workstream is considering its future work plan and the initiatives that may be taken up in 2023.

The Health Workstream will meet in regulator-only session to consider its activities and initiatives for 2023, which may include, among other things: 1) the continuation of its education on benefit design relating to specific areas of focus, such as preventative care and mental health coverage (beyond pure parity); 2) exploring the practical considerations for adjusting one's benchmark plan under the relatively new federal Centers for Medicare & Medicaid Services (CMS) process and guidance from states that have done that; 3) the evolution of 1033 waivers and state activity focusing on and targeting specific issues in innovative ways intended to address health inequity; and 4) working with the Health Insurance and Managed Care (B) Committee and the Big Data and Artificial Intelligence (H) Working Group to look at doing a survey on the use of artificial intelligence (AI) with respect to health insurance.

#### 5. Heard an Update on the Member Diversity Leadership Forum

Evelyn Boswell, NAIC Director of Diversity, Equity & Inclusion, provided an update on the Member Diversity Leadership Forum. The Forum meets quarterly, with a designated leader from each jurisdiction, sharing information and best practices. In addition to the Forum, the NAIC has started DE&I leadership breakfast meetings at national meetings and created DE&I coursework for state insurance regulators. Rodney Hugle, Assistant Director of Financial Standards & Examination, Kentucky Department of Insurance (DOI), provided information regarding the Member Diversity Leadership Forum and sharing DE&I best practices across territories, and he read the positive comments about the regulator coursework. The coursework program, Foundations of Diversity, Equity and Inclusion for Regulators, was piloted in February 2023 and is now available to all state insurance regulators through the NAIC Education and Training Department.

Mr. Hugle reported that as of March 15, 66 state insurance regulators have registered for the Foundations of Diversity, Equity and Inclusion for Regulators course, which currently has a rating of 4.5 out of 5. Mr. Hugle said the Member Diversity Leadership Forum is great for sharing DE&I best practices across states. He talked about the Kentucky DOI's internship program, developed under Commissioner Clark's leadership and in partnership with Kentucky State University, a historically black land-grant university. Other Kentucky executive branch agencies are using the program, which has expanded to include the University of Kentucky and the University of Louisville.

Commissioner Humphreys shared that the Pennsylvania Insurance Department's diversity council participated in the NAIC's Foundations of Diversity, Equity and Inclusion for Regulators and had positive feedback. He now plans to roll it out more broadly across the Department—not mandating it, but creating incentives for the Department's bureaus with the greatest participation.

Ms. Boswell went on to share next steps. The next Member Diversity Leadership Forum meeting is scheduled for April 24, with Ohio presenting its best practices. On June 8 in Kansas City, MO, is the NAIC's 3<sup>rd</sup> Annual DE&I Conference, "Awareness in Action." The conference is invitation only, and the NAIC will pay for one regulator from each jurisdiction to attend.

Having no further business, the Special (EX) Committee on Race and Insurance adjourned.

SharePoint/NAIC Support Staff Hub/Committees

**LIFE INSURANCE AND ANNUITIES (A) COMMITTEE**

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Accelerated Underwriting (A) Working Group Regulatory Guidance Document Jan. 25, 2023,  
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Examination Guidelines (D) Working Group (Attachment Two-B) ..... 5-18

Draft: 4/3/23

Life Insurance and Annuities (A) Committee  
Louisville, Kentucky  
March 23, 2023

The Life Insurance and Annuities (A) Committee met in Louisville, KY, March 23, 2023. The following Committee members participated: Judith L. French, Chair (OH); Carter Lawrence, Vice Chair (TN); Mark Fowler (AL); Barbara D. Richardson (AZ); Karima M. Woods represented by Philip Barlow (DC); Doug Ommen (IA); Vicki Schmidt (KS); James J. Donelon (LA); Eric Dunning (NE); Marlene Caride (NJ); Scott Kipper (NV); Adrienne A. Harris represented by Mona Bhalla (NY); Glen Mulready (OK); Scott A. White represented by Don Beatty and Craig Chupp (VA); and Nathan Houdek (WI). Also participating was: Rachel Hemphill (TX).

1. Adopted its Feb. 24 Minutes

Director French said the Committee met Feb. 24 and took the following action: 1) adopted its 2022 Fall National Meeting minutes; 2) adopted revisions 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 49A); and 3) adopted *Actuarial Guideline LIV—Nonforfeiture Requirements for Index-Linked Variable Annuity Products* (AG 54).

Commissioner Caride made a motion, seconded by Director Dunning, to adopt the Committee's Feb. 24 minutes (Attachment One). The motion passed unanimously.

2. Adopted the Report of Life Actuarial (A) Task Force

Hemphill said the Life Actuarial (A) Task Force met Mar. 20–21 at the Spring National Meeting. She said the Task Force had a robust discussion of the impacts of a rising interest rate environment, including hearing from the Society of Actuaries (SOA) on relevant actuarial research, as well as hearing from company actuaries regarding their sensitivity testing and ongoing monitoring of the appropriateness of their assumptions, including dynamic lapse behavior.

Hemphill said the Task Force re-exposed an amendment proposal form (APF) to shorten the time lag in Valuation Manual (VM)-50/VM-51 mortality experience reporting from two years to one year. She explained that this change will require a transitional year in which companies submit two years of mortality experience data, but then it will allow for more timely analysis and reporting of mortality experience and the development of mortality tables. She said the industry supports these efforts, but there may be a need for additional flexibility in the reporting deadlines in the first year or two as companies adjust their processes to the new reporting timeline.

Hemphill reported that the Task Force continued discussion on the work to develop a replacement economic scenario generator, including hearing an update on the activities of the Economic Scenario Generator Governance Drafting Group and the Economic Scenario Generator Technical Drafting Group and hearing a presentation from NAIC staff on quantitative results from the Economic Scenario Generator field test.

Commissioner Lawrence made a motion, seconded by Director Chupp, to adopt the report of the Life Actuarial (A) Task Force. The motion passed unanimously.

### 3. Adopted the Report of the Accelerated Underwriting (A) Working Group

Commissioner Houdek said the Accelerated Underwriting (A) Working Group met Feb. 22 and took the following action: 1) exposed the draft regulatory guidance for accelerated underwriting (AU) in life insurance for a 45-day public comment period ending April 15; and 2) exposed the draft referral to the Market Conduct Examination Guidelines (D) Working Group for a 30-day public comment period ending March 24.

Commissioner Lawrence made a motion, seconded by Commissioner Ommen, to adopt the report of the Accelerated Underwriting (A) Working Group, including its Feb. 22 minutes (Attachment Two). The motion passed unanimously.

### 4. Heard a Presentation from the ACLI and the SOA on the Current State of Life Insurance

Patrick C. Reeder (American Council of Life Insurers—ACLI) explained that the ACLI's chief economist and vice president of research, Andrew Melnyk, will be giving a high-level presentation focused solely on life insurance and not the other products that life insurers sell. He said that Dale Hall, managing director of research at the SOA Research Institute, will give the second part of the presentation, focusing on mortality trends.

Melnyk discussed a number of slides illustrating the changes in life insurance over time from a variety of vantage points. His first slide showed annual percentage changes in life insurance death benefits paid from 1910 to 2021 to illustrate how the last few years of the COVID-19 pandemic fit into the historical context. He said between 1920 and 2021, the greatest percentage increases occurred in 1918, which saw a 40% increase, followed by 1926, with a 15.3% increase. Next was 2020, which saw a 15.4% increase, and 2021, which saw a 10.8% increase. The next slide illustrated life insurance death benefits paid over time between 1880 and 2021 in dollars, adjusted for inflation. He said the graph shows increases in the actual amounts paid over time, with a steep, significant jump in the amount paid over the last two years. He said this illustrates why the life insurance industry is important and that it has been consistently meeting its obligations.

Melnyk said the next slide shows annual life insurer risk-based capital (RBC) ratios between 2018 and 2021. He said the average RBC ratio in 2020 was 428%. In 2021, it was 443%, which is a bit better than the average in 2018, when it was 424%. He said the percentage of companies with RBC greater than 200% (by assets) in those four years also has remained relatively constant. There are less than 1% of companies with RBC below 200%, which illustrates the strength of the life insurance industry.

Melnyk said the next slide compares individual and group life insurance purchases between 1985 and 2021. He said the graph shows a steady increase in individual life insurance purchases over time. He said there was a slight dip in group purchases between 2019 and 2021 during the COVID-19 years, which can be attributed, at least in part, to the erratic labor market and unprecedented unemployment due to stay-at-home orders. He said that individuals continue to purchase life insurance, and he anticipates a continuing increase in individual purchases. He said that in looking back in history, there was unprecedented growth in the life insurance market in the years following the 1918 pandemic. He said between 1917 and 1926, the dollar amount of in-force life insurance more than doubled. He said that there were other factors involved at the time, like World War I and an exploding economy, but he said he thought that the industry might experience an increase coming out of COVID-19, just to a lesser degree. He said there seems to have been an increase in demand for life insurance during the last few years, but that may be short-lived. He said the Life Insurance Marketing and Research Association (LIMRA) has looked into this and anticipates things will return to a more normal level.

Melnyk discussed the next slide showing a graph of life insurance as a percentage of gross domestic product (GDP) from 1945 to 2021. He said the graph strips away price and premiums and shows mortality and the savings component of life insurance in relation to the economy as a whole. He explained that the graph shows that life



insurance, as a percentage of GDP, was on an upward trend throughout most of the World War II era, but since the mid-1990s, it has started to fall. He said that he does not have an explanation for this trend, and it is something that requires much more study, but it suggests society is underinsured.

The last slide graphs the percentage of families reporting any life insurance coverage between 1968 and 2019, based on data from the U.S. Federal Reserve *Survey of Consumer Finances* (SCF), which is an extensive survey of household finances. He said this graph shows that the percentage of families self-reporting any life insurance coverage at all has steadily declined, from a high of 85.4% of families reporting life insurance coverage in 1971, to a low of 59.4% of families in 2019. He said once more current data is available, it will be seen if the pandemic had any effect on these numbers.

Reeder pointed out that the ACLI *Life Insurers Fact Book* was the resource for much of the data provided in the presentation. He said it contains a great deal of information about the life insurance industry and is available on the ACLI's website. He said that the data in the first few slides of the presentation shows that state insurance regulation works and that the industry provides an important resource for consumers. He said that while the last couple of slides show a decline, the ACLI is looking into the reasons for that decline and how to remedy that, which involves delving into questions of race and insurance and how to break down barriers to access, particularly in underserved communities. He said that the ACLI is researching how technology may decrease barriers and increase access in underserved communities.

Hall said, in his presentation, he would make some observations about mortality and discuss how those population trends relate to insured mortality based on reviewed historical U.S. population mortality data from the Centers for Disease Control and Prevention (CDC). He said since 1999, there have been reasonably strong mortality improvements in the U.S., with the strongest improvements in the first 10 years of this century. After that, between 2010 to 2019, mortality continued to improve but at a slower pace. In 2019, the population mortality rate was 715 deaths per 100,000. He said there was a 16.8% increase in 2020 (4.9% with COVID-19 removed) with age-adjusted rates at 835 deaths per 100,000. He said mortality increased again in 2021 by another 5.3%, with 880 deaths per 100,000, which is the same mortality rate as in 1999. Hall said we are awaiting fourth-quarter 2022 data, but the full year is looking like it is down from 2021, which is close to results for 2020. Hall said that population life expectancy is one statistic that can be used to compare where trends are over time.

Hall reviewed the next slide showing changes in mortality rates by cause of death. Hall said heart disease has increased as a cause of death in the population after many years of downward trends, and mortality due to cancer increased for the first time in 22 years. Hall pointed out that there was a large increase in mortality due to chronic conditions such as diabetes, liver disease, and hypertension. Hall said that many of these may be the result of people putting off care during the pandemic and hopefully will improve as people return to normal. Hall discussed the chart comparing the relationship between population mortality trends to group life and individual life trends. Historically, insured mortality is 30%–50% of what happens in the population, and this seems to have held true during the pandemic. He showed a slide illustrating actual to expected mortality trends in the insured market compared with actual and expected mortality trends in the population. He said some of the largest actual to expected ratios occurred during the delta and omicron variants in late 2021. He said data for the second quarter of 2022 shows the ratio of actual to expected claims below 100% for the first time since the start of the pandemic, and there may be some indication, based on third- and fourth-quarter data from 2022, that things are slowly getting back to a more normal actual to expected ratio. Hall explained that his final slide shows ratios of individual life insurance claims during 2020–2022 compared to 2017–2019. He said the largest individual life mortalities were in the third or fourth quarter of 2021 and started to come down in 2022.

Commissioner Lawrence asked about the ACLI slide that showed a 25% decline in the percentage of households reporting life insurance coverage from the high in 1971 to the low in 2019. He wondered whether there was any information available that would show the demographic distribution of the decline, such as the differences by

geographical area or socioeconomic sector. Melnyk said they had not looked into that data very deeply and did not have that information. Commissioner Mulready said that a 25% decline in coverage and a 25% increase in death rates is concerning for the industry. Reeder said that this was a large reason why the ACLI is spending a lot of time making sure it accesses consumers and identifies what has changed to cause the decline. He said that the ACLI does not have the socioeconomic and demographic information related to data that comes from the federal government. He said that there have been a lot of changes in family structure over time, and the insurance industry has to learn to innovate. He said that the industry has to be more deliberate in its efforts to reach underrepresented communities and that it must make sure barriers come down and engagement is fostered in the industry at every level.

Commissioner Mulready said he heard a report of a 40% increase in deaths and another report recently about an increase in heart attacks in young people. He asked if there was any information about the average age of death. Reeder said the ACLI saw that reporting, and the thinking is that the reporting was based on early SOA research that was not fully understood by those reporting on it as far as the trending. Hall said that there are many ways to look at group life data, such as by occupation code or areas of the country. He said another important way to study excess mortality is by looking at different age bands. Hall said some of the overall pandemic results show a 30% increase in excess mortality, and some of that was concentrated in some of the younger working ages. He cautioned, however, that the mortality rates for younger age groups are already quite low, so when excess deaths are added on to what is already a small number, the percentages get higher. Hall said that in the group insurance market, it is important for insurers to consider demographic data in order to make the right assessment of the risks associated with a particular group. He said, for example, that insurers should consider the potential impact of retired lives that might be part of the group, or how much of the group is the working population, and that different occupation codes have different exposures, especially during a pandemic.

Commissioner Donelon said that he was in Tokyo about 10 years ago for a meeting about the much higher take-up rate per capita of life insurance in Japan than in the U.S. but that Europeans owned much less life insurance. He said if this is still the case, it might indicate that cultural factors are the driver of whether someone purchases insurance. Melnyk said that he is not aware that the statistics have changed and thinks there are many variables that affect the demand for life insurance. He said cultural factors are variables to be considered. He said he knows that, for example, in Japan, it is not uncommon for a person to purchase a whole life insurance policy as soon as they graduate from college. He said that saving is also much more common in the culture, so that may have something to do with it as well.

Birny Birnbaum (Center for Economic Justice—CEJ) said the ACLI *Life Insurers Fact Book* contains some interesting information that could complement the presentation. He said in 1955, the U.S. population was around 165 million people, and there were 22 million individual life insurance policies in force. He said in 2021, the population had doubled, but there were only 10 million individual insurance policies in force. He said the number of group certificates during that same time frame went up from 2.2 million to more than 25 million, but that is still less than what was in force for group policies in 2004. Birnbaum said these statistics illustrate that insurance companies are marketing their products more as investments than death protection and focusing more on affluent consumers and higher face amount policies.

Birnbaum said another piece of information that gets at the issue of underserved communities is the difference in life expectancy by income and by race. He said there is a widening gap in life expectancy based on income and that communities are underserved, not because of changing needs for life insurance, but because producers are not serving them. He said that these factors need to be considered when thinking about how to address insurance for the underserved. He said that insurance companies recognize these trends, so the question is how to get involved with more loss prevention and loss mitigation to make risky policies less risky and more attractive for insurance companies to write. Brendan Bridgeland (Center for Insurance Research—CIR) asked if there have been any comparisons of product offerings and innovations and the decline in household life insurance ownership. He

asked whether there has been a focus on using life insurance products as investment planning for high-net-worth individuals at the same time as a decline in sales to lower and moderate-income families.

Reeder said that since 1955, there has been an increase in group life insurance, which is a part of the socioeconomic changes during which insurance became more readily accessible through the workplace. The ACLI agrees with Birnbaum and Bridgeland and wants to bring products to the consumers who need them. He said if the industry is not thoughtful about increasing access, it will continue to struggle, which is why they are putting time and energy into programs and initiatives to decrease barriers to producer licensing and being thoughtful as an industry. He said that Birnbaum and Bridgeland raise valid concerns, and they are the types of things the ACLI is looking at. Melnyk said that the ACLI has not done a study like Bridgeland suggested of product offerings. He said there have been some observations looking at ownership patterns in underserved communities, and there is some indication that ownership peaks at later ages. Still, there has not been a lot of research done beyond that.

Director Richardson said that around five years ago, she heard that the average age of a life insurance producer was approximately 57 years old. She wondered if that was still true or if the industry had found a way to reach a younger and more diverse group. Reeder said that is still the case and that the industry recognizes the need to bring new people into the industry, not just as producers, but in every aspect of the industry. Reeder said he would provide some follow-up information about the industry efforts in this area.

Brenda J. Cude (University of Georgia) said that the graph showing the percentage of families reporting any life insurance comes from data from the SCF, which notoriously does not do a good job of asking life insurance questions. She said one example is a question regarding health insurance. The question asks if a person has health insurance; if they do not, it asks why. She said there is no parallel question for life insurance. She also said the survey asks about term and whole life insurance, but it is possible that a person has universal life or coverage through an employer and may answer no. She said if there was a desire to make suggestions to the Federal Reserve Board (FRB) regarding ways to improve the questions they ask about life insurance in the SCF, she would be available to assist with that project. She said she knows many researchers who would value that. Melnyk said this was a comprehensive survey, but the depth could be better, so to the extent that the NAIC would want to work with the FRB to improve the survey, it would be willing to help. He also mentioned that the ACLI uses a proprietary database to confirm the information from the SCF and has found that the information generally matches. Birnbaum suggested that some of the granular data that the NAIC collects could be repurposed to inform some of the questions and research that was talked about.

## 5. Discussed Other Matters

Director French recognized Peter G. Gallanis' retirement as president of the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) with the following resolution:

WHEREAS, Peter G. Gallanis has served as President of the National Organization of Life and Health Insurance Guaranty Associations ("NOLHGA") since 1999 and, prior to that, served as the Special Deputy Insurance Receiver for the State of Illinois; and

WHEREAS, Peter has been a longtime friend and supporter of the NAIC, working with Insurance Commissioners and NAIC Task Forces and Working Groups on a host of issues relating to troubled company resolution; and

WHEREAS, Peter has worked tirelessly to protect consumers of insolvent life and health insurance companies and to support the national state-based guaranty system, including by speaking and testifying on insurance matters before a number of courts, state legislatures, Congress, the NAIC, the IAIS, and the FSB; and

WHEREAS, Peter’s dedication to the guaranty system has taken him around the world, from Canada to Switzerland to Taiwan to Thailand and to state capitals across the country, not to mention his beloved Chicago.

THEREFORE, BE IT RESOLVED, that the Life Insurance and Annuities (A) Committee wishes to express its heartfelt gratitude to Peter G. Gallanis, on the occasion of his retirement as President of NOLHGA, for more than three decades of service to state regulators, the guaranty system, and the consumers they protect.

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.

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Draft: 3/8/23

Life Insurance and Annuities (A) Committee  
Virtual Meeting  
February 24, 2023

The Life Insurance and Annuities (A) Committee met Feb. 24, 2023. The following Committee members participated: Judith L. French, Chair, and Peter Weber (OH); Carter Lawrence, Vice Chair (TN); Mark Fowler (AL); Shane W. Foster (AZ); Karima M. Woods (DC); Doug Ommen (IA); Vicki Schmidt (KS); James J. Donelon (LA); Eric Dunning represented by Megan VanAusdall (NE); Marlene Caride (NJ); Nick Stosic (NV); Adrienne A. Harris represented by Mona Bhalla (NY); Scott A. White (VA); and Nathan Houdek (WI). Also participating were: Fred Andersen (MN); Glen Mulready (OK); and Rachel Hemphill (TX).

1. Adopted its 2022 Fall National Meeting Minutes

Commissioner Houdek made a motion, seconded by Commissioner Ommen, to adopt the Committee's Dec. 14, 2022, minutes (see *NAIC Proceedings – Fall 2022, Life Insurance and Annuities (A) Committee*). The motion passed unanimously.

2. Adopted the Revised AG 49-A

Hemphill explained that the Life Actuarial Task Force adopted edits to *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-based Interest Sold on or after December 14, 2020* (AG 49-A), effective May 1, 2023, to address an issue in indexed universal life (IUL) illustrations where some companies are illustrating non-benchmark indices in a more favorable manner than benchmark indices, particularly for products with uncapped volatility-controlled funds and a fixed bonus. These “quick fix” edits address a pressing issue in current practice, while the Indexed Universal Life (IUL) Illustration (A) Subgroup continues to discuss longer-term larger-scale improvements.

Andersen clarified that the revisions to AG 49-A are proposed to be effective for illustrations of policies that are sold on or after May 1, 2023. He said the term “sold” has been used in the past, is the term in the current guideline, and has not presented a problem.

Birny Birnbaum (Center for Economic Justice—CEJ) said that the term “sold” is still unclear and would allow for the continued use of illustrations that have been determined to be deceptive and abusive well after May 1. He said not only will policies not be fully paid for until well after May 1, but also policies that were sold before May 1 will continue to be illustrated using the old methodology after May 1. He suggested that it would be easier to administer and more protective of consumers to prohibit the use of the illustrations after May 1. Birnbaum said that insurers would not be required to go back and re-do any illustrations; it would simply require companies to say that they are no longer going to be using the illustration methodology that is deceptive and that state insurance regulators have decided is not appropriate.

Andersen clarified that the revisions to AG 49-A arose out of a concern that there should be a level playing field between the illustrations of benchmark indices and non-benchmark indices, rather than the determination that the illustrations were misleading, per se. Birnbaum said that even if state insurance regulators have not explicitly said the illustrations were misleading, the fact that the guideline has been revised twice is an implicit acknowledgment that insurers have continued to use product design to game the illustration guideline.

Director French said she appreciates Birnbaum sharing his point of view. She reiterated that these changes were just a first step, more work was ongoing, and that “sold” was the term used in the original guideline. Director French said that the revisions to AG 49-A are an example of state insurance regulators trying to get ahead of any actions that could be misleading. She said state insurance regulators also have market conduct exams as a tool available to address any activities that are in fact misleading to consumers.

Commissioner White made a motion, seconded by Commissioner Donelon, to adopt the revisions to AG 49-A (see *NAIC Proceedings – Spring 2023, Executive (EX) Committee and Plenary, Attachment One*). The motion passed unanimously.

### 3. Adopted AG 54

Hemphill explained that the Life Actuarial (A) Task Force adopted *Actuarial Guideline LIV—Nonforfeiture Requirements for Index-linked Variable Annuity Products* (AG 54) addressing index-linked variable annuities (ILVAs), effective July 1, 2024. AG 54 provides principles outlining the conditions under which an ILVA is consistent with the definition of a variable annuity and exempt from the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805) and specifies nonforfeiture requirements consistent with variable annuities. The guideline promotes consistency while allowing for reasonable product variation, outlining that interim values should provide equitable treatment to the contract holder and the insurance company.

Weber said that this guideline is important because it ensures that consumers’ expectations are met in that gains will be realized when indices go up, not just that they will experience losses when the indices go down.

Commissioner White made a motion, seconded by VanAusdall, to adopt AG 54 (see *NAIC Proceedings – Spring 2023, Executive (EX) Committee and Plenary, Attachment Two*). The motion passed unanimously.

### 4. Discussed Other Matters

Director French said that there had been some discussions about using national meetings as an opportunity to have presentations of general interest to a wide audience. She asked anyone having any ideas for topics or areas of interest that the Committee might want to hear about to let her or Jennifer Cook (NAIC) know.

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A Cmte/2023 Spring National Meeting/2-24-2 ACmte min Draft

Draft: 3/13/23

Accelerated Underwriting (A) Working Group  
Virtual Meeting  
February 22, 2023

The Accelerated Underwriting (A) Working Group of the Life Insurance and Annuities (A) Committee met Feb. 22, 2023. The following Working Group members participated: Nathan Houdek, Chair and Lauren Van Buren (WI); Grace Arnold, Vice Chair, represented by Sarah Gillaspey (MN); Jason Lapham (CO); Russ Gibson (IA); Cynthia Amann (MO); Ross Hartley (ND); Megan VanAusdall (NE); Matthew Gendron (RI); and David Hippen (WA).

1. Exposed the Draft of an Accelerated Underwriting Guidance Document and Referral

Commissioner Houdek explained that he would chair the Working Group in 2023 along with Commissioner Grace Arnold (MN) as vice chair. He said that since the Working Group met last, a regulator-only drafting group has been working on developing guidance for regulators on accelerated underwriting. He explained that a draft Accelerated Underwriting Guidance Document (Attachment Two-A) along with a draft referral to the Market Conduct Examination Guidelines (D) Working Group (Attachment Two-B) were distributed prior to the call. Commissioner Houdek explained that the purpose of the virtual meeting today is to review these drafts and formally expose them for comment.

Gillaspey reviewed the draft guidance document and referral. She said the document begins with a brief explanation of NAIC process—that the Working Group was created in 2019 and drafted an educational paper that was adopted by the Life Insurance and Annuities (A) Committee in the Spring of 2022. She said the guidance keys off on a definition of accelerated underwriting that was the result of the presentations heard by the Working Group and the subsequent feedback that the Working Group received through drafting the educational paper. She explained that the guidance focuses on ensuring that life insurers utilize new technologies in ways that comply with existing laws. In addition to coordinating with other NAIC groups working on similar issues, the guidance recognizes that future efforts to develop additional regulations, model laws, data processes, and tools that apply to insurers, data, and vendors may be needed. Gillaspey explained that the guidance focuses on questions and considerations for Departments of Insurance (DOIs) as they review accelerated underwriting programs focusing on ensuring that accelerated underwriting programs are fair, transparent, and secure, and includes examples of questions and requests for information that DOIs may want to use. The goal is to create a useful working document for regulators.

Gillaspey said the Working Group also developed a referral to the Market Conduct Examination Guidelines (D) Working Group, asking them to consider adding some specific guidance to the *Market Regulation Handbook*. She said that the drafting group thought the *Market Regulation Handbook* (Handbook) was a logical place to house some of the knowledge that came out of the educational paper and would be useful to regulators during reviews involving accelerated underwriting programs. She explained that the additions to the Handbook would be based on the *Unfair Trade Practices Act* (#880) and would provide specific guidance to regulators regarding questions to ask life insurers and the types of documents they may want to review to ensure that accelerated underwriting programs are not unfairly discriminatory—that data is fair, data use is transparent, and data is secure. She said the Accelerated Underwriting (A) Working Group is happy to work with the Market Conduct Examination Guidelines (D) Working Group at any point as it considers this referral and any additions to the Handbook.

Birny Birnbaum (Center for Economic Justice—CEJ) asked whether the drafting group had considered making a referral to the Innovation, Cybersecurity, and Technology (H) Committee. He also asked why the drafting group thinks there is a need for additional regulations, models, processes, and tools if current regulations apply. Also,

regulators have broad authority to review accelerated underwriting programs in the same way as traditional underwriting programs and ensure they are not unfairly discriminatory. Gillaspey explained that the drafting group wanted to have as many useful tools as possible for regulators as they review these products, and the Handbook is a tool for that. She said that it makes sense to give examiners an idea of the kinds of questions to ask based on the information learned through the process of researching and drafting the educational report. Van Buren said that insurers are using accelerated underwriting programs currently, and regulators need the appropriate tools to ask about these practices. She said other groups are also looking at these issues and that there is a survey underway looking at accelerated underwriting in life insurance that will inform any future actions on this topic. Any revisions to the Handbook put out now will ensure that practices comply with existing law.

Birnbaum asked where existing laws fall short of necessitating additional regulations, model laws, data processes, and tools. Van Buren said that additional information will likely come from the other groups that are looking into this issue, as well as out of the survey that is underway. Miguel Romero (NAIC) mentioned that the Innovation, Cybersecurity, and Technology (H) Committee is aware of the ongoing work of this Working Group. Romero also explained that a referral to the Market Conduct Examination Guidelines (D) Working Group makes sense right now because there is an existing Handbook that can be revised to address the issue. On the other hand, while the Innovation, Cybersecurity, and Technology (H) Committee has work ongoing, there is no defined place to receive a referral.

Amann pointed out that the Innovation, Cybersecurity, and Technology (H) Committee is a newer Committee and did not exist when the Accelerated Underwriting (A) Working Group was created. She also explained that exam standards rely on having a model, but this issue is so prominent right now that these questions can help guide an examiner when they are doing an underwriting guideline review or looking at rate reviews. She said these questions help frame the kind of review an examiner would conduct.

Peter Kochenburger (University of Connecticut School of Law) said that the draft guidance document refers to prohibiting unfair discrimination but does not define it. He said there is a lot of debate about what “unfairly discriminatory” means, especially in the context of proxy discrimination. Van Buren explained that the guidance is based on state law, so what that term means is going to be consistent with the state’s laws that prohibit unfair discrimination. Birnbaum said that states differ in their understanding of unfair discrimination. In the context of life insurance, insurers have an unfortunate history of using certain occupations as a proxy for race. Whereas in property and casualty insurance, there is precedent for considering unfair discrimination to involve the violation of either actuarial standards or intentional use of race or other protective classes. He said unintentional discrimination or using a proxy for race in life insurance is unfair discrimination, and he does not understand why any state would not consider that to be unfair discrimination.

Commissioner Houdek proposed forwarding the referral to the Market Conduct Examination Guidelines (D) Working Group and exposing the draft guidance document for a formal 30-day comment period following this call. He said the plan is to have another open meeting to discuss any comments received before finalizing the guidance. Jennifer McAdam (American Council of Life Insurers—ACLI) said she was working on other responses to accelerated underwriting issues happening across the country and requested a longer comment period on the guidance document.

Commissioner Houdek agreed to expose the draft guidance document for a 45-day public comment period ending April 15.

Birnbaum requested a comment period for the referral since the guidance document references the referral, and any comments on the guidance document may implicate the referral. Commissioner Houdek agreed to expose



the referral to the Market Conduct Examination Guidelines (D) Working Group for a 30-day public comment period ending March 24.

Having no further business, the Accelerated Underwriting (A) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A Cmte /AUWG/AUWG min 2-23-23 final

**Draft January 25, 2023**

**Comments are requested by close of business Friday, April 14, 2023**

**Accelerated Underwriting (A) Working Group  
Ad Hoc Drafting Subgroup  
Regulatory Guidance and Considerations**

**Introduction**

The Accelerated Underwriting Working Group (AUWG) was created by the Life Insurance and Annuities (A) Committee at the NAIC 2019 Summer National Meeting. One of the original charges given to the Working Group was to “... 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, if appropriate, drafting guidance for the states.”

A significant portion of the AUWG’s work over the last three years benefitted from a multitude of presentations from the life insurance industry, actuarial consulting firms, a machine learning assurance company, and consumer advocate groups. These presentations are summarized in an educational paper adopted by the Life Insurance and Annuities (A) Committee at the NAIC 2022 Spring National Meeting.

The AUWG’s analysis and recommendations for life insurers and regulators included in the educational paper are based on the following definition:

Accelerated underwriting (AU) is the use of big data, artificial intelligence, and machine learning to underwrite life insurance in an expedited manner. The process generally uses predictive models and machine learning algorithms to analyze applicant data, which may include the use of non-traditional, non-medical data, provided either by the applicant directly or obtained through external sources. The process is typically used to replace all or part of traditional underwriting in life insurance and to allow some applicants to have certain medical requirements waived, such as paramedical exams and fluid collection.

The educational paper includes recommendations for insurers and regulators designed to ensure new technologies are utilized by life insurers in ways that comply with existing insurance law. While existing insurance laws vary from state to state, the recommendations acknowledge that most states: 1) require life insurance underwriting to be based on expected losses and expenses; 2) require insurers that collect consumer data to maintain that data in secure systems; and 3) prohibit unfair discrimination in insurance underwriting.

Below, the AUWG presents regulatory guidance for State Departments of Insurance (DOIs) when reviewing accelerated underwriting programs used by life insurers. The regulatory guidance expounds on the recommendations the AUWG made in its educational paper and provides sample questions and areas for review for DOIs.

Also, the AUWG is making a referral to the **Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee** with suggested additions to the NAIC’s *Market Regulation Handbook* (MRH) (Attachment A). The AUWG has concluded that it

would be beneficial to include additional guidance in the NAIC’s MRH that addresses questions involving accelerated underwriting in life insurance.

Finally, the AUWG understands that there are other NAIC groups working on similar or overlapping issues related to accelerated underwriting. The AUWG plans to coordinate with the following groups:

- **The Big Data and Artificial Intelligence (H) Working Group under the Innovation, Cybersecurity and Technology (H) Committee.**

The Big Data and Artificial Intelligence (H) (BDAI) Working Group has three charges:

- A. Research the use of big data and artificial intelligence (AI) including machine learning (ML) in the business of insurance, and evaluate existing regulatory frameworks for overseeing and monitoring their use. Present findings and recommendations to the Innovation, Cybersecurity, and Technology (H) Committee including potential recommendations for development of model governance for the use of big data and AI including ML for the insurance industry.
- B. Review current audit and certification programs and/or frameworks that could be used to oversee insurers’ use of consumer and non-insurance data and models using intelligent algorithms including AI and in alignment with the NAIC AI Principles. If appropriate, issue recommendations and coordinate with the appropriate SME committees on the development of or modifications to model laws, regulations, handbooks, and regulatory guidance regarding data analysis, marketing, rating, underwriting and claims, regulation of data and model vendors, regulatory reporting requirements, and consumer disclosure requirements.
- C. Assess data and regulatory tools needed for state insurance regulators to appropriately monitor the marketplace, and evaluate the use of big data, algorithms, and ML, including AI/ML in underwriting, rating, claims, and marketing practices This assessment shall include a review of currently available data and tools, as well as recommendations for development of additional data and tools, as appropriate. Based on this assessment, propose a means to include these tools in existing and/or new regulatory oversight and monitoring processes to promote consistent oversight and monitoring efforts across state insurance departments.

To achieve its charges, the BDAI Working Group formed 4 Workstreams:

- **Workstream 1** – focused on surveys of the industry related to their use of AI/ML systems. The survey of the life insurance industry has been piloted with a select few life insurers and the survey is in the final stages of revision and is expected to be sent to all life insurers in first quarter 2023.
- **Workstream 2** - focused on the appropriate regulatory evaluation to produce a recommended regulatory framework for monitoring and overseeing industry’s use of third-party data and model vendors.
- **Workstream 3** – focused on gathering data and evaluating information from sources, including vendors, academics, industry, international supervisory authorities, on governance models/frameworks and software tools/resources, which could assist regulators in overseeing and monitoring industry’s use of data and AI/ML and eliminate unintended bias in such use.
- **Workstream 4** – focused on evaluating how best to implement the expectations outlined in the *NAIC’s Principles on Artificial Intelligence* and provide suggestions on next steps, which could include regulatory guidance or development of a model regulation and report back to the working group and ultimately the H Committee.

In addition, it is clear to the AUWG that additional regulations, model laws, data, processes, and tools are needed for DOIs to appropriately monitor the use of accelerated underwriting programs used by life insurers. Such additional regulations, model laws, data, processes, and tools should include regulating data and vendors that provide external consumer non-traditional, non-medical data and predictive models to insurers. In addition, they should mandate consumer disclosures related to insurers' use of such data in models using ML algorithms. The AUWG recommends that the Innovation Cybersecurity and Technology (H) Committee include the consideration of these potential regulations, models laws, data processes, and tools as part of its Committee's work.

The AUWG also believes that its work, including the regulatory guidance below and the referral to the Market Conduct Examination Guidelines (D) Working Group, may be useful to the Workstreams under the Big Data and Artificial Intelligence (H) Working Group.

In addition, the AUWG understands that any work that is completed by the Workstreams under the BDAI Working Group may be useful to incorporate into the regulatory guidance below along with any potential standard(s) developed by the Market Conduct Examination Guidelines (D) Working Group related to accelerated underwriting in life insurance.

- **The Privacy Protections (H) Working Group under the Innovation, Cybersecurity and Technology (H) Committee**

The Privacy Protections (H) Working Group is working on replacing the NAIC's Insurance Information and Privacy Protection Model Act (#670) and the Privacy of Consumer Financial and Health Information Regulation (#672) with one new model. Although this group is addressing a unique set of issues, it will require coordination, especially with regard to definitions.

## **Regulatory Guidance**

Following the adoption of the educational paper, the AUWG continued its work on the second part of its charge: drafting a guidance document for DOIs to use when reviewing accelerated underwriting programs used by life insurers to ensure the programs are fair, transparent, and secure in compliance with existing law.

Making sure that the use of accelerated underwriting is fair to consumers is important because its use impacts both the availability and affordability of life insurance to consumers. Ensuring that insurers use accelerated underwriting in a transparent manner is important because consumers should understand what personal data is being accessed by insurers and how that data is being used. Lastly, insurers accessing sensitive consumer data have a duty to secure that data to protect consumers from the harm of unauthorized disclosure.

The AUWG developed the following regulatory considerations for DOIs when reviewing a life insurer's use of accelerated underwriting programs:

- Data inputs are transparent, accurate, reliable, and the data itself is evaluated for unfair bias.

- External data sources, algorithms or predictive models are based on sound actuarial principles, including a causal or rational explanation why a rating variable is correlated to expected loss or expense, and why that correlation is consistent with the expected direction of the relationship.<sup>1</sup>
- Predictive models or machine learning algorithm(s) within accelerated underwriting accurately assess and price risk.
- Predictive models or machine learning algorithm(s) achieve an outcome that is not unfairly discriminatory.
- Reason(s) for an adverse underwriting decision are provided to the consumer along with all information upon which the insurer based its adverse underwriting decision.
- The insurer establishes and follows procedures to protect the consumer’s privacy and the consumer’s data.
- The insurer has a mechanism in place to correct mistakes if found in consumer data.
- The insurer will produce information upon request as part of regular filing submission reviews or market conduct examinations.
- The insurer has procedures in place to address the following requirements pertaining to the consumer: Notice Requirements, Opting-Out of Data Sharing, Correcting or Deleting Information, Data Portability, and Restricting the use of Data.

Using these regulatory expectations as a baseline for review, DOIs may:

- Review a life insurer’s initial submission of policy filings to confirm the proper use of data elements.
- Request a life insurer provide and/or file accelerated underwriting data sources, predictive models, and algorithms and/or summaries for analysis.
- Request a life insurer provide additional information and/or explanation about how a particular predictive model or machine learning algorithm is used in an accelerated underwriting program.
- Request a life insurer provide information about source data used as part of its accelerated underwriting programs regardless of whether the data or score is provided by a third party.
- Request a life insurer provide information about its auditing of data sets, predictive models, and machine learning algorithms to ensure they are accurate, reliable, and do not result in unfairly discriminatory outcomes.

The following are examples of questions and requests for information DOIs may want to submit to life insurers when reviewing AU programs:

- What specific external data or information about life insurance applicants is being utilized by the accelerated underwriting program?
- How does the company obtain any external data or information used as part of its life insurance accelerated underwriting program?
- Explain in detail how the company discloses to applicants for life insurance what external information is used in its accelerated underwriting program and how this external information is used in the accelerated underwriting program.

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<sup>1</sup> For clarity and consistency, this bullet borrows language from the Casualty Actuarial and Statistical (C) Task Force *Regulatory Review of Predictive Models White Paper* to describe this concept, replacing the language from the Accelerated Underwriting Educational Paper recommendation, which said: “External data sources, algorithms or predictive models are based on sound actuarial principles, including a valid explanation or rationale for any claimed correlation or causal connection.”

- Ask for a copy of all company disclosures provided to applicants regarding the company's accelerated underwriting program.
- What process or recourse does the company provide to applicants for life insurance should they receive an adverse underwriting decision?
- What process or recourse does the company provide to applicants for life insurance to correct mistakes in the external data or information?
- How is external data or information about life applicants utilized, stored, and destroyed after the completion of the underwriting process?
- How does the company audit data sets, predictive models, and machine learning algorithms to ensure accuracy, reliability, and outcomes insurance that are not unfairly discriminatory?
- How often does the company perform audits?
- Does the company perform audits internally or does it utilize a third-party to perform independent audits?
- Has the company modified its predictive models or machine learning algorithms, or the data sets used by the models and algorithms, as a result of an audit? If so, what modifications were made and why?
- Ask the company to provide a copy of audit results.
- How does the company ensure that the model(s) it uses are based on sound actuarial principles?
- How does the company address potential unfair discrimination by ensuring that external consumer data's correlation to risk is not outweighed by any correlation to a protected class(es).

The AUWG offers this guidance to the state DOIs for consideration, while recognizing that there is more work to come. The AUWG anticipates that the work of the other NAIC groups on this topic, including the referral to the Market Conduct Examination Guidelines (D) Working Group and the results of the BDAI Working Group Workstream 1 life insurance survey will lead to additional guidance regarding accelerated underwriting in life insurance.

Draft 1-11-23

Comments are requested by close of business Friday, March 24, 2023

### MEMORANDUM

TO: **Market Conduct Examination Guidelines (D) Working Group** of the Market Regulation and Consumer Affairs (D) Committee

FROM: Accelerated Underwriting (A) Working Group of the Life Insurance and Annuities (A) Committee

DATE: January ?, 2023

RE: Suggested additions to the NAIC's *Market Regulation Handbook* addressing accelerated underwriting in life insurance

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The Accelerated Underwriting Working Group (AUWG) was created by the Life Insurance and Annuities (A) Committee at the NAIC 2019 Summer National Meeting to "... 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, if appropriate, drafting guidance for the states."

The AUWG drafted an education paper that was adopted by the Life Insurance and Annuities (A) Committee on April 7, 2022. The AUWG continues its work to draft guidance for the states reviewing life insurers' use of accelerated underwriting. As part of that work, the AUWG makes this referral to the Market Conduct Examination Guidelines (D) Working Group to include additional guidance in the NAIC's *Market Regulation Handbook* (MRH) that will address questions involving accelerated underwriting in life insurance. The AUWG believes that adding additional explanation and review criteria about accelerated underwriting in the MRH is necessary to alert the market conduct examiner to the novel data and processes utilized by life insurers in accelerated underwriting.

Existing regulations apply to accelerated underwriting programs in the same way as traditional underwriting programs. DOIs have broad authority to examine the processes and procedures of life insurers to determine if their accelerated underwriting programs comply with the statutes and regulations of the department, in particular the state equivalent to the *Unfair Trade Practices Act* (#880)<sup>1</sup>, to ensure that these accelerated underwriting programs are not unfairly discriminatory.

The AUWG recommends that a new standard be included in Chapter 23 – Conducting the Life and Annuity Examination related to a life insurer's use of big data, artificial intelligence, and machine learning to underwrite life insurance. The applicable standard should address how accelerated underwriting programs used by life insurers are fair, transparent, and secure. The types of documents to be reviewed by examiners should include policy rates and forms, accelerated underwriting models and/or summaries of those models, information about source data used as part of the accelerated underwriting program, consumer disclosures, and testing and/or auditing policies and procedures of the models.

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<sup>1</sup> See Section 4G(1) Unfair Discrimination. Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any life insurance policy or annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such policy.

Review procedures and criteria should include the following:

- Ensure data is fair. Determine if the company has policies in place for and regularly performs audits of its data sets, predictive models, and machine learning algorithms to ensure data inputs are accurate and reliable, and do not result in unfairly discriminatory outcomes. Determine if the predictive model(s) and machine learning algorithms are based on sound actuarial principles.
- Ensure data use is transparent. Determine if the company discloses to applicants for life insurance the external information used in its accelerated underwriting program and how that external information is used in the accelerated underwriting program. Determine if the company provides a process or recourse to applicants for life insurance if they receive an adverse underwriting decision. Determine if the company provides applicants for life insurance an opportunity to correct mistakes in external data or information used in the accelerated underwriting program.
- Ensure data is secure. Determine how external data or information about life insurance applicants is utilized, stored, and destroyed by the company after the completion of the underwriting process.

The AUWG defers to the Market Conduct Examination Guidelines (D) Working Group regarding whether any updates to the MRH should be made to the chapter pertaining to life insurance as recommended above, or should be included in a chapter that deals specifically with the use of big data, algorithms, and machine learning by insurers generally. The AUWG looks forward to working with the Market Conduct Examination Guidelines (D) Working Group to draft the recommended changes to the MRH.



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Draft: 4/10/23

Life Actuarial (A) Task Force  
Louisville, Kentucky  
March 20–21, 2023

The Life Actuarial (A) Task Force met in Louisville, KY, March 20–21, 2023. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Lori K. Wing-Heier represented by Sharon Comstock (AK); Mark Fowler represented by Sanjeev Chaudhuri (AL); Ricardo Lara represented by Ahmad Kamil and Ted Chang (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang and Bruce Sartain (IL); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Timothy N. Schott represented by Marti Hooper (ME); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT).

1. Adopted its March 2, Feb. 23, Feb. 2, and Jan. 26 Minutes and the Reports of the Variable Annuities Capital and Reserve (E/A) Subgroup, the Longevity Risk (E/A) Subgroup, the Indexed Universal Life (IUL) Illustration (A) Subgroup, and the Index-Linked Variable Annuity (A) Subgroup.

The Task Force met March 2, Feb. 23, Feb. 2, and Jan. 26. During these meetings, the Task Force took the following action: 1) exposed referrals received from the Valuation of Securities (E) Task Force; 2) exposed a Valuation Manual (VM)-20, Requirements for Principle-Based Reserves for Life Products/VM-21, Requirements for Principle-Based Reserves for Variable Annuities, Economic Scenario Generator Technical Drafting Group topics, timing, and decision points document; 3) adopted amendment proposal form (APF) 2022-09, which addresses reporting issues in VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation; 4) exposed APF 2023-04, which clarifies VM-31 reporting requirements that support company experience mortality rates; 5) reported that it met Feb. 9 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings, to discuss the economic scenario generator corporate model; 6) adopted its 2022 Fall National Meeting minutes; 7) exposed proposed charges for the proposed Economic Scenarios (E/A) Subgroup; 8) adopted APF 2022-10, which clarifies VM-20 requirements for universal life policies with non-material secondary guarantees; 9) adopted APF 2023-02, which adds disclosure requirements to VM-31 to explain any reporting discrepancies between the annual statement and the principle-based reserving (PBR) actuarial report; 10) exposed APF 2023-01, a non-substantive amendment to clarify the value of starting assets in VM-21; 11) exposed APF 2023-03, which addresses a series of clean-up items in VM-20, VM-21, and VM-31; 12) responded to a referral from the Financial Regulation Standards and Accreditation (F) Committee by conveying the Task Force's recommendation to remove the *Actuarial Opinion and Memorandum Regulation (#822)* as an accreditation standard; 13) adopted APF 2022-07, which clarifies a VM-20 net premium reserve (NPR) mortality adjustment; and 14) adopted APF 2022-08, which clarifies that companies only reporting VM-21 reserves determined using the alternative methodology are subject to limited governance requirements under VM-G, Appendix G — Corporate Governance Guidance for Principle-Based Reserves.

The Task Force reviewed the reports of the Longevity Risk (E/A) Subgroup, the Variable Annuities Capital and Reserve (E/A) Subgroup, the Indexed Universal Life (IUL) Illustration (A) Subgroup, and the Index-Linked Variable Annuity (A) Subgroup.

Chupp made a motion, seconded by Slutsker, to adopt the Task Force’s March 2 (Attachment One), Feb. 23 (Attachment Two), Feb. 2 (Attachment Three), and Jan. 26 (Attachment Four) minutes and the reports of the Longevity Risk (E/A) Subgroup (Attachment Five), the Variable Annuities Capital and Reserve (E/A) Subgroup (Attachment Six), the Indexed Universal Life (IUL) Illustration (A) Subgroup (Attachment Seven), and the Index-Linked Variable Annuity (A) Subgroup (Attachment Eight). The motion passed unanimously.

## 2. Adopted the Report of the VM-22 (A) Subgroup

Slutsker noted that his report would cover an introduction to the VM-22, Requirements for Principle-Based Reserves for Non-Variable Annuities framework (VM-22), a project history, a project plan, a discussion of the Standard Projection Amount, and the relationship between the VM-22 project and the NAIC’s economic scenario generator project. After Slutsker walked through the presentation, Hemphill asked a couple of questions regarding the prospective versus retrospective considerations: 1) Does the Task Force need to consider the exemption differently depending on if VM-22 is ultimately prospective or retrospective?; and 2) Will the VM-22 field test focus only on new business or will in-force business be included? Regarding the field test, Slutsker said that while final decisions have not yet been made, there had been some discussions of testing in-force business. Slutsker also noted that given the likely later implementation of in-force business in VM-22, the Subgroup could consider any impacts to the exemption threshold when in-force business is added.

Brian Bayerle (American Council of Life Insurers—ACLI) asked how the timing of the VM-22 field test would work given the current status of the economic scenario generator project. Slutsker noted that the VM-22 timeline relies on the progress of the economic scenario generator project, and additional timeline delays were possible. Slutsker further stated that it is possible that if the scenarios for the second-round economic scenario generator project are a lot closer to final, the VM-22 field test could be performed simultaneously with the economic scenario generator field test. Bayerle responded that there could be challenges with securing consultant resources for the VM-22 field test if the timeline for the project is indefinite, to which Slutsker agreed.

Boston asked whether a change would need to be made to the *Standard Valuation Law* (#820) if VM-22 was made to be retrospective. Hemphill asked that the NAIC’s legal team looks into the issue of retrospective application of VM-22 and provide an opinion on what would need to occur. Bruce Friedland (Friedland Consulting Services LLC) asked whether there was any consideration of using the current prescribed scenarios for the VM-22 field test. Slutsker noted that had not come up in Subgroup discussions but that his personal view was that it would not be very fruitful to utilize the current prescribed scenarios given the expected large changes to the prescribed scenarios in the future arising from the NAIC economic scenario generator project.

Slutsker made a motion, seconded by Yanacheak, to adopt the report of the VM-22 (A) Subgroup (Attachment Nine), including its March 1 minutes (Attachment Ten). The motion passed unanimously.

## 3. Heard a Presentation on the Impact of a Rising Interest Rate Environment

Andersen introduced the agenda for the discussion of the current rising interest rate environment, which would include his presentation (Attachment Eleven), a presentation (Attachment Twelve) by Dale Hall (Society of Actuaries—SOA), and a roundtable discussion of industry panelists, including Theresa Resnick (Everlake Life), Stephen McNamara (New York Life), and Paul Hance (Pacific Life). After Andersen and Hall concluded their presentations, Slutsker moderated the roundtable discussion of the impact of rising interest rates on insurance organizations. Carmello noted that he was surprised to see the prevalence of annuities without a market value adjustment (MVA) and asked if the companies were seeing different experiences with lapses depending on whether an MVA was present. McNamara noted that his company’s MVAs were limited to the surrender charge period. While they did see some difference in lapse experience before and after the surrender charge period ended, he noted that their lapse experience overall is fairly minimal regardless. Resnick noted that her company

did see different experiences between annuities with an MVA and without, but they also include different lapse assumptions between those groups.

Hemphill asked whether when margins were developed for lapse assumptions, a margin was needed for both the dynamic portion of the lapse formula in addition to the base or if a margin on top of the base assumption could be sufficient. McNamara stated that his organization leans toward a conservative dynamic lapse assumption and that margins were applied to both the base and dynamic portion of the formula. However, McNamara said that his investment team had challenged the conservatism of their dynamic lapse assumptions and would like something more on a best-estimate basis to better manage the assets supporting the business, which is leading the team to reconsider their lapse assumptions. Resnick said that their approach to margin development is to try to keep it simple so that the results can be explained to senior management. However, they do employ more complex sensitivity testing to ensure that the margins are robust.

Muldoon asked what types of metrics companies are reviewing regarding early warning signs for liquidity risk. McNamara replied that they are monitoring their anticipated cash needs, policyholder behavior, general market conditions, and credit spreads. Muldoon then asked how many additional withdrawals the company is expecting to see, given the rising interest rate environment. McNamara said that additional withdrawals are part of their dynamic lapse formulae that varied by product and that they would expect to see more withdrawals, particularly in a prolonged high interest rate environment. Tsang asked if companies were changing their crediting rate strategy to control the level of lapses and reduce the stress on liquidity. Resnick stated that they were increasing credited rates with the rising interest rate environment but that there were challenges due to a lack of data on how policyholders will react with respect to higher credited rates.

#### 4. Heard an Update on the AG 53 Review Plan

Andersen noted that Actuarial Guideline 53 (AG 53) was adopted last year, which added provisions to asset adequacy testing (AAT) to ensure that claims will be paid even if complex assets do not perform as expected. He said that during the development of AG 53, regulators agreed to not add any guard rails into AAT in favor of well-thought-out company disclosures. Andersen said that if companies only include minimal information in their AG 53 disclosures, it may lead the state insurance regulators reviewing the disclosures to conclude that the company does not have a sufficient rationale for the high-yield assumptions on their assets. He further stated that companies with a greater proportion of their assets in the high-yield category without sufficient disclosure could expect to receive greater scrutiny in the form of follow-up questions after regulatory review.

#### 5. Adopted the Report of the Experience Reporting (A) Subgroup and Heard an Update on VM-50/VM-51 Experience Reporting

Andersen said that Pat Allison (NAIC) would be delivering a presentation (Attachment Thirteen) on the NAIC's VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats mortality experience collection progress.

Andersen made a motion, seconded by Chou, to adopt the report of the Experience Reporting (A) Subgroup. The motion passed unanimously.

#### 6. Exposed APF 2021-08

Mary Bahna-Nolan (MBN Advisors Inc.) walked through APF 2021-08, which would reduce the time lag in the VM-50/VM-51 mortality experience collection. Hemphill suggested a friendly amendment to change the years used in the example in APF 2021-08 for clarity. Bahna-Nolan agreed that the clarification was an improvement. Bayerle noted that their comments on APF 2021-08 would likely include suggestions for language changes that are

reflective of how the experience collection deadlines have worked in practice over the NAIC's two years of mortality experience collection and requested that the comment period be longer than 21 days.

Chupp made a motion, seconded by Eom, to expose APF 2021-08 (Attachment Fourteen) for a 30-day public comment period ending April 21, 2023. During the discussion of the motion, Allison noted that the NAIC is supportive of APF 2021-08. The motion passed unanimously.

7. Heard a Presentation on the VM-21/C3 Phase II Economic Scenario Generator Field Test Results

Scott O'Neal (NAIC) walked through a presentation (Attachment Fifteen) of the VM-21/C-3 Phase II economic scenario generator field test results. Mark Tenney (Mathematical Finance Company) asked if there was any response bias present due to the companies that had not participated or dropped out during the process. O'Neal responded that although there was a good amount of participation for variable annuity products that would tend to reduce potential bias, the average results of the field test could be highly dependent on a small number of larger players. Chang asked how the baseline comparisons to the field test runs would look if you split the participants that used the Academy Interest Rate Generator (AIRG) in their valuation versus those that used a proprietary economic scenario generator. O'Neal replied that due to the limited participation of companies that used a proprietary economic scenario generator, it would not be possible to detail in a public call. However, O'Neal stated it was likely that the reserve and capital increases for the field test runs would be relatively smaller given the requirement that proprietary economic scenario generators be at least as conservative as the AIRG.

8. Exposed APF 2023-05

Bayerle walked through APF 2023-05, which revises hedge modeling language in the *Valuation Manual* to address index hedge modeling. Hemphill noted concerns with "tied directly to the contracts falling under the scope of VM-21 stochastic reserve requirements," language included in Section 4.A.4.a and Section 4.A.4.b, along with additional editorial language corrections. Neither the Task Force nor Bayerle opposed making Hemphill's suggested modifications to the exposure document.

Slutsker made a motion, seconded by Yanacheak, to expose APF 2023-05 (Attachment Sixteen) with the discussed modifications for a 21-day public comment period ending Apr. 12, 2023, with the edits described above. The motion passed unanimously.

9. Heard an Update from the Academy's Life Practice Council

Amanda Barry-Moilanen (American Academy of Actuaries—Academy) walked through a presentation (Attachment Seventeen) providing an update from the Academy's Life Practice Council.

10. Heard an Update on the Activities of the Economic Scenario Generator Governance Drafting Group, the VM-20/VM-21 Economic Scenario Generator Technical Drafting Group, and the SPA Drafting Group

Hemphill said that she would provide an update on the Economic Scenario Generator Governance Drafting Group, the VM-20/VM-21 Economic Scenario Generator Technical Drafting Group, and the Standard Projection Amount (SPA) Drafting Group in order to promote transparency into each group's activities. She stated the Economic Scenario Generator Governance Drafting Group met several times to determine recommendations for the ongoing governance of the economic scenario generator. As for the activities of the Technical Drafting Group, Hemphill said that it met to discuss VM-20 stochastic exclusion test results from the field test. Hemphill said that the Drafting Group currently has a planned series of topics to discuss a document that has been exposed and that the group will resume calls in early April to cover those topics, with potential modifications based on any comments received. Finally, for the SPA Drafting Group, Hemphill said that the results of a company survey were discussed

at a public meeting and that more details would be discussed at a regulator-only session after the Spring National Meeting.

#### 11. Heard an Update on SOA Research and Education

Hall delivered a presentation (Attachment Eighteen) on the SOA's research and education initiatives. Yanacheak asked about how the data breakout groups were chosen for the payout annuity study. Hall said that these were categories that industry participants were using in their financial modeling. Regarding a potential new mortality table for payout annuities, Slutsker asked: 1) if the slope in the latest study would be considered in deciding whether a new mortality table was needed; and 2) how long it would take the SOA to create a new mortality table. Hall stated that the slope is an important consideration in deciding whether to create a new mortality table and that it would take approximately 12–18 months to create a new mortality table.

Andersen asked if the data from 2020 to 2023 that included COVID-19 would make it challenging to decide on the assumptions for a new mortality table. Hall replied that dealing with COVID-19 in the data was the new normal and something everyone would need to adjust to. Carmello asked if the SOA was looking into group annuity mortality and how much representation of the industry was present in the current payout annuity study. Hall replied that the SOA was looking into group annuity mortality and that the payout annuity mortality study represented approximately 75% to 80% of the industry.

#### 12. Heard an Update from the Academy Council on Professionalism and Education.

Shawna Ackerman (Actuarial Board for Counseling and Discipline—ABCD) noted that the ABCD received 96 requests for guidance, with 20% of those requests coming from life actuaries.

Rob Damler (Actuarial Standards Board—ASB) said that the ASB was very active, with more than 15 actuarial standards of practice (ASOPs) undergoing review. Damler said that the Task Force may be particularly interested in the current work on ASOP 41, which discusses actuarial communications, and ASOP 12, which deals with risk classification.

#### 13. Heard an Update on Mortality Improvement

Marianne Purushotham (SOA) delivered a presentation (Attachment Nineteen) on the work of the joint SOA Mortality and Longevity Oversight Advisory Council (MLOAC) and Mortality Improvements Life Work Group (MILWG). Carmello asked if the Task Force should be considering mortality improvement, given the level of uncertainty present due to the impact of the COVID-19 virus and other mortality drivers that have occurred recently. Hemphill noted that instead of calling it a "mortality improvement" assumption, it should potentially be referred to as a "mortality trend," given that deterioration is also considered. Hemphill further stated that the mortality trend assumption approved last year included deterioration in the initial years followed by recovery and improvement.

#### 14. Adopted Portions of APF 2023-03

Hemphill walked through APF 2023-03, noting that the Task Force would be considering adopting the language associated with the VM-21 portion of section three, along with sections four and five, outlined in the cover sheet. Hemphill stated that a comment letter (Attachment Twenty) from the ACLI in response to the exposure of APF 2023-03.

Slutsker made a motion, seconded by Eom, to adopt the discussed portions of APF 2023-03 (Attachment Twenty-One). During a discussion of the motion, Chupp asked why the VM-20 portion of Section 3 was not going to be

included in the adoption. Hemphill replied that although she felt the VM-20 language in Section 3 would work in its current form, there may be some additional clarifying language that could be added to limit the possibility of misinterpretation. Chupp noted that he would prefer to adopt the VM-20 language now to ensure consistency with the new VM-21 language in Section 3. Slutsker and Eom agreed to modify their motion to adopt to include the VM-20 language from Section 3. The motion passed unanimously.

15. Adopted APF 2023-01

Hemphill discussed APF 2023-01, which clarifies the value of starting assets in VM-21.

Weber made a motion, seconded by Chupp, to adopt APF 2023-01 (Attachment Twenty-Two). The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/2023-1 Spring/Spring Natl Meeting/Meeting Minutes Packet/LATF Spring National Meeting Minutes.docx



Draft: 3/11/23

Life Actuarial (A) Task Force  
Virtual Meeting  
March 2, 2023

The Life Actuarial (A) Task Force met March 2, 2023. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill and Iris Huang (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Lori K. Wing-Heier represented by Sharon Comstock (AK); Mark Fowler represented by Sanjeev Chaudhuri (AL); Ricardo Lara represented by Ahmad Kamil (CA); Andrew N. Mais represented by Wanchin Chou and Manny Hidalgo (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Timothy N. Schott represented by Marti Hooper (ME); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Adrienne A. Harris represented by Bill Carmello (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Steve Boston (PA); Jon Pike represented by Tomasz Serbinowski (UT); and Allan L. McVey represented by Tim Sigman (WV).

1. Exposed Referrals Received from the Valuation of Securities (E) Task Force

Charles Therriault (NAIC) walked through the first informational referral from the Valuation of Securities (E) Task Force to the Life Actuarial (A) Task Force proposing that the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) be amended to define structured equity and fund investments and exclude these investments from filing exemption eligibility. Nancy Bennett (American Academy of Actuaries—Academy) asked if making these investments ineligible for a filing exemption would have an impact on the calculation of prescribed default costs or other unintended consequences. Therriault responded that any changes to reporting classification would be decided by the other task forces and working groups at the NAIC and that this proposal would strictly be looking at assessing a risk designation that is more consistent with the underlying risk of the investment.

Carmello made a motion, seconded by Tsang, to expose the first informational referral (Attachment One-A) for a 21-day public comment period ending March 22. The motion passed unanimously.

Therriault then walked through the second referral from Valuation of Securities (E) Task Force requesting that the Life Actuarial (A) Task Force respond with ideas on how it could use investment information on a proposed new analytical capability at the NAIC's Securities Valuation Office (SVO), and whether it is supportive of the initiative. Tsang asked if company-determined investment risk measures, such as asset duration, would be consistently reported. Therriault responded that one of the benefits of building out the proposed analytical capability at the SVO would be that these risk measures would be determined consistently by the SVO across all companies. Tsang then asked if the purpose of this capability would be to spot outliers. Therriault said that the initial purpose of the data would be to identify inconsistencies with ratings that were assigned to securities, but that part of the purpose of this referral is to see how other groups could make use of the data. Bennett then asked if this new capability would effectively make the SVO a rating agency. Therriault replied that this new capability would not make the SVO a rating agency in effect, and these additional risk measures that the SVO is seeking to obtain are common throughout the industry and have been for decades.

Leung made a motion, seconded by Hidalgo, to expose the second informational referral (Attachment One-B), with a cover letter added to explain that the Task Force is seeking commentary on the five questions outlined in the referral, for a 42-day public comment period ending April 14. The motion passed unanimously.

2. Exposed a VM-20/VM-21 ESG Technical Drafting Group Topics, Timing, and Decision Points Document

Hemphill walked through a document that outlined the timing for upcoming discussions of the VM-20/VM-21 Economic Scenario Generator (ESG) Technical Drafting Group and decisions that would need to be made.

Chupp made a motion, seconded by Leung, to expose the document (Attachment One-C) for a 21-day public comment period ending March 23. The motion passed unanimously.

3. Adopted APF 2022-09

Hemphill walked through amendment proposal form (APF) 2022-09, noting that one comment letter from the American Council of Life Insurers (ACLI) had been received and was supportive of the APF.

Hidalgo made a motion, seconded by Leung, to adopt APF 2022-09 (Attachment One-D). The motion passed unanimously.

4. Exposed APF 2023-04

Huang walked through APF 2023-04, which clarifies the VM-31 reporting requirements that support that the company experience mortality rates are not lower than what the company actually expects to occur.

Chupp made a motion, seconded by Leung, to expose the APF 2023-04 (Attachment One-E) for a 21-day public comment period ending March 23. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.

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TO: Elizabeth Kelleher Dwyer, Chair, Financial Conditions (E) Committee  
 Marlene Caride, Chair, Financial Stability (E) Task Force  
 Bob Kasinow, Chair, Macroprudential (E) Working Group  
 Thomas Botsko, Chair, Capital Adequacy (E) Task Force  
 Phillip Barlow, Chair, Risk-Based Capital Investment Risk and Evaluation (E) Working Group  
 Cassie Brown, Chair, Life Actuarial (A) Task Force  
 Judy Weaver, Chair, Financial Analysis (E) Working Group  
 Dale Bruggeman, Chair, Statutory Accounting Principles (E) Working Group  
 Fred Andersen, Chair, Valuation Analysis (E) Working Group

FROM: Carrie Mears, Chair, Valuation of Securities (E) Task Force

CC: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)  
 Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau  
 Dan Daveline, Director, NAIC Financial Regulatory Services  
 Todd Sells, Director, NAIC Financial Regulatory Policy & Data  
 Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)  
 Julie Gann, Assistant Director, NAIC Solvency Policy  
 Bruce Jenson, Assistant Director, NAIC Solvency Monitoring  
 Pat Allison, Managing Life Actuary, NAIC Financial Regulatory Affairs  
 Jane Koenigsman, Sr. Manager II, NAIC L/H Financial Analysis  
 Andy Daleo, Sr. Manager I, NAIC P/C Domestic and International Analysis  
 Dave Fleming, Sr. Life RBC Analyst, NAIC Financial Regulatory Affairs  
 Jennifer Frasier, Life Examination Actuary, NAIC Financial Regulatory Affairs  
 Scott O'Neal, Life Actuary, NAIC Financial Regulatory Affairs  
 Eva Yeung, Sr. P/C RBC Analyst/Technical Lead, NAIC Financial Regulatory Affairs

RE: Referral on Additional Market and Analytical Information for Bond Investments

DATE: February 13, 2023

**Summary** – The Investment Analysis Office (IAO) staff recommended in its Feb. 25, 2022, memorandum to the Valuation of Securities (E) Task Force (VOSTF) (attached hereto, Blanks Market Data Disclosure v2.pdf) that it would like additional market-data fields added to the annual statement instructions for bond investments. This was, in part, based upon the NAIC's adoption in 2010 of the recommendations of

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the Rating Agency (E) Working Group (RAWG), which was formed following the Great Financial Crisis of 2007-2008 to study the NAIC's reliance on rating agencies, and the IAO staff's recent findings in its Nov. 2021 memo regarding disparities between rating agencies. RAWG recommended that: 1) regulators explore how reliance on rating agencies can be reduced when evaluating new, structured, or alternative asset classes, particularly by introducing additional or alternative ways to measure risk; and 2) consider alternatives for regulators' assessment of insurers' investment risk, including expanding the role of the NAIC Securities Valuation Office ("SVO"); and 3) VOSTF should continue to develop independent analytical processes to assess investment risks. These mechanisms can be tailored to address unique regulatory concerns and should be developed for use either as supplements or alternatives to ratings, depending on the specific regulatory process under consideration.

The NAIC's need for alternative measures of investment risk has only increased since RAWG made its recommendations, as privately issued and rated complex structured finance transactions have become commonplace without adequate ways of identifying them. The SVO recommended the following market data fields to be added to the annual statement instructions: Market Yield, Market Price, Purchase Yield, Weighted Average Life, Spread to Average Life UST, Option Adjusted Spread, Effective Duration, Convexity and VISION Issue ID. Please refer to the attached memo for more detail on each data field.

In comments received from industry there were question as to how the SVO, VOSTF and/or other regulators who would receive the analytic data included in the proposal would utilize that information and why it is of value to them. The SVO was also asked to consider industry's recommendation that the NAIC be responsible for calculating this analytical information by utilizing commercially available data sources and investment models instead of having each individual insurance company incur the costs to implement system changes. The SVO shared their thoughts on the alternatives in the Jul. 14, 2022, memorandum to the VOSTF (attached, Blanks\_Market\_Data\_Options\_v3.pdf).

Capabilities like this within the SVO would permit it to calculate for regulators all the analytic values previously mentioned for any Schedule D investment along with additional measures such as key rate duration (a measure of interest rate sensitivity to maturity points along the yield curve), sensitivity to interest rate volatility, principal and interest cash flow projections for any security or portfolio for any given interest rate projection, loss estimates for any security for any given scenario and many others measures.

**Referral** – VOSTF refers this matter to the above referenced Committees, Task Forces and Working Groups for consideration and requests a response from you by May 15<sup>th</sup> outlining:

1. Indicate if your group is supportive of creating this capability within the SVO.
2. List the investment analytical measures and projections that would be most helpful to support the work performed by your respective group.
3. Describe how your group would utilize the data and why it would be of value.
4. Are there other investment data or projection capabilities that would be useful to your group that could be provided by commercially available data sources or investment models? And if so, please list them.
5. Any other thoughts you may have on this initiative.

Please contact Charles Therriault or Marc Perlman with any questions.

VOSTF\_Referral\_Bond\_Risk\_Measures\_2023-02-13.docx



TO: Thomas Botsko, Chair, Capital Adequacy (E) Task Force  
Rachel Hemphill, Chair, Life Actuarial (A) Task Force  
Philip Barlow, Chair, Risk-Based Capital Investment Risk and Evaluation (E) Working Group

FROM: Carrie Mears, Chair, Valuation of Securities (E) Task Force

CC: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)  
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)  
Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau  
Dave Fleming, Sr. Life RBC Analyst, NAIC Financial Regulatory Affairs  
Jennifer Frasier, Life Examination Actuary, NAIC Financial Regulatory Affairs  
Scott O’Neal, Life Actuary, NAIC Financial Regulatory Affairs  
Eva Yeung, Sr. P/C RBC Analyst/Technical Lead, NAIC Financial Regulatory Affairs

RE: Referral regarding a Proposed Purposes and Procedures Manual (P&P Manual) Amendment to Define and Add Guidance for Structured Equity and Funds

DATE: February 3, 2023

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**Summary** – The SVO has processed several private letter rating (PLR) filings for investments in notes issued by special purpose vehicles or other legal entities that operate as feeder funds which themselves then invest, directly or indirectly, in one or more funds or other equity investments. The SVO proposes defining these investments as Structured Equity and Fund investments.<sup>1</sup> The SVO proposed at the 2022 Fall National Meeting the removal of Structured Equity and Fund investments from Filing Exemption, the reliance upon a credit rating provider (CRP) ratings for the assignment of NAIC Designations. The SVO is concerned about this general structure for the following reasons:

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<sup>1</sup> Proposed Definition: A Structured Equity and Fund investment is a note issued by, or equity or limited partnership interest in, a special purpose vehicle, trust, limited liability company, limited partnership, or other legal entity type, as issuer, the contractually promised payments of which are wholly dependent, directly or indirectly, upon payments or distributions from one or more underlying equity or fund investments. The inclusion of an intervening legal entity or entities between the Structured Equity and Fund investment issuer and the underlying equity or fund(s), does not change the risk that the insurer investment is ultimately dependent, in whole or in part, upon an investment in equity or one or more funds and its underlying investments. Any design that circumvents this definition, and related examples, through technical means but which in substance achieves the same ends or poses the same risk, shall be deemed a Structured Equity and Fund.

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- 1) Circumvent Regulatory Guidance - The introduction of an intervening entity as debt issuer, when the underlying investment is in substance an equity investment, circumvents regulatory guidance established by the Valuation of Securities (E) Task Force, the Statutory Accounting Principles (E) Working Group and the Capital Adequacy (E) Task Force for the reporting of equity investments because, according to the P&P Manual (i) equity and fund investments are ineligible to use credit rating provider (CRP) ratings in the assignment of an NAIC Designation and (ii), in the case of funds, only the SVO is tasked with determining whether a fund produces fixed-income like cash flows and is therefore eligible for specific classification.

**All non-SEC registered funds are required to be reported on Schedule BA. Life insurance entities are permitted to file investments in non-SEC registered private equity funds, partnerships, limited liability companies and joint ventures with the SVO for specific classification on Schedule BA;**

- 2) Reliance on Ratings - These investments are being reported as bonds and receiving bond risk-based capital (RBC) factors based upon the mechanical assignment of NAIC Designations that rely upon CRP ratings through the filing exempt process. The use of CRP ratings would not be permitted for the fund or equity investments which underly these notes if the equity or fund investments were held directly;
- 3) RBC / Investment Limit Arbitrage - The structure may permit in-substance equity and fund investments to obtain better RBC treatment than would otherwise be received if the investments had been directly reported. In addition to improved RBC treatment, the structures could permit entities to hold more underlying equity / fund investments than would be permitted under state investment law; and
- 4) Transparency - The structures typically use two or more interconnected private entities through which the privately rated “bond” securities are issued that are backed by investments in non-public assets. The many non-public layers deny regulators, and possibly insurer investors, transparency into the true underlying risks, credit exposure and nature of the investment. The notes issued are described generically as a “senior note” or “term loan” further obscuring their actual structure and complexity. These structures can invest in any asset including affiliate investments, non-fixed income investments, derivatives, borrowings for the purpose of leverage and non-admitted assets.

It is possible that many of the transactions the SVO has processed would not qualify as bonds eligible for Schedule D-1 reporting according to the principles-based bond definition currently being drafted by the Statutory Accounting Principles (E) Working Group, while others likely will qualify. The bond definition requires a review of the substance of the investment to determine whether it has the substance of a bond; significantly, that the ultimate underlying collateral has fixed income cash flows. In either case, however, the use of a fund intermediary has the potential to be abused and requires significant judgment to understand the substance and nature of the ultimate underlying risk. This has already been recognized by the establishment of processes for the SVO to provide NAIC Designations for fixed-income-like funds. It would then follow that debt instruments backed by the types of funds that would ordinarily be required to be filed with the SVO, should follow the same process.

**Informational Referral** – Given the magnitude of the multiple regulatory arbitrage opportunities, the judgment involved in assessing the nature of the ultimate risk, the lack of transparency, circumvention of regulatory guidance and the reliance on CRP ratings to accomplish these ends, the SVO proposed amending the P&P Manual to include a definition for Structured Equity and Fund and to exclude such investments from Filing Exemption eligibility. The proposed amendment would not change how the investment is classified for reporting by the insurer but it would ensure that the NAIC Designation and Category assigned are appropriate for the risk. This is an informational referral and no direct action is required by the Capital Adequacy (E) Task Force, Life Actuarial (A) Task Force or Risk-based Capital Investment Risk and Evaluation (E) Working Group unless those groups wish to comment on the proposal.

Please contact Charles Therriault or Marc Perlman with any questions.

<https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2023/Referrals/To CATF LATF RBCIRE/VOSTF Referral to CATF LATF RBCIRE - Structured Equity and Funds 2022-02-03.docx>

## Economic Scenario Generator Technical Drafting Group Planned Topics, Tentative Timing, and initial Decision Points

### 1) Stochastic Exclusion Ratio Test

**Timeline:** Initially, 2 more meetings tentatively in March-April, to finish covering field test results and discuss decision points below. Subsequently, two additional meetings after the second round of field testing, to discuss SERT field test results, pick a version of the SERT (if multiple were tested), and to determine SERT cutoff (assuming this form of SERT is selected).

#### **SERT Goals:**

- Practically sort products that may have a constraining SR from those that would not have a constraining SR.
- Give reasonably consistent results over time and in different economic environments.

#### **SERT Decision Points:**

1. **Decision Point:** Should the SERT be removed entirely, given that it is duplicative of what could be provided for the certification method? This could include moving the primary SERT outline to the examples for a broadened certification method. With a QA certifying as to the risks, a more judgment-based evaluation of the variability could be performed rather than having a rough cutoff that does not consider the size of the business or the materiality standard.

**Advantage for removal:** The SERT discourages a holistic assessment and discussion of risk that is more appropriate for PBR. It could potentially be replaced with versions of the certification or demonstration method. One suggested alternative was to run a small, representative scenario set (e.g., 50 scenarios) and show it is not constraining compared to the NPR and DR. This is currently allowable under the stochastic exclusion demonstration test option outlined in 6.A.3.b.iii, except that it is left up to the company to determine “a sufficient number of adverse scenarios”.

**Advantage for retaining:** The SERT is often used because it is simple to implement. Following the same approach but as part of a certification method would require additional reporting and may trigger follow-up questions.

2. **Decision Point:** What products are generally expected to pass the SERT, what products are generally expected to fail, and what percentage of the time should this single test be able to accurately sort these accordingly?



**Proposal:** Pass: most Term with 20 year or shorter level period (non-ROP); Fail: most ULSG (unless minimal guarantees); the current SERT appears to fail roughly 10% of the time.

3. **Decision Point:** Do the SERT scenarios need to be at a moderately adverse level?

**Proposal:** No. The SERT is not a set of scenarios that need to be “passed”. They should reasonably assess whether performing an SR and taking a CTE(70) is likely to produce a higher reserve than the DR. Thus, they should assess whether tail scenarios lead to significant increases. They should generally be representative of the tail, but tail results may not be driven by the 85th percentile. Ultimately, the cutoff, which will be calibrated based on the SERT methodology, is what will determine whether products pass or fail the SERT.

4. **Decision Point:** Should the SERT scenarios be derived directly from the stochastic scenario distribution, as Conning has done or modified, or should they be “stylized” scenarios be created that reflect starting conditions and a level of reversion to a mean? Is there an alternative approach?

**Advantages for scenarios based on full scenario set:** Direct relationship for goal #1; avoids disconnect between the test and its effectiveness for the intended purpose of determining whether there would likely be a SR excess over the DR. The intent is for economic scenario generator updates to be more gradual over time now that we have a vendor to maintain the economic scenario generator. Each update would require an evaluation and potential update of the stylized scenarios as well.

**Advantages for scenarios based on stylized set:** Ease of implementation. Being less responsive means being more predictable.

5. **Decision Point:** How do we evaluate the SERT is appropriately calibrated, independent of the additional risk reflected in the new scenarios? That is, what must be included in a subsequent Field Test to calibrate an appropriate cutoff?

**Proposal:** Adequate coverage of different starting conditions, adequate representation of products (Term, ULSG, VULSG, VULnoSG par & non-par WL).

## 2) Deterministic Reserve

**Timeline:** Initially, 2 meetings tentatively in April. Subsequent to the second round of field testing, two meetings to review DR field test results and to select a version of the DR (if multiple were tested) and confirm DR methodology.

### DR Goal:

- Provide a moderately adverse deterministic scenario that will be adequate to capture risk for products that do not have significant interest rate and or equity risk.

### DR Decision Points:

1. **Decision Point:** Should this scenario be linked to the stochastic exclusion ratio test or can it be separate?  
**Proposal:** Separate. The DR must primarily be suitable for the DR goal above.
2. **Decision Point:** Do we agree with the format of the current deterministic scenario (adverse for 20 years, followed by reversion to mean)?  
**Proposal:** Generally yes, but should consider whether the reversion to mean after 20 years particularly impacts specific products, giving less than a moderately adverse result. The focus for DR reserve adequacy should be policies passing the SET, but we should be mindful that it can be constraining for those with an SR as well.
3. **Decision Point:** Is the deterministic reserve scenario methodology used for the first field test appropriate?  
**Proposal:** The DR scenario used may be beyond moderately adverse. While recalibration will impact the DR level, ask Conning to develop a form of DR that is more consistent with the current DR.

### 3) Scenario Picker Tool

**Timeline:** 3 meetings, tentatively in May

#### Scenario Picker Tool Goal:

- Provide scenario subsets that are reasonably representative of the full 10,000 scenario set for policies and/or contracts that are sensitive primarily to interest rates, equities, or both.

#### Scenario Picker Tool Decision Points:

1. **Decision Point:** Should there be a scenario picker that is included as part of the economic scenario generator?  
**Proposal:** Yes.

2. **Decision Point:** Should custom stratifications be allowed, for both VM-20 and VM-21, if the company provides an off-cycle or model office comparison between the subset and full 10,000 to show there is not material understatement or bias?  
**Proposal:** Yes. This may reduce the importance of having a perfect response for items #3-#5 below.
3. **Decision Point:** What size of subsets are needed?  
**Proposal:** 50, 200, 1000, 2000.
4. **Decision Point:** Should there be stratification based on interest rates and/or equity?  
**Proposal:** There should be two or three versions of the scenario picker tool, which stratify scenarios based on interest rate, equity, and/or both.
5. **Decision Point:** For interest rates, what tenor(s) should be used for stratification?  
**Proposal:** This may be a limitation in the current scenario picker tool. Consider multiple metrics based on different tenors.
6. **Decision Point:** What metric should be used for stratification?  
**Proposal:** Evaluate whether the current scenario picker's metric is reasonable, aside from its narrow focus on a specific interest rate tenor.

#### 4) Company-Specific Market Paths (CSMP)

**Timeline:** 1 meeting, tentatively in May

**CSMP Goal:**

- Provide a reasonable alternative to the CTEPA that gives consistent results but is more tractable.

**CSMP Decision Points:**

7. **Decision Point:** Should the CSMP be removed entirely?  
**Proposal:** Not at this time, but we should consider whether a sunset timeline is appropriate depending on current use. The CTEPA is very widely used, provides greater insight into the differences between company and prescribed assumptions, and is more straightforward to implement (although more time-intensive). Note that the NAIC and regulators are looking into obtaining a more exhaustive list of its use, and will recommend to companies using the CSMP that they participate in ACLI and AAA groups related to this effort as well as the Technical DG.

8. **Decision Point:** Should there be any update to the CSMP Market paths?

**Proposal:** Primarily, updates would be designed to ensure that the 40 scenarios are likely to bracket CTE70(Adj). May need to replace the 1 bps floor on interest rates with a negative [25 bps] floor on interest rates, given the update to the economic scenarios to allow for negative interest rates. No other changes to magnitude of initial equity/interest rate shocks or subsequent equity returns. Interest rate paths (VM requires “all random variables in the generator are set to zero across all time periods” with the intention that “interest rates revert to the same long-term mean”) may be determined as Conning has done for SERT scenario #9 from the initial field test (median path), or we can consider whether Conning can more directly calculate the CSMP subsequent interest rate paths.

## 5) Alternative Methodology

**Timeline:** 1 meeting, tentatively in June

### Alternative Methodology Goal:

- Provide a reasonable alternative to stochastic modeling that captures the risk of the guarantee for contracts with GMDBs only. Note that for contracts with no guarantees, the Alternative Methodology simply refers to AG33, so the focus of our consideration is on contracts with GMDBs.

### Alternative Methodology Decision Points:

1. **Decision Point:** Should the Alternative Methodology be removed entirely?  
**Proposal:** Not at this time, but we should consider whether a sunset timeline is appropriate depending on current use. Note that the NAIC and regulators are looking into obtaining a more exhaustive list of its use, and will recommend to companies using the Alternative Methodology that they participate in ACLI and AAA groups related to this effort as well as the Technical DG. One suggested alternative for maintaining the Alternative Methodology was to revert to AG34 with an increased stress for richer GMDBs. In addition, there was a question of whether LATF would look for companies with a material block of “rich” GMDBs to follow full SR modeling. Consider not allowing **new** use of the Alternative Methodology.
2. **Decision Point:** Should there be a significant update to the Alternative Methodology (updating the table of factors)?  
**Proposal:** No. Based on early input from the AAA, an update of the current factor-based approach would be onerous if not impossible. If the equity scenarios materially differ

from the AIRG, can consider a crude adjustment as was previously done for mortality during VA reform if the impact for the Alternative Methodology is also likely material.

3. **Decision Point:** The Alternative Methodology uses the current AIRG in VM-21 Section 7.C.8 when describing “typical” adjustments to F and G for product design variations. Can Section 7.C.8 be removed, as it only outlines a possible approach, and it will be left to the actuary’s judgment how to adjust results for product design variations? Alternately, can the “prescribed scenarios” be replaced with the option to use either CFT scenarios or the updated prescribed (Conning) scenarios rather than the current AIRG (again, since this is an example)?

**Proposal:** Need input on whether this approach is being relied on. If this is not being used, remove for simplicity since it is not a requirement. If it is being used, update with the option to use CFT scenarios or the updated prescribed (Conning) scenarios.

DRAFT

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force  
Amendment Proposal Form\***

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

**Identification:**

PBR Staff of Texas Department of Insurance

**Title of the Issue:**

VM-31 Reporting Issues:

1. Senior Management and Qualified Actuary are distinct, layered reporting roles in VM-G.
  2. Life and VA Reports do not discuss the aggregate impact of approximations and simplifications.
  3. There are three issues in VM-31's scenario generation documentation for VM-21 in 3.F.9:
    - a) In addition to supporting that the number of scenarios is appropriate for the CTE 70 calculation, the company should also support that the number of scenarios is appropriate for the CTE 98 calculation.
    - b) The version of the ESG should be included and the parameters of the scenario generation should be available upon request.
    - c) A section reference needs to be corrected: VM-21 Section 8.G.1 does not exist.
  4. VM-21 is missing consideration of use of a date prior to the valuation date for the SR and the additional standard projection amount, which is inconsistent with the reporting in VM-31 Section 3.F.12.e.
  5. VM-31 should specifically address actual to expected analyses for certain liability assumptions such as expenses, partial withdrawals, annuitizations as well as GMIB/ GMWB utilization.
  6. Refine VM-31 documentation to address mortality improvement requirements in VM-21 Section 11.C and Section 11.D.
  7. The requirement for the projection period in VM-20 Section 7.A.1.d is not correctly reflected in VM-31 Section 3.D.2.f.
2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM-21 Section 3.I (new), VM-31 Section 3.D.2.f, VM-31 Section 3.D.5.f (new), VM-31 Section 3.D.11.k (new – renumber current 3.D.11.k and 3.D.11.l), VM-31 Section 3.D.14.c, VM-31 Section 3.F.2.f (new – renumber current 3.F.2.f and 3.F.2.g), VM-31 Section 3.F.3.k (new), VM-31 Section 3.F.3.i.vii, VM-31 Section 3.F.9, VM-31 Section 3.F.12.e (remove – renumber current Sections from 3.F.12.f to 3.F.12.m), VM-31 Section 3.F.13.e (New), VM-31 Section 3.F.16.c

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

See attached.

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

1. An internal control certification from Senior Management is required by VM-31. It is not appropriate for the qualified actuary to complete the certification for senior management since these two roles have different responsibilities under VM-G, representing distinct layers of reporting and oversight. Senior

management receives reporting from the qualified actuary for principle-based valuation under VM-20 and VM-21.

2. In order to better understand the aggregate impact of approximations and simplifications used by the company, VM-31 Life Report and VA Report should add a new section to discuss it. If regulators were to gain comfortable with documentation of the aggregate impact, then the requirement that each individual approximation or simplification not bias the reserves downward could be revisited. For context, here are the current sections on approximations, simplifications, and modeling efficiency techniques, which only address the individual impacts.

**VM-31 Section 3.D.11.j**

*j. Approximations, Simplifications, and Modeling Efficiency Techniques – A description of each approximation, simplification or modeling efficiency technique used in reserve calculations, and a statement that the required VM-20 Section 2.G demonstration is available upon request and shows that: 1) the use of each approximation, simplification, or modeling efficiency technique does not understate the reserve by a material amount; and 2) the expected value of the reserve is not less than the expected value of the reserve calculated that does not use the approximation, simplification, or modeling efficiency technique.*

**VM-31 Section 3.F.2.e**

*e. Approximations, Simplifications, and Modeling Efficiency Techniques – A description of each approximation, simplification or modeling efficiency technique used in reserve or TAR calculations, and a statement that the required VM-21 Section 3.H demonstration is available upon request and shows that: 1) the use of each approximation, simplification, or modeling efficiency technique does not understate TAR by a material amount; and 2) the expected value of TAR is not less than the expected value of TAR calculated without using the approximation, simplification, or modeling efficiency technique.*

If discussions of the aggregate impact of approximations, simplifications, and modeling efficiency techniques were included, then there could be a future consideration of the removal of the requirement in VM-20 Section 2.G and VM-21 Section 3.H that approximations, simplifications, and modeling efficiency techniques not bias the reserve downward.

3. For VA, support should also be provided for the number of scenarios used for the C-3 RBC calculation based on CTE 98. For VA, the version of ESG should be included. Correct section reference.
4. VM-21 is missing consideration of use of a date prior to the valuation date for the additional standard projection amount, whereas VM-31 Section 3.F.12.e implies that the intent was for VM-21 to have such a consideration or allowance. VM-20 explicitly addresses such a consideration in VM-20 Section 2.E, and we use that language as a starting point for VM-21.

**VM-20 Section 2.E**

*The company may calculate the DR and the SR as of a date no earlier than three months before the valuation date, using relevant company data, provided an appropriate method is used to adjust those reserves to the valuation date. Company data used for experience studies to determine prudent estimate assumptions are not subject to this three-month limitation.*

5. In order for regulator reviewers to be able to better understand and evaluate a company's liability assumptions for expenses, partial withdrawals, annuitizations, as well as GMIB and GMWB utilization, a comparison of actual to expected should specifically be referenced in VM-31. We have used the

language for actual to expected policyholder behavior analysis in VM-31 Section 3.D.4.c (Life Report) as a format for a general A/E request.

**VM-31 Section 3.D.4.c**

*Actual to Expected Policyholder Behavior Analysis – The results of the most recently available actual to expected (without margins) analysis, including:*

- i. Definitions of the expected basis used in all actual-to-expected ratios shown.*
- ii. Comments addressing the conclusions drawn from the analysis.*

- 6. Adding documentation to confirm that the company has applied historical and future mortality improvement when it would result in an increase in the stochastic reserve as required by VM-21 Section 11.C and Section 11.D.
- 7. The language in VM-31 should be modified to correctly require reporting on VM-20’s requirement for the projection period. For reference, here is the relative passage of VM-20:

**VM-20 Section 7.A.1.d:**

*Projects cash flows for a period that extends far enough into the future so that no obligations remain.*

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

NAIC Staff Comments:

<b>Dates: Received</b>	<b>Reviewed by Staff</b>	<b>Distributed</b>	<b>Considered</b>
11/15/2022, revised 1/30/23	SO		
<b>Notes:</b> APF 2022-09			

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**VM-31 Section 3.D.14.c:**

c. Senior Management on Internal Controls – A certification from senior management, other than the qualified actuary, regarding the effectiveness of internal controls with respect to the principle-based valuation under VM-20, as provided in Section 12B(2) of Model #820.

**VM-31 Section 3.F.16.c:**

c. Senior Management on Internal Controls – A certification from senior management, other than the qualified actuary, regarding the effectiveness of internal controls with respect to the principle-based valuation under VM-21, as provided in Section 12B(2) of Model #820.

**VM-31 Section 3.D.11.k (new – renumber current 3.D.11.k and 3.D.11.l):**

k. Aggregate Impact of Approximations, Simplifications and Modeling Efficiency Techniques – Support that the aggregate impact of approximations and simplifications does not result in a material understatement of the reserve. This should include consideration of not just the magnitude of the sum of the individual impacts when considered in isolation, but also consideration of any potential interaction of approximations, simplifications, and modeling efficiency techniques.

**VM-31 Section 3.F.2.f (new– renumber current 3.F.2.f and 3.F.2.g):**

f. Aggregate Impact of Approximations, Simplifications and Modeling Efficiency Techniques – Support that the aggregate impact of approximations and simplifications does not result in a material understatement of TAR. This should include consideration of not just the magnitude of the sum of the individual impacts when considered in isolation, but also consideration of any potential interaction of approximations, simplifications, and modeling efficiency techniques.

**VM-31 Section 3.F.9:**

9. Scenario Generation – The following information regarding the scenario generation for interest rates and equity returns used by the company in performing a principle-based valuation under VM-21 and in determining the C-3 RBC amount under LR027, as it applies to the calculation of the SR, TAR and CTEPA (if used):

- a. Sources – Identification of the sources or generators used to produce the scenarios. Versions should be identified and parameters to the scenario generation shall be available upon request.
- b. Number of Scenarios – Number of scenarios used, rationale for that number, methods used to determine the sampling error of the CTE 70 and CTE 98 statistic when using the selected number of scenarios, and documentation that any resulting understatement in reserve or TAR, as compared with that resulting from running additional scenarios, is not material, as discussed in VM-21 Section 8.F.
- c. Scenario Reduction Techniques – If a scenario reduction technique is used, a description of the technique and documentation of how the company determined that the technique does not lead to a material understatement of results.
- d. Time-Step – Identification of the time-step of the model (e.g., monthly, quarterly, annual), and results of testing performed to determine that use of a more frequent time-step does not materially increase reserves, as discussed in VM-21 Section ~~8.G.14.F.1~~.

**VM-21 Section 3.I (New):**

The company may calculate the SR and the additional standard projection amount as of a date no earlier than three months before the valuation date, using relevant company data, provided an appropriate method is used to adjust

those amounts to the valuation date. Company data used for experience studies to determine prudent estimate assumptions are not subject to this three-month limitation.

**VM-31 Section 3.F.12.e (remove – renumber current Sections from 3.F.12.f to 3.F.12.m):**

Prior Date – If the additional standard projection amount was developed as of a date prior to the valuation date, disclosure of the prior date, the additional standard projection amount of the in force on the prior date, and an explanation of why the use of such a date will not produce a material change in the results compared to if the results were based on the valuation date. Such an explanation shall describe the process that the qualified actuary used to determine the adjustment, the amount of the adjustment, and the rationale for why the adjustment is appropriate.

**VM-31 Section 3.F.13.e (New):**

Calculations as of a Date Preceding the Valuation Date – If the SR and/or the additional standard projection amount were developed as of a date prior to the valuation date, disclosure of the prior date, the SR and the additional standard projection amount of the in force on the prior date, and an explanation of why the use of such a date will not produce a material change in the results compared to if the results were based on the valuation date. Such an explanation shall describe the process that the qualified actuary used to determine the adjustment required by VM-21 Section 3.I, the amount of the adjustment, and the rationale for why the adjustment is appropriate.

**VM-31 Section 3.D.5.f (New):**

5. Expenses – The following information regarding the expense assumptions used by the company in performing a principle-based valuation under VM-20:

f. Actual to Expected Analysis – The results of the most recently available actual to expected (without margins) analysis, including:

- i. Definitions of the expected basis used in all actual-to-expected ratios shown.
- ii. Comments addressing the conclusions drawn from the analysis.

**VM-31 Section 3.F.3.k (New – renumber current section 3.F.3.k):**

k. Actual to Expected Analysis – Disclosure of the results of the most recently available actual to expected (without margins) analysis for the assumptions including 3.F.3.d Expenses Other than Commissions, 3.F.3.e Partial Withdrawals, 3.F.3.g Annuitization Benefits and 3.F.3.h GMIB and GMWB Utilizations, including:

- i. Definitions of the expected basis used in all actual-to-expected ratios shown.
- ii. Comments addressing the conclusions drawn from the analysis.

**VM-31 Section 3.F.3.i.vii:**

Discussion of any assumptions made on mortality improvements both for applying up to and beyond the valuation date (if applicable), the support for such assumptions, and how such assumptions adjusted the modeled mortality. In a case where mortality improvement as discussed in VM-21 Section 11.C and Section 11.D has not been applied, confirmation that applying such improvement would not result in an increase in the SR.

**VM-31 Section 3.D.2.f:**

Projection Period – Disclosure of the length of projection period and comments addressing the conclusion that ~~no material amount of business remains at the end of the projection period~~ the projection of cash flows extends far enough into the future that no obligations remain for both the deterministic and stochastic models.

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force  
 Amendment Proposal Form\***

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

**Identification:**

PBR Staff of Texas Department of Insurance

**Title of the Issue:**

Companies appear unclear how to support the requirement that “company experience mortality rates shall not be lower than the mortality rates the company expects to emerge” in PBR Actuarial Report under VM-31 Section 3.D.3.1.iv.

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

VM-31 Section 3.D.3.1.iv

January 1, 2023 NAIC *Valuation Manual*

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

See attached.

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

We have observed a consistent issue, where there is not adequate support showing compliance with the requirement that “the company experience mortality rates shall not be lower than the mortality rates the company expects to emerge”. The most commonly provided support is a retrospective quantitative analysis (e.g., the actual to expected analysis), without any further discussion of the mortality rates that the company expects to emerge. The intention of this requirement is to discuss any forward-looking qualitative analysis, rather than just a historical quantitative analysis. The disclosure shall include, but is not limited to, the discussion of underwriting standard changes (or the lack thereof), distribution channel changes (or the lack thereof), any pandemic adjustments (or the lack thereof), and the results of ongoing experience monitoring.

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

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
2/24/23	SO		
Notes: APF 2023-04			

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**VM-31 Section 3.D.3.I.iv**

Description and justification of the mortality rates the company actually expects to emerge, and a demonstration that the anticipated experience assumptions are no lower than the mortality rates that are actually expected to emerge. The description and demonstration should include the level of granularity at which the comparison is made (e.g., ordinary life, term only, preferred term, etc.). For the mortality rates that are actually expected to emerge, the description should include a forward-looking qualitative analysis which includes, but is not limited to, the discussion of any underwriting standard changes (or lack thereof), distribution channel changes (or lack thereof), any pandemic adjustments (or lack thereof), and the results of ongoing experience monitoring.

Draft: 3/7/23

Life Actuarial (A) Task Force  
Virtual Meeting  
February 23, 2023

The Life Actuarial (A) Task Force met Feb. 23, 2023. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill and Chonlada Pongpipattanachai (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Lori K. Wing-Heier represented by Sharon Comstock (AK); Ricardo Lara represented by Ahmad Kamil and Elaine Lam (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Vicki Schmidt represented by Nicole Boyd (KS); Timothy N. Schott represented by Marti Hooper (ME); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello (NY); Judith L. French represented by Peter Weber (OH); Michael Humphreys represented by Steve Boston (PA); Jon Pike represented by Tomasz Serbinowski (UT); and Allan L. McVey represented by Tim Sigman (WV).

1. Reported it Met Feb. 9 in Regulator-to-Regulator Session

Hemphill said that the Task Force met Feb. 9 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings. Hemphill stated that Scott O’Neal (NAIC) provided the Task Force with technical guidance related to the economic scenario generator (ESG) corporate model and that state insurance regulators had a robust discussion of the American Academy of Actuaries’ (Academy’s) simplified corporate model and proposed acceptance criteria. Hemphill further said that regulators have two takeaways from the meeting: 1) they would like to understand the materiality of the difference between the results of the Academy’s simplified corporate model and the Conning corporate model; and 2) they want to know more about any issues with incomplete documentation and/or lack of transparency for both the Academy and Conning corporate models.

2. Adopted its 2022 Fall National Meeting Minutes

Chupp made a motion, seconded by Yanacheak, to adopt the Task Force’s Dec. 11–12, 2022, minutes (*see NAIC Proceedings – Fall 2022, Life Actuarial (A) Task Force*). The motion passed unanimously.

3. Exposed the Proposed Charges for the Proposed Economic Scenarios (E/A) Subgroup

Hemphill said that the Economic Scenario Generator Governance Drafting Group held discussions where it became clear that there was a need for a joint subgroup of the Task Force and the Life Risk-Based Capital (E) Working Group to support the implementation of the ESG and take on a governance role. Hemphill then walked through the proposed charges for the Economic Scenarios (E/A) Subgroup.

Yanacheak made a motion, seconded by Slutsker, to expose the proposed charges (Attachment Two-A) for the Economic Scenarios (E/A) Subgroup for a 21-day public comment period ending Mar 15. The motion passed unanimously.

4. Adopted APF 2022-10

Hemphill noted that the Task Force received a comment letter (Attachment Two-B) from the American Council of Life Insurers (ACLI) that noted support for both amendment proposal form (APF) 2022-10 and APF 2023-02.

Slutsker made a motion, seconded by Chupp to adopt APF 2022-10 (Attachment Two-C). The motion passed unanimously.

5. Adopted APF 2023-02

Lam made a motion, seconded by Chupp, to adopt APF 2023-02 (Attachment Two-D). The motion passed unanimously.

6. Exposed APF 2023-01

Slutsker made a motion, seconded by Leung, to deem APF 2023-01 (Attachment Two-E) non-substantive and expose it for a seven-day public comment period ending March 9. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/ 2023-1-Spring/LATF Calls/02 23/Feb 23 Minutes.docx

The **Economic Scenarios (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.



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February 22, 2023

Rachel Hemphill  
Chair, NAIC Life Actuarial (A) Task Force (LATF)

Re: Exposed APFs from the February 2, 2023, LATF Meeting

Dear Ms. Hemphill:

The American Council of Life Insurers (ACLI) is appreciative of the opportunity to comment on several of the APFs that were exposed by LATF during their meeting on February 2, 2023. This includes APF 2022-09 (VM-31 Reporting Issues), APF 2022-10 (UL with Non-material Secondary Guarantee and IUL NPR), and APF 2023-02 (Supplement Reporting and Reconciliation).

ACLI is supportive of the changes proposed within these APFs and would welcome their adoption at a future LATF meeting.

We will need additional time for our comments on APF 2023-03 but will aim to have responses on items 3 and 4 in that APF by the NAIC Spring Meeting materials cutoff. Additional feedback on items 1 and 2 will be provided as soon as feasible.

We look forward to the discussion at a future LATF meeting. Thank you.

A handwritten signature in cursive script that reads 'B Bayerle'.

A handwritten signature in cursive script that reads 'Colin Masterson'.

cc: Scott O'Neal, NAIC

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133

The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

[acli.com](http://acli.com)



**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force  
 Amendment Proposal Form\***

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

Ben Slutsker, Minnesota Department of Commerce  
 Elaine Lam and Thomas Reedy, California Department of Insurance

Some policies in the ULSG Reserving Category may have a non-material secondary guarantee. This makes them eligible to be excluded from both DR and SR calculations if they pass both the DET and the SET. Currently, the language in VM-20 Section 2.A.2 does not address this possibility, and thus does not clearly state the requirement for those policies. Furthermore, aspects of the NPR calculation may have been unclear for certain indexed universal life policies that pass exclusion tests.

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

Valuation Manual (January 1, 2023 edition), VM-20 Section 2.A.2, Section 3.B.5, and Section 3.B.6

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

See attached.

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

The purpose of this APF is to add language to address the possibility of policies in the ULSG Reserving Category having a non-material secondary guarantee, and thus becoming excluded from both DR and SR calculations if they pass both the DET and the SET. The new proposed subsection within VM-20 Section 2.A.2 clarifies the total minimum reserve calculation for these policies. The new proposed Guidance Note immediately following the new proposed subsection clarifies when the subsection applies, which is only in cases of UL policies with non-material SGs. In addition, edits are proposed to Section 3.B.5 and 3.B.6 of VM-20 to have the NPR on indexed universal life policies that pass both exclusion tests follow VM-A and VM-C calculations.

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

**NAIC Staff Comments:**

<b>Dates:</b> Received	Reviewed by Staff	Distributed	Considered
<u>12/1/2022</u>	<u>SO</u>		
<b>Notes:</b> <u>APF 2022-10</u>			

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New proposed language is in redline below:

**VM-20 Section 2.A.2**

2. ULSG Reserving Category — All policies and riders belonging to the ULSG Reserving Category are to be included in Section 2.A.2.~~c~~<sup>b</sup> unless the company has elected to exclude a group of them from the SR calculation or both the DR and SR calculations and has applied the ~~SET~~applicable exclusion test(s) defined in Section 6, passed the test(s) and documented the results.

a. For the group of policies and riders for which the company did not compute the DR nor the SR: the sum of the policy minimum NPRs for those policies.

**Guidance Note:** This may be applicable for a group of ULSG policies that meet the definition of a “non-material secondary guarantee” and passes both the DET and the SET.

~~a~~.b. For the group of policies and riders for which the company did not compute the SR: the sum of the policy minimum NPRs for those policies plus the excess, if any, of the DR for those policies determined pursuant to Section 4 over the quantity (A–B), where A = the sum of the policy minimum NPRs for those policies, and B = any due and deferred premium asset held on account of those policies.

~~b~~.c. For the group of policies and riders for which the company computes all three reserve calculations: the sum of the policy minimum NPRs for those policies plus the excess, if any, of the greater of the DR for those policies determined pursuant to Section 4 and the SR for those policies determined pursuant to Section 5 over the quantity (A–B), where A = the sum of the policy minimum NPRs for those policies, and B = any due and deferred premium asset held on account of those policies.

~~e~~.d. The due and deferred premium asset, if any, shall be based on the valuation net premiums computed in accordance with Section 3.B.5.d, for the base policy, determined without regard to any NPR floor amount from Section 3.D.2.

**VM-20 Section 3.B.5**

5. For all policies and riders within the ULSG Reserving Category, other than indexed universal life policies for which the company did not compute the DR nor the SR, the NPR shall be determined as follows:

a. If the policy duration on the valuation date is prior to the point when all secondary guarantee periods have expired, the NPR shall be the greater of the reserve amount determined in Section 3.B.5.c and the reserve amount determined in Section 3.B.5.d, subject to the floors specified in Section 3.D.2.

...

**VM-20 Section 3.B.6**

6. For all policies and riders within the All Other VM-20 Reserving Category, as well as indexed universal life policies for which the company did not compute the DR nor the SR, the NPR shall be determined pursuant to applicable methods in VM-A and VM-C for the basic reserve. The mortality tables to be used are those defined in Section 3.C.1 and in VM-M Section 1.H.

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force  
 Amendment Proposal Form\***

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

**Identification:**

Elaine Lam, Office of PBR, California Department of Insurance (CDI)

**Title of Issue:**

Proposal to add disclosure requirements in VM-31, and clarify language in the Annual Statement Instructions related to reporting in the VM-20 Reserves Supplement.

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

Valuation Manual (January 1, 2023 edition) – Proposal to add new section as VM-31 Section 3.C.11

2022 Annual Statement Instructions – Proposal to add a sentence to the instructions for “VM-20 Reserves Supplement”, starting on page 807

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

See attached.

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

1. Add disclosure requirements in VM-31 for the Company to reconcile reported values and explain differences (if any) between reported values in the VM-31 Report (High-Level Results section), in the VM-20 Reserves Supplement (Parts 1A and 1B), and in the Annual Statement (Exhibit 3 for Separate Account values, Exhibit 5 for General Account values, and any other). Regulators have found inconsistencies in the values reported in the different locations. Moreover, without these disclosures, regulators have had a difficult time reconciling values and checking for misreported values.

2. Make a referral to the Blanks (E) Working Group to update the Annual Statement Instructions for the VM-20 Reserves Supplement to clarify that separate account amounts should be included in the Supplement. There has been inconsistent reporting by companies because the current instructions do not specifically address the treatment of separate account amounts.

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

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
<u>1/29/23</u>	<u>SO</u>		
<b>Notes:</b> <u>APF 2023-02</u>			

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New proposed language in the *Valuation Manual* is in redline below:

**(new section)**

**VM-31 Section 3.C.11**

11. Reconciliation of Reported Values – A reconciliation of reported values and an explanation of differences, if any, between reported values in Section 3.B.5 (High-Level Results), in the VM-20 Reserves Supplement – Part 1A and Part 1B, and in the Annual Statement (Exhibit 3 for Separate Account values, Exhibit 5 for General Account values, and any other).

For referral to the Blanks (E) Working Group, new proposed language in the Annual Statement Instructions is in redline below:

**VM-20 RESERVES SUPPLEMENT**

**Life Insurance Reserves Valued According to VM-20 by Product Type**

This Supplement provides information on the reserves required to be calculated by Section VM-20 of the *Valuation Manual*. This includes the Net Premium Reserve and, as applicable, the Deterministic Reserve and the Stochastic Reserve. Only business issued on or after Jan. 1, 2017, valued by the requirements of VM-20 should be reported in Part 1A and Part 1B. Part 1A and Part 1B are intended to aid regulators in the analysis of reserves as determined under Section VM-20 of the *Valuation Manual* for both the prior and current year.

This Supplement also provides information regarding business where VM-20 of the *Valuation Manual* is not required to be applied. Companies exempted from the requirements of Section VM-20 are not required to complete Part 1A or Part 1B of this Supplement but must complete Part 2 or Part 3 as applicable.

**VM-20 RESERVES SUPPLEMENT – PART 1A**

**Life Insurance Reserves Valued According to VM-20 by Product Type**

Part 1A of this Supplement breaks out, by product type, the prior year and current year reported reserves on a Post-Reinsurance-Ceded and Pre-Reinsurance-Ceded basis as defined in Section 8.D of Section VM-20 of the *Valuation Manual*. The Due and Deferred Premium Asset for the current year is also shown.

Section VM-20 of the *Valuation Manual* requires that the Post-Reinsurance-Ceded Reserve be determined by three VM-20 Reserving Categories: Term Insurance, Universal Life with Secondary Guarantees (ULSG) and all other. Term Insurance should be reported on line 1.1. ULSG, including Variable Universal Life with a secondary guarantee, Indexed life insurance with a secondary guarantee, regular Universal Life with a secondary guarantee, and ULSG policies with a non-material secondary guarantee as defined in Section VM-01 of the *Valuation Manual*, should be reported on line 1.2. Each of the other products reported in lines 1.3 – 1.8 should be determined as the sum of the policy reserves using the policy reserves determined following the allocation process of VM-20 Section 2. A similar process should be used for each of the pre-reinsurance-ceded reserves. Both Post-Reinsurance-Ceded Reserves and Pre-Reinsurance-Ceded Reserves, as defined in VM-20, include separate account amounts where applicable to the policies in scope.

**Columns 1 & 2 – Reported Reserve**

Provide the reported reserve, in whole dollars, for the prior year and current year for each line item. Post-Reinsurance-Ceded is net of reinsurance ceded. Pre-Reinsurance-Ceded should be prior to any reinsurance ceded and include reinsurance assumed. Sections 2 and 8 in the *Valuation Manual* further describe the required reserve and treatment of reinsurance. The reported reserve for the current year should reflect all policies in force as of the end of the current year. The reported reserve for the prior year should reflect all policies in force as of the end of the prior year.

Etc...

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force  
 Amendment Proposal Form\***

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

**Identification:**

PBR Staff of Texas Department of Insurance

**Title of the Issue:**

The values of the starting assets defined in the two sentences in VM-21 Section 4.D.1.a are not identical.

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

VM-21 Section 4.D.1.a in January 1, 2023 NAIC Valuation Manual

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

1. Starting Asset Amount

a. For the projections of accumulated deficiencies, the value of assets at the start of the projection shall be set equal to the approximate value of statutory reserves at the start of the projection plus the allocated amount of PIMR attributable to the assets selected. Assets shall be valued consistently with their annual statement values. The amount of such asset values shall equal the sum of the following items plus the allocated amount of PIMR attributable to the assets selected, all as of the start of the projection:

- i. All of the separate account assets supporting the contracts;
- ii. Any hedge instruments held in support of the contracts being valued; and
- iii. An amount of assets held in the general account equal to the approximate value of statutory reserves as of the start of the projections less the amount in (i) and (ii).

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

The edit is necessary to have the identical value of the assets at the start of the projection as in the first sentence (i.e., For the projections of accumulated deficiencies, the value of assets at the start of the projection shall be set equal to the approximate value of statutory reserves at the start of the projection **plus the allocated amount of PIMR attributable to the assets selected**).

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

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
1/9/23, 2/7/23	SO		
<b>Notes:</b> APF 2023-01			

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Draft: 3/7/23

Life Actuarial (A) Task Force  
Virtual Meeting  
February 2, 2023

The Life Actuarial (A) Task Force met Feb. 2, 2023. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill and Iris Huang (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Lori Wing-Heier represented by Sharon Comstock (AK), Ricardo Lara represented by Ahmad Kamil and Elaine Lam (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Timothy N. Schott represented by Marti Hooper (ME); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Steve Boston (PA); Jon Pike represented by Tomasz Serbinowski (UT).

1. Exposed APF 2022-09

Huang noted that amendment proposal form (APF) 2022-09 covers a series of VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation, issues. Chupp asked how the support required in the proposed new VM-31 Section 3.D.11.k would differ from the current requirement for a demonstration available on request that the impact of each approximation and/or simplification does not materially understate the reserves. Hemphill replied that the new VM-31 Section 3.D.11.k would require a holistic discussion of the simplifications, and interactions between simplifications, and why they would not materially understate or bias the reserve downwards in aggregate, whereas the current demonstration for each individual simplification that is available upon request requires a rigorous analysis with quantitative support. Chupp then also mentioned a drafting error he found after reviewing APF 2022-09.

Slutsker made a motion, seconded by Yanacheak, to expose APF 2022-09 with a correction of the drafting error (Attachment Three-A) for a 21-day public comment period ending Feb. 22. The motion passed unanimously.

2. Exposed APF 2022-10

Slutsker introduced APF 2022-10, noting that it clarifies the VM-20, Requirements for Principle-Based Reserves for Life Products, valuation requirements for universal life with secondary guarantee (ULSG) policies with a non-material secondary guarantee and indexed universal life policies that pass exclusion tests.

Slutsker made a motion, seconded by Chupp, to expose APF 2022-10 (Attachment Three-B) for a 21-day public comment period ending Feb. 22. The motion passed unanimously.

3. Exposed APF 2023-02

Lam said that the purpose of APF 2023-02 is to add additional disclosure requirements to VM-31 to reconcile reported values to the Annual Statement and to make a referral to the Blanks (E) Working Group to update the instructions for the VM-20 Reserves Supplement.

Lam made a motion, seconded by Chupp, to expose APF 2023-02 (Attachment Three-C) for a 21-day public comment period ending Feb. 22. The motion passed unanimously.

#### 4. Exposed APF 2023-03

Hemphill walked through the series of clean-up items in APF 2023-03 for VM-20; VM-21, Requirements for Principle-Based Reserves for Variable Annuities; and VM-31. Hemphill noted that the change to the net premium reserve (NPR) formula in VM-20 Section 3.B.5.c.ii.4 would not generally be expected to result in material changes to the NPR calculation.

Slutsker made a motion, seconded by Weber, to expose APF 2023-03 (Attachment Three-D) for a 21-day public comment period ending Feb. 22. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/ 2023-1-Spring/LATF Calls/02 02/Feb 2 Minutes.docx

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force  
Amendment Proposal Form\***

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

**Identification:**

PBR Staff of Texas Department of Insurance

**Title of the Issue:**

VM-31 Reporting Issues:

1. Senior Management and Qualified Actuary are distinct, layered reporting roles in VM-G.
2. Life and VA Reports do not discuss the aggregate impact of approximations and simplifications.
3. There are three issues in VM-31's scenario generation documentation for VM-21 in 3.F.9:
  - a) In addition to supporting that the number of scenarios is appropriate for the CTE 70 calculation, the company should also support that the number of scenarios is appropriate for the CTE 98 calculation.
  - b) The version of the ESG should be included and the parameters of the scenario generation should be available upon request.
  - c) A section reference needs to be corrected: VM-21 Section 8.G.1 does not exist.
4. VM-21 is missing consideration of use of a date prior to the valuation date for the SR and the additional standard projection amount, which is inconsistent with the reporting in VM-31 Section 3.F.12.e.
5. VM-31 should specifically address actual to expected analyses for certain liability assumptions such as expenses, partial withdrawals, annuitizations as well as GMIB/ GMWB utilization.
6. Refine VM-31 documentation to address mortality improvement requirements in VM-21 Section 11.C and Section 11.D.
7. The requirement for the projection period in VM-20 Section 7.A.1.d is not correctly reflected in VM-31 Section 3.D.2.f.

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

VM-21 Section 3.I (new), VM-31 Section 3.D.2.f, VM-31 Section 3.D.5.f (new), VM-31 Section 3.D.11.k (new – renumber current 3.D.11.k and 3.D.11.l), VM-31 Section 3.D.14.c, VM-31 Section 3.F.2.f (new – renumber current 3.F.2.f and 3.F.2.g), VM-31 Section 3.F.3.k (new), VM-31 Section 3.F.3.i.vii, VM-31 Section 3.F.9, VM-31 Section 3.F.12.e (remove – renumber current Sections from 3.F.12.f to 3.F.12.m), VM-31 Section 3.F.13.e (New), VM-31 Section 3.F.16.c

January 1, 2023 NAIC *Valuation Manual*

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

See attached.

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

1. An internal control certification from Senior Management is required by VM-31. It is not appropriate for the qualified actuary to complete the certification for senior management since these two roles have different responsibilities under VM-G, representing distinct layers of reporting and oversight. Senior



management receives reporting from the qualified actuary for principle-based valuation under VM-20 and VM-21.

2. In order to better understand the aggregate impact of approximations and simplifications used by the company, VM-31 Life Report and VA Report should add a new section to discuss it. If regulators were to gain comfortable with documentation of the aggregate impact, then the requirement that each individual approximation or simplification not bias the reserves downward could be revisited. For context, here are the current sections on approximations, simplifications, and modeling efficiency techniques, which only address the individual impacts.

**VM-31 Section 3.D.11.j**

*j. Approximations, Simplifications, and Modeling Efficiency Techniques – A description of each approximation, simplification or modeling efficiency technique used in reserve calculations, and a statement that the required VM-20 Section 2.G demonstration is available upon request and shows that: 1) the use of each approximation, simplification, or modeling efficiency technique does not understate the reserve by a material amount; and 2) the expected value of the reserve is not less than the expected value of the reserve calculated that does not use the approximation, simplification, or modeling efficiency technique.*

**VM-31 Section 3.F.2.e**

*e. Approximations, Simplifications, and Modeling Efficiency Techniques – A description of each approximation, simplification or modeling efficiency technique used in reserve or TAR calculations, and a statement that the required VM-21 Section 3.H demonstration is available upon request and shows that: 1) the use of each approximation, simplification, or modeling efficiency technique does not understate TAR by a material amount; and 2) the expected value of TAR is not less than the expected value of TAR calculated without using the approximation, simplification, or modeling efficiency technique.*

If discussions of the aggregate impact of approximations, simplifications, and modeling efficiency techniques were included, then there could be a future consideration of the removal of the requirement in VM-20 Section 2.G and VM-21 Section 3.H that approximations, simplifications, and modeling efficiency techniques not bias the reserve downward.

3. For VA, support should also be provided for the number of scenarios used for the C-3 RBC calculation based on CTE 98. For VA, the version of ESG should be included. Correct section reference.
4. VM-21 is missing consideration of use of a date prior to the valuation date for the additional standard projection amount, whereas VM-31 Section 3.F.12.e implies that the intent was for VM-21 to have such a consideration or allowance. VM-20 explicitly addresses such a consideration in VM-20 Section 2.E, and we use that language as a starting point for VM-21.

**VM-20 Section 2.E**

*The company may calculate the DR and the SR as of a date no earlier than three months before the valuation date, using relevant company data, provided an appropriate method is used to adjust those reserves to the valuation date. Company data used for experience studies to determine prudent estimate assumptions are not subject to this three-month limitation.*

5. In order for regulator reviewers to be able to better understand and evaluate a company's liability assumptions for expenses, partial withdrawals, annuitizations, as well as GMIB and GMWB utilization, a comparison of actual to expected should specifically be referenced in VM-31. We have used the

language for actual to expected policyholder behavior analysis in VM-31 Section 3.D.4.c (Life Report) as a format for a general A/E request.

**VM-31 Section 3.D.4.c**

*Actual to Expected Policyholder Behavior Analysis – The results of the most recently available actual to expected (without margins) analysis, including:*

- i. Definitions of the expected basis used in all actual-to-expected ratios shown.*
- ii. Comments addressing the conclusions drawn from the analysis.*

6. Adding documentation to confirm that the company has applied historical and future mortality improvement when it would result in an increase in the stochastic reserve as required by VM-21 Section 11.C and Section 11.D.
7. The language in VM-31 should be modified to correctly require reporting on VM-20’s requirement for the projection period. For reference, here is the relative passage of VM-20:

**VM-20 Section 7.A.1.d:**

*Projects cash flows for a period that extends far enough into the future so that no obligations remain.*

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

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
11/15/2022, revised 1/30/23	SO		
Notes: APF 2022-09			

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**VM-31 Section 3.D.14.c:**

c. Senior Management on Internal Controls – A certification from senior management, other than the qualified actuary, regarding the effectiveness of internal controls with respect to the principle-based valuation under VM-20, as provided in Section 12B(2) of Model #820.

**VM-31 Section 3.F.16.c:**

c. Senior Management on Internal Controls – A certification from senior management, other than the qualified actuary, regarding the effectiveness of internal controls with respect to the principle-based valuation under VM-21, as provided in Section 12B(2) of Model #820.

**VM-31 Section 3.D.11.k (new – renumber current 3.D.11.k and 3.D.11.l):**

k. Aggregate Impact of Approximations, Simplifications and Modeling Efficiency Techniques – Support that the aggregate impact of approximations and simplifications does not result in a material understatement of the reserve. This should include consideration of not just the magnitude of the sum of the individual impacts when considered in isolation, but also consideration of any potential interaction of approximations, simplifications, and modeling efficiency techniques.

**VM-31 Section 3.F.2.f (new– renumber current 3.F.2.f and 3.F.2.g):**

f. Aggregate Impact of Approximations, Simplifications and Modeling Efficiency Techniques – Support that the aggregate impact of approximations and simplifications does not result in a material understatement of TAR. This should include consideration of not just the magnitude of the sum of the individual impacts when considered in isolation, but also consideration of any potential interaction of approximations, simplifications, and modeling efficiency techniques.

**VM-31 Section 3.F.9:**

9. Scenario Generation – The following information regarding the scenario generation for interest rates and equity returns used by the company in performing a principle-based valuation under VM-21 and in determining the C-3 RBC amount under LR027, as it applies to the calculation of the SR, TAR and CTEPA (if used):

- a. Sources – Identification of the sources or generators used to produce the scenarios.  
Versions should be identified and parameters to the scenario generation shall be available upon request.
- b. Number of Scenarios – Number of scenarios used, rationale for that number, methods used to determine the sampling error of the CTE 70 and CTE 98 statistic when using the selected number of scenarios, and documentation that any resulting understatement in reserve or TAR, as compared with that resulting from running additional scenarios, is not material, as discussed in VM-21 Section 8.F.
- c. Scenario Reduction Techniques – If a scenario reduction technique is used, a description of the technique and documentation of how the company determined that the technique does not lead to a material understatement of results.
- d. Time-Step – Identification of the time-step of the model (e.g., monthly, quarterly, annual), and results of testing performed to determine that use of a more frequent time-step does not materially increase reserves, as discussed in VM-21 Section 4.F.1.

Deleted: 8.G.1

**VM-21 Section 3.I (New):**

The company may calculate the SR and the additional standard projection amount as of a date no earlier than three months before the valuation date, using relevant company data, provided an appropriate method is used to adjust

those amounts to the valuation date. Company data used for experience studies to determine prudent estimate assumptions are not subject to this three-month limitation.

**VM-31 Section 3.F.12.e (remove – renumber current Sections from 3.F.12.f to 3.F.12.m):**

**VM-31 Section 3.F.13.e (New):**

Calculations as of a Date Preceding the Valuation Date – If the SR and/or the additional standard projection amount were developed as of a date prior to the valuation date, disclosure of the prior date, the SR and the additional standard projection amount of the in force on the prior date, and an explanation of why the use of such a date will not produce a material change in the results compared to if the results were based on the valuation date. Such an explanation shall describe the process that the qualified actuary used to determine the adjustment required by VM-21 Section 3.I, the amount of the adjustment, and the rationale for why the adjustment is appropriate.

**Deleted: Prior Date** – If the additional standard projection amount was developed as of a date prior to the valuation date, disclosure of the prior date, the additional standard projection amount of the in force on the prior date, and an explanation of why the use of such a date will not produce a material change in the results compared to if the results were based on the valuation date. Such an explanation shall describe the process that the qualified actuary used to determine the adjustment, the amount of the adjustment, and the rationale for why the adjustment is appropriate.¶

**VM-31 Section 3.D.5.f (New):**

5. Expenses – The following information regarding the expense assumptions used by the company in performing a principle-based valuation under VM-20:

- f. Actual to Expected Analysis – The results of the most recently available actual to expected (without margins) analysis, including:
  - i. Definitions of the expected basis used in all actual-to-expected ratios shown.
  - ii. Comments addressing the conclusions drawn from the analysis.

**VM-31 Section 3.F.3.k (New – renumber current section 3.F.3.k):**

- k. Actual to Expected Analysis – Disclosure of the results of the most recently available actual to expected (without margins) analysis for the assumptions including 3.F.3.d Expenses Other than Commissions, 3.F.3.e Partial Withdrawals, 3.F.3.g Annuitization Benefits and GMIB and 3.F.3.h GMWB Utilizations, including:
  - i. Definitions of the expected basis used in all actual-to-expected ratios shown.
  - ii. Comments addressing the conclusions drawn from the analysis.

**VM-31 Section 3.F.3.i.viii:**

Discussion of any assumptions made on mortality improvements both for applying up to and beyond the valuation date (if applicable), the support for such assumptions, and how such assumptions adjusted the modeled mortality. In a case where mortality improvement as discussed in VM-21 Section 11.C and Section 11.D has not been applied, confirmation that applying such improvement would not result in an increase in the SR.

**VM-31 Section 3.D.2.f:**

Projection Period – Disclosure of the length of projection period and comments addressing the conclusion that the projection of cash flows extends far enough into the future that no obligations remain for both the deterministic and stochastic models.

**Deleted:** no material amount of business remains at the end of the projection period

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force  
 Amendment Proposal Form\***

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

Ben Slutsker, Minnesota Department of Commerce  
 Elaine Lam and Thomas Reedy, California Department of Insurance

Some policies in the ULSG Reserving Category may have a non-material secondary guarantee. This makes them eligible to be excluded from both DR and SR calculations if they pass both the DET and the SET. Currently, the language in VM-20 Section 2.A.2 does not address this possibility, and thus does not clearly state the requirement for those policies. Furthermore, aspects of the NPR calculation may have been unclear for certain indexed universal life policies that pass exclusion tests.

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

Valuation Manual (January 1, 2023 edition), VM-20 Section 2.A.2, Section 3.B.5, and Section 3.B.6

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

See attached.

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

The purpose of this APF is to add language to address the possibility of policies in the ULSG Reserving Category having a non-material secondary guarantee, and thus becoming excluded from both DR and SR calculations if they pass both the DET and the SET. The new proposed subsection within VM-20 Section 2.A.2 clarifies the total minimum reserve calculation for these policies. The new proposed Guidance Note immediately following the new proposed subsection clarifies when the subsection applies, which is only in cases of UL policies with non-material SGs. In addition, edits are proposed to Section 3.B.5 and 3.B.6 of VM-20 to have the NPR on indexed universal life policies that pass both exclusion tests follow VM-A and VM-C calculations.

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

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
12/1/2022	SO		
Notes: APF 2022-10			

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New proposed language is in redline below:

**VM-20 Section 2.A.2**

2. ULSG Reserving Category — All policies and riders belonging to the ULSG Reserving Category are to be included in Section 2.A.2.g unless the company has elected to exclude a group of them from the SR calculation or both the DR and SR calculations and has applied the applicable exclusion test(s) defined in Section 6, passed the test(s) and documented the results.

Deleted: b  
Deleted: SET

a. For the group of policies and riders for which the company did not compute the DR nor the SR: the sum of the policy minimum NPRs for those policies.

**Guidance Note:** This may be applicable for a group of ULSG policies that meet the definition of a “non-material secondary guarantee” and passes both the DET and the SET.

b. For the group of policies and riders for which the company did not compute the SR: the sum of the policy minimum NPRs for those policies plus the excess, if any, of the DR for those policies determined pursuant to Section 4 over the quantity (A–B), where A = the sum of the policy minimum NPRs for those policies, and B = any due and deferred premium asset held on account of those policies.

c. For the group of policies and riders for which the company computes all three reserve calculations: the sum of the policy minimum NPRs for those policies plus the excess, if any, of the greater of the DR for those policies determined pursuant to Section 4 and the SR for those policies determined pursuant to Section 5 over the quantity (A–B), where A = the sum of the policy minimum NPRs for those policies, and B = any due and deferred premium asset held on account of those policies.

d. The due and deferred premium asset, if any, shall be based on the valuation net premiums computed in accordance with Section 3.B.5.d, for the base policy, determined without regard to any NPR floor amount from Section 3.D.2.

**VM-20 Section 3.B.5**

5. For all policies and riders within the ULSG Reserving Category, other than indexed universal life policies for which the company did not compute the DR nor the SR, the NPR shall be determined as follows:

a. If the policy duration on the valuation date is prior to the point when all secondary guarantee periods have expired, the NPR shall be the greater of the reserve amount determined in Section 3.B.5.c and the reserve amount determined in Section 3.B.5.d, subject to the floors specified in Section 3.D.2.  
...

**VM-20 Section 3.B.6**

6. For all policies and riders within the All Other VM-20 Reserving Category, as well as indexed universal life policies for which the company did not compute the DR nor the SR, the NPR shall be determined pursuant to applicable methods in VM-A and VM-C for the basic reserve. The mortality tables to be used are those defined in Section 3.C.1 and in VM-M Section 1.H.

Deleted: .

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force  
 Amendment Proposal Form\***

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

**Identification:**

Elaine Lam, Office of PBR, California Department of Insurance (CDI)

**Title of Issue:**

Proposal to add disclosure requirements in VM-31, and clarify language in the Annual Statement Instructions related to reporting in the VM-20 Reserves Supplement.

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

Valuation Manual (January 1, 2023 edition) – Proposal to add new section as VM-31 Section 3.C.11

2022 Annual Statement Instructions – Proposal to add a sentence to the instructions for “VM-20 Reserves Supplement”, starting on page 807

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

See attached.

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

1. Add disclosure requirements in VM-31 for the Company to reconcile reported values and explain differences (if any) between reported values in the VM-31 Report (High-Level Results section), in the VM-20 Reserves Supplement (Parts 1A and 1B), and in the Annual Statement (Exhibit 3 for Separate Account values, Exhibit 5 for General Account values, and any other). Regulators have found inconsistencies in the values reported in the different locations. Moreover, without these disclosures, regulators have had a difficult time reconciling values and checking for misreported values.

2. Make a referral to the Blanks (E) Working Group to update the Annual Statement Instructions for the VM-20 Reserves Supplement to clarify that separate account amounts should be included in the Supplement. There has been inconsistent reporting by companies because the current instructions do not specifically address the treatment of separate account amounts.

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

NAIC Staff Comments:

<b>Dates:</b> Received	Reviewed by Staff	Distributed	Considered
1/29/23	SO		
<b>Notes:</b> APF 2023-02			

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New proposed language in the *Valuation Manual* is in redline below:

(new section)

**VM-31 Section 3.C.11**

11. **Reconciliation of Reported Values** – A reconciliation of reported values and an explanation of differences, if any, between reported values in Section 3.B.5 (High-Level Results), in the VM-20 Reserves Supplement – Part 1A and Part 1B, and in the Annual Statement (Exhibit 3 for Separate Account values, Exhibit 5 for General Account values, and any other).

For referral to the Blanks (E) Working Group, new proposed language in the Annual Statement Instructions is in redline below:

**VM-20 RESERVES SUPPLEMENT**

**Life Insurance Reserves Valued According to VM-20 by Product Type**

This Supplement provides information on the reserves required to be calculated by Section VM-20 of the *Valuation Manual*.

This includes the Net Premium Reserve and, as applicable, the Deterministic Reserve and the Stochastic Reserve. Only

business issued on or after Jan. 1, 2017, valued by the requirements of VM-20 should be reported in Part 1A and Part 1B.

Part 1A and Part 1B are intended to aid regulators in the analysis of reserves as determined under Section VM-20 of the

*Valuation Manual* for both the prior and current year.

This Supplement also provides information regarding business where VM-20 of the *Valuation Manual* is not required to be

applied. Companies exempted from the requirements of Section VM-20 are not required to complete Part 1A or Part 1B of

this Supplement but must complete Part 2 or Part 3 as applicable.

**VM-20 RESERVES SUPPLEMENT – PART 1A**

**Life Insurance Reserves Valued According to VM-20 by Product Type**

Part 1A of this Supplement breaks out, by product type, the prior year and current year reported reserves on a Post-

Reinsurance-Ceded and Pre-Reinsurance-Ceded basis as defined in Section 8.D of Section VM-20 of the *Valuation Manual*.

The Due and Deferred Premium Asset for the current year is also shown.

Section VM-20 of the *Valuation Manual* requires that the Post-Reinsurance-Ceded Reserve be determined by three VM-20



Reserving Categories: Term Insurance, Universal Life with Secondary Guarantees (ULSG) and all other. Term Insurance should be reported on line 1.1. ULSG, including Variable Universal Life with a secondary guarantee, Indexed life insurance with a secondary guarantee, regular Universal Life with a secondary guarantee, and ULSG policies with a non-material secondary guarantee as defined in Section VM-01 of the *Valuation Manual*, should be reported on line 1.2. Each of the other products reported in lines 1.3 – 1.8 should be determined as the sum of the policy reserves using the policy reserves determined following the allocation process of VM-20 Section 2. A similar process should be used for each of the pre-reinsurance-ceded reserves. **Both Post-Reinsurance-Ceded Reserves and Pre-Reinsurance-Ceded Reserves, as defined in VM-20, include separate account amounts where applicable to the policies in scope.**

Columns 1 & 2 – Reported Reserve

Provide the reported reserve, in whole dollars, for the prior year and current year for each line item.

Post-Reinsurance-Ceded is net of reinsurance ceded. Pre-Reinsurance-Ceded should be prior to any reinsurance ceded and include reinsurance assumed. Sections 2 and 8 in the *Valuation Manual* further describe the required reserve and treatment of reinsurance. The reported reserve for the current year should reflect all policies in force as of the end of the current year. The reported reserve for the prior year should reflect all policies in force as of the end of the prior year.

Etc...

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force  
Amendment Proposal Form\***

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

**Identification:**

PBR Staff of Texas Department of Insurance

**Title of the Issue:**

Address several clean-up items for VM-20, as well as related VM-21 and VM-31 Sections.

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

VM- 20 Section 3.B.5.c.ii.4, VM-20 Section 5.B.3, VM-20 Section 7.E.2 and Guidance Note below, VM-21 Section 4.D.4.c, VM-20 Section 7.K.3, VM-31 Section 3.D.6.f, VM-20 Section 9.A.4

January 1, 2023 NAIC Valuation Manual

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

See attached.

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

1. The formula for calculating the NPR for ULSG based on the value of the SG in VM-20 Section 3.B.5.c.ii.4 excludes the EA from the scaling of the NPR. This is inconsistent with the formula for calculating the NPR for ULSG disregarding the SG in VM-20 Section 3.B.5.d.iv. The scale is the prefunding ratio of actual SG (denoted ASG) to fully funded SG (denoted FFSG), and it makes intuitive sense that the NPR would be scaled to decrease or increase relative to the level of funding of the SG.
2. The VM-20 Section 5.B.3 stochastic reserve methodology is missing an aggregate cash surrender value (CSV) floor for scenario reserves before calculating CTE70. This allows scenario reserves that exceed the CSV to be dampened or eliminated by being averaged with scenario reserves. A CSV floor in the NPR does not address this concern, because it does not reflect the scenario reserves in the SR that exceed the CSV. In contrast, in VM-21 Section 4.B.1 scenario reserves are floored at the aggregate CSV as appropriate. Scenario reserves, as the asset requirement for specific scenarios, should be held at or above the CSV.
3. Add consideration to VM-20 Section 7.E.2 consistent with VM-21 Section 4.D.4.c’s requirement on the company’s assumed cost of borrowing along with the associated Guidance Note. Editorial clarifications to the existing Guidance Note in VM-21.
4. VM-20 Section 7.K.3 should clarify the requirement to reflect the hedge modeling error or insufficiency. Related to this change, more discussion about the hedging strategy and hedge modeling should be added to the Life Report section of the VM-31 Section 3.D.6.f report.

5. VM-20 Section 9.A.4 implies companies can elect to stochastically model risk factors other than interest rates & equities. Stochastic assumptions are not subject to the requirements of Section 9 relating to prudent estimate assumptions. Nor are any guidance/specific requirements provided if companies elect to stochastically model other risk factors. Add consideration to VM-20 consistent with VM-21 Section 12.B.4’s requirement about the risk factors other than interest rates & equities that are stochastically modelled, which was added to VM-21 for this same reasoning.

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

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
<a href="#">1/30/23</a>	<a href="#">SO</a>		
Notes: <a href="#">APF 2023-03</a>			

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**VM-20 Section 3.B.5.c.ii.4**

- 4) The NPR for an insured age x at issue at time t shall be according to the formula below:

$$\text{Min} \left[ \frac{ASG_{x+t}}{FFSG_{x+t}}, 1 \right] \cdot (NSP_{x+t} - E_{x+t})$$

**VM-20 Section 5.B.3**

3. Set the scenario reserve equal to the sum of the statement value of the starting assets across all model segments and the maximum of the amounts calculated in Subparagraph 2 above.

The scenario reserve for any given scenario shall not be less than the cash surrender value in aggregate on the valuation date for the group of contracts modeled in the projection.

**VM-20 Section 7.E.2**

2. Model at each projection interval any disinvestment in a manner that is consistent with the company’s investment policy and that reflects the company’s cost of borrowing where applicable, provided that the assumed cost of borrowing is not lower than the rate at which positive cash flows are reinvested in the same time period, taking into account duration, ratings, and other attributes of the borrowing mechanism. Gross asset spreads used in computing market values of assets sold in the model shall be consistent with, but not necessarily the same as, the gross asset spreads in Section 7.E.1.d and Section 7.E.1.f above, recognizing that starting assets may have different characteristics than modeled reinvestment assets.

**Guidance Note:** The simple language above "provided that the assumed cost of borrowing is not lower than the rate at which positive cash flows are reinvested in the same time period" is intended to prevent excessively optimistic borrowing assumptions. If in any case, the assumed cost of borrowing restriction cannot be fully applied or followed precisely, then as with all other simplifications/approximations, the company shall not allow borrowing assumptions to materially reduce the reserve.

**VM-21 Section 4.D.4.c**

**Guidance Note:** The simple language above "provided that the assumed cost of borrowing is not lower than the rate at which positive cash flows are reinvested in the same time period" is intended to prevent excessively optimistic borrowing assumptions. If in any case, the assumed cost of borrowing restriction cannot be fully applied or followed precisely, then as with all other simplifications/approximations, the company shall not allow borrowing assumptions to materially reduce the reserve.

- Deleted:** This limitation is being referred to Life Actuarial (A) Task Force for review.
- Deleted:** not intended to impose a literal requirement. It is
- Deleted:** to reflect a general concept
- Deleted:** It is recognized that borrowing parameters and rules can be complicated, such that modeling limitations may not allow for literal compliance, in every time step, as long as the reserve is not materially affected. However, if
- Deleted:** the company is unable to fully apply this
- Deleted:** prudence dictates that a

**VM-20 Section 7.K.3**

3. In circumstances where one or more material risk factors related to a derivative program are not fully captured within the cash-flow model used to calculate CTE 70, the company shall reflect the approximation, simplification or model limitations in the modeling of such risk factors by increasing the SR as described in Section 5.E. The company shall also be able to justify that the method appropriately reflects the potential error using historical experience, e.g., analysis of historical performance or backtesting.

### **VM-31 Section 3.D.6.f**

- f. Risk Management – Detailed description of model risk management strategies, such as hedging and other derivative programs, including any future hedging strategies supporting the policies and any adjustments to the SR pursuant to VM-20, Section 7.K.3 and VM-20, Section 7.K.4, specific to the groups of policies covered in this sub-report and not discussed in the Life Summary Section 3.C.5. Documentation of any future hedging strategies should include documentation addressing each of the CDHS documentation attributes. The following should be included in the documentation:
- i. Descriptions of basis risk, gap risk, price risk and assumption risk.
  - ii. Methods and criteria for estimating the a priori effectiveness of the strategy.
  - iii. Results of any reviews of actual historical hedging effectiveness.
  - iv. Strategy Changes – Discussion of any changes to the hedging strategy during the past 12 months, including identification of the change, reasons for the change, and the implementation date of the change.
  - v. Hedge Modeling – Description of how the hedge strategy was incorporated into modeling, including:
    - Differences in timing between model and actual strategy implementation.
    - For a company that does not have a future hedging strategy supporting the contracts, confirmation that currently held hedge assets were included in the starting assets.
    - Evaluations of the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, and other items that are likely to result in materially adverse results.
    - Discussion of the projection horizon for the future hedging strategy as modeled and a comparison to the timeline for any anticipated future changes in the company's hedging strategy.
    - If residual risks and frictional costs are assumed to have a value of zero, a demonstration that a value of zero is an appropriate expectation.
    - Any discontinuous hedging strategies modeled, and where such discontinuous hedging strategies contribute materially to a reduction in the SR, any evaluations of the interaction of future trigger definitions and the discontinuous hedging strategy, including any analyses of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.

- The approach and rationale used to reflect the hedge modeling error(s).

#### **VM-20 Section 9.A.4**

4. If the company elects to stochastically model risk factors in addition to those listed in Section 9.A.3 above, the requirements in this section for determining prudent estimate assumptions for these risk factors do not apply.

It is expected that companies will not stochastically model risk factors other than the economic scenarios, such as policyholder behavior or mortality, until VM-20 has more specific guidance and requirements available. Companies shall discuss with domiciliary regulators if they wish to stochastically model other risk factors.

Draft: 2/28/23

Life Actuarial (A) Task Force  
Virtual Meeting  
January 26, 2023

The Life Actuarial (A) Task Force met Jan. 26, 2023. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Lori K. Wing-Heier represented by Sharon Comstock (AK); Ricardo Lara represented by Ahmad Kamil (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT).

1. Heard a Presentation on Practitioner Considerations for Guideline Excess Spread Under AG 53

Marc Altschull (Actuarial Risk Management) and Dave Bulin (Actuarial Risk Management) said that they would be delivering a presentation (Attachment Four-A) based on a paper their organization produced for the Society of Actuaries' (SOA's) Financial Research Institute on the guideline excess spread methodology under *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves (AG 53)*. Altschull noted that the AG 53 requirements ask companies for additional documentation, including an excess spread attribution that is the main subject of the presentation. After Altschull and Bulin completed the presentation, Hemphill said that there was no one-size-fits-all approach to spread attribution and that companies would need to reflect their specific asset and risk profiles.

Tsang then asked if appointed actuaries would be able to get spread attribution analyses from their investment departments that they would have performed as part of their normal business functions. Bulin agreed that the appointed actuaries would be unlikely to have the deep investment knowledge required for the attribution analysis, and would likely need to work with investment departments, outside investment managers, and/or consultants. Bulin further stated that there was a lack of research on spread attribution and that it would be a challenge for companies to break out the spread into distinct liquidity, credit, and other risk components. Tsang questioned whether there were a small number of risk factors that would describe the majority of the spread variation. Altschull noted that the risk factors would be dependent on the asset class, to which Hemphill agreed.

2. Discussed a Referral from the Financial Regulation Standards and Accreditation (F) Committee

Dan Schelp (NAIC) said that he prepared a memorandum (Attachment Four-B) in which he compared the significant elements of the *Actuarial Opinion and Memorandum Regulation (#822)* to the requirements laid out in VM-30, Actuarial Opinion and Memorandum Requirements, to assist the Task Force in responding to the referral from the Financial Regulation Standards and Accreditation (F) Committee. Schelp said that it is the opinion of the NAIC Legal Division that state adoption of the *Valuation Manual* should be considered substantially similar to Model #822 for accreditation purposes. Schelp then went through specific sections of both requirements that he had highlighted in the memorandum to support the opinion of the NAIC Legal Division.

Chupp made a motion, seconded by Weber, to recommend that NAIC staff prepare a memorandum conveying the Task Force's recommendation that Model #822 be removed as an accreditation standard. The motion passed unanimously.

3. Adopted APF 2022-07

Brian Bayerle (American Council of Life Insurers—ACLI) summarized amendment proposal form (APF) 2022-07 as a clarification of a previously adopted amendment to the *Valuation Manual* that requires adjustments to the mortality table used in the determination of the net premium reserve if the anticipated experience of the group of policies exceeds the table.

Chupp made a motion, seconded by Chou, to adopt APF 2022-07 (Attachment Four-C). The motion passed unanimously.

4. Adopted APF 2022-08

Bayerle said that the purpose of APF 2022-08 was to clarify that companies that only utilize the Alternative Methodology under VM-21, Requirements for Principle-Based Reserves for Variable Annuities, are subject to limited governance requirements under VM-G, Appendix G — Corporate Guidance for Principle-Based Reserves.

Chupp made a motion, seconded by Schallhorn, to adopt APF 2022-08 (Attachment Four-D). The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/ 2023-1-Spring/LATF Calls/01 26/Jan 26 Minutes.docx





# Practitioner Considerations for Guideline Excess Spread Attribution Methodology under Actuarial Guideline LIII (AG53)

JANUARY | 2023



# Practitioner Considerations for Guideline Excess Spread Attribution Methodology under Actuarial Guideline LIII (AG53)

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# Practitioner Considerations for Guideline Excess Spread Attribution Methodology under Actuarial Guideline LIII (AG53)

## Introduction

NAIC Actuarial Guideline LIII (“AG 53”), effective for year-end 2022, requires Appointed Actuaries for non-exempted life insurers to disclose detailed information about investment activities and risks, focusing primarily on assets used to support Asset Adequacy Testing. The greater degree of disclosure and transparency will enable regulators to better understand the investment risks included in insurers’ balance sheets. The riskiness of investments has become a topic of increasing concern as insurance investment holdings have become more complex.

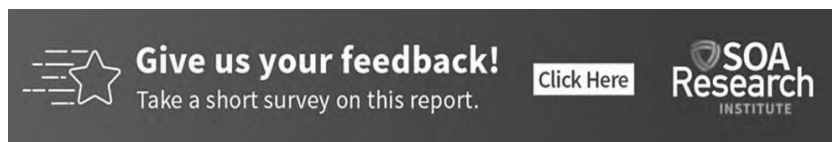
A section of AG 53 (section 5.B.) requires an attribution of Net Market Spreads<sup>1</sup> in excess of an Investment Grade Net Spread Benchmark for many “complex” assets.

While the use of attribution analysis in some areas of investment practice, such as performance attribution, is a long-standing and well-established practice, there currently is no broadly accepted quantitative construct to decompose market spreads into component pieces. Historically there has been no requirement to attribute spreads or changes in spreads to individual risk components. The introduction of AG 53 necessitates the development of a methodology to conduct spread attribution.

The Society of Actuaries engaged Actuarial Risk Management to produce this resource for practitioners. The report describes general principles to inform the development of a methodology to attribute spread to different investment risks. This paper will list and define a number of risks that are inherent in fixed income investments. Many of these risks could serve as the components of an attribution. **Please note we are using the term “general principles” to convey considerations that can aid a practitioner. This paper is in no way intending these general principles to be perceived as any type of standard or requirements related to AG 53.**

**The paper is also not intended to create a specific methodology to attribute Guideline Excess Spread<sup>2</sup> nor does it develop a “safe harbor” approach.**

The documentation requirements for AG 53 can be found at <https://content.naic.org/sites/default/files/inline-files/AG%2053.pdf>. The principles will build on financial industry research and analytics where practical.



<sup>1</sup> Net Market Spread: For each asset grouping, shall mean the spread over comparable Treasury bonds that equates the fair value as of the valuation date with modeled cash flows, less the default assumption used in asset adequacy analysis. (Definition directly from AG 53)

<sup>2</sup> Guideline Excess Spread: The net spread derived by subtracting the Investment Grade Net Spread Benchmark from the Net Market Spread for non-equity-like instruments. Investment expenses shall be excluded from this calculation. (Definition directly from AG 53)

## Section 1: Background on Actuarial Guideline LIII (“AG 53”) and the Requirement for Guideline Excess Spread Attribution

AG 53, adopted by the NAIC Life Insurance and Annuities (A) Committee on July 20, 2022 and effective for year-end 2022, is “intended to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for asset adequacy analysis performed by life insurers”<sup>3</sup>.

One key focus of AG 53 is on “Projected High Net Yield” (PHNY) assets, defined in Section 4.F. of the guideline as follows:

- F. Projected High Net Yield Assets.** Currently held or reinvestment assets that are either:
- i. An Equity-like Instrument assumed to have higher value at projection year 10 or later than under an assumption of annual total returns, before the deduction of investment expenses, of 4% for the first 10 projection years after the valuation date followed by 5% for projection year 11 and after. Aggregation shall be done at a level of granularity that is consistent with or more granular than how the assets are grouped, i.e., compressed, in the asset adequacy analysis model, or
  - ii. Assets other than Equity-like Instruments where the assumed Guideline Excess Spread is higher than zero. In addition:
    - (a) Aggregation of the comparison between the assumed Net Market Spread from each asset and the Investment Grade Net Spread Benchmark shall be done at a level of granularity that is consistent with or more granular than how the assets are grouped, i.e., compressed, in the asset adequacy analysis model.
    - (b) For applicable assets that do not have an explicit WAL or term to maturity, the Appointed Actuary shall disclose the method used to determine the appropriate WAL used for comparing to the Investment Grade Net Spread Benchmark.
    - (c) For purposes of the comparison between the assumed Net Market Spread from each asset and the Investment Grade Net Spread Benchmark, investment expenses shall be excluded.

*Note: “WAL” is Weighted Average Life, weighted average time to receipt of principal from an investment.*

Under AG 53, non-equity (fixed income) investments with a Net Market Spread greater than that of the Investment Grade Net Spread Benchmark are subject to a greater degree of scrutiny. The expected performance of such investments is of particular interest and as such requires disclosure of an attribution by source of the Net Market Spread over the Investment Grade Net Spread Benchmark. Note that the Guideline Excess Spread attribution is required for both existing assets and assumed reinvestment asset purchases.

It is noted in Section 3.F.iii. of AG 53 that cash or equivalents, Treasuries, and agency bonds as well as Public non-convertible, fixed-rate corporate bonds with no or immaterial callability are excluded from the Guideline Excess Spread attribution requirement.

This Guideline Excess Spread attribution is focused on understanding the sources of risk and return. Many of these sources of risk (see Section 5) have increased in magnitude on insurer balance sheets greatly over the past few decades. There is increased complexity, breadth, and magnitude of insurer investments, and disclosure is required in Section 5.B. under AG 53:

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<sup>3</sup> National Association of Insurance Commissioners. Actuarial Guideline LIII — Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves. naic.org, October 6, 2022, [AG 53.pdf \(naic.org\)](#) (accessed October 6, 2022).

B. For projected high net yield assets for non-equity-like instruments, either currently held or in assumed reinvestments, perform and disclose the following attribution analysis steps at the asset type level associated with the templates in Section 6:

- i. State the assumed Guideline Excess Spread.
- ii. Estimate the proportion of the Guideline Excess Spread attributable to the following factors:
  - (a) Credit risk
  - (b) Illiquidity risk
  - (c) Deviations of current spreads from long-term spreads defined in Appendix 1
  - (d) Volatility and other risks (identify and describe these risks in detail)

AG53-6

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Appendix C AG LIII

- iii. Provide commentary on the results of Section 5.B.ii. Also, where judgment is applied, provide supporting rationale of how the expected return in excess of the Investment Grade Net Spread Benchmark is estimated.

**Guidance Note:** A best-efforts approach is expected for the year-end 2022 attribution analysis.

## Section 2: Objectives for Developing Principles for Attribution Analysis

Guideline Excess Spread attribution analysis requires an Appointed Actuary to develop an appropriate methodology. The authors used the following objectives to develop general principles to aid Appointed Actuaries in this analysis.

1. The principles can be universally and consistently applied to all life insurers and all types of fixed income investments.
2. The principles are expected to remain valid for any stage of the economic cycle and be applicable to any new fixed income investment classes that insurers may hold in their general account.
3. The principles are to be as objective and unbiased as possible notwithstanding areas of subjectivity and professional judgment that recognizes spread attribution analysis continues to mature.
4. The principles are likely to evolve as lessons are learned over time with meeting the requirement.
5. The principles are consistent with statutory valuation rules and companies' investment valuation frameworks.
6. The principles are consistent with other applications of quantifying investment risk utilized in other financial reporting activities (e.g., ASC 326 Current Expected Credit Losses or "CECL").

### Section 3: Challenges and Limitations

There are a number of challenges and limitations to developing and implementing an attribution methodology. The following are key challenges and limitations:

**Lack of Previous Research:** We are not aware of any research on fully decomposing market spreads into component pieces. The limited available research is driven at least in part by a lack of demand for spread attribution – there has been very limited demand for understanding spread decomposition from investors. While many investors utilize certain market benchmarks to understand marginal compensation for marginal risk taking, research on spread attribution has to date been very limited. Many analyses utilized to understand risks are more focused on what happens if a risk becomes realized (e.g., stress tests, VaR) and less so on what compensation is being received for the risk being assumed.

**Lack of Data:** While there is an increasing amount of market spread data that is available, it is largely focused on the more liquid sectors of the investment markets. AG 53 – while not excluding more liquid parts of the fixed income market – is more focused on increasingly complex assets. Therefore, AG 53’s focus is on the less liquid parts of the fixed income markets and thus areas with less available data.

**Non-Comparability of Data:** Due to insurers employing different methodologies and market practices to determine spreads, the spreads and resulting spread attribution analyses may not be comparable across life insurance companies.

**Lack of/Inconsistent Understanding:** There is a wide range of views of market participants. Because of the wide range of knowledge, expertise, and perspectives, efforts to increase the consistency and comparability of analyses across the industry may be beneficial.

**Granularity of Attribution:** In developing a methodology, there are likely to be tradeoffs between the number of attribution buckets, the complexity of the attribution analysis and the usefulness of the analysis. The choice of risk(s) that each bucket covers will drive some of the complexity of the spread attribution analysis. There is the potential that chosen buckets will overlap, adding complexity to the analysis to account for such redundancies. Additionally, when spread attributions are aggregated, for example from the CUSIP level to the rows shown in the AG 53 template, there may be some degree of useful information lost. An example of this may be positive attributions offsetting negative attributions.

**Variety of Asset Classes and Types of Risk:** There are a wide range of both asset types and types of risk that must be considered in the spread attribution. Many of these asset types are fairly new and may have an increasing level of complexity which leads to not all risks being known or fully understood.



## Section 4: Market Spreads - Overview

In order to perform spread attribution, it is first important to understand what market spreads are and how they are related to other key market metrics and analytics. The objective of this section is to provide a common base of understanding for practitioners.

### 4.1 RELATIONSHIP BETWEEN PRICE, RISK-FREE RATE, AND SPREAD

There is a direct, formulaic relationship between the price, assumed cash flows, underlying risk-free rate, and market spread of a fixed income investment:

$$\text{Price} = \sum_{t=1}^T \frac{\text{Coupon}_t}{(1 + \text{Risk-Free Rate} + \text{Spread})^t} + \frac{\text{Principal}_t}{(1 + \text{Risk-Free Rate} + \text{Spread})^t}$$

Companies determine price, cash flows, and risk-free rates for each investment, then calibrate the spread that replicates the price. Each company has their own processes around each of these inputs (price, cash flows, and risk-free rates), and the resulting input variation may lead to variation of market spreads across the industry for identical investment holdings:

- **Price:** In many cases, especially for publicly traded assets, prices are provided by various pricing services. For publicly traded assets, there should be a high degree of consistency of the price assumed among investors for any individual holding. In other cases where there is a limited market (e.g., private placements), the investor may determine the price based upon a model (“mark-to-model”) with various inputs.
- **Cash flows:** For certain fixed income investments without embedded options, cash flows are contractually fixed. For structured assets (e.g., asset-backed securities, structured credit) and other assets with embedded options, cash flows will be more difficult to project and are heavily model- and assumption-dependent. For these types of assets, there may be a wider range of assumed cash flows among investors. Modeled cash flows used in asset pricing utilizing the formula above are expected to be best-estimate, single-path deterministic, and before any considerations of default risk. Investment expenses are not included in asset level cash flows for this purpose.
- **Risk-free rate:** This is the market yield on a Treasury security with the same or similar weighted average life (WAL) as the fixed income investment being considered. To be consistent, the risk-free yield must be determined as of the same date and time as the asset price.
- **Spread:** This is the addition to the risk-free rate that results in a discount rate equating the present value of cash flows to the price of the investment.

#### 4.2 VALUATION FRAMEWORK

A formalized valuation framework provides structure and guidance on how fair values (prices) for investments are determined. Related, ASC 820-10 for US GAAP categorizes and requires disclosure on securities based on how their fair values are determined. There are three categories of fair value inputs under ASC 820-10<sup>4</sup>:

- **Level 1:** Quoted prices (unadjusted) in active markets for identical assets or liabilities that the reporting entity can access at the measurement date.
- **Level 2:** Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
- **Level 3:** Unobservable inputs for the asset or liability.

Prices based upon Level 1 inputs are most common for Treasuries, common stocks, mutual funds and ETFs. Prices including Level 2 inputs are the most common pricing approach for insurance company investments and it is applicable to most publicly traded securities. Prices including Level 3 inputs are more common for privately issued investments which are becoming a larger proportion of insurer balance sheets.

Consistency is an important consideration between a company's valuation framework and the spread attribution. This is of particular note for assets that are mark-to-model<sup>5</sup> and are heavily dependent upon company-provided assumptions (e.g., US GAAP Level 3 assets). The derivation of the market spreads used to determine fair values are consistent with the spread attribution disclosed for AG 53.

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<sup>4</sup> Financial Accounting Standards Board. Fair Value Measurement (Topic 820). Fasn.org, June 30, 2022, [820-10 Overall \(fasn.org\)](#) (accessed November 25, 2022).

<sup>5</sup> Mark-to-model: The practice of pricing an asset using a financial model instead of utilizing a market price.

## Section 5: Types of Asset Risk and Relationship to Spread

While it is not plausible to identify all of the risks in an insurer's investment portfolio, there are a number of common risks in life insurer fixed income portfolios. A risk spread, that is incremental to the risk-free rate, compensates investors for known and some unknown risks. Generally, the more of a specific risk that an asset contains, the larger the spread that will be attributed to that specific risk for that asset.

### 5.1 TYPES OF RISKS THAT CAN LEAD TO ASSET LOSS

Below is a comprehensive, but not exhaustive, list and definitions of different types of fixed income investment risks that may impact spreads. Not all risks are mutually exclusive, so there may be overlap between different risks. The first two risks listed below are specifically identified in the AG 53 templates. The risks that follow the first two are listed alphabetically.

- **Credit risk:** Risk that an asset defaults, experiences a reduction in expected recovery amount or is downgraded by a credit rating organization
- **Illiquidity risk:** Risk that an investor can only sell an asset at less than its true value or cannot be sold at all; generally driven by a wider bid-ask spread
- **Call / prepayment risk:** Risk that an asset is called or prepaid by the issuer or borrower and the investor must reinvest proceeds in a lower rate environment than the original investment was purchased
- **Complexity risk:** Risk that an asset is more difficult to analyze and model, requiring more time and expense to understand the asset and limiting the pool of investors interested in investing in the asset, thus decreasing demand and lowering the price that an asset could otherwise receive in an open market
- **Event risk:** Risk that asset values are adversely impacted by a single event such as a natural disaster, industrial accident or corporate takeover
- **Exchange-rate / currency risk:** Risk that a non-US dollar denominated asset declines in value due to adverse currency rate movements
- **Inflation / purchasing power risk:** Risk that higher than expected inflation erodes the purchasing power of a fixed income asset's cash flows
- **Interest rate risk:** Risk that interest rates increase and the value of the asset declines
- **Political / legal risk:** Risk that actions of a government adversely affect the value of an asset
- **Sector risk:** Risk of an adverse differential movement of all assets in one sector relative to another
- **Structure risk:** Risk that timing of cash flows differs from expected
- **Volatility risk:** Risk that the value of an asset with an embedded option declines due to changes in implied volatility

### 5.2 OTHER FACTORS THAT MAY AFFECT PRICE AND SPREAD

There are other factors that may impact the price and spread of an asset. While these may not be considered risks per se, they may impact asset valuation.

**Private origination:** If assets are privately originated, there is generally a limited or exclusive market and therefore pricing may be more favorable to the originator than in an efficient market. This means that assets may be acquired for a lower value and therefore with a higher spread.

**Newer asset class:** Early adopters of investing in certain asset classes often enjoy higher spread and/or returns before other investors become more comfortable with the asset class. Newer asset classes do not always ultimately end with lower spreads as sometimes the riskiness of an asset class is underappreciated, and as risks are better

understood, the market reprices spreads to the better understood levels of risk. In other cases, risks are less than originally thought, and subsequently as demand increases, prices rise and market spreads narrow.

**Information asymmetry:** This occurs when there is an imbalance of knowledge and/or expertise between buyers and sellers of an asset. The asymmetry can favor either the buyer or the seller.

## Section 6: Principles for Attribution Analysis

While this whitepaper does not propose any specific methodology, this section describes a set of principles that an Appointed Actuary can utilize to help in developing a methodology and performing the Guideline Excess Spread attribution as required by AG 53. As stated earlier in the document, the following are not intended as standards or specific requirements for conducting the analysis. All of the general principles have been developed by the authors and are not requirements of AG 53.

### 6.1 PRINCIPLES

#### GENERAL / BACKGROUND

1. Overall general consistency with conducting other analyses under Actuarial Standards of Practice set the framework for performing the Guideline Excess Spread attribution.
2. Professional actuarial judgment (as per ASOP No. 1, Section 2.9) is an aspect of this analysis because this is an emerging area with limited historical practice within investment management.
3. Subject matter experts are an important resource for an Appointed Actuary to consult with, as necessary, because of their special knowledge and the nature of the analysis.

#### RISK IDENTIFICATION

4. Consistency of risks identified in a company's AG 53 report with risks identified in ORSA, investment policy, risk appetite, and other related company documents is an important objective.
5. It is useful to identify risks for each asset class prior to quantifying Net Market Spread risk components.
6. Asset classes do not necessarily all have the same risks, so the Guideline Excess Spread attribution components may vary by asset class.
7. It is very unlikely that any single risk will constitute the entirety of a single investment's risks.
8. Each identified risk may not need to be a separate attribution category. It may be more useful for related risks to be grouped together into a single attribution category for the spread attribution analysis.

#### RISK QUANTIFICATION

9. The amount of Net Market Spread attributed to a particular risk may cover both the best-estimate "cost" of that risk as well as any adjustments for uncertainty related to that risk.
10. All Net Market Spreads are measured relative to risk-free rates, so all risks are evaluated relative to risk-free assets.
11. Certain risks may be evaluated for exclusion in the Guideline Excess Spread attribution, as they either have been accounted for before spreads are determined or are risks that do not impact market spreads. Examples:
  - a. Interest rate risk, as defined in Section 5.1, may be considered for exclusion as a spread attribution category as this risk is compensated for as part of the underlying risk-free yield and not as part of the Net Market Spread.
  - b. Asset-liability management (ALM) risk may be considered for exclusion as a spread attribution category as it is the result of mismatches between assets and liabilities and will be unique to each company. The market value and spread of an asset are independent of an investor's ALM position.
12. Given that many risks are correlated, correlations are a component of the attribution analysis to consider.
13. Guideline Excess Spread attribution components may be negative. This would imply that a particular risk of an asset or asset class (as represented by the spread attribution of an asset) is less than that of the Investment Grade Net Spread Benchmark. An illustrative example is included in Appendix B.
14. A material amount of the Guideline Excess Spread may be attributed to identified risks including the impact of any correlation among risks. Minimizing the amount of Guideline Excess Spread not attributed to specific identified risks is an overall objective.

15. When looking to history to develop assumptions, it is important to recognize that historical metrics may not be predictive.

#### **AGGREGATION AND PRESENTATION**

16. Presentation of Guideline Excess Spread attribution at the asset class level in the provided templates should reasonably reflect the risks included in the holdings for each asset class. The methodology used in determining and/or aggregating spread attribution across the individual investments underlying each row in the template should be reasonable and not biased by the choice of presentation or aggregation.

#### **FUTURE CONSIDERATIONS**

17. Spread attribution methodologies may evolve as new asset classes are added to insurers' investment portfolios and also as characteristics of asset classes evolve through time.
18. Spread attributions may not be static through time. The spread attributed to a specific risk can vary as economic and market conditions change.

#### **6.2 OTHER CONSIDERATIONS**

Below is a list of other considerations for the Appointed Actuary in performing the Guideline Excess Spread attribution analysis:

- Degree of granularity: While this attribution analysis can be performed at the individual asset level, there is no requirement to perform this analysis (nor disclose it) at the individual asset level. There are likely approaches where reasonably similar investments will be grouped together for this exercise.
- Number of attribution categories chosen: The template includes Credit and Illiquidity risks, leaving additional attribution categories to the judgment of the Appointed Actuary.
- Degree of judgment: For asset types with less available information, the attribution will be more challenging and require a greater degree of professional actuarial judgment.
- Additional analysis: An Appointed Actuary may want to perform additional scenario projections depending on the results of the Guideline Excess Spread attribution analysis. For example, if an Appointed Actuary identifies a significant amount of spread being attributed to illiquidity, they may want to perform some sensitivity or stress tests around liquidity risk. This can be with higher or lower spreads or other factors depending upon the risks and conditions of additional scenarios tested.

## Section 7: Ideas for Follow-up Research

While this research paper can provide useful information to an Appointed Actuary in complying with AG 53, there are many areas of additional research that are not covered by this paper and may be useful in the future. A partial list of ideas for follow-up research are below:

- Covenants in assets with credit risk vary in their specific elements and strength
- Impact of credit ratings issued by various rating agencies
- Correlations among different risk factors
- Additional ways to leverage the spread attribution analysis beyond the requirement in AG 53 (e.g., asset allocation analysis, investment portfolio construction)
- Specific methodological approaches to spread attribution and development of an accepted industry methodology as a “safe harbor”
- Survey of current practices resulting in publication of a practice note



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## Section 8: Acknowledgments

The authors' deepest gratitude goes to those without whose efforts this project could not have come to fruition: the Project Oversight Group for their diligent work overseeing, reviewing, and editing this report for accuracy and relevance. Any opinions expressed may not reflect their opinions nor those of their employers.

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Appendix A: Guideline Excess Spread Attribution Templates

Below is a link to the templates as provided by the NAIC. Part of the template focused on Guideline Excess Spread attribution is illustrated below.

TEMPLATES – link: [AAT AG Templates - 090822.xlsx](#)

Section 5b: Attribution for Asset Adequacy Testing Guideline Excess Spreads - Reinvestments											Check
Asset Type	Net Market Spread	IG Net Spread Benchmark <sup>1</sup>	Guideline Excess Spread	Credit Risk	Illiquidity Risk	Excess Spread Components Related to Each Risk					
						[Other Risk Component #1]	[Other Risk Component #2]	[Other Risk Component #3]	[Other Risk Component #4]	[Other Risk Component #5]	
Treasuries and Agencies	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Public Corporate Bonds	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Convertible Bonds	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	TRUE
Floating Rate Notes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	TRUE
Municipal Bonds	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	TRUE
Other Private Bonds	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	TRUE
Preferred Stock	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	TRUE
Agency Mortgage Backed Securities	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	TRUE
Non-Agency Commercial Mortgage Backed Securities	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	TRUE
Non-Agency Residential Mortgage Backed Securities	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	TRUE
Collateralized Loan Obligations	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	TRUE
Other Asset Backed Securities	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	TRUE
Equities or Equity-Like Instruments	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Real Estate	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Mortgage Loans	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	TRUE
Schedule BA Assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Derivative Instruments linked to Equity-Like Instrumen	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Other Derivative Instruments	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Other - Not Covered Above	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	TRUE

(1) "IG Net Spread Benchmark" = Investment Grade Net Spread Benchmark

Additional Commentary

Appendix B: Illustrative Example of Spread Attribution with Negative Guideline Excess Spread Components

				<i>Spread Components Related to Each Risk</i>				
Asset Type	Net Market Spread			Risk Factor A	Risk Factor B	Risk Factor C	Risk Factor D	Other Risk Factors / Unallocated
Asset Class XYZ	2.5%			0.3%	0.7%	0.5%	0.8%	0.2%
IG Net Spread Benchmark	1.5%			1.0%	0.5%	0.0%	0.0%	0.0%
				<i>Excess Spread Components Related to Each Risk</i>				
Asset Type	Net Market Spread	IG Net Spread Benchmark <sup>1</sup>	Guideline Excess Spread	Risk Factor A	Risk Factor B	Risk Factor C	Risk Factor D	Other Risk Factors / Unallocated
Asset Class XYZ	2.5%	1.5%	1.0%	-0.7%	0.2%	0.5%	0.8%	0.2%

Risk Factor A has a negative Excess Spread Component in this illustrative example as Asset Class XYZ has less net Market Spread attributed to it (0.3%) than the Investment Grade Net Spread Benchmark (1.0%).

## Appendix C: Potential Sources of Information

There are a number of sources of information – both subject matter experts and vendor systems – as well as market analytics which may be useful in performing this analysis.

### POTENTIAL RESOURCES

There are a number of resources that an Appointed Actuary can utilize in performing the Guideline Excess Spread attribution. First, as this is a fairly technical analysis, subject matter experts are an important resource for conducting the analysis. Subject matter experts can be internal (e.g., portfolio managers, investment traders, asset class specialists, asset pricing specialists) and/or external (e.g., consultants). Additionally, investment analytical systems may have useful analytics that may be utilized in the attribution.

### MARKET ANALYTICS

There are a number of existing and widely accepted market metrics that may be useful in the attribution analysis. While there is likely no single system or set of metrics that would directly allow the Appointed Actuary to perform the entire attribution, the metrics below may be useful for pieces of the attribution analysis:

### CREDIT-RELATED

- **VM-20 Table A** (Baseline Annual Default Costs) ([pbr-2021-table-a-baseline-annual-default-costs.xlsx](#) ([live.com](#))): NAIC-derived annual default costs used by many companies in Principles-Based Reserves (and related) work. Derived from Moody's Corporate Bond Default Study data.
- **Probability of Default (PD)**: This is a quantitatively derived likelihood that a bond will default over a specified time horizon, based upon companies with similar characteristics at similar points in the economic and credit cycles. Many PDs are for a 1-year horizon. Others are through-the-cycle, intended to reflect an entire economic cycle. There are a number of PD models, the most well-known is the Merton model.
- **Loss Given Default (LGD)**: This is the loss, expressed as a percent of par, for a bond that defaults. It is equivalent to (100% - recovery rate).
- **Credit Default Swap (CDS)**: A financial derivative that provides default protection against a bond issuer. CDS can either be bought (buying protection) or sold (selling protection, which is equivalent to adding credit risk). Most CDS are originally contracted for 5-year tenors. Prices on most CDS are generally expressed in bps per year per dollar of notional value that the buyer pays to the seller.

Note: Since the majority of pure credit risk on life insurer balance sheets (e.g., public corporates) is out of scope for the Guideline Excess Spread attribution, and the CDS market is primarily on public corporates, there may be limited direct applicable information for CDS on assets that are the focus of AG 53. However, there are takeaways and learnings that could be applied when comparing CDS vs. asset spreads. Additionally, CDS can help inform any attribution of the Investment Grade Net Spread Benchmark.

### VOLATILITY / CALL / PREPAYMENT-RELATED

- **Option-adjusted spread (OAS)**: market spread based on a stochastic analysis, as opposed to a single deterministic path; as the name states, adjusts for embedded optionality in an asset; historically has been performed using swap rates
- **Zero-volatility spread (ZVS or Z-spread)**: a special case of OAS where volatility is zero and all paths collapse into a single spot rate curve; similar to nominal spread except cash flows discounted using spot rates instead of a single risk-free yield – also uses swap rates instead of Treasuries

**LIQUIDITY-RELATED**

- **Liquidity Credit Score (LCS):** a quantitative framework developed by Barclays ([BARCLAYS RESEARCH](#) [\(barcap.com\)](#)) that quantifies hypothetical transactions costs
  - There is a very strong correlation between a bond’s market spread and LCS
  - LCS is not a spread but could be used to develop a quantitative relationship that converts it into a spread component

## Appendix D: Other Practical and Technical Implications

There are a number of practical and fairly technical issues that an Appointed Actuary may come across in performing this analysis. Below is a partial list of some of these issues:

- Different market conventions on quoting yield and spread
  - Day count differences
    - Treasury: ACT/ACT
    - Corporates: 30/360
  - Spreads quoted off underlying Treasury
    - Corporates: maturity or WAL
    - ABS: closest on-the-run Treasury
- Periodicity of payments
  - Treasury / US Corporates: semi-annual
  - Structured assets: primarily monthly or quarterly
- Mixing different yield curves, option pricing models, etc. that are inputs to spread
  - Example: using OAS and ZVS (based off swaps curve) is not directly comparable to a nominal spread to Treasuries

These are likely rounding errors relative to broader attribution assumptions that a company must make but are worth considering and incorporating into the initial analysis.

## References

Fabozzi, Frank J (edited by). *Handbook of Fixed Income Securities, Ninth Edition*.

Konstantinovskiy, Vadim. Barclays Liquidity Cost Scores (LCS®): A Brief Introduction. April 27, 2020, [https://live.barcap.com/publiccp/RSR/nyfipubs/barcap-email-mkting/qps/LCS\\_In-brief.pdf](https://live.barcap.com/publiccp/RSR/nyfipubs/barcap-email-mkting/qps/LCS_In-brief.pdf), (accessed October 20, 2022).

National Association of Insurance Commissioners. Actuarial Guideline LIII — Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves. October 6, 2022, <https://content.naic.org/sites/default/files/inline-files/AG%2053.pdf>, (accessed October 6, 2022).

## About The Society of Actuaries Research Institute

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## MEMORANDUM

TO: Life Actuarial (A) Task Force

FROM: NAIC Legal Division  
Daniel Schelp—Chief Counsel, Regulatory Affairs

RE: Comparison of Model #822 to VM-30 for Accreditation Purposes

DATE: January 18, 2023

Both the *Standard Valuation Law* (#820) and the *Actuarial Opinion and Memorandum Regulation* (#822) are currently part of the NAIC’s *Liabilities and Reserves Accreditation Standard*. Model #820 provides that the *Valuation Manual* should be adopted uniformly by the states. It came to the attention of the Financial Regulation Standards and Accreditation (F) Committee that there is substantial overlap between the significant elements of Model #822 and the *Valuation Manual* with respect to actuarial opinions; i.e., VM-01 “Definitions for Terms in Requirements” and VM-30 “Actuarial Opinion and Memorandum Requirements.” The Committee requested that the Life Actuarial (A) Task Force review the accreditation standard for Model #822 to determine whether VM-01 and VM-30 meet the necessary actuarial opinion requirements of Model #822. This would permit Model #822 to be removed from the accreditation standards, with the *Valuation Manual* standing alone as the accreditation standard for actuarial opinions.

To help facilitate this discussion by the Task Force, the NAIC Legal Division has prepared the following comparison of the significant accreditation elements of Model #822 with VM-01 & VM-30 to determine whether state adoption of the *Valuation Manual* is substantially similar to Model #822 for accreditation purposes:

### ***Actuarial Opinion and Memorandum Regulation (#822)***

#### **v. Scope provisions similar to those in Section 3?**

Section 1A(1) “Scope” of VM-30 provides, as follows: “The following provisions contain the requirements for the actuarial opinion of reserves and for supporting actuarial memoranda in accordance with Section 3 of Model #820, and are collectively referred to as Actuarial Opinion and Memorandum (AOM) requirements.” In addition, Section 3B of Model #820 is applicable to all actuarial opinions filed after the operative date of the *Valuation Manual*. Section III of the Introduction to the *Valuation Manual* provides:

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Kansas City 1100 Walnut Street NW, Suite 1500, Kansas City, MO 64106-2197	p   816 842 3600	f   816 783 8175
New York One New York Plaza, Suite 4210, New York, NY 20004	p   212 398 9000	f   212 382 4207

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### III. Actuarial Opinion and Report Requirements

Requirements regarding the annual actuarial opinion and memorandum pursuant to Section 3 of Model #820 are provided in VM-30, Actuarial Opinion and Memorandum Requirements. The requirements in VM-30 are applicable to all annual statements with a year-ending date on or after the operative date of the Valuation Manual. Existing actuarial opinion and memorandum requirements continue to apply to all annual statements with a year-ending date before the operative date of the Valuation Manual.

Unlike the reserving requirements under VM-20, there is no small company exemption applicable to the actuarial opinion and memorandum requirements. Therefore, VM-30 should apply to all applicable actuarial opinions filed after the operative date of the *Valuation Manual*. It is the opinion of the NAIC Legal Division that VM-30 meets the requirements of this significant element.

#### w. Definitions similar to Section 4?

Section 1A(1) of VM-30 provides for the definition of “Actuarial Opinion”, while VM-01 contains the definitions of “Actuarial Standards Board” and “Annual Statement.” VM-01 also provides for the definition of “Appointed Actuary” that is similar to Section 5C of Model #822, and the definition of “Qualified Actuary” that is similar to Section 5B. Section 2B of VM-30 then provides for the definition of “Asset Adequacy Analysis” that meets the standards of Section 5D of Model #822. It is the opinion of the NAIC Legal Division that VM-01 and VM-30 meet the requirements of this significant element.

#### x. General Requirements similar to Section 5?

Section 2 of VM-30 provides general requirements under Model #822 for Section 5A “Submission of Statement of Actuarial Opinion”; Section 5C “Appointed Actuary”; Section 5D “Standards for Asset Adequacy Analysis”; and Section 5E “Liabilities Covered” of Model #822. VM-01 then provides for the general requirements for the definition of “Qualified Actuary” under Section 5B of Model #822. However, it should be noted that Section 2A(1) of VM-30 does not provide that the commissioner may grant an extension for submission of the statement of actuarial opinion similar to Section 5A(2) of Model #822. It is the opinion of the NAIC Legal Division that VM-01 and VM-30 meet the requirements of this significant element.

#### y. Provisions for statement of actuarial opinion based on an asset adequacy analysis similar to Section 6?

Section 2A(1) of VM-30 provides for the General Requirements for Submission of Statement of a Life Actuarial Opinion, while Section 3A of VM-30 provides for Statement of Actuarial Opinion Based on an Asset Adequacy Analysis similar to Section 6 of Model #822. It should be noted that the Alternate Option(s) to the requirements of Section 6B(6)(c) set forth in Section 6F of Model #822 permitting the commissioner to accept the valuation of a foreign insurer are not fully addressed in VM-30. However,

Section 3A(7)(c) of VM-30 does provide alternative language for use in such situations. It is the opinion of the NAIC Legal Division that VM-30 meets the requirements of this significant element.

**z. Provisions for description of an actuarial memorandum including an asset adequacy analysis similar to Section 7?**

Section 3B of VM-30 provides for a Description of the Actuarial Memorandum, Including an Asset Adequacy Analysis similar to Section 7 of Model #822. It is the opinion of the NAIC Legal Division that VM-30 meets the requirements of this significant element.

**aa. Provisions for regulatory asset adequacy issues summary similar to Section 7?**

Section 3B(13) of VM-30 provides for a Regulatory Asset Adequacy Issues Summary similar to Section 7C of Model #822. It is the opinion of the NAIC Legal Division that VM-30 meets the requirements of this significant element.

Dates: Received	Reviewed by Staff	Distributed	Considered
11/18/22, updated 12/14	SO		
APF 2022-07			

Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force  
**Amendment Proposal Form**

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

Brian Bayerle, ACLI – Clarification of adjustments to mortality for policies subject to the NPR and for policies that pass the Life PBR Exemption when anticipated experience exceeds the prescribed CSO table.

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

Valuation Manual (January 1, 2022 edition), VM-20 Section 3.C.1.g, VM-20 Section 6.B.5.d.

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

See attached.

**12/14/22 Update:** The redline indicates changes from the Valuation Manual. Redline sections that are highlighted indicate changes from the previous 9/8/22 exposure. Some deletions of text that was added in the 9/8/22 version but deleted in the 12/14/22 exposure were not included in the redline below, including the removal of mortality rate capping language from sections 3.C.1.g.i and 3.C.1.g.ii and replacement into section 3.C.1.g.ii.a and the deletion of references to “FUW” policies in the guidance note.

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

The purpose of this proposed amendment is to clarify the intent and calculation of the mortality adjustments to the CSO table when anticipated mortality exceeds the prescribed CSO table. The current wording of Section 3.C.1.g has led to confusion by many and a lack of consistent interpretations. The APF does not change the current requirements of VM-20, it only provides clarification. This APF revises the edits made by APF 2018-57.

There are five questions the APF is trying to answer:

1. **What policies are intended to be addressed by Section 3.C.1.g?**

The primary intent of Section 3.C.1.g is to address the higher anticipated mortality for policies that are not subject to full underwriting (FUW), such as simplified issue policies and final expense policies. It is typical for these types of policies to have mortality experience worse than the CSO table, and thus, an adjustment is necessary.

The intent of Section 3.C.1.g is not to test every possible FUW subset (e.g., attained age blocks, individual underwriting classes with lower credibility, etc.) to determine if its mortality experience is higher than the CSO table even though more aggregate mortality experience is lower than the CSO table. However, if a large, credible block or subset of FUW policies (e.g., a block of FUW business assumed from another company that has significantly different mortality experience than the rest of the assuming company’s FUW business, or a large block of business from an era when the company had significantly more permissive underwriting, etc.) is expected to have worse experience than the CSO table, then the adjustments in 3.C.1.g should be made.

A guidance note has been added following Section 3.C.1.g. to provide this clarification.

**2. What is meant by the current language in Section 3.C.1.g that the “adjustments should be consistent with the adjustments made for the DET Net Premium test” in Section 6.B.5.d?**

This wording has led to a lot of confusion. Some have interpreted this wording to mean that the adjustment factors should be the same as those defined in Section 6.B.5.d. Others have concluded that this means the form of the adjustments should be the same. Others have concluded that this means the same methodology should be used to determine the adjustments. And if the company does not elect to use the DET, there are no adjustment factors to be consistent with.

This APF clarifies that for the group of policies where the DET has been elected, the methodology to test whether adjustments are needed should be consistent with Section 6.B.5.d (that is, using a comparison of the PV of future death claims) and a reasonably consistent approach should be used to determine the adjustment factors). For groups of policies where the DET has not been elected, a reasonably consistent approach should be used.

**3. Are the adjustments to the CSO table in Section 3.C.1.g determined on a seriatim basis or can policies be grouped to determine the adjustments?**

The current wording is not clear as to whether the adjustments are determined on a seriatim basis or grouped basis, resulting in inconsistent interpretations. This APF clarifies that the adjustments to the CSO table for the NPR calculation are to be determined using a group of policies (consistent with the approach used in Section 6.B.5.d), not on a seriatim basis. Since the NPR is calculated on a policy-by-policy basis, the application of the adjustments must be applied to each policy on a seriatim basis, but the factors themselves can be determined using a group of policies.

Determining the adjustment factors on a seriatim basis is inconsistent with determining mortality experience for any other purpose. When data is not credible, the resulting mortality rates may not be smooth or consistent. For example, if the anticipated experience for male age 50 results in an adjustment factor of 1.3, but the adjustment factor for male age 48 is 2.1 (based on limited non-credible data), this results in the mortality rate for male 48 being higher than the rate for male 50.

This APF clarifies that the determination of the adjustment factors in Section 3.C.1.g. is to be done on a grouped basis. However, similar to the DET requirement, a company may not group together policies with significantly different risk profiles.

**4. How do the requirements of Section 3.C.1.g apply to policies that pass the Life PBR Exemption?**

Policies that pass the Life PBR Exemption are still subject to the requirements of Section 3.C.1 (per Section II.G.4 of the Valuation Manual). But Section 3.C.1.g includes references to the NPR and the DET which do not apply to these policies. To clarify, section 3.C.1.g. has been split into two sections: 1) policies that pass the Life PBR Exemption and 2) policies that are not utilizing the Life PBR Exemption and are subject to the NPR requirements. For policies that pass the Life PBR Exemption, all references to the NPR and DET have been removed.

**5. How do the requirements in Section 3.C.1.g. apply when calculating deficiency reserves?**

Policies that pass the Life PBR Exemption still must determine deficiency reserves, which has led to confusion on how the requirements of section 3.C.1.g apply when determining deficiency reserves. Section 3.C.1 is based on the basic reserve calculation (Section 3.B.6). Once the valuation mortality rates have been adjusted (if needed) by Section 3.C.1.g for the basic reserve, then the calculation of X-factors for the deficiency reserve follows the normal approach as described in VM-A and VM-C. This APF clarifies that the mortality adjustment in 3.C.1.g only applies to the basic reserve for policies that pass the Life PBR Exemption, and not the deficiency reserve.

Deficiency reserves are not needed for policies that are not utilizing the Life PBR Exemption. The NPR for policies other than term and ULSG equals the basic reserve defined in VM-A and VM-C, the NPR for term and ULSG follow the requirements of Section 3.4 and 3.5, and the DR and SR calculations already reflect the circumstances that give rise for the need for a deficiency reserve.

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### Section 3: Net Premium Reserve

#### C. Net Premium Reserves Assumptions

- 1.g For a group of policies where the anticipated mortality experience ~~materially~~ exceeds the prescribed CSO mortality rates determined in Section 3.C.1.a through 3.C.1.d~~f~~ above, the company shall adjust the CSO mortality rates as follows:
- i. For policies that pass the Life PBR Exemption, the CSO mortality rates used to determine the basic reserve for each policy shall be adjusted in a manner commensurate with the anticipated mortality experience for the policies. The methodology used to test whether adjustments are needed can be performed on an aggregate basis for the group of policies using a reasonable method to compare the respective mortality rates, such as comparing the present value of future death claims discounted at the valuation interest rate used for VM-A and VM-C. However, for the purposes of this comparison, a company may not group together policies with significantly different risk profiles. If an adjustment is needed, the determination of the adjustment factors should use a reasonable methodology, subject to a cap that ensures that mortality rates do not exceed 1,000 per 1,000.
  - ii. For policies where the Life PBR Exemption is not utilized, the CSO mortality rates used in the NPR calculation shall be adjusted in a manner commensurate with the anticipated mortality experience for the policies.
    - a) When the company elects to use the DET in Section 6.B for a group of policies, the methodology used to test whether adjustments are needed should be consistent with the methodology used in Section 6.B.5.d (that is, using a comparison of the PV of future death claims discounted at the valuation rate used for the NPR) . For the purposes of this comparison, a company may not group together policies with significantly different risk profiles. If an adjustment is needed, the determination of the adjustment factors should use a reasonably consistent methodology to the one used in Section 6.B.5.d., subject to a cap that ensures that the mortality rates do not exceed 1,000 per 1,000.
    - b) For the group of policies where the DET is not used, the company should use a reasonably consistent approach to the one described in paragraph a) above to test whether adjustments are needed and to determine the adjustment factors. The resulting adjustment factors are not required to be identical to the adjustment factors determined in paragraph a) above.

The resulting NPR must not be lower than the NPR calculated without adjustments to the CSO mortality rates.

**Guidance Note:** It is anticipated that the 3.C.1.g adjustments are generally applicable but not limited to policies with limited underwriting, such as simplified issue or final expense. The intent of Section 3.C.1.g. is not to test every possible group of policies (e.g., attained age blocks, individual underwriting classes with lower credibility, etc.) to determine if its mortality experience is higher than the CSO table even though more aggregate mortality experience is lower than the CSO table. However, if a large, credible block or group of policies (e.g., a block of business assumed from another company that has significantly different mortality experience than the rest of the assuming company's business, or a large

block of business from an era when the company had significantly more permissive underwriting, etc.) is expected to have worse experience than the CSO table, then the adjustments in 3.C.1.g should be made.

## **Section 6: Stochastic and Deterministic Exclusion Tests**

### **B. Deterministic Exclusion Test (DET)**

- 5.d. If the anticipated mortality for the group of policies exceeds the prescribed CSO mortality rates for the NPR determined in Section 3.C.1.a through 3.C.1.g, then the company shall use anticipated mortality to determine the valuation net premium. For this purpose, mortality shall be measured as the present value of future death claims as of the valuation date discounted at the valuation interest rate used for the NPR.

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force  
 Amendment Proposal Form\***

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

Brian Bayerle, ACLI – Clarify requirements on groups of contracts that use the Alternative Method/AG33 in VM-21 and are not subject to a principles-based valuation. Such contracts should not be not subject to VM-G but still require a sub-report under VM-31.

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

Valuation Manual Jan. 1, 2023 Edition; VM-21 Section 3.E, VM-31 Section 2.A, VM-G Section 1 and Section 4.A.3.

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

See attached.

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

There is some ambiguity about the governance requirements if a principles-based valuation is not performed.

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

NAIC Staff Comments:

<b>Dates: Received</b>	<b>Reviewed by Staff</b>	<b>Distributed</b>	<b>Considered</b>
11/4/22	SO		
<b>Notes:</b> APF 2022-08			



**VM-21****Section 3: Reserve Methodology**

## E. Alternative Methodology

For a group of variable deferred annuity contracts that contain either no guaranteed benefits or only GMDBs—i.e., no VAGLBs—the reserve may be determined using the Alternative Methodology described in Section 7 rather than using the approach described in Section 3.C and Section 3.D. However, in the event that the approach described in Section 3.C and Section 3.D has been used in prior valuations for that group of contracts, the Alternative Methodology may not be used without approval from the domiciliary commissioner.

The reserve for the group of contracts to which the Alternative Methodology is applied shall not be less than the aggregate cash surrender value of those contracts.

Groups of contracts to which the Alternative Methodology is applied are only subject to the applicable requirements for the Alternative Methodology in VM-21. Groups of contracts to which the Alternative Methodology is applied are subject to the applicable sub-report requirements outlined in VM-31 Sections 3.E and 3.F. Groups of contracts to which the Alternative Methodology is applied are not subject to the requirements of VM-G Sections 2 and 3.

**VM-31****Section 2: General Requirements**

- A. Each year a company shall prepare, under the direction of one or more qualified actuaries, as assigned by the company under the provisions of VM-G, a PBR Actuarial Report if the company computes a deterministic reserve or stochastic reserve or performs an exclusion test for any policy as defined in VM-20, or computes an aggregate reserve for any contract as defined in VM-21.

A company that does not compute any deterministic or stochastic reserves under VM-20 for a group of policies as a result of the policies in that group passing the exclusion tests as defined in VM-20 Section 6 must still develop a sub-report for that group of policies that addresses the relevant requirements of Section 3.

A company that computes reserves under the Alternative Methodology defined in VM-21 must still develop a sub-report with the applicable requirements to the Alternative Methodology for that group of policies that addresses the relevant requirements of Section 3.

**VM-G****Section 1: Introduction, Definition and Scope**

- A. The corporate governance guidance provided in VM-G is applicable only to a principle-based valuation calculated according to methods defined in VM-20 and VM-21, **except for the following condition:**

For a company that does not compute any deterministic or SR under VM-20 as a result of passing the exclusion tests as defined in VM-20 Section 6, and ~~it does not calculate any~~ all contracts subject to reserves under VM-21 are determined by application of the Alternative Methodology, VM-G Sections 2 and 3 below are generally not applicable; the requirements of Section 4 are still applicable. However, if the company calculated the SERT using the DR method outlined in VM-20 Section 6.A.2.b.i.a, or the Stochastic Exclusion Demonstration Test outlined in VM-20 Section 6.A.3, then VM-G Sections 2 and 3 are applicable.

**Section 4: Responsibilities of Qualified Actuaries**

- A.3 The responsibility for providing a summary report to the board and to senior management on the valuation processes used to determine and test PBR, the principle-based valuation results, the general level of conservatism incorporated into the company's PBR, the materiality of PBR in relationship to the overall liabilities of the company, and significant and unusual issues and/or findings.

If Sections 2 and 3 are not applicable because the company met the requirements to be exempt from Section 2 and Section 3 as outlined in Section 1.A, this particular reporting to board and senior management is limited to:

- a. For VM-20, notifying senior management if the company is at risk of failing either exclusion test, and if so, reporting on the company's readiness to calculate deterministic and SR-; and
- b. For VM-21, notifying senior management if the company may not be able to use the Alternative Methodology for all business subject to VM-21, and if so, reporting on the company's readiness to calculate a SR.

March 20<sup>th</sup>, 2023

**From:** Seong-min Eom, Chair  
The Longevity Risk (E/A) Subgroup

**To:** Rachel Hemphill, Chair  
The Life Actuarial (A) Task Force

**Subject:** The Report of the Longevity Risk (E/A) Subgroup to the Life Actuarial (A) Task Force

The Longevity Risk (E/A) Subgroup has not met since the Fall National Meeting. The subgroup will resume the meetings once the currently exposed VM-22 PBR methodology is finalized and adopted to develop and recommend longevity risk factor(s) for the product(s) that were excluded from the application of the current longevity risk factors.

March 20, 2023

**From:** Pete Weber, Chair  
The Variable Annuities Capital and Reserve (E/A) Subgroup

**To:** Rachel Hemphill, Chair  
The Life Actuarial (A) Task Force

**Subject:** The Report of the Variable Annuities Capital and Reserve (E/A) Subgroup (VACR SG) to the Life Actuarial (A) Task Force

The VACR SG has not met since the Fall National Meeting. At the request of LATF, the Chair has made a request to the Society of Actuaries to expand the work they are currently carrying out for the VM-22 Standard Projection Amount Mortality DG to include variable annuities. More specifically, to develop mortality rates to be used as prescribed assumptions within the VM-21 Standard Projection Amount. Work continues on this project and a report and recommendations are still several weeks away.

March 20, 2023

**From:** Fred Andersen, Chair  
Indexed Universal Life (IUL) Illustration (A) Subgroup

**To:** Rachel Hemphill, Chair  
The Life Actuarial (A) Task Force

**Subject:** The Report of the Indexed Universal Life (IUL) Illustration (A) Subgroup (IUL Illustration SG) to the Life Actuarial (A) Task Force

The IUL Illustration SG has not met since the adoption of group's main work product, revisions to Actuarial Guideline 49A, by the Life Actuarial (A) Task Force on December 11, 2022. The revisions to Actuarial Guideline 49A were subsequently adopted by the Life Insurance and Annuities (A) Committee and will be considered by the NAIC's Executive (EX) Committee and Plenary at the upcoming Spring National Meeting on March 25. The IUL Illustration SG will continue to meet after the Spring NAIC National Meeting to consider broader measures for improving IUL illustrations.

March 20, 2023

**From:** Pete Weber, Chair  
Index-Linked Variable Annuity (A) Subgroup

**To:** Rachel Hemphill, Chair  
The Life Actuarial (A) Task Force

**Subject:** The Report of the Index-Linked Variable Annuity (A) Subgroup (ILVA SG) to the Life Actuarial (A) Task Force

The ILVA SG has not met since the adoption of group's main work product, Actuarial Guideline 54 (ILVA), by the Life Actuarial (A) Task Force on December 11, 2022. Actuarial Guideline 54 was subsequently adopted by the Life Insurance and Annuities (A) Committee and will be considered by the NAIC's Executive (EX) Committee and Plenary at the upcoming Spring National Meeting on March 25. After full adoption of Actuarial Guideline 54, the Life Actuarial (A) Task Force will consider next steps for the ILVA SG, which could include folding any relevant remaining charges into those of the Task Force and/or disbanding the ILVA SG.

**mn** COMMERCE DEPARTMENT

# VM-22 Project Overview

Ben Slutsker, Chair, NAIC VM-22 Subgroup

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# Agenda

- Introduction to Non-Variable Annuity PBR
- History and Project Plan
- Exposures and Upcoming Meetings
- Key Issues
- Standard Projection Amount
- Field Test and ESG

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# What is Non-Variable Annuity PBR?

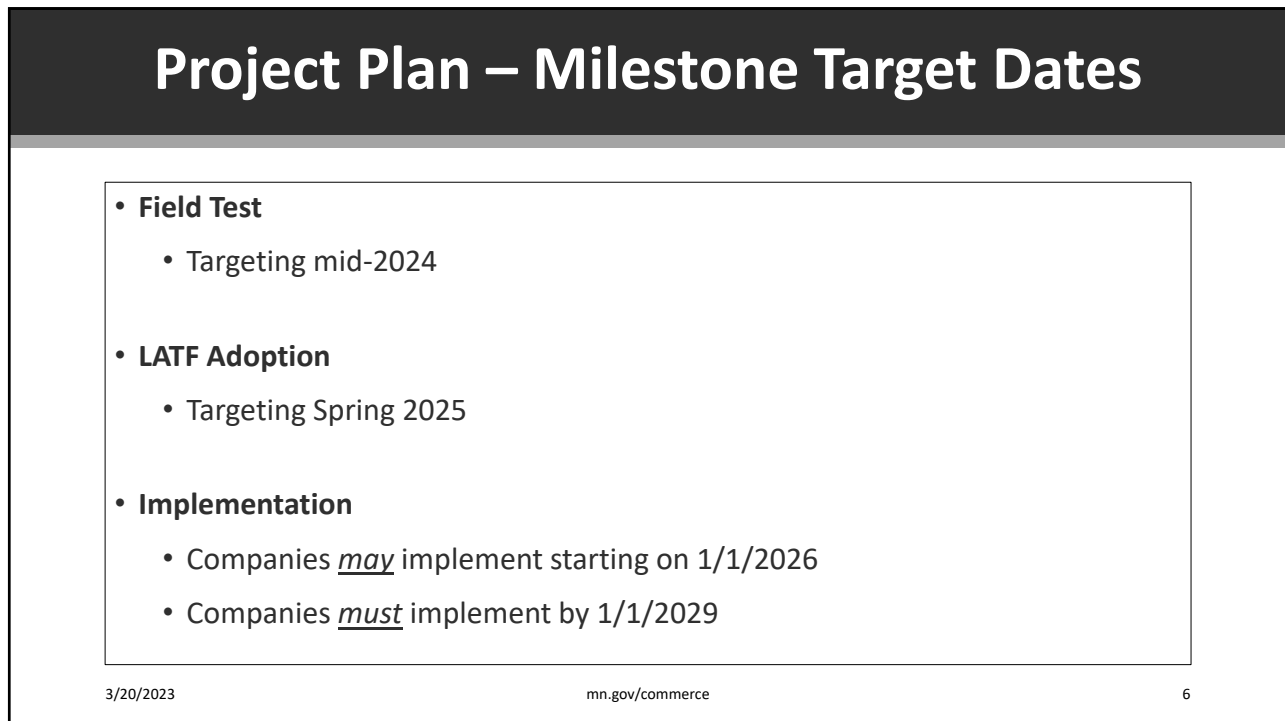
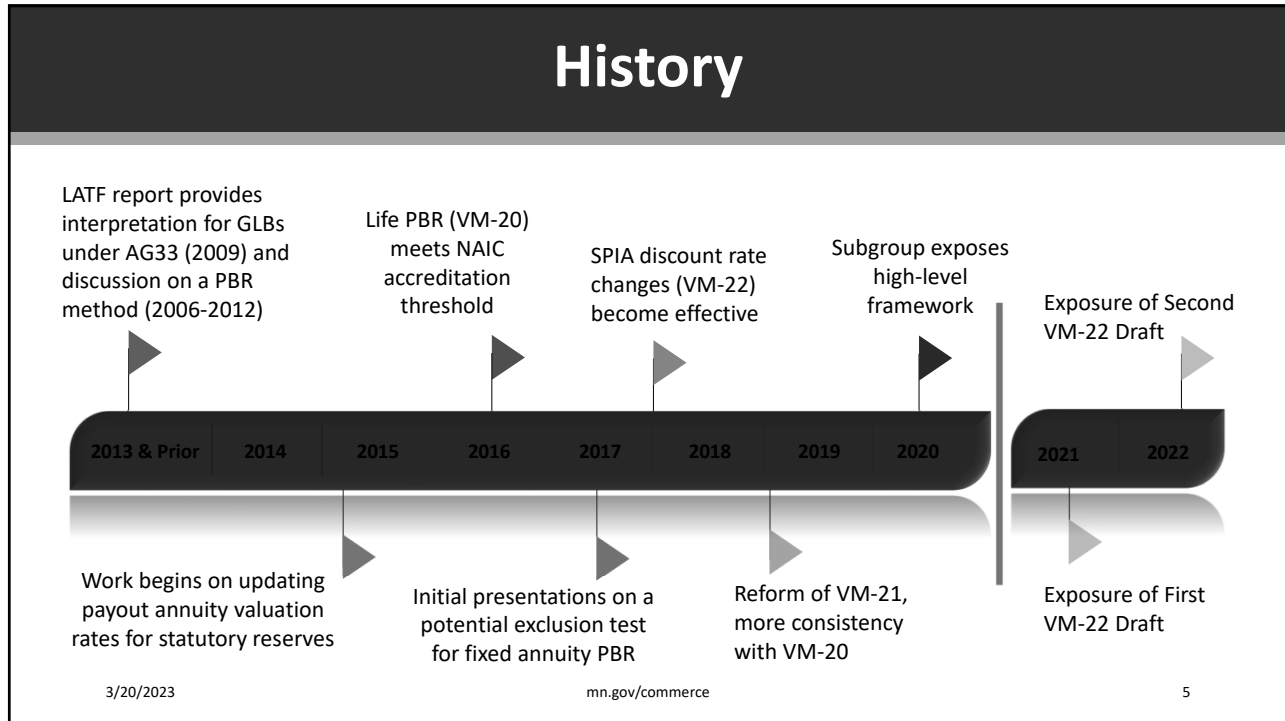
- **Principle-Based Reserving (PBR)**
  - Statutory reserve framework that uses company-specific assumptions
  - Multiple economic scenarios through stochastic reserving (CTE70)
  - Applicable to all fixed annuity contracts, except GICs and stable value contracts<sup>1</sup>
- **Contrast to current reserve framework**
  - Formulaic methodology: Actuarial Guideline 33
  - Highest present value of future guaranteed benefits less considerations across all possible product options and scenarios using prescribed assumptions
- **Requirements contained in NAIC Valuation Manual**
  - Process for adopting amendments to valuation manual permits streamlined updates

(1) RILAs and Contingent Deferred Annuities to follow VM-21 in latest draft

# Why Non-Variable Annuity PBR?

- **PBR exists in life insurance and variable annuities**
  - All variable annuity contracts and only life contracts issued in 2020+ (or implementation date if earlier)
- **Advantage of PBR is addressing product complexity**
  - More guaranteed living benefits, index options, and other features
  - Contracts that are hybrid variable, indexed, and fixed annuities
- **One challenge is that additional resources are required to review and audit**
  - Two companies may have identical products and populations, but different views on future assumptions
  - More calculation detail: asset modeling, dynamic lapses, and rider utilization





## Project Plan – 2022 (past)

DRAFT TIMELINE	12 21	1 22	2 22	3 22	4 22	5 22	6 22	7 22	8 22	9 22	10 22	11 22	12 22
SPA DG - develop assumptions/methodology	█	█	█	█	█	█	█	█	█	█			
VM22 SG calls - Address comment letters and edits					█	█	█	█	█	█	█		
ESG Field Test #1							█	█	█	█	█	█	
Second VM-22 exposure												█	█
NAIC National Meeting December 12 - 15, Tampa FL												█	█
ESG Field Test #1 Analysis												█	█
SPA Discussions at VM-22 Subgroup												█	█

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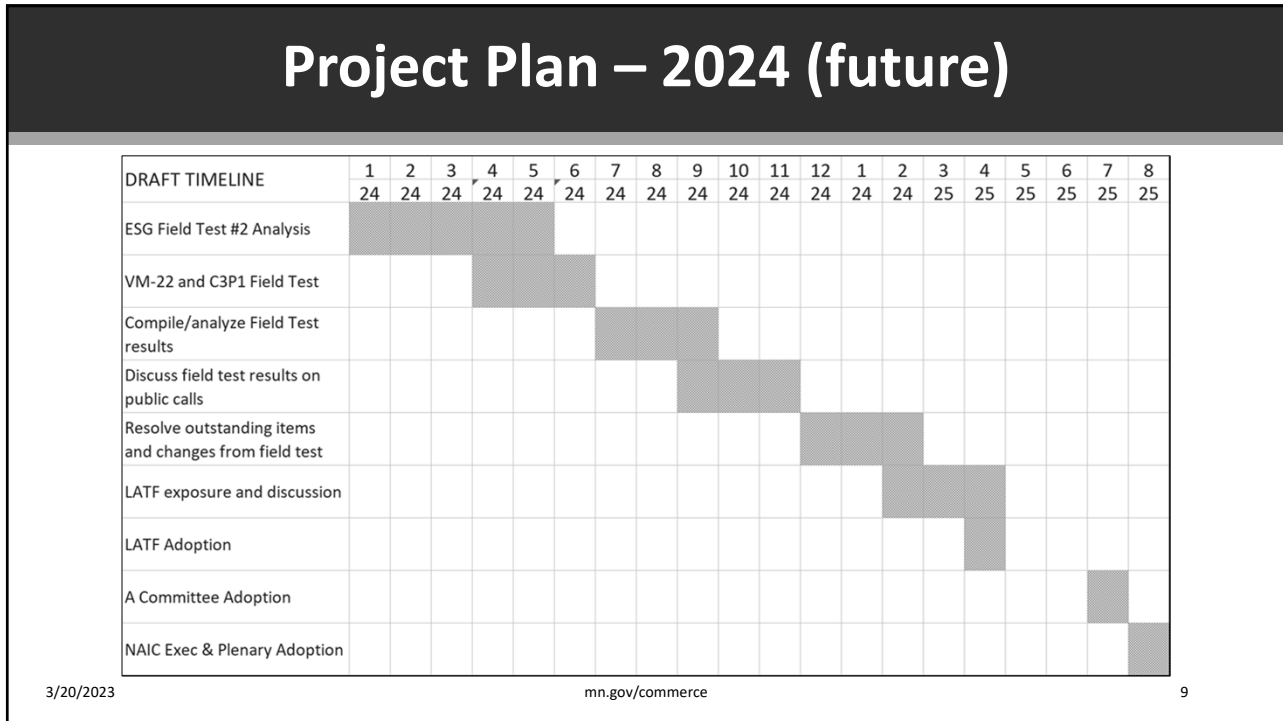
## Project Plan – 2023 (present)

DRAFT TIMELINE	1 23	2 23	3 23	4 23	5 23	6 23	7 23	8 23	9 23	10 23	11 23	12 23
ESG Field Test #1 Analysis	█	█	█									
SPA Discussions at VM-22 Subgroup	█	█	█									
Discuss comments from Fall VM-22 draft exposure			█	█	█	█						
SPA Structure Exposure				█	█	█						
VM-31 DG meetings to prepare recommendation						█	█	█				
VM-31 Exposure									█	█	█	
Discuss Comments on SPA Structure Exposure									█	█	█	
ESG Field Test #2 (timeline estimate)											█	█

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## Upcoming Meetings

- **Scheduled to meet on a bi-weekly basis in 2023**
  - First meeting held on 3/1; next to be held on 4/12 (due to NAIC National Meeting)
- **Focus on comments for VM-22 Exposure**
  - Review on comment-by-comment basis
- **Firm up standard methodology mechanics**
  - Assumptions and Methodology

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## First Exposure Comments

- **Initial exposure in July 2021**
  - Academy proposal
  - NAIC VM-22 Subgroup aggregation categories
- **Eleven comment letters**
  - Nearly 400 comments
- **Categorized each comment into one of four tiers**
  - Based on priority
  - Determined order of discussion in NAIC VM-22 Subgroup

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## Second Exposure Comments

- **Exposure in October 2022**
  - Included revisions based on 2022 discussions
  - Reflects Subgroup decisions on how to address each comment in first exposure
- **Three comment letters**
  - Nearly 200 comments
- **Process to discuss comments will mirror the first exposure**
  - Categorized each comment into one of four tiers
  - For the fourth tier (less substantive or non-controversial), initial edits will be shared by the Subgroup and will be taken up on public calls upon request from interested parties

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## Key Issues Preliminarily Determined

- **Aggregation**
  - Payout vs. Accumulation vs. Longevity Reinsurance Reserving Categories
- **Exclusion test: applicability and concept**
  - Pass = option to use pre-PBR; fail = must use PBR
  - Stochastic exclusion ratio test, demonstration test, or certification method
- **Use of PBR Exemption**
  - Companies with volume of business below a threshold may be exempt
- **Different treatment for index credit hedging programs**
  - Reflect a hedge margin and, unlike other programs, no requirement to model without hedges

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## Key Issues in midst of Being Determined

- **Longevity reinsurance**
  - Currently discussing a “k-factor” methodology similar to CRVM
- **Exclusion test carveout for payout annuities**
  - Certain types of payout annuity contracts that can automatically pass exclusion testing?
- **Allocation of reserves to each contract**
  - Narrowed down to one proposed methodology based on an actuarial present value calculation
- **PBR Exemption level**
  - Decide the appropriate threshold to permit exemption eligibility
- **SPA mechanics**
  - Upcoming exposure and placeholder assumptions

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## Key Issues Yet to Be Determined

- **Reinvestment guardrail**
  - Use current VM-20/VM-21 or Academy proposal or something else?
- **Exclusion test threshold**
  - Passing level for the stochastic exclusion ratio text
- **Level of minimum index credit hedge margin**
  - To be determined based on future field test results
- **Standard Projection Amount treatment**
  - Minimum reserve floor or disclosure-only?

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## Standard Projection Amount

- **VM-22 Subgroup is recommending to develop calculation**
  - No recommendation on whether to use as a disclosure or floor
- **LATF to address how to use the standard projection amount**
  - Targeting consistency with VM-21
- **Drafting groups have presented initial mortality, policyholder behavior, and other liability assumptions**
  - Society of Actuaries have developed mortality factors upon drafting group requests
  - Willis Towers Watson and Academy presented proposed expense assumptions

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## Field Test

- **Jointly run by NAIC, Academy, ACLI**
  - Selecting consultant to manage field test
  - Targeting mid-2024
- **Will test both principle-based capital and reserves**
  - Comparison to today's standards (CARVM vs. C-3 Phase I)
  - Sensitivities and impact of margins
  - To inform decisions around exclusion ratio test and reinvestment mix
- **Applies to recently issued inforce business**
  - Will help approximate the impact to future written contracts

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## Relationship to Economic Scenario Generator

- **NAIC Economic Scenario Generator provides scenarios**
  - Generates assumptions for treasuries, equities, and bond funds
- **Currently under development**
  - Forming acceptance criteria
  - Already one field test and planning for a second field test
- **Dependency**
  - Field testing an economic scenario generator materially different than the one ultimately adopted could lead to results different than future reserve levels

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# Prospective vs Retrospective

- **Initially prospective**
  - For ease of project management and regulation changes
  - Start to review impact and work through mechanics
- **To explore retrospective implementation**
  - After initial prospective implementation
  - Consider the development of principle-based capital
- **Applicability of additional contracts out-of-scope**
  - GICs, funding agreements, and stable value contracts

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# Questions?

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Draft: 3/11/23

Valuation Manual (VM)-22 (A) Subgroup  
Virtual Meeting  
March 1, 2023

The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met March 1, 2023. The following Subgroup members participated: Ben Slutsker, Chair (MN); Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); Vincent Tsang (IL); Nicole Boyd (KS); William Leung (MO); Bill Carmello and Amanda Fenwick (NY); Rachel Hemphill and Iris Huang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Heard an Update on the VM-22 Project Plan

Slutsker walked through an updated project plan (Attachment Ten-A), including noting that a VM-22, Requirements for Principle-Based Reserves for Non-Variable Annuities, field test would not occur in 2023 due to dependencies on the economic scenario generator (ESG) project. Slutsker said that the latest target for adoption of VM-22 was 2025.

2. Discussed the VM-22 Exemption

Slutsker said that the Subgroup had voted last year to include an exemption for small companies in the draft VM-22 requirements and that now the Subgroup would need to decide on how the threshold would be defined. Chupp commented that for VM-20, Requirements for Principle-Based Reserves for Life Products, one of the goals was to right size reserves so that some companies would see increases and others would see decreases to reserves. Chupp then asked if one would expect reserves to be lower for the new VM-22 methodology compared to the current methodology. Slutsker noted that while there were no field test results to point to, there was a general expectation that reserves would be lower for the new VM-22 methodology for many, though not all, products. Chris Conrad (American Academy of Actuaries—Academy) noted that the Academy supports basing the exemption on gross of reinsurance values, to which a number of regulators agreed.

Carmello made a motion, seconded by Tsang, to use gross of reinsurance values to define the threshold. The motion passed unanimously.

Slutsker then stated that the next part of the exemption discussion to define was the level of the threshold. Conrad said the Academy supports level of \$1 billion dollars of reserves based on comparisons made to the Life PBR Exemption. Brian Bayerle (American Council of Life Insurers—ACLI) said that the ACLI could be supportive of \$1 billion to \$2 billion dollars as the exemption threshold.

A roll call vote was then conducted on the threshold amount for an individual company, with Yanacheak and Carmello voting for a \$3 billion statutory reserve exemption level and the remaining, and large majority of, Subgroup members present voting for a \$1 billion exemption threshold.

Having no further business, the VM-22 (A) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/ 2023-1-Spring/VM-22 Calls/03 01/Mar 1 Minutes.docx

**PBR VM-22 Project Draft Timeline**

**EFFECTIVE DATE GOALS**

1/1/2026		PBR VM-22 mandatory prospectively																													
#	DRAFT TIMELINE	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8
8	Discuss comments from Fall VM-22 draft exposure	23	23	23	23	23	23	23	23	23	23	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24
9	SPA Structure Exposure																														
10	VM-31 DG meetings to prepare recommendation																														
11	VM-31 Exposure																														
12	Discuss Comments on SPA Structure Exposure																														
13	ESG Field Test #2 (timeline estimate)																														
14	ESG Field Test #2 Analysis																														
15	VM-22 and C3P1 Field Test																														
16	Compile/analyze Field Test results																														
17	Discuss field test results on public calls																														
18	Resolve outstanding items and changes from field test																														
19	LATF exposure and discussion																														
20	LATF Adoption																														
21	A Committee Adoption																														
22	NAIC Exec & Plenary Adoption																														

**NAIC VM-22 Drafting Discussion Log - 2022 Exposure**

#	Topic	Description	Date	Tier	Outcome
1	Exemption Threshold Level	Discuss potential reserve thresholds, below which companies can apply for VM-22 exemption	3/1/2023	1	
2	Exemption Reinsurance Treatment	Are the reserves for the exemption levels gross or net of reinsurance?	3/1/2023	1	
3	Longevity Reinsurance k-factor Approach	Consider principles-based methods for longevity reinsurance requirements?	3/1/2023	1	
4	GLB Exemption Eligibility	Allow GLBs to be eligible for the exemption? Only if in payout status? What if only the GLB piece is reinsured?	TBD	2	
5	VM-21 vs. VM-22 Applicability	For principles in Section II, say "shall follow" or "generally expected to follow"?	TBD	2	
6	Combo Product Valuation	Should nursing riders and combo products be valued under PBR or prior formulaic reserves?	TBD	2	
7	Reserving Category for GLB with Depleted AV	Use principle-based categorization or require a specific reserving category?	TBD	2	
8	Frequency of Reviewing PBR Assumptions	Current text specifies reviewing experience annually, but assumptions periodically - align the two? Every 3 years?	TBD	2	
9	Rider Valuation	Add "After issuance" for determining whether a rider's reference to base policy results in valuing them together?	TBD	3	
10	Two Benefits in a Contract	"May" or "should" assume the more valuable of two benefits in a contract?	TBD	3	
11	Longevity Reinsurance Premium Frequency	Remove the statement specifying that premiums are paid over the life of the annuitant?	TBD	3	
12	Separate Account References	Remove references to the Separate Account in VM-22?	TBD	3	
13	Guidance Note in Section 3.A	Make guidance note part of formal text?	TBD	3	
14	Aggregation within each Reserving Category	Clarifying guidance on aggregation within reserving categories	TBD	3	
15	Revisiting Aggregation	View expressed that a more principles-based approach for aggregation	TBD	3	
17	Annuitization from Other Host Contracts	VM-21 vs. VM-22 treatment for annuitizations from host contracts	TBD	3	
18	Supplementary Contracts	Need a definition for supplementary contracts?	TBD	3	
16	Pre-determined Reinsurance Premiums	If premiums are pre-determined for longevity reinsurance, how does the k-factor approach apply?	TBD	3	
19	Index Credit Hedge Margin	Determine prescribed minimum margins	TBD	3	

NAIC VM-22 Drafting Discussion Log - 2022 Exposure

#	Topic	Description	Date	Tier	Outcome
20	Projection Period	No obligations or not <i>material</i> obligations at the end of the projection period?	TBD	3	
21	MVA Threshold	Should there be a percentage threshold of market value assets in a portfolio to determine MVA treatment?	TBD	3	
22	Longevity Reinsurance Guidance Note	Clarify guidance note saying that deterministic assumptions are not appropriate for longevity reinsurance	TBD	3	
23	Term Certain in SPIA SET exemption	Include "Annuities Certain" and "Supplementary Contracts" from Exhibit 7 in SPIA threshold definition?	TBD	3	
24	PRT Exclusion Testing treatment	Keep ineligibility for PRT and longevity reinsurance to automatically pass exclusion test through SPIA carveout?	TBD	3	
25	SPIAs with increasing benefits & optionality	Allow SPIA exclusion test treatment to include fixed COLA, 50% joint, non-elective changes) rather than 5% standard	TBD	3	
26	Payout Annuity Exemption Definition	Remove group annuities from payout exemption reserve definition if excluding PRT/reinsurance from carveout?	TBD	3	
27	Index vs. Non-Index Hedging Bifurcation	What if a company does not clearly separate hedging strategies for index vs. non-index hedge programs?	TBD	3	
28	E Factor Examples	Clarify examples listed for the E-factor for hedging purposes is non-exhaustive?	TBD	3	
29	Sensitivity Test Immateriality	Should sensitivity testing include assumptions that are deemed to be immaterial? (e.g., account transfers, etc.)	TBD	3	
30	Less Conservative Than Experience	Allow immaterial risk factors or low/no credibility to not be bound by less conservative than experience limit?	TBD	3	

NAIC VM-22 Drafting Discussion Log - 2021 Exposure

#	Topic	Description	Date	Tier	Outcome
1	VM-22 Scope and Definitions	Keep current definitions for what is in-scope or focus only on non-variable annuities out of scope	4/13/2022, 10/4/2022	1	Exposed principles in Section II of the Valuation Manual, moved definitions to VM-01, and removed references to product names in VM-22 section 2
2	Reserving categories and aggregation	Determine Option 1 or Option 2 from exposed reserve category definitions	4/13/2022	1	Preliminary vote to pursue Option 1
3	Small Company Exemption	Fixed Annuity PBR exemption, similar to life PBR exemption for smaller carriers?	4/13/2022, 10/4/2022	1	Voted to pursue a "Fixed Annuity PBR Exemption"; Exposed ACLI proposed threshold based on prior year reserves, with some modifications
4	Reinvestment Guardrail	Keep VM-20/VM-21 mix, Academy mix, TX mix, or other? Wait until field test for final decision?	4/27/2022	1	Wait until observing impact in field testing results before voting on a reinvestment mix guardrail
5	Principles & Risks Across VM Chapters	Build one section in the Valuation Manual for principles that apply to VM-20, VM-21, and VM-22	4/27/2022	2	Openness to interested party proposals for a common "principles" section, but will focus on working through other VM-22 decisions before exploring
6	General Assumptions Section	Add a section to the VM-22 draft on general considerations and requirements for assumption	4/27/2022	2	Will include a proposed general assumptions section ("Section 13") from Texas, to be consistent with a recent APF adoption on VM-21
7	Transition Period	Permit 1) early adoption and 2) retrospective adoption to the start of the 3-year transition period?	4/27/2022	2	Decided to not pursue early adoption; VM-22 will say silent on retrospective adoption to start of transition period, similar to VM-20
8	Minimum Error for Index Credit Hedges	What should be the minimum breakage expense (i.e., error) for modeling hedges supporting index credits?	5/11/2022	2	Will wait until seeing field testing results before minimum threshold
9	Longevity Reinsurance	How should longevity reinsurance be defined and treat negative reserves/recurring premiums?	5/11/2022	2	Academy presented on longevity reinsurance and will provide a refined definition; New Jersey proposal is exposed for reserving requirements
10	Categories for VM-31 Disclosures	What level of granularity should be required for disclosing PBR reserves for product groups in VM-31?	5/11/2022	2	Will wait until seeing field testing results before determining granularity of disclosures
11	Exclusion Test: SPIA contracts	Allow SPIAs to have the option of PBR vs. pre-PBR valuation without an exclusion test?	6/1/2022	2	Voted to allow SPIAs automatically pass exclusion testing, subject to criteria around optionality and a liability duration threshold (TBD)
12	Exclusion Test: PRT Certification Method	Allow PRT contracts to use the Certification Method for exclusion testing?	6/1/2022	2	Do not allow PRT to undergo the Certification Method
13	Exclusion Test: Grouping	Group between products with significantly different risk profiles?	6/1/2022	2	Do not allow grouping between products with significantly different risk profiles, consistent with VM-20 and TDI's proposal
14	Exclusion Test: Future Premiums	For the stochastic exclusion ratio test, determine whether to include future premiums	6/1/2022	2	Include future premiums in the numerator, but only benefits and expenses in the denominator, consistent with VM-20.
15	Exclusion Test: Deterministic Reserve	To pass the deterministic test, does the company need to pass or disclose 16 scenarios with baseline mortality?	6/1/2022	2	Require passing the ratio test for 16 economic scenarios under 100% of the anticipated experience mortality assumption
17	Import Reinsurance Wording from VM-20	Import VM-20 wording on incorporating contractual or additional characteristics for modeling reinsurance?	6/14/2022	2	Include proposed wording from VM-20
18	Fair Value Certification	Include fair value certification, similar to existing VM-21 requirement?	6/14/2022	2	Include fair value certification disclosure for non-index credit hedging programs
16	PRT Mortality	Permit PRT mortality with limited credibility to follow a third-party provider instead of an industry table?	6/14/2022	2	Voted in favor of using a prescribed table; do not permit a third party table upon limited credibility
19	Allocation Method	Determine Option 1 or Option 2? Wait until observing field test results before deciding?	9/21/2022	2	Using an ACLI proposal based on Option 2 for the VM-22 exposure, which addresses a tax issue for non-life contingent annuities

NAIC VM-22 Drafting Discussion Log - 2021 Exposure

#	Topic	Description	Date	Tier	Outcome
20	Working Reserve	Use a working reserve concept to serve as a floor for contracts without cash surrender value?	6/29/2022	2	Academy will work on a working reserve concept for contracts without cash surrender value, though may be little impact due to reserving categories
21	Grouping for Fund Value Depletion	Appropriate reserving category for deferred annuities with GMWBs/GMIBs that have depleted fund value	6/29/2022	2	Decided to leave these contracts in the "Payout Reserving Category" for now, but will add a drafting note to solicit feedback an optional approach
22	RBC Guidance Note	Retain the guidance note in VM-21 that discusses the relationship between reserves and RBC?	8/17/2022	3	ACLI will provide the full text for the Subgroup to consider
23	Principle 1	Should the edits to Principle 1 for VM-22 be incorporated into VM-21 as well?	8/17/2022	3	For now, will plan to focus only on VM-22, as LATF can explore the other VM chapters upon the Subgroup's recommendation of the VM-22 draft to LATF
24	Principle 2	Does setting an SR to be reasonably conservative over a span of economic cycles contradict other principles?	7/13/2022	3	ACLI will provide the full text for the Subgroup to consider
25	Aggregation Limits	Guidance note stating aggregation may not be possible for experience rated group and reinsurance treaties	7/13/2022	3	Will include this text in the VM-22 draft
26	Principle 3	Delete "Generally, assumptions are to be based on the conservative end of the confidence interval"?	7/13/2022	3	Retain this language
27	Principle 5	Delete sentence about the principle to not reduce the reserve unless reducing the risk?	7/13/2022	3	Retain this language
28	Risks not reflected	Retain or remove the list of "Risks not reflected" in VM-22?	7/13/2022	3	Remove subsection 3, but keep section 4 and update title to include "risks not reflected"
29	Separate Account References	Recommendation to delete all references to "separate accounts" in VM-22	7/13/2022	3	For now, will keep references to "separate accounts" and will add a drafting note to solicit feedback
30	Combination Risks	Proposal to delete "Risks modeled in the company's risk assessment processes that are related to the contracts"	7/13/2022	3	Retain this language
31	Immaterial Risks	Recommendation to delete sentence about not reflecting risks that do not materially affect the reserves	7/13/2022	3	Remove this language
32	Liquidity Risk	Refer to liquidity risks for "run on bank" or "sudden and significant levels of withdrawals and surrenders"	7/13/2022	3	Use the "run on bank" description
33	Significant Future Reserve Increases	Strike this item from the list of risks not reflected?	7/13/2022	3	Retain this language
34	Fixed Annuity Definition	Need to define a "fixed annuity"?	7/13/2022	3	Will replace all references to "fixed annuity" with "non-variable annuity"
35	Longevity Swaps	Are these contracts included in the definition of PRT?	7/13/2022	3	As a follow-up, Academy will include reviewing the definition of PRT when revisiting the definition of longevity risk
36	CSV and GMDB definitions	Retain VM-21 definitions for "cash surrender value" and "guaranteed minimum death benefits"?	7/13/2022	3	Will not retain the definition for "cash surrender value" and will move the "guaranteed minimum death benefits" to VM-01
37	Assumed reserve level for RBC	Question whether CTE70 was the assumed level for reserves upon determining RBC	7/19/2022	3	Question relates to RBC, and therefore did not discuss as part of the VM-22 Subgroup
38	VM-23	Consider reinstating "VM-23" to avoid confusion around the where exemptions/exclusions point to vs. PBR?	7/19/2022, 10/4/2022	3	Exposed moving the current VM-22 requirements (previously Section 14 in the VM-22 draft) to a separate "VM-V" section in the Valuation Manual.

NAIC VM-22 Drafting Discussion Log - 2021 Exposure

#	Topic	Description	Date	Tier	Outcome
39	Pre-Reinsurance	Request to develop further guidance around pre-reinsurance	7/19/2022	3	ACLI will consider whether to provide suggested language to clarify pre-reinsurance cash flow requirements in response to the next exposure
40	Deterministic Reserve	Use this term for the single scenario reserve calculated upon passing the deterministic exclusion test?	7/19/2022	3	Will replace "scenario reserve" with "deterministic reserve". Also added "aggregate minimum reserve" as the term for the final reserve
41	Deterministic Certification Option	Keep this terminology or change?	7/19/2022	3	Given that the term "deterministic reserve" will not be used, decided to keep this terminology
42	Stochastic Exclusion Test	Change Section 3.E to "Stochastic Exclusion Test" header?	7/19/2022	3	Accepted comment and made change to update header
43	Guidance Note for Exclusion Test	Remove the guidance note that clarifies that AG33/AG35 may be used upon passing the exclusion test	7/19/2022	3	Decided to remove this guidance note
44	Prudent Estimate Assumptions	Move Section 3.G to Section 4 of the document?	7/19/2022	3	Subgroup decided to hold off for now
45	Simplifications	Port over VM-21 Section 3.H on simplifications, approximations, and modeling efficiency techniques?	7/19/2022	3	Subgroup agreed to add this wording for simplifications, to be consistency with VM-21
46	Review experience every three years?	Make this a requirement for the qualified actuary?	7/19/2022	3	Subgroup agreed to include a requirement to review experience every three years
47	Simplification example for the SPA	Add an example of a simplification for the SPA upon development	7/19/2022	3	Delete for now and revisit upon development of the SPA
48	Stochastic Mortality	Consider including stochastic mortality in the stochastic reserve for longevity reinsurance?	7/19/2022	3	Subgroup agreed to port over VM-20 language on stochastic modeling when static prudent estimates are not appropriate for liability assumptions
49	MVA Guidance Note	Is the market value adjustment guidance note from VM-21 still appropriate for VM-22?	8/17/2022	3	Subgroup decided to remove guidance note
50	Hedging Reorganization	Move parts of Section 4.A.4 to Section 9, which covers hedging	8/17/2022	3	Open to comments on restructuring this section during the next exposure
51	Future Hedging Programs	Align VM-22 draft to be consistent with APF 2020-12 adopted edits for VM-21?	8/17/2022	3	Subgroup decided to be consistent with APF 2020-12 language
52	Index Credit Hedge Margin	Does this reflect both model risk and real-world error? How does stress testing justify the error?	8/17/2022	3	Wording is added to state that both sources of error are reflected in the margin; in addition the reference to stress testing will be removed
53	Margin on Hedging Paragraph	Remove this paragraph if included in another section, even upon edits from TDI/OPBR?	8/17/2022	3	Open to comments on restructuring this section during the next exposure
54	Revenue Sharing	Is the section of revenue sharing applicable to non-variable products?	8/17/2022	3	Decided to retain this section
55	Projection Period	Use consistent language with VM-20?	8/17/2022	3	Kept the first sentence to be consistent with VM-20, but removed the second proposed sentence, since now the approximation section has been added
56	PIMR	Include pre-tax IMR in VM-22?	8/17/2022	3	Refer to LATF
57	MVA on CSV Floor	Apply the market value adjustment factor to the cash surrender value reserve floor for applicable products?	9/7/2022	3	Will not add language applying the MVA to the CSV floor; instead new language states the MVA shall only apply when assets are held at market value

NAIC VM-22 Drafting Discussion Log - 2021 Exposure

#	Topic	Description	Date	Tier	Outcome
58	Consistency with Managed Business	Modify NAER requirement to have assets modeled in a manner consistent with how business is managed?	8/24/2022	3	ACLI will consider whether to recommend specific edits related to this comments
59	Limits on NAER	Define a specific cap or floor for the NAER instead of saying it should not be "unreasonably high"?	8/24/2022	3	Subgroup decided to modify language to change "unreasonably high" to "extremely positive or negative", which covers both directions
60	Reserve Floor	NY comment on using CARVM as a reserve floor	8/24/2022	3	Will hold off on discussing the standard projection amount until after the other sections of VM-22 are re-exposed, in Fall of 2022
61	Longevity Reinsurance & SPA	Require the k-factor approach to address negative reserve issue for longevity reinsurance in SPA?	8/24/2022	3	Will hold off on discussing the standard projection amount until after the other sections of VM-22 are re-exposed, in Fall of 2022
62	Standard Projection Amount	Equitable comment on supporting SPA with company assumptions insignificant risk factors	8/24/2022	3	Will hold off on discussing the standard projection amount until after the other sections of VM-22 are re-exposed, in Fall of 2022
63	Exclusion Testing & SPA	Modify exclusion test to address the standard projection amount?	8/24/2022	3	Will hold off on discussing the standard projection amount until after the other sections of VM-22 are re-exposed, in Fall of 2022
64	Hedging eligibility for exclusion testing	Refine wording around the restriction for not allowing blocks with hedging programs to use exclusion testing?	8/24/2022	3	Academy will suggest possible disclosures to better identify "hedging programs solely supporting index credits"
65	Mortality Stress Tests	If using the NY7 for the Certification Method, add mortality stress scenarios?	8/24/2022	3	Added language for mortality stress scenarios if using the NY7 Certification Method
66	Mortality Shock	Include the mortality shock for the ratio test based on the company materiality standard if more restrictive?	8/24/2022	3	No objections to modifying the stochastic exclusion ratio test to use the company materiality standard if more restrictive
67	Baseline Mortality Test	Include the baseline mortality test in determining the exclusion test?	6/1/2022	3	Subgroup agreed to include the baseline mortality scenario for the stochastic exclusion ratio test
68	Permutations	Include note on number of exclusion test permutations for clarity?	6/1/2022	3	Updated guidance note to include the number of permutations, inclusive of testing economic scenarios under the mortality baseline
69	Non-Proportional Reinsurance	Add definition for non-proportional reinsurance	8/24/2022	3	Decided to add a guidance note that references the APPM for clarification on the non-proportional reinsurance
70	SERT if Other Tests Fail	Prohibit passing the SERT if the demonstration test fails?	8/24/2022	3	Added language to prohibit passing the stochastic exclusion ratio test if the demonstration test fails
71	Demonstration Test	Remove options in 1.a and 2.a?	8/24/2022	3	ACLI will take back and decide whether to recommend removing the demonstration test altogether, or only certain components/language
72	Deterministic Exclusion for SPA	Consider SPA for the deterministic exclusion test	8/24/2022	3	Will hold off on discussing the standard projection amount until after the other sections of VM-22 are re-exposed, in Fall of 2022
73	Deterministic Exclusion Scenario	Is the deterministic certification intended not be applicable for blocks with index credit hedging?	9/7/2022	3	Intent is for the deterministic certification option to not apply to also not apply to hedging programs supporting index credits; no changes made
74	SPIA Guidance Note	Remove guidance note specifying that the deterministic exclusion test applies to SPIAs?	9/7/2022	3	No objections to removing guidance note
75	Delta Hedging	Replace or remove example about delta hedging for VM-22?	9/7/2022	3	Remove example referring to delta hedging
76	Non-Elective Benefits	Remove guidance note to limit modeling non-elective benefits after CSV is depleted if reducing reserves?	9/7/2022	3	No objections to language, but removed guidance note because the similar wording already existed in the paragraph above

NAIC VM-22 Drafting Discussion Log - 2021 Exposure

#	Topic	Description	Date	Tier	Outcome
77	100% Policyholder Efficiency	Assuming 100% policyholder inefficiency contradicts VM Section II 6.H.2., so revise VM Section II?	9/21/2022	3	Replace VM Section II language with the principle that efficiency increases over time
78	NGE Board of Directors	Comment that only allowing NGE exclusion if approved by the Board does not necessarily seem reasonable	9/21/2022	3	Removed this language from the draft, but added a drafting note to inquire on why potential language may be appropriate
79	Unsupported Judgement	Comment to remove the reference to using "unsupported actuarial judgement" from Section 11	9/21/2022	3	No objections to removing this language
80	Mortality and Reinsurance	Does Section 11.A require evaluation of a plus vs. minus segment differently for pre- vs. post reinsurance?	9/21/2022	3	This language is not included in VM-21 and was removed from the VM-22 draft
81	Mortality Improvement	Is the mortality improvement requirement intended to apply to all mortality assumptions in VM-22?	9/21/2022	3	Addressed by clarifying that this section only applies to industry mortality assumptions
82	Option 1 DR vs SR	Require separate allocation for DR vs. SR for allocation Option 1 (Section 13)?	9/21/2022	3	Agreed to add wording to clarify the allocation between the DR and SR should be separate
83	Option 2 for Direct Iteration Method	Option 2 is not designed to work for the Direct Iteration Method	9/21/2022	3	ACLI will consider adding language to address the direct iteration method
84	Option 2 Single Scenario	Could produce unstable allocation when products with different risk profiles are aggregated for PBR	9/21/2022	3	Reserving categories will require separate allocation for payouts and accumulation-based annuities
85	Index-linked annuity	This term is used in the proposed Section II, Subsection 2 draft, but is not defined	10/4/2022	3	Implicitly addressed through the proposed set of principles for scope of VM-21 vs. VM-22 in Section II of the Valuation Manual
86	Modified Guaranteed Annuities (MGAs)	VM-21 has language that exempts contracts falling under scope of MDL-255; does this contradict Section II edits?	10/4/2022	3	Implicitly addressed through the proposed set of principles for scope of VM-21 vs. VM-22 in Section II of the Valuation Manual

# RISING INTEREST RATE ISSUES

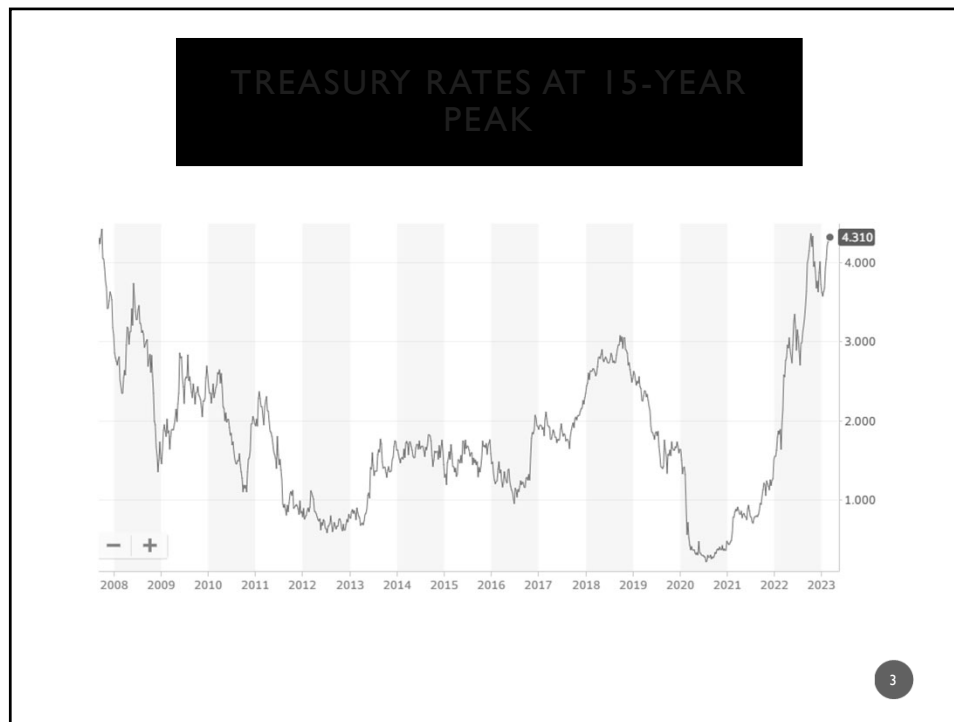
March 2023

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## AGENDA

- Overview of Rising Interest Rate topic
  - Fred Andersen, Minnesota Department
- Dynamic Lapse and Other Relevant Experience
  - Dale Hall, Society of Actuaries
- Appointed Actuary Roundtable on Rising Interest Rate Impact
  - Ben Slutsker, Minnesota Department (Moderator)
  - Theresa Resnick, Everlake Life
  - Stephen McNamara, New York Life
  - Robert Egan, Global Atlantic

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### PAST 15 YEARS

- Annuities with high long-term guaranteed credited rates on the books of many life insurers
- Declining portfolio yields due to lower reinvestment rates
  - Due to declining Treasury rates and steady spreads
- With high guarantees, annuity liabilities thought of as “sticky”
- Increased illiquidity in supporting assets
  - Little perceived risk of people surrendering their rich-guarantee annuities

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## 2022 – RISING INTEREST RATES

- Insurers with deferred annuities model up interest rate scenarios
  - Disintermediation risk
    - Rising rates -> declining bond market values (higher discounting of bond coupons and par)
      - A particular concern with illiquid assets
    - Declining asset market values only matter if asset is sold
    - A company investing long may not be able to reinvest to take advantage of rising rates
    - A competitor may be positioned to offer favorable credited rates
    - Surprise surrenders may occur, triggering sale of “underwater” assets
      - Losses for the insurer

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## DYNAMIC LAPSES – A:E


- Life insurers with deferred annuities have assumed dynamic lapses
- Question: how will dynamic lapse experience compare to assumptions?
  - Dale Hall will provide information from the Society of Actuaries and other research

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## OTHER RISING RATE ISSUES


- **Accuracy of asset market values**
  - Most assets have a deep secondary market – straightforward valuation
  - Some complex assets are valued internally
    - AG 53 contains a question on this issue – step-by-step description required
- **Most issues should have been captured in past cash-flow testing**
  - A reason for multiple interest rate scenario testing
- **Some issues – wait and see**
  - Appointed Actuary roundtable will provide perspectives



# CHANGING INTEREST RATES: RESEARCH UPDATE

March 2023

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## Presentation Disclaimer

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## Fixed Rate Deferred Annuity Surrenders

- Last large SOA/LIMRA study released in 2006 with large focus on fixed deferred annuities; approximately 70% were book value products with no market value adjustment or equity index component
- Looking to initiate update to study this year
- Key factors impacting surrender activity
  - Time remaining in surrender charge period
  - Age of policyholder
  - Distribution method
  - Difference between Credited Rate and New Market Rate
- Factors reaffirmed by other industry studies in recent years
- Surrender functions commonly modeled using level and time remaining of surrender charges, current credited rates and proxy for potential new money rate from competing products



<https://www.soa.org/resources/experience-studies/2005-2009/deferred-annuity-persist>  
<https://ruark.co/wp-content/uploads/2021/08/COVID-and-annuity-PH-behavior-2021-update.pdf>

## Product Lines and Considerations

- AAA Asset Adequacy Analysis Practice Note
  - [https://www.actuary.org/sites/default/files/files/Asset\\_Adequacy\\_Practice\\_Note\\_Exposure\\_August2014.pdf](https://www.actuary.org/sites/default/files/files/Asset_Adequacy_Practice_Note_Exposure_August2014.pdf)
  - Increased focus for sensitivity testing include dynamic lapse parameters
  - Base Lapses and Dynamic Lapses both among the most commonly sensitivity-tested assumptions
- Interactions Between Dynamic Lapses and Interest Rates in Stochastic Modeling
  - SOA Product Matters
  - <https://www.soa.org/globalassets/assets/library/newsletters/product-development-news/2010/june/pro-2010-iss77-xue.pdf>



## Product Lines and Considerations


- The Impact of a Rising Interest Rate Environment on Life Insurance
  - <https://www.soa.org/sections/reinsurance/reinsurance-newsletter/2021/october/rsn-2021-10-tall/>
- The Impact of a Rising Interest Rate Environment on GAAP and Statutory Financial Reporting
  - <https://www.soa.org/sections/financial-reporting/financial-reporting-newsletter/2021/july/fr-2021-07-su/>



## Product Lines and Considerations

- Market Trends and Product Designs in a Rising Interest Rate Environment
  - <https://www.soa.org/sections/product-dev/product-dev-newsletter/2021/november/pm-2021-11-sun-moench-strother-ruscito-lee-mu/>
- Mechanics of Dividends
  - <https://www.soa.org/resources/research-reports/2022/mechanics-dividends/>






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## Update on Mortality Experience Data Collection

Pat Allison, FSA, MAAA

March 20, 2023

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## Update on 2021 Data Collection

- NAIC actuarial staff has calculated Actual to Expected mortality ratios for each company based on their submitted data for observation years 2018 and 2019.
- We have asked companies to review their A/E's and let us know if they are in line with their expectations.
- During their review, some companies have identified corrections that needed to be made to their data. So far, 11 companies have resubmitted their 2018 and 2019 data and another 6 companies have indicated that they plan to do so.


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## Update on 2021 Data Collection

Status on company A/E approvals for observation years 2018 and 2019:

Companies that have approved their A/E	88
Companies that have resubmitted 2018 and 2019 and have been provided revised A/E ratios to review	4
Companies that have indicated they plan to resubmit 2018 and 2019 data	6
Companies that have not yet approved their A/E. NAIC staff is meeting with these companies to discuss further.	9
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## Update on 2021 Data Collection

- NAIC staff is working with the SOA to verify the consistency and integrity of the data, initially focusing on analysis of data from companies that have approved their A/E ratios.
- Data analysis includes:
  - Comparison of 2018 and 2019 data collected by the NAIC vs. data collected prior to the 2018 observation year
  - Review of consistency of companies/data from year to year
  - Comparisons to population data
  - Statistical analysis

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## Update on 2022 Data Collection

- We have received initial data submissions from 105 companies (all companies selected for observation year 2020).
- This year we had 69 resubmissions compared to 125 last year. The reduction in resubmissions is a result of the data files being much cleaner this time.
- Many companies have communicated to the NAIC that they have implemented process improvements in order to provide better data.
- Approximately 25 companies have requested an extension in order to submit corrected data files and/or respond to NAIC feedback.

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## Update on 2022 Data Collection

- For the 2022 data collection, we asked companies to voluntarily use a new “Death due to Covid-19” cause of termination (this becomes mandatory in 2023). Many companies have done so.
- Similarly, we asked companies to voluntarily use new plan codes for Paid-Up Additions and One Year Term coverages purchased with dividends. Many companies have done this as well.
- The NAIC has hired 2 data scientists to assist with validations and data analysis.

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Dates: Received	Reviewed by Staff	Distributed	Considered
Notes:			

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force**

**Amendment Proposal Form\***

- Identify yourself, your affiliation and a very brief description (title) of the issue.  
Society of Actuaries Valuation Basic Table Team – Chair Larry Bruning  
Revisions to VM-51 to allow for the data experience reporting observation calendar year to be one year prior to the reporting calendar year.

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

January 1, 2023, version of the Valuation Manual – VM-51 Section 2.D.

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

**Section 2: Statistical Plan for Mortality**

- Process for Submitting Experience Data Under This Statistical Plan

Data for this statistical plan for mortality shall be submitted on an annual basis. Each company required to submit this data shall submit the data using the Regulatory Data Collection (RDC) online software submission application developed by the Experience Reporting Agent. For each data file submitted by a company, the Experience Reporting Agent will perform reasonability and completeness checks, as defined in Section 4 of VM-50, on the data. The Experience Reporting Agent will notify the company within 30 days following the data submission of any possible errors that need to be corrected. The Experience Reporting Agent will compile and send a report listing potential errors that need correction to the company.

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be one year prior to the reporting calendar year. For example, if the current calendar year is 2022 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year 2021, which is the observation calendar year. For the 2024 reporting calendar year, companies who are required to submit data for this statistical plan for mortality will be required to submit two observation calendar years of data, namely observation calendar year 2022 and observation calendar year 2023. For reporting calendar years after 2024, companies who are required to submit data for this statistical plan for mortality will be required to submit one observation calendar year of data.

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Given an observation calendar year of 20XX, the calendar year method requires reporting of experience data as follows:

- Report policies in force during or issued during calendar year 20XX.



Dates: Received	Reviewed by Staff	Distributed	Considered
Notes:			

- ii. Report terminations that were incurred in calendar year 20XX and reported before July 1, 20XX+1. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during the second quarter, and the data is to be submitted according to the requirements of the *Valuation Manual* in effect during that calendar year. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Dec. 31 of the reporting calendar year. State the reason for the proposed amendment? (You may do this through an attachment.)


This APF is needed for the following reasons:

1. There is a need to shorten the time period between data observation and data collection to facilitate more timely analysis and reporting of mortality experience.
2. Under a Principle Based Reserving methodology, valuation basic tables should reflect recent and current mortality experience.

**Deleted:** For any reporting calendar year, the data call will occur during the second quarter, and data is to be submitted according to the requirements of the *Valuation Manual* in effect during that calendar year. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Dec. 31 of the reporting calendar year.

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**NAIC Economic Scenario  
Generator Field Test:  
VM-21 and C3 Phase II  
Quantitative Results**

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**March 20, 2023**

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**Agenda**

1. Background and Purpose
2. Limitations
3. Field Test Run Descriptions
4. Field Test Participation
5. High-Level Results, Observations, and Drivers of Results
6. Next Steps
7. Detailed Field Test Results

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## Background and Purpose


- The purpose of this presentation is to summarize quantitative information from the VM-21/C3 Phase II field test participants to:
  - Understand the impact on reserves and capital,
  - Evaluate the impact of hedging programs across field test scenario sets,
  - Review the range of results across field test participants,
  - Compare the stability of results over time, and
  - Inform regulator decision-making on model and calibration choices.


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## Limitations

- The NAIC took steps to review the quantitative results for reasonableness, including comparing field test data to annual statement values, reviewing qualitative survey responses, sending questions to participants, and asking participants to confirm that the NAIC compilations matched their intended result submission. However, the accuracy and reliability of the results are ultimately dependent on the quality of participant submissions.
- The field test reserve and/or capital participant analytics (average reserve/ capital impact, range of impacts, etc.) can be strongly dependent on a subset of the participants. Results shown today for the different field test runs will include varying numbers of participants corresponding to the levels of participation for that run. The lack of participation in some of the runs will limit their applicability to the overall variable annuity industry.
- Four legal entities were excluded from the analysis due to results that did not seem reasonable to the NAIC.
- A number of comparisons between company-provided field test or baseline runs are made in the presentation. These comparisons are limited to the participation of whichever run had the least participation. For example, as Baseline 2 (as of 12/31/19 + 200 BP) had significantly lower participation than run 2A, many of the 2A results will not be shown for this comparison.
- For the most part, companies did not make changes to their models to account for changes in the field test scenario sets. Therefore, field test results may not be fully representative of company results post implementation of the new scenarios.

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<h2>Field Test Run Descriptions</h2>		
<b>Note: Bold = Required Run</b>		
Run #	Description	Purpose of Run
<b>Baseline #1</b>	Scenario set(s) the company used for 12/31/21 statutory reporting	Baseline used as comparative basis for 12/31/21 runs
Baseline #2	ESG the company used for 12/31/21 statutory reporting of reserves and RBC, but modified to produce scenario sets with a 12/31/19 yield curve modified using a 200 BP increase across all maturities	Baseline used as comparative basis for 12/31/19 + 200 BP runs
<b>Test #1a</b>	GEMS Baseline Equity and Corporate model scenarios as of 12/31/21, and Conning Treasury model calibration with generalized fractional floor as of 12/31/21	Tests Conning Treasury model w/ GFF and Baseline Equity at YE 2021
<b>Test #1b</b>	Same as Test #1a, but with Alternative Treasury model calibration with shadow floor as of 12/31/21	Tests Alternative Treasury model with shadow floor and Baseline Equity at YE 2021
<b>Test #2a</b>	Same as Test #1a, but with Equity, Corporate, and Treasury models with a 12/31/19 starting yield curve modified using a 200 BP increase across all maturities. All other initial market conditions are unchanged. The Equity model parameters would be adjusted from #1a so that the year 30 median Large Cap Equity gross wealth factors remain consistent with #1a.	Stresses the starting Treasury rates using the same calibration as 1a to evaluate whether the model produces appropriate results in different economic environments
<b>Test #2b</b>	Same as Test #2a, but with the Alternative Treasury model calibration with shadow floor instead of the Conning Treasury model calibration with generalized fractional floor	Same as 2a, but designed to stress the 1b calibration

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<h2>Field Test Run Descriptions</h2>		
<b>Note: Bold = Required Run</b>		
Run #	Description	Purpose of Run
Test #3	Conning Treasury model calibration with generalized fractional floor as of 12/31/21, GEMS Corporate model as of 12/31/21, and GEMS Baseline Equity model corresponding to a 12/31/19 yield curve with a 200 BP increase across all maturities	Attribution analysis that will illustrate how much of the difference between runs #1a and #2a is driven by the equity model vs the Treasury and Corporate models
Test #4	Same as Test #3, but using Alternative Treasury model calibration with shadow floor as of 12/31/21	Same as #3, but with respect to runs #1b and #2b.
<b>Test #5a</b>	Same as #1a, but with Conning’s original Equity model calibration that had significantly lower Gross Wealth Factor’s (GWFs) than the AIRG Equity Model.	Tests Conning Treasury model w/ GFF and original equity model as of year-end 2021.
<b>Test #5b</b>	Same as #5a but using a 12/31/19 starting yield curve modified using a 200 BP increase across all maturities. The parameters of Conning’s original Equity model are used without any adjustment.	Stresses the starting Treasury rates to understand the full impact of equity-Treasury linkage in Conning’s original equity model
Test #6	Same as #1a, but with the ACLI’s GEMS® Equity Calibration	Tests the ACLI’s GEMS® Equity Calibration that assumes a constant mean equity return independent of rates and increases alignment with AIRG equity model GWFs

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## Field Test Participation: VM-21 and C3 Phase II

- 26 participant legal entity results are summarized in this presentation. The individual level of participation for each field test run is shown below.
- Hedging practices varied throughout the field test participants, but a majority used 1,000 scenario subset sizes and the AIRG in their reporting.
- Several participants commented that the value of results for field test runs 3 and 4 may be limited, and therefore those results have not been prioritized to be included in this presentation.

Hedge Modeling	Implicit	Explicit	No Model	Runoff
	7	8	9	2
Was Proprietary Economic Scenario Generator Used?	Yes		No	
	4		22	
Number of Scenarios	1000		<1000	>=1000
	22		2	2

**Valuation Dates:** 12/31/21 12/31/19 + 200 BP Hybrid

Field Test Run	Baseline 1*	Baseline 2	1A*	1B*	2A*	2B*	3	4	5A*	5B*	6
Number of Participants	26	11	26	26	26	26	13	13	25	25	12

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## Participant Separate Account Fund Distribution

Equity and Bond Funds (AIRG Names)	Type	Average Variable Annuity Separate Account Allocation
Diversified Large Capitalized U.S. Equity	Equity	41.3%
Diversified International Equity	Equity	10.9%
Intermediate Risk Equity	Equity	11.3%
Aggressive Equity	Equity	6.7%
Money Market	Bond	4.0%
U.S. Intermediate Term Government Bonds	Bond	4.3%
U.S. Long Term Corporate Bonds	Bond	12.6%
Diversified Fixed Income	Bond	5.3%
Diversified Balanced Allocation (60/40)	Equity and Bond	3.6%
<b>Total</b>		<b>100%</b>

Average Equity Fund Separate Account Allocation: **72.4%**

Average Bond Fund Separate Account Allocation: **27.6%**

- Participants were asked to provide the approximate separate account fund mapping that was used for the 12/31/21 field test runs. Data from 26 participating legal entities was included in this analysis.
- The average separate account allocation is shown in the table. Note that the average is simply an average allocation by fund across the participating legal entities, and is not weighted by the legal entity separate account balance
- All of the participating legal entities had a majority of their separate account funds mapped to equity funds, with the smallest allocation to equities being approximately 60%. The maximum equity fund allocation was 93%.

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## Participant Guaranteed Benefit Type Distribution

Type of Guaranteed Minimum Death or Living Benefit	Average Variable Annuity GMXB Allocation by:	
	% of Separate Account	% of Net Amount at Risk
Guaranteed Minimum Death Benefit (GMDB) Only	40.2%	46.9%
GMDB/Guaranteed Minimum Income Benefit (GMIB) Combo	9.3%	7.4%
GMDB/Guaranteed Minimum Withdrawal Benefit (GMWB) Combo	41.9%	41.4%
GMDB/Guaranteed Minimum Accumulation Benefit (GMAB) Combo	0.4%	0.1%
Other Benefit Combination	8.3%	4.3%
<b>Total</b>	<b>100%</b>	<b>100%</b>

- The distributions of guaranteed benefit types provided in the table above are shown as a percentage of separate account and as a percentage of net-amount-at-risk (NAAR). Note that the average above is a simple average across the participants and does not reflect any weighting by participant separate account or NAAR.
- The most prevalent guarantee types, by both the separate account and NAAR measures, are GMDB only and GMDB/GMWB combo.
- While the distribution of guaranteed benefits offered by companies could vary significantly within individual participants between the separate account and NAAR measures, overall, the measures showed a similar prevalence of guarantee types across participants.

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## High-Level Results: Comparisons to Baseline

Average Percent Increase over Baseline	Statistic	1A	1B	2A	2B	5A	5B	6
<b>VM-21 Reserve for Guaranteed Benefits</b>	<b>Max</b>	1,578%	1,279%	2,730%	2,802%	2,862%	5,645%	492%
	<b>Average</b>	29.4%	13.4%	13.5%	5.6%	78.7%	28.3%	10.1%
	<b>Min</b>	-20.7%	-47.8%	-94.9%	-79.5%	4.3%	0%	-14.0%
<b>Risk-Based Capital</b>	<b>Max</b>	6,782%	755%	2,709%	3,136%	17,100%	4,599%	12,161%
	<b>Average</b>	69.1%	43.4%	9.7%	11.6%	114%	26.5%	56%
	<b>Min</b>	-56.4%	-100%	-88.2%	-88.2%	-21.0%	-12.7%	-8.2%
<b>Number of Participants</b>		26	26	11	11	25	11	12

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## High-Level Observations

- For every field test run, there was a huge range in the reserve and capital impacts across the participating companies. Additional review of individual company results in a regulator-only session may provide a more complete understanding of the underlying factors behind the range of results.
- The field test runs generally produced increases in reserves and capital. However, a minority of participants had substantial reserve and/or capital decreases for some of the runs.
- A number of companies commented that guaranteed benefits were out-of-the-money due to the economic environment (favorable stock market), and that field test impacts would have been larger if a less favorable environment had been tested.

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## Drivers of Field Test Results

- **Hedging** – Companies that modeled hedging (either implicitly or explicitly) had much smaller impacts to reserves and capital on average vs. those that did not.
- **Relative importance of equity returns vs. interest rates** – This varied among companies. Many commented that equity returns were the main driver of results, while others noted that equity and interest rate impacts were nearly equal, or that interest rates were the primary driver.
- **Distribution of guaranteed benefit types** – There was a range in the distribution of guaranteed benefit types among participants. Some had primarily GMDB or lower guarantees, leading to smaller impacts vs. those with richer benefits.
- **Proprietary economic scenario generators** - Some companies used a proprietary economic scenario generator to produce their baseline results, so reserve and/or capital increases are generally smaller (since these generators are typically more conservative than the AIRG).
- **Hedge costs** - Some companies noted that the field test runs increased hedge costs.
- **Company-specific modeling assumptions** – For some companies, this had a significant impact

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## High-level Results: Stability of Results Across Valuation Dates

- On average, reserves and capital decreased when comparing the results produced using the 12/31/19 + 200 BP scenarios to their corresponding 12/31/21 results (i.e. Baseline 1 vs Baseline 2, 1A vs 2A, 1B vs 2B, and 5A vs. 5B)
- For reserves, the smallest change in magnitude (and tightest range of results) came from comparing Baseline 1 to Baseline 2. However, the average reduction in reserves was comparable to the other field test results. The comparison of 5B to 5A (which included the full impact of the GEMS® equity-Treasury linkage) showed the largest swing in reserves.
- For risk-based capital results, the average decrease in results from Baseline 1 to Baseline 2 (-0.9%) was much smaller in magnitude than the other field test runs. The change from 1A to 2A was the largest in magnitude, but was comparable to the change seen from 1B to 2B and from 5A to 5B.

Reserve/Capital Amount	% Increase from Baseline 1 to Baseline 2			% Increase from 1A to 2A			% Increase from 1B to 2B			% Increase from 5A to 5B		
	Min	Avg.	Max	Min	Avg.	Max	Min	Avg.	Max	Min	Avg.	Max
<b>VM-21 Reserve for Guaranteed Benefits</b>	-84.2%	-51.7%	89.1%	-100%	-63.4%	1,486%	-100%	-61.4%	4,668%	-100%	-68.6%	255.3%
<b>Risk-Based Capital</b>	-100%	-0.9%	746.2%	-100%	-67.6%	20.7%	-100%	-66.4%	77.4%	-100%	-59.5%	63.2%
<b>Number of Participants</b>	11			26			26			25		

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## Next Steps

- The NAIC will look to present economic scenario generator field test results for VM-20 and C3 Phase I in the next 1 – 2 months after the Spring National Meeting. Additional time for follow-up discussions may be necessary
- Regulators will continue to work with interested parties in economic scenario generator drafting groups to continue progress on reserve/capital framework specific implementation tasks
- The Life Actuarial (A) Task Force will engage with the American Academy of Actuaries and other interested parties to decide on stylized facts and acceptance criteria ahead of a recalibration of the economic scenario generator and a second field test.

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# Detailed Field Test Results: VM-21/C3 Phase II

## Field Test 1A: US Treasury Overview

- Field Test 1A (as of 12/31/21) included a recalibration of the Conning GEMS® US Treasury model that was designed to meet the regulator’s acceptance criteria related to low for long, the prevalence of high interest rates, upper and lower bounds, initial yield curve fit, and yield curve shape. The frequency and severity of negative interest rates were controlled using a generalized fractional floor.
- The 1A UST scenario set as of 12/31/21 had a much higher prevalence of low UST rates, including negative interest rates, compared to the scenarios produced by the AIRG as of 12/31/21, which is floored at 1 BP.
- The 1A UST scenario set also included greater and more frequent high UST rates, with maximum UST rates greatly exceeding that of the AIRG. While a floor was employed in all of the field test UST scenario sets, no cap was employed on how high rates could get.

**1A: 10,000 1-yr UST Scenario Percentiles by Projection Month as of 12/31/21**

Percentile	12	60	120	240	360
Min	-0.49%	-0.97%	-0.94%	-0.91%	-0.93%
1%	-0.17%	-0.51%	-0.58%	-0.56%	-0.56%
10%	0.10%	-0.14%	-0.19%	-0.13%	-0.11%
25%	0.25%	0.14%	0.14%	0.19%	0.25%
50%	0.62%	0.84%	1.18%	1.61%	2.09%
75%	1.63%	2.83%	3.59%	4.39%	4.93%
95%	3.15%	6.14%	7.78%	9.35%	10.38%
99%	4.32%	8.86%	11.38%	13.53%	14.47%
Max	7.93%	14.36%	19.89%	25.18%	26.72%

**AIRG: 10,000 1-yr UST Scenario Percentiles by Projection Month as of 12/31/21**

Percentile	12	60	120	240	360
Min	0.01%	0.01%	0.01%	0.01%	0.01%
1%	0.01%	0.21%	0.33%	0.32%	0.32%
10%	0.27%	0.66%	0.87%	0.98%	0.99%
25%	0.47%	0.96%	1.22%	1.41%	1.45%
50%	0.69%	1.35%	1.68%	1.99%	2.10%
75%	0.92%	1.78%	2.27%	2.74%	2.90%
95%	1.29%	2.57%	3.40%	4.29%	4.66%
99%	1.59%	3.37%	4.75%	6.17%	6.31%
Max	2.31%	5.82%	10.94%	13.22%	12.76%

**1A-AIRG: 10,000 1-yr UST Scenario Percentiles by Projection Month**

Difference	12	60	120	240	360
Min	-0.5%	-1.0%	-0.9%	-0.9%	-0.9%
1%	-0.2%	-0.7%	-0.9%	-0.9%	-0.9%
10%	-0.2%	-0.8%	-1.1%	-1.1%	-1.1%
25%	-0.2%	-0.8%	-1.1%	-1.2%	-1.2%
50%	-0.1%	-0.5%	-0.5%	-0.4%	0.0%
75%	0.7%	1.0%	1.3%	1.7%	2.0%
95%	1.9%	3.6%	4.4%	5.1%	5.7%
99%	2.7%	5.5%	6.7%	7.4%	8.2%
Max	5.6%	8.5%	8.9%	12.0%	14.0%

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## Field Test 1A: Equity Overview

- The 1A equity scenario set used a calibration that targeted the median gross wealth factor (GWF) produced by the AIRG at the end of 30 years. This recentring of the equity return distribution with changes to the starting interest environment partially mitigates the impact of the GEMS® equity-Treasury linkage functionality.
- While the GWF's between the AIRG and field test 1A are consistent at the 50<sup>th</sup> percentile at the end of the 30<sup>th</sup> projection year, the 1A scenario set generally has somewhat lower GWFs in the lower percentiles and earlier projection years compared to the AIRG.
- In the later durations and higher percentiles, the 1A GWFs are greater than those produced by the AIRG.

**1A: 10,000 SP500 GWF %-tiles by Projection Month**

	12	60	120	240	360
Min	0.50	0.28	0.24	0.39	0.39
1.0%	0.71	0.59	0.59	0.83	1.17
2.5%	0.77	0.68	0.75	1.06	1.60
5.0%	0.82	0.78	0.87	1.34	2.11
10.0%	0.87	0.89	1.05	1.69	2.86
25.0%	0.97	1.09	1.40	2.54	4.88
50.0%	1.07	1.35	1.88	4.01	8.99
75.0%	1.16	1.64	2.57	6.49	16.98
90.0%	1.25	1.96	3.41	10.26	31.70
95.0%	1.31	2.20	4.04	13.67	47.46
97.5%	1.35	2.45	4.70	17.57	66.83
99.0%	1.41	2.77	5.65	23.45	101.58
Max	1.81	4.53	13.89	55.97	457.07

**AIRG: 10,000 SP500 GWF %-tiles by Projection Month**

	12	60	120	240	360
Min	0.41	0.32	0.26	0.35	0.38
1.0%	0.70	0.62	0.66	0.83	1.22
2.5%	0.76	0.72	0.77	1.10	1.69
5.0%	0.82	0.81	0.92	1.41	2.25
10.0%	0.89	0.93	1.12	1.83	3.09
25.0%	0.98	1.16	1.51	2.74	5.11
50.0%	1.09	1.45	2.09	4.27	8.84
75.0%	1.19	1.81	2.88	6.80	15.35
90.0%	1.30	2.22	3.81	10.15	24.98
95.0%	1.37	2.48	4.44	12.92	34.25
97.5%	1.44	2.72	5.17	15.65	45.88
99.0%	1.52	3.06	6.18	20.49	60.45
Max	1.92	4.77	11.86	66.94	235.95

**1A/AIRG: GWF Ratios by Projection Month**

SP500	12	60	120	240	360
Min	123%	90%	94%	113%	101%
1.0%	101%	96%	90%	100%	95%
2.5%	102%	95%	97%	96%	95%
5.0%	100%	96%	95%	95%	94%
10.0%	99%	96%	93%	92%	92%
25.0%	98%	94%	92%	93%	96%
50.0%	98%	93%	90%	94%	102%
75.0%	98%	90%	90%	95%	111%
90.0%	97%	88%	90%	101%	127%
95.0%	95%	89%	91%	106%	139%
97.5%	94%	90%	91%	112%	146%
99.0%	93%	90%	92%	114%	168%
Max	94%	95%	117%	84%	194%

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## Field Test 1A Quantitative Results

- For field test 1A, the average field test participant VM-21 reserve for guaranteed benefits increased by 29.4% and the average Risk-Based Capital increased by 69.1%.
- However, the results were highly skewed among participants, with many seeing higher impacts to reserves and capital than the average indicates.
- Several participants noted that the lower equity returns and lower (and negative) interest rates that were more prevalent in 1A compared to the AIRG led to increases in reserves and capital. The lower equity returns result in more guaranteed benefits being in-the-money and less account value-based fee income. Lower interest rates lead to less discounting of future guaranteed benefit claims.
- Participants that modeled hedging (implicitly or explicitly) saw smaller impacts to reserves (25.4%) and capital (67.8%) than those that did not model hedging (163.3% and 91.6% for reserves and capital respectively).

Reserve/Capital Amount	Percentage Increase over Baseline					
	Average	Min	Percentiles			Max
			25th	50th	75th	
<b>VM-21 Reserve for Guaranteed Benefits</b>	29.4%	-20.7%	19.0%	69.5%	170.5%	1,578%
<b>Risk-Based Capital</b>	69.1%	-56.4%	11.6%	29.6%	256.9%	6,782%

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**26/30 Participants**

## Field Test 1B: US Treasury Overview

- Field Test 1B (as of 12/31/21) included a calibration of the Conning GEMS® US Treasury model that was designed to meet regulator acceptance criteria but placed additional emphasis on maintaining realistic term premiums throughout the projection. Towards that end, there was a significantly lower frequency of inversions (e.g. ~5% of 1B scenarios had 10 year/2year UST inversions at the end of year 30 compared to ~12% seen in 1A). The average level of inversion was also significantly lower (e.g. in 1B 10 year/2 year UST inversions average ~30 BP at the end of year 30, compared to ~90 BP average inversion level for 1A).
- 1B also included lower and less frequent high interest rates than 1A, but still contained greater and more frequent high interest rates than the AIRG.
- The frequency and severity of negative interest rates were controlled using a shadow floor that preserves the arbitrage free nature of the scenarios. The 1B UST scenario set has a comparable amount of low/negative UST rates to 1A, but significantly more severe and frequent low (and negative) UST rates compared to the AIRG.

**1B: 10,000 1-yr UST Scenario Percentiles by Projection Month**

Percentile	12	60	120	240	360
Min	-0.59%	-1.08%	-1.24%	-1.18%	-1.19%
1%	-0.10%	-0.51%	-0.61%	-0.59%	-0.58%
10%	0.22%	-0.04%	-0.10%	-0.02%	0.06%
25%	0.42%	0.26%	0.27%	0.37%	0.49%
50%	0.65%	0.65%	0.71%	0.88%	1.28%
75%	0.88%	1.24%	1.67%	2.60%	3.52%
95%	1.76%	3.38%	4.38%	5.99%	7.49%
99%	2.57%	4.89%	6.44%	8.90%	10.64%
Max	4.25%	10.28%	11.63%	17.99%	22.87%

**AIRG: 10,000 1-yr UST Scenario Percentiles by Projection Month**

Percentile	12	60	120	240	360
Min	0.01%	0.01%	0.01%	0.01%	0.01%
1%	0.01%	0.21%	0.33%	0.32%	0.32%
10%	0.27%	0.66%	0.87%	0.98%	0.99%
25%	0.47%	0.96%	1.22%	1.41%	1.45%
50%	0.69%	1.35%	1.68%	1.99%	2.10%
75%	0.92%	1.78%	2.27%	2.74%	2.90%
95%	1.29%	2.57%	3.40%	4.29%	4.66%
99%	1.59%	3.37%	4.75%	6.17%	6.31%
Max	2.31%	5.82%	10.94%	13.22%	12.76%

**1B-AIRG: 10,000 1-yr UST Scenario Percentiles by Projection Month**

Difference	12	60	120	240	360
Min	-0.6%	-1.1%	-1.2%	-1.2%	-1.2%
1%	-0.1%	-0.7%	-0.9%	-0.9%	-0.9%
10%	0.0%	-0.7%	-1.0%	-1.0%	-0.9%
25%	-0.1%	-0.7%	-1.0%	-1.0%	-1.0%
50%	0.0%	-0.7%	-1.0%	-1.1%	-0.8%
75%	0.0%	-0.5%	-0.6%	-0.1%	0.6%
95%	0.5%	0.8%	1.0%	1.7%	2.8%
99%	1.0%	1.5%	1.7%	2.7%	4.3%
Max	1.9%	4.5%	0.7%	4.8%	10.1%

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## Field Test 1B: Equity Overview

- The 1B equity scenario set used the same calibration as 1A. However, due to the equity-Treasury linkage, the resulting GWFs are different. The largest differences between the 1A and 1B equity GWFs are seen at the upper percentiles at the end of the 30<sup>th</sup> projection year, with the 1B being substantially lower and more in line with the AIRG.
- The median GWF at the end of the 30<sup>th</sup> projection year for 1B (7.99) is materially lower than both 1A (8.99) and the AIRG (8.84).
- Finally, the 1<sup>st</sup> percentile GWF at the end of the 30<sup>th</sup> projection year for 1b (1.19) was consistent with those of 1A (1.17) and the AIRG (1.22).

**1B: 10,000 SP500 GWF %-tiles by Projection Month**

	12	60	120	240	360
Min	0.51	0.30	0.26	0.34	0.27
1.0%	0.71	0.61	0.61	0.82	1.19
2.5%	0.78	0.70	0.76	1.05	1.59
5.0%	0.83	0.80	0.90	1.33	2.07
10.0%	0.88	0.92	1.08	1.68	2.72
25.0%	0.98	1.12	1.42	2.47	4.57
50.0%	1.08	1.38	1.90	3.78	7.99
75.0%	1.17	1.68	2.56	5.85	13.71
90.0%	1.26	2.00	3.32	8.61	23.14
95.0%	1.32	2.24	3.94	10.91	32.00
97.5%	1.36	2.50	4.53	13.70	43.02
99.0%	1.42	2.80	5.44	17.25	61.86
Max	1.83	4.67	14.21	76.72	258.35

**AIRG: 10,000 SP500 GWF %-tiles by Projection Month**

	12	60	120	240	360
Min	0.41	0.32	0.26	0.35	0.38
1.0%	0.70	0.62	0.66	0.83	1.22
2.5%	0.76	0.72	0.77	1.10	1.69
5.0%	0.82	0.81	0.92	1.41	2.25
10.0%	0.89	0.93	1.12	1.83	3.09
25.0%	0.98	1.16	1.51	2.74	5.11
50.0%	1.09	1.45	2.09	4.27	8.84
75.0%	1.19	1.81	2.88	6.80	15.35
90.0%	1.30	2.22	3.81	10.15	24.98
95.0%	1.37	2.48	4.44	12.92	34.25
97.5%	1.44	2.72	5.17	15.65	45.88
99.0%	1.52	3.06	6.18	20.49	60.45
Max	1.92	4.77	11.86	66.94	235.95

**1B/AIRG: GWF Ratios by Projection Month**

SP500	12	60	120	240	360
Min	124%	94%	102%	98%	71%
1.0%	102%	98%	93%	99%	98%
2.5%	103%	98%	99%	95%	94%
5.0%	101%	99%	97%	94%	92%
10.0%	100%	99%	96%	92%	88%
25.0%	99%	97%	94%	90%	89%
50.0%	99%	95%	91%	88%	90%
75.0%	99%	93%	89%	86%	89%
90.0%	97%	90%	87%	85%	93%
95.0%	96%	90%	89%	84%	93%
97.5%	95%	92%	88%	88%	94%
99.0%	94%	91%	88%	84%	102%
Max	95%	98%	120%	115%	109%

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**NAIC NATIONAL MEETING SPRING 2023**

## Field Test 1B Quantitative Results

- For field test 1B, the average field test participant VM-21 reserve for guaranteed benefits increased by 13.4%, and the average Risk-Based Capital increased by 43.3%, compared to 29.4% and 68.0% for 1A reserves and capital, respectively.
- Some participants noted exposure to high UST rates, which were less frequent and severe in 1B compared to 1A.
- Participants that modeled hedging (implicitly or explicitly) saw smaller impacts to reserves (10.1%) and capital (41.9%) than those that did not model hedging (127.4% and 68.9% for reserves and capital respectively).

Reserve/Capital Amount	Percentage Increase over Baseline					Max
	Average	Min	Percentiles			
			25th	50th	75th	
<b>VM-21 Reserve for Guaranteed Benefits</b>	13.4%	-47.8%	3.9%	23.7%	53.2%	1,279%
<b>Risk-Based Capital</b>	43.4%	-100.0%	-12.8%	5.1%	40.7%	755%

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

26/30 Participants

**NAIC NATIONAL MEETING SPRING 2023**

## Field Test 2A: US Treasury Overview

- Field Test 2A (as of 12/31/19 + 200 BP) used the same calibration as 1A (Conning Calibration with a Generalized Fractional Floor) but with a 12/31/19 starting yield curve modified using a 200 BP increase across all maturities.
- The higher starting interest environment leads to greater and more frequent high interest rates and less severe and less frequent low interest rates in 2A compared to 1A.
- Compared to the AIRG with a 12/31/19 + 200 BP starting interest environment, the 2A scenario set has a greater frequency and severity of high UST rates and more prevalent and severe low (and negative) UST rates.

**2A (12/31/19 + 200 BP): 10,000 1-yr UST Scenario Percentiles by Projection Month**

Percentile	12	60	120	240	360
Min	-0.13%	-0.78%	-0.82%	-0.89%	-0.92%
1%	0.29%	-0.27%	-0.42%	-0.49%	-0.53%
10%	1.34%	0.19%	0.02%	-0.04%	-0.06%
25%	2.26%	0.87%	0.39%	0.31%	0.32%
50%	3.34%	2.89%	2.69%	2.43%	2.54%
75%	4.49%	5.15%	5.38%	5.47%	5.53%
95%	6.19%	8.80%	10.06%	10.86%	11.30%
99%	7.44%	11.88%	13.61%	15.32%	15.70%
Max	11.48%	17.62%	22.91%	27.07%	28.97%

**AIRG (12/31/19 + 200 BP): 10,000 1-yr UST Scenario Percentiles by Projection Month**

Percentile	12	60	120	240	360
Min	0.31%	0.01%	0.01%	0.01%	0.01%
1%	1.25%	0.47%	0.34%	0.29%	0.31%
10%	1.82%	1.22%	1.06%	1.04%	1.00%
25%	2.16%	1.72%	1.58%	1.53%	1.50%
50%	2.53%	2.35%	2.24%	2.21%	2.18%
75%	2.92%	3.06%	3.08%	3.10%	3.05%
95%	3.55%	4.39%	4.77%	4.96%	4.94%
99%	4.06%	5.66%	6.73%	7.29%	6.73%
Max	5.24%	9.85%	16.66%	15.13%	13.59%

**2A-AIRG: 10,000 1-yr UST Scenario Percentiles by Projection Month**

Difference	12	60	120	240	360
Min	-0.4%	-0.8%	-0.8%	-0.9%	-0.9%
1%	-1.0%	-0.7%	-0.8%	-0.8%	-0.8%
10%	-0.5%	-1.0%	-1.0%	-1.1%	-1.1%
25%	0.1%	-0.8%	-1.2%	-1.2%	-1.2%
50%	0.8%	0.5%	0.4%	0.2%	0.4%
75%	1.6%	2.1%	2.3%	2.4%	2.5%
95%	2.6%	4.4%	5.3%	5.9%	6.4%
99%	3.4%	6.2%	6.9%	8.0%	9.0%
Max	6.2%	7.8%	6.3%	11.9%	15.4%

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## Field Test 2A: Equity Overview

- The targets of the 2A equity scenarios is designed to align the GWF at the end of the 30<sup>th</sup> projection year (8.97) with those produced by the AIRG (8.84) no matter the starting interest rate environment. However, there is still an impact to the 2A equity scenarios due to the increased starting interest rate environment and the equity-Treasury linkage compared to the 1A equity scenarios.
- The largest differences between the 2A and 1A equity GWFs are seen at the upper percentiles at the end of the 30<sup>th</sup> projection year, for example the 99<sup>th</sup> percentile GWF for 1b is 127.28 at the end of the 30<sup>th</sup> year compared to 101.58 for the 1A scenario set.
- The same considerations apply when comparing 2A to the AIRG with a 12/31/19 + 200 BP starting interest rate environment, with the largest differences between the GWFs of 2A and the AIRG occurring in the higher percentiles and later projection years.

**2A: 10,000 SP500 GWF %-tiles by Projection Month**

	12	60	120	240	360
Min	0.51	0.30	0.26	0.40	0.36
1.0%	0.73	0.65	0.64	0.83	1.07
2.5%	0.79	0.75	0.80	1.08	1.46
5.0%	0.84	0.85	0.95	1.34	1.93
10.0%	0.90	0.97	1.15	1.73	2.63
25.0%	1.00	1.20	1.54	2.64	4.71
50.0%	1.10	1.48	2.11	4.38	8.97
75.0%	1.20	1.82	2.96	7.42	18.20
90.0%	1.29	2.19	4.01	12.10	35.66
95.0%	1.35	2.46	4.74	16.60	54.53
97.5%	1.39	2.73	5.63	22.33	83.32
99.0%	1.45	3.10	7.00	30.39	127.28
Max	1.87	5.11	15.80	86.26	817.22

**AIRG: 10,000 SP500 GWF %-tiles by Projection Month**

	12	60	120	240	360
Min	0.41	0.32	0.26	0.35	0.38
1.0%	0.70	0.62	0.66	0.83	1.22
2.5%	0.76	0.72	0.77	1.10	1.69
5.0%	0.82	0.81	0.92	1.41	2.25
10.0%	0.89	0.93	1.12	1.83	3.09
25.0%	0.98	1.16	1.51	2.74	5.11
50.0%	1.09	1.45	2.09	4.27	8.84
75.0%	1.19	1.81	2.88	6.80	15.35
90.0%	1.30	2.22	3.81	10.15	24.98
95.0%	1.37	2.48	4.44	12.92	34.25
97.5%	1.44	2.72	5.17	15.65	45.88
99.0%	1.52	3.06	6.18	20.49	60.45
Max	1.92	4.77	11.86	66.94	235.95

**2A/AIRG: GWF Ratios by Projection Month**

SP500	12	60	120	240	360
Min	124%	95%	99%	116%	94%
1.0%	104%	104%	97%	100%	88%
2.5%	105%	103%	103%	98%	87%
5.0%	103%	105%	103%	95%	86%
10.0%	101%	104%	102%	94%	85%
25.0%	101%	103%	102%	96%	92%
50.0%	101%	102%	101%	103%	101%
75.0%	101%	100%	103%	109%	119%
90.0%	100%	99%	105%	119%	143%
95.0%	98%	99%	107%	129%	159%
97.5%	97%	100%	109%	143%	182%
99.0%	96%	101%	113%	148%	211%
Max	98%	107%	133%	129%	346%

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## Field Test 2A Quantitative Results

- The average field test participant VM-21 reserve for guaranteed benefits increased by 13.5%, and the average Risk-Based Capital increased by 9.7%.
- Comparisons to the baseline results were limited by participation in the optional Baseline 2 run.
- Less severe and less frequent low (and negative) UST rates combined with higher equity GWFs (relative to 1A) throughout the projection contributed to smaller reserve and capital increases.
- Participants that modeled hedging (implicitly or explicitly) saw smaller impacts to reserves (10.1%) and capital (41.9%) than those that did not model hedging (127.4% and 68.9% for reserves and capital respectively).

Reserve/Capital Amount	Percentage Increase over Baseline					
	Average	Min	Percentiles			Max
			25th	50th	75th	
<b>VM-21 Reserve for Guaranteed Benefits</b>	13.5%	-94.9%	-29.8%	0%	21.5%	2,730%
<b>Risk-Based Capital</b>	9.7%	-88.2%	-15.1%	-0.5%	24.3%	2,709%

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**11/30 Participants**

## Field Test 2B: US Treasury Overview

- Field Test 2B (as of 12/31/19 + 200 BP) used the same calibration as 1B (Alternative Calibration with Shadow Floor) but with a 12/31/19 starting yield curve modified using a 200 BP increase across all maturities. Again, generally inversions were significantly less frequent and less severe in the 2B scenario set compared to 2A.
- The higher starting interest environment leads to greater and more frequent high interest rates and less severe and frequent low interest rates in 2B compared to 1B.
- Compared to the AIRG with a 12/31/19 + 200 BP starting interest environment, the 2B scenario set has a greater frequency and severity of high UST rates and more prevalent and severe low (and negative) UST rates.
- Compared to the 2A scenario set, the 2B scenario set has less frequent negative UST rates and less frequent 1-year UST rates over 10%.

**2B: 10,000 1-yr UST Scenario Percentiles by Projection Month**

Percentile	12	60	120	240	360
Min	0.28%	-0.64%	-0.99%	-1.05%	-1.14%
1%	0.77%	0.11%	-0.17%	-0.33%	-0.44%
10%	1.49%	0.70%	0.48%	0.36%	0.31%
25%	2.27%	1.30%	0.97%	0.86%	0.83%
50%	3.12%	2.83%	2.78%	2.64%	2.69%
75%	3.99%	4.54%	4.79%	5.04%	5.35%
95%	5.31%	7.10%	8.25%	9.24%	10.18%
99%	6.23%	9.11%	10.77%	12.84%	13.81%
Max	8.40%	15.44%	17.83%	23.70%	28.40%

**AIRG (12/31/19 + 200 BP): 10,000 1-yr UST Scenario Percentiles by Projection Month**

Percentile	12	60	120	240	360
Min	0.31%	0.01%	0.01%	0.01%	0.01%
1%	1.25%	0.47%	0.34%	0.29%	0.31%
10%	1.82%	1.22%	1.06%	1.04%	1.00%
25%	2.16%	1.72%	1.58%	1.53%	1.50%
50%	2.53%	2.35%	2.24%	2.21%	2.18%
75%	2.92%	3.06%	3.08%	3.10%	3.05%
95%	3.55%	4.39%	4.77%	4.96%	4.94%
99%	4.06%	5.66%	6.73%	7.29%	6.73%
Max	5.24%	9.85%	16.66%	15.13%	13.59%

**2B-AIRG: 10,000 1-yr UST Scenario Percentiles by Projection Month**

Difference	12	60	120	240	360
Min	0.0%	-0.6%	-1.0%	-1.1%	-1.2%
1%	-0.5%	-0.4%	-0.5%	-0.6%	-0.7%
10%	-0.3%	-0.5%	-0.6%	-0.7%	-0.7%
25%	0.1%	-0.4%	-0.6%	-0.7%	-0.7%
50%	0.6%	0.5%	0.5%	0.4%	0.5%
75%	1.1%	1.5%	1.7%	1.9%	2.3%
95%	1.8%	2.7%	3.5%	4.3%	5.2%
99%	2.2%	3.4%	4.0%	5.5%	7.1%
Max	3.2%	5.6%	1.2%	8.6%	14.8%

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## Field Test 2B: Equity Overview

- The 2B equity scenario set used the same calibration as 2A. However, due to the equity-Treasury linkage, the resulting GWFs are different. The largest differences between the 2A and 2B equity GWFs are seen at the upper percentiles at the end of the 30<sup>th</sup> projection year, with the 2B being substantially lower and more in line with the AIRG (though still higher).
- The median GWF at the end of the 30<sup>th</sup> projection year for 2B (9.15) is consistent with both 2A (8.97) and the AIRG (8.84).
- Finally, the 1<sup>st</sup> percentile GWF at the end of the 30<sup>th</sup> projection year for 2B (1.13) was consistent with those of 1A (1.17) and the AIRG (1.22).

**2B: 10,000 SP500 GWF %-tiles by Projection Month**

	12	60	120	240	360
Min	0.51	0.32	0.30	0.40	0.35
1.0%	0.73	0.63	0.64	0.85	1.13
2.5%	0.79	0.74	0.81	1.09	1.58
5.0%	0.84	0.84	0.96	1.37	2.04
10.0%	0.90	0.96	1.14	1.79	2.80
25.0%	0.99	1.18	1.54	2.71	4.89
50.0%	1.10	1.46	2.08	4.34	9.15
75.0%	1.20	1.78	2.84	7.02	17.15
90.0%	1.29	2.13	3.75	10.90	31.48
95.0%	1.34	2.39	4.50	14.15	47.27
97.5%	1.39	2.66	5.20	18.23	66.95
99.0%	1.45	3.01	6.21	24.31	103.48
Max	1.87	4.81	16.83	142.35	599.47

**AIRG: 10,000 SP500 GWF %-tiles by Projection Month**

	12	60	120	240	360
Min	0.41	0.32	0.26	0.35	0.38
1.0%	0.70	0.62	0.66	0.83	1.22
2.5%	0.76	0.72	0.77	1.10	1.69
5.0%	0.82	0.81	0.92	1.41	2.25
10.0%	0.89	0.93	1.12	1.83	3.09
25.0%	0.98	1.16	1.51	2.74	5.11
50.0%	1.09	1.45	2.09	4.27	8.84
75.0%	1.19	1.81	2.88	6.80	15.35
90.0%	1.30	2.22	3.81	10.15	24.98
95.0%	1.37	2.48	4.44	12.92	34.25
97.5%	1.44	2.72	5.17	15.65	45.88
99.0%	1.52	3.06	6.18	20.49	60.45
Max	1.92	4.77	11.86	66.94	235.95

**2B/AIRG: GWF Ratios by Projection Month**

SP500	12	60	120	240	360
Min	124%	100%	116%	116%	92%
1.0%	104%	102%	98%	103%	92%
2.5%	104%	102%	105%	99%	94%
5.0%	103%	104%	103%	97%	91%
10.0%	101%	103%	102%	98%	90%
25.0%	101%	102%	102%	99%	96%
50.0%	101%	100%	100%	102%	103%
75.0%	101%	98%	99%	103%	112%
90.0%	99%	96%	99%	107%	126%
95.0%	98%	97%	101%	110%	138%
97.5%	97%	98%	101%	117%	146%
99.0%	95%	98%	101%	119%	171%
Max	97%	101%	142%	213%	254%

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**NAIC** NATIONAL MEETING **SPRING 2023**

## Field Test 2B Quantitative Results

- The average field test participant VM-21 reserve for guaranteed benefits increased by 5.6%, and the average Risk-Based Capital increased by 11.6%, compared to 13.5% and 9.7% for 2A reserves and capital, respectively.
- Participants that modeled hedging (implicitly or explicitly) saw smaller increases to reserves (4.1%) and capital (4.1%) than those that did not model hedging (276.0% and 414.6% for reserves and capital respectively).

Reserve/Capital Amount	Percentage Increase over Baseline					
	Average	Min	Percentiles			Max
			25th	50th	75th	
<b>VM-21 Reserve for Guaranteed Benefits</b>	5.6%	-79.5%	-1.4%	0.5%	42.8%	2,802%
<b>Risk-Based Capital</b>	11.6%	-88.2%	-4.8%	16.5%	26.7%	3,136%

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11/30 Participants

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## Field Test 5A: Treasury and Equity Overview

- The 5A scenario set uses the exact same UST scenarios as 1A.
- For the 5A equity scenario set, the Conning's original equity model calibration is used that includes the full impact of the equity-Treasury linkage. With 5A's lower overall UST rates, the equity GWFs at the lower percentiles are much more severe than the AIRG and other field test scenario sets. For example, the 1<sup>st</sup> percentile of equity GWFs for 5A is .39, compared to 1.22 for the AIRG and 1.19 for 1A.
- The median GWF at the end of the 30<sup>th</sup> projection year for 5A (5.88) is significantly lower than with both 1A (8.99) and the AIRG (8.84).

	12	60	120	240	360
Min	0.47	0.13	0.06	0.04	0.05
1.0%	0.71	0.45	0.36	0.38	0.39
2.5%	0.76	0.57	0.48	0.54	0.65
5.0%	0.82	0.67	0.63	0.73	0.95
10.0%	0.87	0.80	0.82	1.04	1.48
25.0%	0.96	1.02	1.20	1.79	2.93
50.0%	1.05	1.28	1.69	3.09	5.88
75.0%	1.14	1.56	2.31	5.11	11.43
90.0%	1.21	1.85	3.02	8.11	21.44
95.0%	1.26	2.04	3.59	10.76	32.94
97.5%	1.30	2.23	4.11	13.83	47.77
99.0%	1.35	2.50	4.83	18.95	71.23
Max	1.68	3.79	10.89	64.69	494.22

	12	60	120	240	360
Min	0.41	0.32	0.26	0.35	0.38
1.0%	0.70	0.62	0.66	0.83	1.22
2.5%	0.76	0.72	0.77	1.10	1.69
5.0%	0.82	0.81	0.92	1.41	2.25
10.0%	0.89	0.93	1.12	1.83	3.09
25.0%	0.98	1.16	1.51	2.74	5.11
50.0%	1.09	1.45	2.09	4.27	8.84
75.0%	1.19	1.81	2.88	6.80	15.35
90.0%	1.30	2.22	3.81	10.15	24.98
95.0%	1.37	2.48	4.44	12.92	34.25
97.5%	1.44	2.72	5.17	15.65	45.88
99.0%	1.52	3.06	6.18	20.49	60.45
Max	1.92	4.77	11.86	66.94	235.95

SP500	12	60	120	240	360
Min	114%	40%	24%	11%	13%
1.0%	101%	73%	54%	46%	32%
2.5%	100%	79%	62%	49%	39%
5.0%	100%	83%	68%	51%	42%
10.0%	99%	86%	73%	57%	48%
25.0%	98%	88%	79%	65%	57%
50.0%	97%	88%	81%	72%	66%
75.0%	96%	86%	80%	75%	74%
90.0%	94%	83%	79%	80%	86%
95.0%	92%	82%	81%	83%	96%
97.5%	91%	82%	80%	88%	104%
99.0%	89%	82%	78%	92%	118%
Max	87%	80%	92%	97%	209%

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## Field Test 5A Quantitative Results

- The average field test participant VM-21 reserve for guaranteed benefits increased by 78.7%, and the average Risk-Based Capital increased by 114%.
- Several participants noted that the very low equity returns present in 5A were a major driver of the increase in their results.
- Participants that modeled hedging (implicitly or explicitly) saw smaller impacts to reserves (64.5%) and capital (108.7%) than those that did not model hedging (371.7% and 279.6% for reserves and capital respectively).

Reserve/Capital Amount	Percentage Increase over Baseline					
	Average	Min	Percentiles			Max
			25th	50th	75th	
<b>VM-21 Reserve for Guaranteed Benefits</b>	78.7%	4.3%	69.9%	347.8%	643.6%	2,862%
<b>Risk-Based Capital</b>	114%	-21.0%	34.2%	84.6%	388.9%	17,100%

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**25/30 Participants**

## Field Test 5B: Treasury and Equity Overview

- The 5B scenario set uses the exact same UST scenarios as 2A (as of 12/31/19 + 200 BP).
- For the 5B equity scenario set, the Conning’s original equity model calibration is used that includes the full impact of the equity-Treasury linkage. With 5B’s higher starting interest levels, the equity GWFs at the lower percentiles are higher than those in 5A, but still lower than those in the AIRG and 2A. For example, the 1<sup>st</sup> percentile of equity GWFs for 5A is .54, compared to 1.22 for the AIRG and 1.07 for 2A.
- The median GWF at the end of the 30<sup>th</sup> projection year for 5B is 8.59, which is in the ballpark of the corresponding GWFs for both 2A (8.97) and the AIRG (8.84).

5B: 10,000 SP500 GWF %-tiles by Projection Month

	12	60	120	240	360
Min	0.48	0.14	0.07	0.05	0.07
1.0%	0.74	0.53	0.44	0.50	0.54
2.5%	0.79	0.66	0.60	0.71	0.90
5.0%	0.85	0.78	0.78	0.98	1.30
10.0%	0.91	0.93	1.03	1.39	2.05
25.0%	1.00	1.19	1.51	2.43	4.14
50.0%	1.10	1.50	2.15	4.33	8.59
75.0%	1.19	1.85	3.01	7.48	17.74
90.0%	1.27	2.20	4.04	12.44	35.86
95.0%	1.32	2.43	4.84	17.03	57.52
97.5%	1.36	2.69	5.60	22.65	84.51
99.0%	1.41	3.01	6.78	31.13	132.92
Max	1.76	4.87	16.46	115.46	1058.35

AIRG: 10,000 SP500 GWF %-tiles by Projection Month

	12	60	120	240	360
Min	0.41	0.32	0.26	0.35	0.38
1.0%	0.70	0.62	0.66	0.83	1.22
2.5%	0.76	0.72	0.77	1.10	1.69
5.0%	0.82	0.81	0.92	1.41	2.25
10.0%	0.89	0.93	1.12	1.83	3.09
25.0%	0.98	1.16	1.51	2.74	5.11
50.0%	1.09	1.45	2.09	4.27	8.84
75.0%	1.19	1.81	2.88	6.80	15.35
90.0%	1.30	2.22	3.81	10.15	24.98
95.0%	1.37	2.48	4.44	12.92	34.25
97.5%	1.44	2.72	5.17	15.65	45.88
99.0%	1.52	3.06	6.18	20.49	60.45
Max	1.92	4.77	11.86	66.94	235.95

5B/AIRG: GWF Ratios by Projection Month

SP500	12	60	120	240	360
Min	118%	44%	27%	14%	17%
1.0%	106%	85%	67%	60%	44%
2.5%	105%	91%	77%	64%	54%
5.0%	104%	96%	85%	69%	58%
10.0%	103%	99%	91%	76%	66%
25.0%	102%	103%	99%	89%	81%
50.0%	101%	104%	103%	101%	97%
75.0%	100%	102%	105%	110%	116%
90.0%	98%	99%	106%	123%	144%
95.0%	96%	98%	109%	132%	168%
97.5%	95%	99%	109%	145%	184%
99.0%	93%	98%	110%	152%	220%
Max	92%	102%	139%	172%	449%

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## Field Test 5B Quantitative Results

- The average field test participant VM-21 reserve for guaranteed benefits increased by 28.3%, and the average Risk-Based Capital increased by 26.8% for field test 5B, compared to much higher average reserve (78.7%) and capital (114%) increases for 5A.
- The equity-Treasury linkage produced higher equity returns in the 5B scenario set as of 12/31/19 + 200 BP, leading to more favorable results for participants.
- Participants that modeled hedging (implicitly or explicitly) saw smaller increases to reserves (25.2%) and capital (15.1%) than those that did not model hedging (586.1% and 638.8% for reserves and capital respectively).

Reserve/Capital Amount	Percentage Increase over Baseline					
	Average	Min	Percentiles			Max
			25th	50th	75th	
<b>VM-21 Reserve for Guaranteed Benefits</b>	28.3%	0%	14.4%	68.7%	219.7%	5,645%
<b>Risk-Based Capital</b>	26.5%	-12.7%	5.9%	45.4%	84.4%	4,599%

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

11/30 Participants

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## Field Test 6: Treasury and Equity Overview

- The field test 6 scenario set uses the exact same UST scenarios as 1A.
- The equity calibration for scenario set 6 assumes a constant mean equity return independent of rates and increases alignment with AIRG equity model GWFs.
- The median GWF at the end of the 30<sup>th</sup> projection year for 6 is 9.49, which is close but somewhat higher than the the corresponding GWFs for both 1A (8.99) and the AIRG (8.84).
- While there are differences (somewhat lower GWFs in low percentiles, lower GWFs at higher percentiles), the equity scenarios from 6 overall are more consistent with those produced by the AIRG than other field test scenario sets.

**6: 10,000 SP500 GWF %-tiles by Projection Month**

	12	60	120	240	360
Min	0.43	0.14	0.13	0.31	0.23
1.0%	0.71	0.57	0.59	0.79	1.20
2.5%	0.77	0.68	0.76	1.08	1.73
5.0%	0.83	0.80	0.92	1.41	2.32
10.0%	0.89	0.94	1.14	1.85	3.20
25.0%	0.99	1.19	1.58	2.90	5.41
50.0%	1.09	1.50	2.17	4.55	9.49
75.0%	1.19	1.82	2.90	6.83	15.89
90.0%	1.28	2.15	3.66	9.85	24.35
95.0%	1.33	2.34	4.22	12.01	31.70
97.5%	1.38	2.52	4.76	14.36	39.68
99.0%	1.43	2.75	5.37	17.19	52.06
Max	1.79	3.97	9.38	33.26	135.23

**AIRG: 10,000 SP500 GWF %-tiles by Projection Month**

	12	60	120	240	360
Min	0.41	0.32	0.26	0.35	0.38
1.0%	0.70	0.62	0.66	0.83	1.22
2.5%	0.76	0.72	0.77	1.10	1.69
5.0%	0.82	0.81	0.92	1.41	2.25
10.0%	0.89	0.93	1.12	1.83	3.09
25.0%	0.98	1.16	1.51	2.74	5.11
50.0%	1.09	1.45	2.09	4.27	8.84
75.0%	1.19	1.81	2.88	6.80	15.35
90.0%	1.30	2.22	3.81	10.15	24.98
95.0%	1.37	2.48	4.44	12.92	34.25
97.5%	1.44	2.72	5.17	15.65	45.88
99.0%	1.52	3.06	6.18	20.49	60.45
Max	1.92	4.77	11.86	66.94	235.95

**6/AIRG: GWF Ratios by Projection Month**

SP500	12	60	120	240	360
Min	106%	44%	50%	88%	60%
1.0%	101%	92%	89%	95%	98%
2.5%	102%	95%	99%	98%	102%
5.0%	101%	100%	100%	100%	103%
10.0%	100%	101%	102%	101%	103%
25.0%	101%	103%	104%	106%	106%
50.0%	100%	103%	104%	107%	107%
75.0%	100%	100%	101%	101%	104%
90.0%	99%	97%	96%	97%	97%
95.0%	97%	95%	95%	93%	93%
97.5%	96%	92%	92%	92%	86%
99.0%	94%	90%	87%	84%	86%
Max	93%	83%	79%	50%	57%

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## Field Test 6 Quantitative Results

- The average field test participant VM-21 reserve for guaranteed benefits increased by 10.1%, and the average Risk-Based Capital increased by 56%, compared to 29.4% and 68.0% for 1A reserves and capital, respectively.
- Given the alignment between the AIRG and scenario set 6 equity GWFs, the increases in reserves and capital compared to the baseline are likely driven primarily by the UST model calibration.
- The effect of hedging was less clear in the results of the participants who elected to perform field test 6. There were a limited number of companies that participated in field test 6 and that did not model hedging.

Reserve/Capital Amount	Percentage Increase over Baseline					
	Average	Min	Percentiles			Max
			25th	50th	75th	
<b>VM-21 Reserve for Guaranteed Benefits</b>	10.1%	-14.0%	7.2%	62.2%	218.6%	492.2%
<b>Risk-Based Capital</b>	56%	-8.2%	13.4%	21.7%	216.7%	12,161%

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**12/30 Participants**

Dates: Received	Reviewed by Staff	Distributed	Considered
3/7/23	SO		
Notes: APF 2023-05			

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force  
 Amendment Proposal Form\***

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

**Identification:**

Brian Bayerle, ACLI

**Title of the Issue:**

Revise hedge modeling language to address index credit hedging.

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

VM-01, VM-21 Section 4.A.4, VM-21 Section 9, VM-21 Section 9.C.2, VM-31 Section 3.F.8.d

January 1, 2023 NAIC Valuation Manual, APF 2020-12

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

See attached.

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

Index credit hedging is fundamentally different than the dynamic GMxB hedging which formed the conceptual underpinnings for VM-21. For example, the relatively fixed parameters of traditional GMxBs drive the hedging approach. In contrast, indexed products (including RILAs) have flexible crediting parameters which are continually reset based on hedge availability and costs, as well as current market conditions. In short, GMxB contract features drive hedging, while index product hedging drives contract features.

Since the reforms of VM-21 and C3P2, ILVA products have experienced major market growth. Several carriers, with the agreement of regulators and auditors, have interpreted the current VM-21 guidance as permitting the effects of index credit hedging to be reflected in product cash flows instead of within the “best efforts” and “adjusted” scenarios. Both regulators and industry would benefit from the codification of this approach within VM-21.

ACLI’s proposal borrows heavily from the Academy’s draft VM-22. The “error” for index credit hedging is describes as a percentage reduction to hedge payoffs. The percentage reduction must be supported by relevant, credible, and documented experience. A minimum of 1% is proposed as a regulatory guardrail.

The ACLI proposal would subject index credit hedging to the “clearly defined” documentation requirements of VM-21. Substantively, the change would (a) include index credit hedge purchases with the VM-21 “adjusted” run, and (b) permit index credit hedging to reflect a different, and potentially lower, level of ineffectiveness.

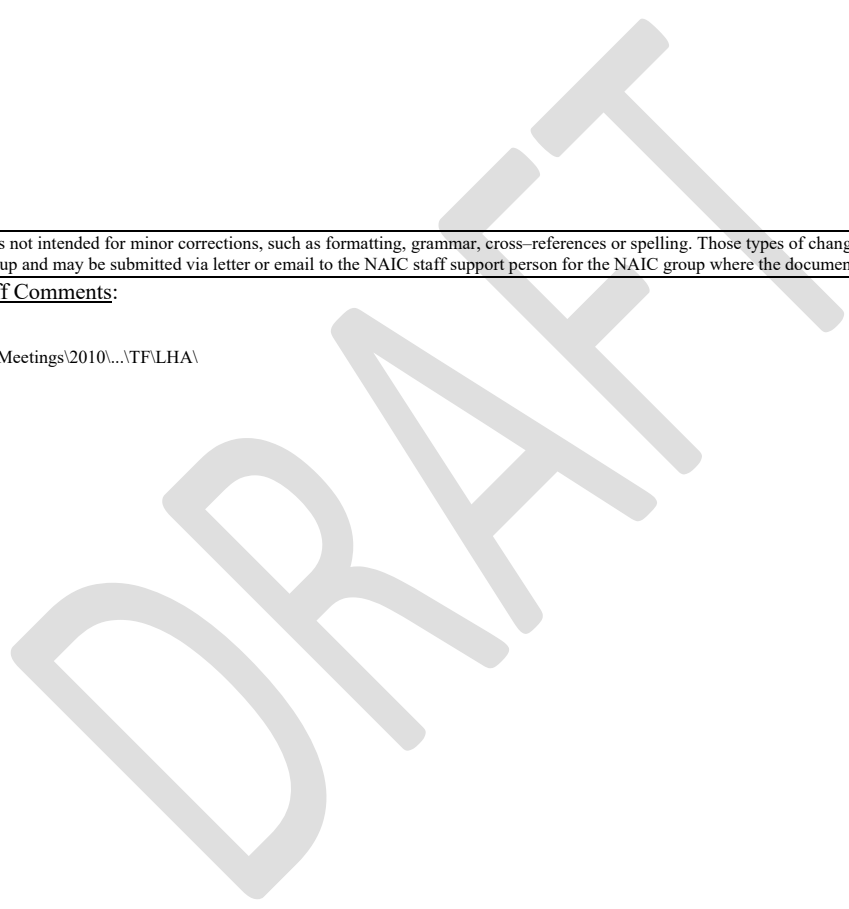
<b>Dates:</b> Received	Reviewed by Staff	Distributed	Considered
3/7/23	SO		
<b>Notes:</b> APF 2023-05			

ACLI supports aligning the index credit hedging guidance between VM-21 and VM-22. We started with draft VM-22 verbiage in creating this APF. In a few areas, our members have suggested technical improvements to the draft VM-22 definitions. It may be appropriate to carry these over to VM-22.

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

NAIC Staff Comments:

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Notes: APF 2023-05			

## **VM-01**

The term “Index Credit Hedge Margin” means a margin capturing the risk of inefficiencies in the company’s hedging program supporting index credits. This includes basis risk, persistency risk, and the risk associated with modeling decisions and simplifications. It also includes any uncertainty of costs associated with managing the hedging program and changes due to investment and management decisions.

The term “Index Credit” means any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy values that is directly linked to one or more indices. Amounts credited to the policy resulting from a floor on an index account are included. An Index Credit may be positive or negative.

The term “Index Crediting Strategies” means the strategies defined in a contract to determine index credits for a contract. For example, this may refer to underlying index, index parameters, date, timing, performance triggers, and other elements of the crediting method.

## **VM-21 Section 4.A.4**

### 4. Modeling of Hedges

- a. For a company that does not have a future hedging strategy supporting the contracts tied directly to the contracts falling under the scope of VM-21 stochastic reserve requirements:
  - i. The company shall not consider the cash flows from any future hedge purchases or any rebalancing of existing hedge assets in its modeling, since they are not included in the company’s investment strategy supporting the contracts.
  - ii. Existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets.
- b. For a company with one or more future hedging strategies supporting the contracts tied directly to the contracts falling under the scope of VM-21 stochastic reserve requirements:
  - i. For a future hedging strategy with hedge payoffs that solely offset interest credits associated with indexed interest strategies (indexed interest credits):
    - a) In modeling cash flows, the company shall include the cash flows from future hedge purchases or any rebalancing of existing hedge assets that are intended solely to offset interest credits to contract holders.
    - b) Existing hedging instruments that are currently held by the company for offsetting the indexed credits in support of the contracts falling under the scope of these requirements shall be included in the starting assets.
    - c) An Index Credit Hedge Margin for these hedge instruments shall be reflected in both the “best efforts” and the “adjusted” runs by reducing index interest credit hedge payoffs by a margin multiple that shall be justified by sufficient and credible company experience and account for model error. It shall be no less than [1%] multiplicatively of the interest credited. In the absence of sufficient and credible company experience, a margin of

Dates: Received	Reviewed by Staff	Distributed	Considered
3/7/23	SO		
Notes: APF 2023-05			

[20%] shall be assumed. There is no cap on the index credit hedge margin if company experience indicates actual error is greater than [20%].

- ii. For a company with one or more future hedging strategies supporting the contracts that do not solely offset indexed interest credits, the detailed requirements for the modeling of the hedges are defined in Section 9. The following requirements do not supersede the detailed requirements.
  - a) The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the projections used in the determination of the SR.
  - b) The projections shall take into account the appropriate costs and benefits of hedge positions expected to be held in the future through the execution of the future hedging strategies supporting the contracts. Because models do not always accurately portray the results of hedge programs, the company shall, through back-testing and other means, assess the accuracy of the hedge modeling. The company shall determine a SR as the weighted average of two CTE values; first, a CTE70 (“best efforts”) representing the company’s projection of all of the hedge cash flows, including future hedge purchases, and a second CTE70 (“adjusted”) which shall use only hedge assets held by the company on the valuation date and only no future hedge purchases associated solely with indexed interest credited. These are discussed in greater detail in Section 9. The SR shall be the weighted average of the two CTE70 values, where the weights reflect the error factor determined following the guidance of Section 9.C.4.
  - c) The company is responsible for verifying compliance with all requirements in Section 9 for all hedging instruments included in the projections.
  - d) The use of products not falling under the scope of these requirements (e.g., equity-indexed annuities) as a hedge shall not be recognized in the determination of accumulated deficiencies.
- iii. If a company has a more comprehensive hedge strategy combining index credits, guaranteed benefit, and other risks (e.g., full fair value or economic hedging), an appropriate and documented bifurcation method should be used in the application of sections 4.A.4.b.i and 4.A.4.b.ii above for the hedge modeling and justification. Such bifurcation methods may quantify the specific risk exposure attributable to index credit liabilities versus other liabilities such as guaranteed living benefits, and apply such for the basis for allocation.

**VM-21 Section 9**

Section 9: Modeling Hedges under a Future Non-Index Credit Hedging Strategy

A. Initial Considerations

- 1. This section applies to modeling of hedges other than situations where the company only hedges index credits. If the company clearly separates index credit hedging from other hedging, then this section only applies to the other hedging if the index hedging follows the requirements in Section

Dates: Received	Reviewed by Staff	Distributed	Considered
3/7/23	SO		
Notes: APF 2023-05			

4.A.4.b.i. If the company does not clearly separate index credit hedging from other hedging, then this section is applicable for modeling of all hedges.

2. Subject to Section 9.C.2, the appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the calculation of the SR, determined in accordance with Section 3.D and Section 4.D.

(Subsequent sections to be renumbered)

**VM-21 Section 9.C.2**

2. The company shall calculate a CTE70 (adjusted) by recalculating the CTE70 assuming the company has no future hedging strategies supporting the contracts except hedge purchases solely related to strategies to hedge index credits, therefore following the requirements of Section 4.A.4.a and 4.A.4.b.i.

**VM-31 Section 3.F.8.d.x (new subsection)**

- x. Justification for the margin for any future hedging strategy that offsets interest credits associated with indexed interest strategies (indexed interest credits), including relevant experience, other relevant analysis, and an assessment of potential model error.
- y. The method used to bifurcate comprehensive hedge strategies (i.e., strategies combining index credits, guaranteed benefit, and other risks (e.g., full fair value or economic hedging), per section 4.A.4.c

# Life Practice Council Update

Ben Slutsker, MAAA, FSA  
Vice President, Life Practice Council  
Amanda Barry-Moilanen  
Policy Analyst, Life

Life Actuarial Task Force (LATF) Meeting  
March 21, 2023

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## Academy Webinars and Events

2

- Recent
  - [PBR Bootcamp: Governance and Reporting](#)—March 15
- Upcoming
  - [Post-NAIC update on asset topics](#)—April 4
  - [PBR Bootcamp: Assets \(Part 1\)](#)—April 19
  - [PBR Bootcamp: Assets \(Part 2\)](#)—April 26
  - Bank-Owned Life Insurance/Corporate Owned Life Insurance (BOLI/COLI) webinar—TBD
  - Additional PBR webinars in 2023

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## Recent Activity

3

- Created a new group, the Asset Adequacy and Reinsurance Issues Task Force
  - Will focus on issues related to emerging reinsurance transactions and follow-ups to Actuarial Guideline (AG) 53 and asset adequacy testing
- Delivered recommended edits to the fixed annuity principle-based reserving framework to the Valuation Manual (VM)-22 (A) Subgroup
- Developed a white paper on considerations for market risk benefits in new accounting standards on targeted improvements for long-duration contracts in U.S. GAAP accounting

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## Recent Activity

4

- Presented to the Risk-Based Capital Investment Risk and Evaluation (E) Working Group on considerations for collateralized loan obligation C-1 factors at the Fall National Meeting
  - As a follow-up, submitted clarification questions for the working group to consider for developing a framework
- Proposed to the Life Risk-Based Capital (E) Working Group structural updates, revisions to instructions, and a new financial statement note to address the newly adopted C-2 mortality factors

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## Ongoing Activity

5

- Developed multiple education sessions on economic scenario generators and acceptance criteria for the Life Actuarial (A) Task Force
- Engaging in the discussions on a fixed annuity principle-based reserving framework in the VM-22 (A) Subgroup
- Revisiting the covariance methodology in life risk-based capital
- Creating a discussion brief related to asset assumptions
- Updating the asset adequacy analysis practice note

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## Thank you


6

Questions?

- For more information, please contact the Academy's life policy analyst, Amanda Barry-Moilanen, at [barrymoilanen@actuary.org](mailto:barrymoilanen@actuary.org).

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**SOCIETY OF ACTUARIES  
RESEARCH UPDATE TO  
LATF**

March 21, 2023

R. DALE HALL, FSA, MAAA, CERA, CFA  
Managing Director of Research



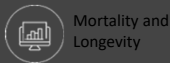
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# 2014-19 Individual Payout Annuity Experience Study – Report



## 2014-2019 Payout Annuity Mortality Study

- Study was published in December 2022
- This is the first study released under Experience Studies Pro, the partnership between the SOA Research Institute and LIMRA
- For access to full report and detailed study results in Tableau, companies must purchase the Standard Data Package (SDP)



## 2014-2019 Payout Annuity Mortality Study

- High-level results:

Metric	Current Study, 2014-2019	Previous Study, 2009-2013
Exposure in contract years	4,323,432	4,494,272
Exposure in annual income years	33,639,077,075	26,831,330,765
Number of deaths	236,331	230,019

A/E by Amount, Expected Basis = 2012 IAM Basic w/Scale G2	Current Study, 2014-2019	Previous Study, 2009-2013
Overall	108.7%	106.4%
Females	106.7%	104.8%
Males	110.9%	107.7%



## 2014-2019 Payout Annuity Mortality Study

- Additional detail available in the full report:

- Expected bases:
  - 2012 IAM Basic Table
  - 2012 IAM Basic Table with Scale G2
  - 2012 IAM Period Table
  - 2012 IAM Period Table with Scale G2
  - 2019 SSA Table
- Data breakouts:
  - Sex
  - Attained age group
  - Contract year group
  - Study year
  - Tax class
  - Annual income group
  - Contract type
  - Refund feature
  - Benefit class
  - Annuitant status



## 2014-2019 Payout Annuity Mortality Study

- This completed study will be the basis for VM-22 Mortality SPA development for Payout Annuities
- Mortality adjustment factors by sex and attained age groups are being reviewed and developed
  - Previous factors were developed based on the 2009-2013 study
  - Will analyze any material differences in factors from 2009-13 study to current study
- Does the mortality experience in this study demonstrate the need for a new base table?
  - Would be an update to the 2012 Individual Annuity Mortality (IAM) Basic Table
  - Has not been discussed or decided on yet
  - Would a new table be the expected basis for Fixed and Variable annuities as well, or does each product line need its own table?

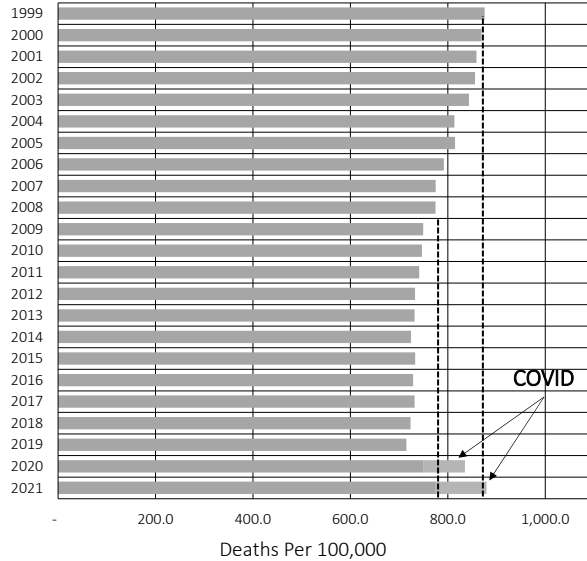


## US Population Mortality Observations: Updated with 2021 Experience



## Historical U.S. Population Mortality

- Total Population
  - 2021 mortality rate of 879.7/100,000 (0.9%)
  - 5.3% increase over 2020 (2019 to 2020 was 16.8%)
  - 23% higher in 2021 than 2019
  - highest rate in last 23 years
- COVID
  - 2021 mortality rate of 104.1 deaths/100,000
  - 22.6% increase over 2020
  - 8% decrease if 2020 ‘annualized’
- Without COVID
  - 2021 mortality rate of 775.6 deaths/100,000
  - 3.3% increase over 2020 (2019 to 2020 was 4.9%)
  - Highest since 2008



## Change in Mortality Rates by Cause of Death

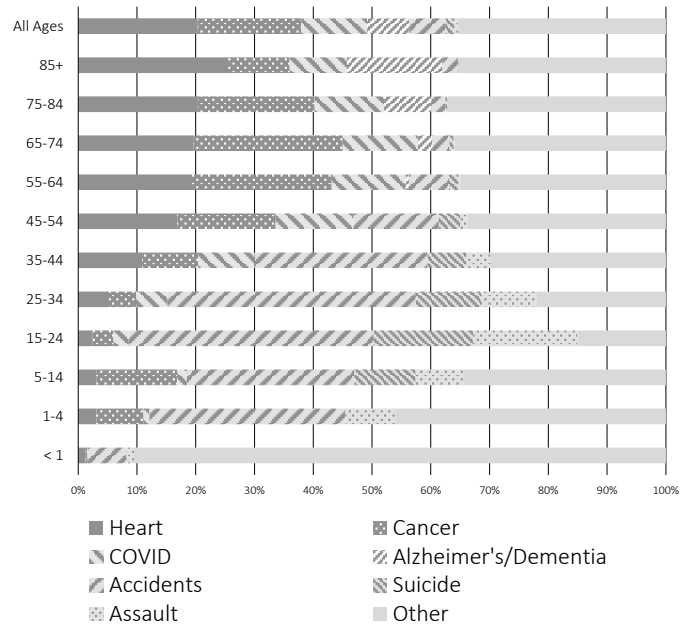
- Heart disease: 3.3% increase in 2021 following 4.1% increase in 2020
- Cancer: 2021 had first increase in last 22 years
- Accidents, diabetes, liver, hypertension, assaults 2021 increases over very large 2020 increases
- Deaths from suicides back up after decrease in 2020
- Good news in Alzheimer’s, pulmonary and flu/pneumonia

Cause of Death	2021 Deaths %	Change in Age-Adjusted Mortality Rates	
		2019-2020	2020-2021
Heart Disease	20.1%	4.1%	3.3%
Cancer	17.5%	-1.4%	1.7%
COVID	12.0%	n/a	22.6%
Alzheimer's/Dementia	6.7%	7.9%	-4.5%
Accidents	6.5%	16.8%	12.4%
Stroke	4.7%	5.1%	5.9%
Pulmonary	4.1%	-4.6%	-4.7%
Diabetes	3.0%	14.9%	2.4%
Liver	1.6%	16.9%	9.1%
Suicide	1.4%	-3.0%	4.2%
Hypertension	1.2%	13.1%	6.1%
Flu & Pneumonia	1.2%	5.9%	-19.3%
Assault	0.8%	28.9%	5.1%
Other	19.3%	6.2%	6.2%
<b>All CODs</b>	<b>100.0%</b>	<b>16.8%</b>	<b>5.3%</b>

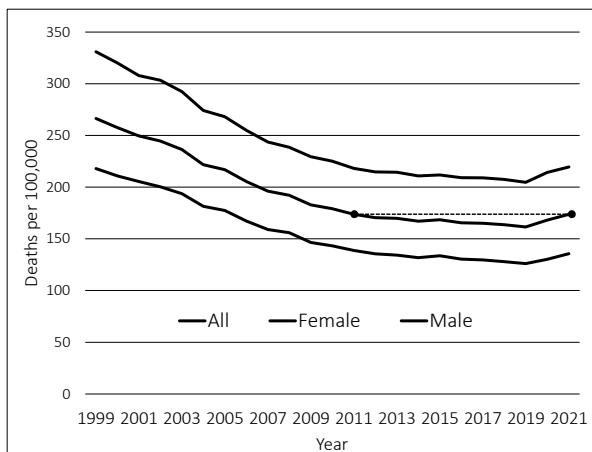


## 2020 & 2021 Causes of Death by Age Group

- Heart disease, cancer and COVID dominate ages 55-84
- Ages 45-54
  - #1 is Heart disease, then cancer, accidents & COVID
- Accidents dominate ages 1-44
- Suicide and assault are prominent for ages 5-34
- COVID not in top 3 for ages <35



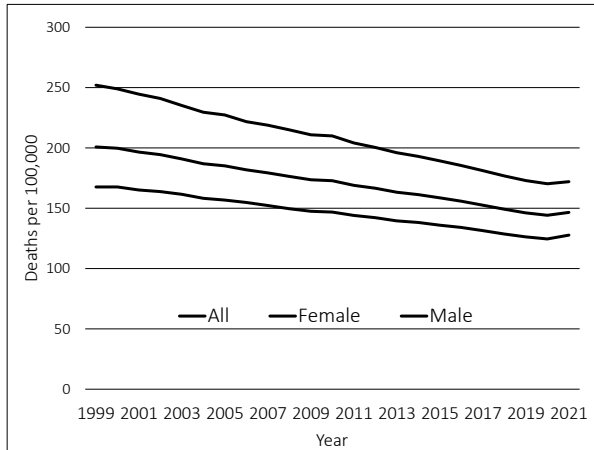
## Heart Disease



All Ages	Average Annual Improvement		Cumulative Improvement	Average Annual Improvement	
	1999-2009	2009-2019	2019-2021	2019-2020	2020-2021
All	3.7%	1.2%	-7.6%	<b>-4.1%</b>	<b>-3.3%</b>
Male	3.6%	1.1%	-7.2%	-4.6%	-2.5%
Female	3.9%	1.5%	-7.5%	-3.2%	-4.1%
Age Group (includes both sexes)					
< 1	3.5%	3.0%	-4.9%	8.5%	-14.7%
1 - 4	2.3%	1.2%	9.7%	14.6%	-5.6%
5 - 14	2.4%	2.0%	-9.3%	6.2%	-16.4%
15 - 24	1.5%	1.5%	-7.2%	-0.1%	-7.2%
25 - 34	-0.2%	0.2%	-20.0%	<b>-13.7%</b>	-5.6%
35 - 44	1.2%	0.6%	-16.6%	<b>-14.7%</b>	-1.7%
45 - 54	1.5%	0.8%	-11.4%	<b>-11.1%</b>	-0.3%
55 - 64	3.4%	0.0%	-9.6%	<b>-9.7%</b>	0.0%
65 - 74	4.9%	0.8%	-7.1%	-6.5%	-0.6%
75 - 84	4.1%	2.0%	-5.4%	-2.6%	-2.7%
85+	3.3%	1.3%	-7.4%	-0.6%	-6.7%

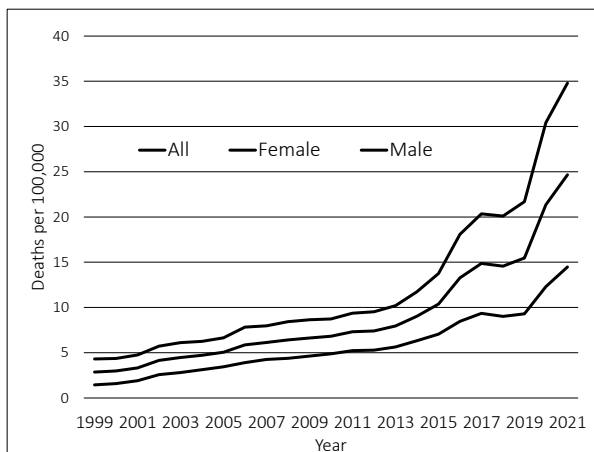


## Cancer



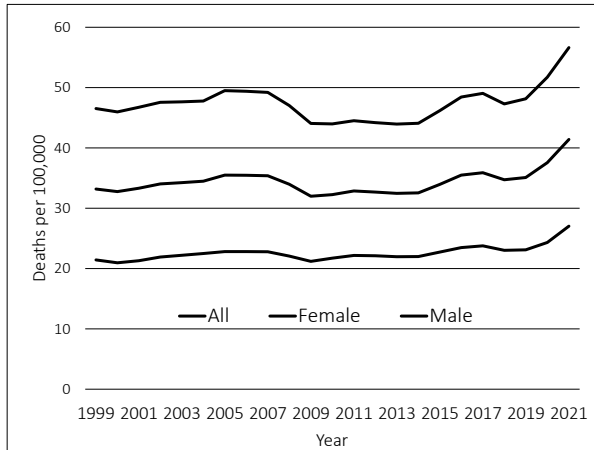
All Ages	Average Annual Improvement		Cumulative Improvement	Average Annual Improvement	
	1999-2009	2009-2019	2019-2021	2019-2020	2020-2021
All	1.4%	1.7%	-0.3%	1.4%	<b>-1.7%</b>
Male	1.8%	2.0%	0.5%	1.5%	-1.0%
Female	1.3%	1.5%	-1.2%	1.3%	-2.5%
Age Group (includes both sexes)					
< 1	-0.3%	2.4%	-0.3%	0.6%	-0.9%
1 - 4	2.3%	1.8%	-2.4%	-9.3%	6.3%
5 - 14	1.2%	1.5%	-0.9%	-2.2%	1.3%
15 - 24	1.7%	1.4%	5.6%	5.6%	0.0%
25 - 34	1.0%	1.4%	-2.1%	0.4%	<b>-2.5%</b>
35 - 44	2.0%	1.6%	-0.5%	0.8%	<b>-1.3%</b>
45 - 54	1.2%	2.6%	5.2%	1.6%	3.7%
55 - 64	2.1%	1.4%	4.1%	1.3%	2.9%
65 - 74	2.1%	2.0%	2.1%	0.8%	1.3%
75 - 84	0.9%	1.9%	-1.1%	1.6%	<b>-2.7%</b>
85+	0.6%	0.8%	-9.0%	2.1%	<b>-11.4%</b>

## Opioids



All Ages	Average Annual Improvement		Cumulative Improvement	Average Annual Improvement	
	1999-2009	2009-2019	2019-2021	2019-2020	2020-2021
All	-8.7%	-8.9%	-59.5%	<b>-38.0%</b>	<b>-15.6%</b>
Male	-7.2%	-9.6%	-60.5%	-40.3%	-14.4%
Female	-12.3%	-7.2%	-55.7%	-32.4%	-17.7%
Age Group (includes both sexes)					
< 1					-87.7%
1 - 4		-4.0%	-175.9%	-50.9%	-82.9%
5 - 14		-2.6%	-128.1%	-96.8%	-15.9%
15 - 24	-12.3%	-5.5%	-67.9%	<b>-61.2%</b>	-4.1%
25 - 34	-10.0%	-10.5%	-53.9%	<b>-36.7%</b>	<b>-12.6%</b>
35 - 44	-4.7%	-10.2%	-63.0%	<b>-40.6%</b>	<b>-16.0%</b>
45 - 54	-9.5%	-6.2%	-56.5%	<b>-34.0%</b>	<b>-16.7%</b>
55 - 64	-16.8%	-10.4%	-62.6%	<b>-31.1%</b>	<b>-24.1%</b>
65 - 74	-13.8%	-12.7%	-61.8%	<b>-25.0%</b>	<b>-29.5%</b>
75 - 84	-7.4%	-6.3%	-16.0%	7.0%	<b>-24.7%</b>
85+		-3.1%	-25.9%	-4.7%	<b>-20.2%</b>

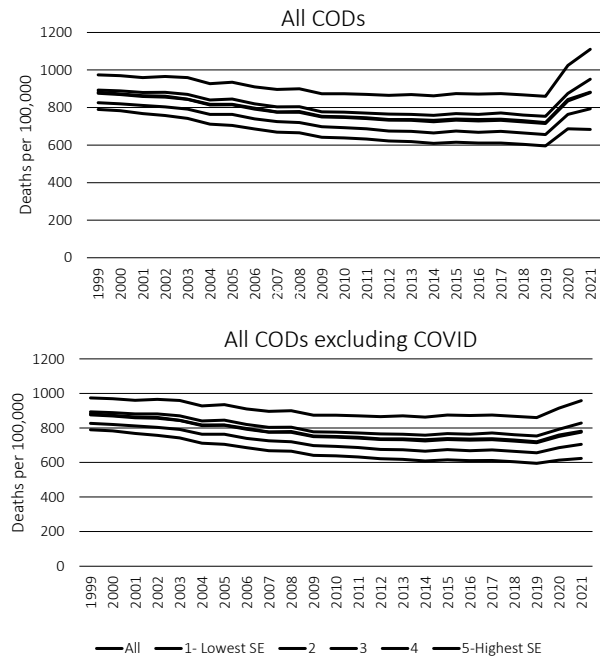
## Accidents excluding Opioids



All Ages	Average Annual Improvement		Cumulative Improvement	Average Annual Improvement	
	1999-2009	2009-2019	2019-2021	2019-2020	2020-2021
All	0.4%	-0.9%	-18.0%	-7.0%	-10.3%
Male	0.5%	-0.9%	-17.7%	-7.5%	-9.5%
Female	0.1%	-0.9%	-17.1%	-5.3%	-11.2%
Age Group (includes both sexes)					
< 1					
1 - 4			-16.2%	-1.3%	-14.7%
5 - 14		1.3%	-12.2%	-3.2%	-8.8%
15 - 24	3.4%	2.2%	-16.9%	-13.3%	-2.8%
25 - 34	0.5%	-0.3%	-27.1%	-16.3%	-9.3%
35 - 44	0.6%	-1.1%	-25.6%	-13.3%	-10.9%
45 - 54	-1.9%	-0.4%	-17.8%	-9.8%	-7.3%
55 - 64	-0.5%	-3.0%	-17.8%	-8.3%	-8.7%
65 - 74	0.8%	-1.9%	-12.7%	-2.1%	-10.4%
75 - 84	-0.3%	-1.1%	-9.6%	1.9%	-11.8%
85+		-2.0%	-18.1%	-1.6%	-16.2%

## Mortality by Socioeconomic (SE) Group

Quintile	Average Annual Improvement		Cumulative 2021 Improvement			
	1999-2009	2009-2019	With COVID		Without COVID	
			Since 2019	Since 2020	Since 2019	Since 2020
1 – Lowest SE	1.1%	0.2%	-29.1%	-8.5%	-11.3%	-4.7%
2	1.4%	0.3%	-26.2%	-8.8%	-9.9%	-4.4%
3	1.6%	0.4%	-22.5%	-4.7%	-8.5%	-2.9%
4	1.7%	0.6%	-20.8%	-3.9%	-7.4%	-2.8%
5 – Highest SE	2.1%	0.7%	-14.7%	0.5%	-4.7%	-1.8%
All	1.5%	0.5%	-23.0%	-5.3%	-8.4%	-3.3%
High-Low	1.0%	0.6%	14.4%	9.2%	6.6%	3.0%



## US Population Mortality Observations: Updated with 2021 Experience

QR code to final report:



Additional Life Research

## Experience Studies

Project Name	Objective	Link/Expected Completion Date
2014-19 Individual Payout Annuity Experience Study - Report	Examine the mortality experience from 2014-19 under individual payout annuity contracts.	<a href="https://www.soa.org/resources/experience-studies/2022/14-19-payout-annuity-mortality/#public">https://www.soa.org/resources/experience-studies/2022/14-19-payout-annuity-mortality/#public</a>
COVID-19 Cause of Death Study - 2021 Q4 Update	Publish a cause of death study for individual life insurance.	<a href="https://www.soa.org/resources/experience-studies/2022/cause-of-death-q4/">https://www.soa.org/resources/experience-studies/2022/cause-of-death-q4/</a>
COVID-19 Reported Claim Study - 2Q 2022 Update	Draft a research study reviewing Covid-19 reported deaths by quarter.	<a href="https://www.soa.org/resources/experience-studies/2022/us-ind-life-covid-19-q2/">https://www.soa.org/resources/experience-studies/2022/us-ind-life-covid-19-q2/</a>
Group Life COVID-19 Mortality Survey Update - through June 2022	Complete an update on a mortality study assessing the impact of COVID-19 on Group Life Insurance.	<a href="https://www.soa.org/resources/experience-studies/2022/group-life-covid-19-mortality-06-2022/">https://www.soa.org/resources/experience-studies/2022/group-life-covid-19-mortality-06-2022/</a>
US Population Mortality Observations: Updated with 2021 Experience	Explore observations from the release of the 2021 U.S. population mortality data.	<a href="https://www.soa.org/resources/research-reports/2023/us-population-mortality/">https://www.soa.org/resources/research-reports/2023/us-population-mortality/</a>
COVID-19 Individual Life Mortality Study - Experience Study Report - 2022 Q1	Complete a mortality study assessing the impact of COVID-19 on Individual Life Insurance.	3/16/2023
COVID-19 Reported Claim Study - 3Q 2022 Update	Draft a research study reviewing Covid-19 reported deaths by quarter	3/16/2023
2011-2015 Deferred Annuity Mortality Study	Examine the mortality experience from 2011-2015 in deferred annuity contracts and release a report with the findings and a database with the experience data.	3/31/2023
2019-20 Fixed Indexed Annuity Study - Report	Examine lapse and the utilization of guaranteed living withdrawal benefit options on fixed index annuity policies under a Joint SOA/LIMRA project and release Tableau visualizations with the observations from the study.	4/15/2023
COVID-19 Cause of Death Study - 2022 Q1 Update	Publish a cause of death study for individual life insurance	4/15/2023



## Practice Research & Data Driven In-house Research

Project Name	Objective	Link/Expected Completion Date
2022 Mortality Improvement Company Survey	Survey life insurers and annuity companies to see how mortality improvement assumptions have changed in light of COVID.	<a href="https://www.soa.org/resources/research-reports/2022/mort-improve-survey/">https://www.soa.org/resources/research-reports/2022/mort-improve-survey/</a>
Guideline Excess Spread Attribution Analysis	Specify general considerations to guide the development of a methodology to attribute spread to different investment risks related to AGS3.	<a href="https://www.soa.org/resources/research-reports/2023/methodology-ag3/">https://www.soa.org/resources/research-reports/2023/methodology-ag3/</a>
Mortality and Mental Illness	Examine the impact on mortality of mental illness during the COVID-19 pandemic.	<a href="https://www.soa.org/resources/research-reports/2022/2022-mental-illness-us-mort-long/">https://www.soa.org/resources/research-reports/2022/2022-mental-illness-us-mort-long/</a>
International Comparison of Regulatory Requirements Study Note - 2021-08	Capital Adequacy Regulatory Requirements in Life Insurance across 4 key models in the US, Canada, EU and Bermuda.	3/13/2023
Mortality and Race	Summarize available literature on mortality and race and discuss actuarial aspects.	4/17/2023
Maternal Mortality	Study maternal mortality in US and compare to other countries.	4/30/2023
Unhealthy Longevity	Examine differences in mortality/longevity between impaired vs healthy lives.	4/30/2023
Expert Opinion on Impact of COVID-19 on Future Mortality - Survey 2	Survey panel of experts on short and mid term thoughts on future population and insured mortality.	5/31/2023





# Mortality Improvements Life Work Group (MILWG)— 2023 Update and Work Plan

Academy Mortality Improvements Life Work Group (MILWG);  
SOA Mortality and Longevity Oversight Advisory Council (MLOAC)

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Life Actuarial Task Force (LATF) — NAIC 2023 Spring Meeting (3/21/23)

## Agenda

- Recap: approved approach for 2022 HMI and FMI scales
- 2023 scale updates (HMI and FMI)
- MILWG 2023 work plan



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# Recap: approved approach for Recap: 2022 HMI and FMI scales



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## 2022 HMI/FMI General Methodology

HMI Scale Year	Historical Component: <i>Historical Data (10 yrs)</i> <i>SSA Data – Gen Population Mean</i>	Estimated/Future Component: <i>SSA (Social Security Administration)</i> <i>Alt2 Projection (20 yr average)</i>
2022	Averaging Period: 2010-2020	Averaging Period: 2020-2040
FMI Scale Year	Process	Long-Term Rate (LTR)
2022	<b>Basic Scale:</b> <ul style="list-style-type: none"> <li>• Grades to LTR at projection yr 10 (2032)</li> <li>• Remains at LTR for projection yrs 10-15</li> <li>• Grades to no additional MI at projection yr 20 (2042)</li> <li>• Margin for uncertainty included to develop <b>“Loaded Scale”</b></li> </ul>	Average of SSA Alt 2 MI for projection years 10-15 (decision point on whether to change LTR basis)



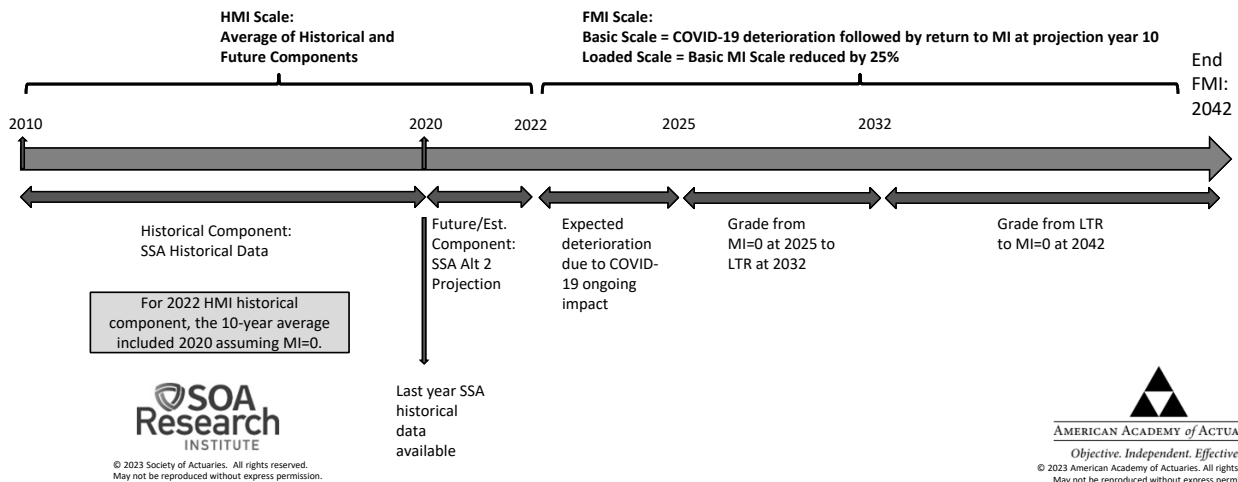
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# HMI/FMI General Methodology

Example : Scale Year = 2022



## COVID-19 Modifications to General Methodology for 2022 HMI and FMI

### HMI Modified Approach:

Use average from 2010–2020 but include 2020 mortality = 2019 mortality

- Assumes zero improvement for 2020
- Results in less mortality improvement in general than HMI Approach 1

### FMI Modified Approach:

Basic scale : include COVID-19 impact (deterioration in mortality) in early years of the FMI scale

- Assume deterioration for 2023 and 2024 followed by zero improvement in 2025.
- Then grade to long-term (LT) MI level based on Social Security Administration (SSA) Intermediate projection at year 10 (grade from 2025–2032).

Loaded scale (prudent estimate) = scale above plus 25% general margin for uncertainty in trend



# Issues Addressed

- SSA Alt 2—appears to be a reasonable basis for the LTR development
  - ▣ Primary criticism of SSA’s intermediate projection has been concern that MI implied rates are too low
- Appropriateness of inclusion of COVID-19 impacts in FMI
  - ▣ Consistent with Industry Mortality Group principle that states that the shock impact of COVID-19 or other short-term mortality events should only be included in the future mortality expectations to the extent they are expected to continue
  - ▣ Recommended inclusion of FMI deterioration in the first 3 years of the reserve projection estimates the expected future impact of COVID-19

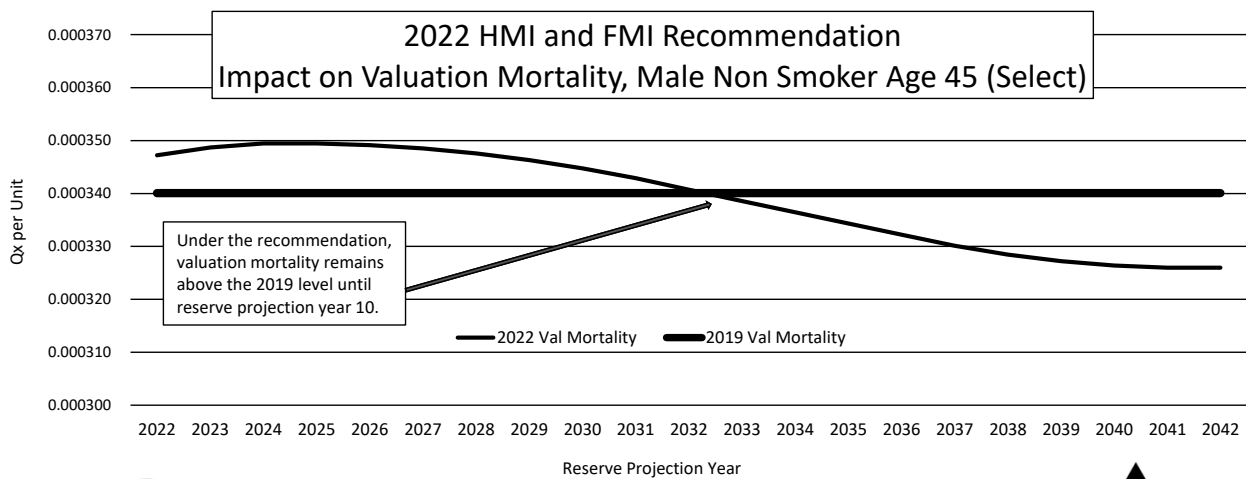


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## General Impact of 2022 Modifications on Valuation Mortality



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# 2023 Scale Updates (HMI and FMI)



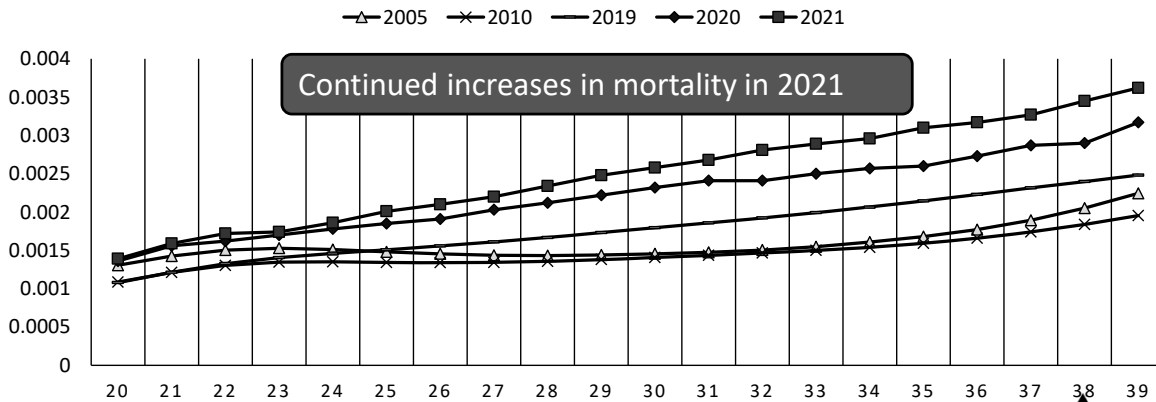
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## 2023 HMI Scale – Males Preliminary 2021 Mortality Data

### AGES 20-39



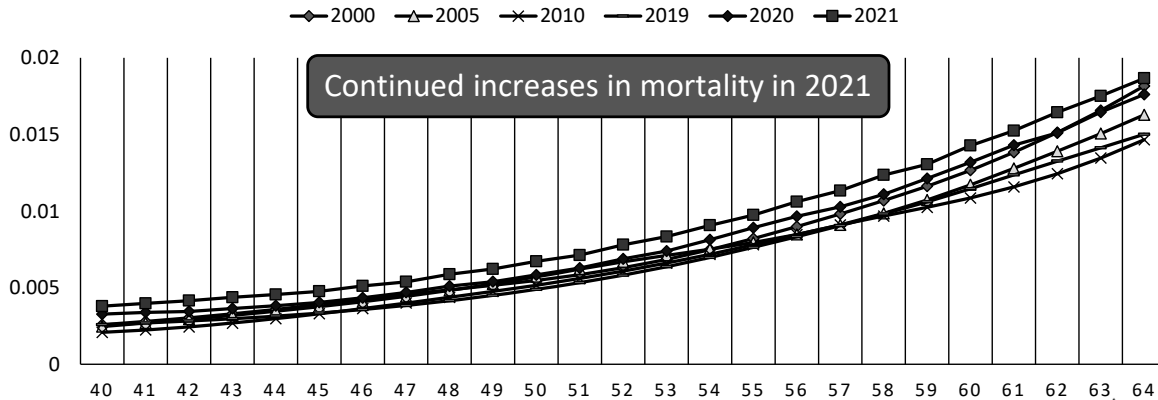
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## 2023 HMI Scale – Males Preliminary 2021 Mortality Data

### ADULTS, 40-64

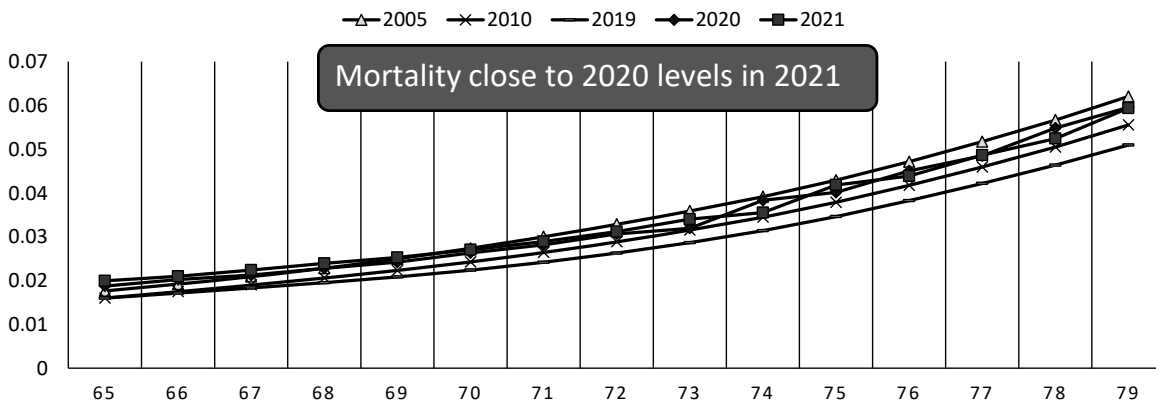


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## 2023 HMI Scale – Males Preliminary 2021 Mortality Data

### ADULTS, 65-79

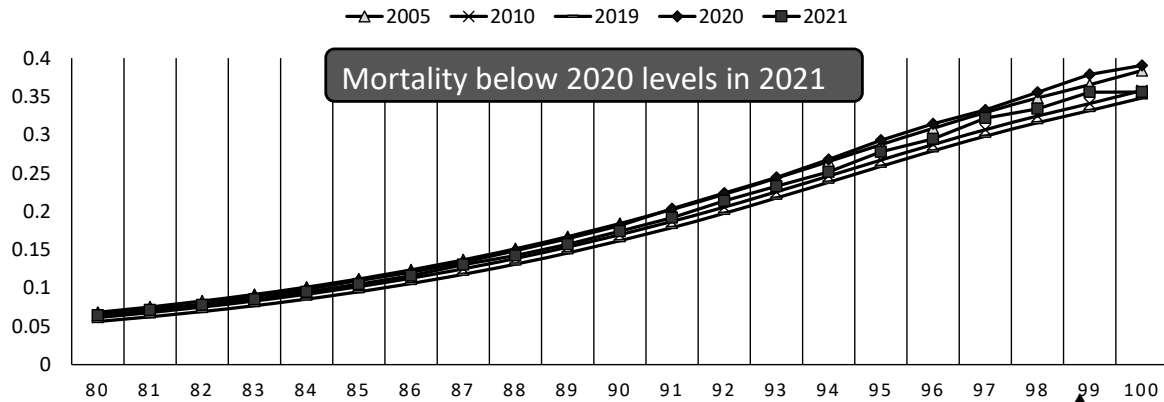


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# 2023 HMI Scale – Males Preliminary 2021 Mortality Data

## ADULTS, 80 AND OLDER



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# MILWG 2023 Work Plan



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# 2023 Plan

- Approach to COVID-19 impact for 2023 – FMI and HMI
- Revisit HMI methodology in light of recent and expected experience
- Insured vs. general population MI recommendation
- Revisit FMI margin structure
- Revisit smoothing approach for HMI and FMI
- Review recommendation for MI with 2008 VBT Limited Underwriting (LU) table



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# Approach to COVID-19 impact

- Quantification of COVID-19 impact
  - Data sources
  - Consideration of short- vs. medium- vs. longer-term impacts
  - Return to previously projected mortality level over time or residual excess mortality
  - Insured vs. general population considerations
  - Direct adjustment to MI rates or reflected in additional margins
- Implicit margins in MI scale development
  - Data source—general population data unadjusted for insured population differences (largest source of margin)
    - Starting MI level (HMI)
    - Long-term rate (FMI)
  - Limit on FMI assumption (20 years)



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# COVID-19 Impact Discussions

- Revisit the question of inclusion/exclusion of COVID-19 deaths
  - Could remove deaths directly attributed to COVID-19 as primary cause
  - This will not remove COVID-19 deaths where it was not reported as the primary cause
- Review data for other causes of death and how much those trends will likely continue
  - Utilize data from SOA research on excess mortality for individual life insureds
  - Utilize cause of death information from SOA general population mortality research
- Keep in mind goal of this scale development work

HMI: Establish a reasonable starting point for valuation mortality

FMI: Establish a reasonable expectation of ongoing life insured mortality



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# HMI Methodology Review

To be completed for 2023 HMI Scale Recommendation

- Data sources – historical and future/estimated components
- Gender and age scales
- Historical averaging period – 10 years
- Averaging methodology
- Forecast/estimate averaging period – 20 years
- Continue with 50/50 weighting for average



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## Insured vs General Population Mortality Recommendation (HMI and FMI)

Data review and analysis, initial thinking to be completed in 2023

- Data sources – historical and future/estimated components
- SOA Mortality Improvement Model (MIM) support work:
  - ▣ Updated 2020-2021 data with COVID-19 impacts
  - ▣ Developing/documenting potential methodology to remove COVID-19 impact for data analysis work
  - ▣ Compare population data by socioeconomic decile to 2015 VBT and to actual industry experience for the same periods



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## Other MILWG Projects

- Revisit FMI margin structure
- Revisit smoothing approach for HMI and FMI
- Review recommendation for MI with 2008 VBT Limited Underwriting (LU) table



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# Questions?



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# Appendix



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## Reserve Impact—NAIC Model Office

- Universal Life with Secondary Guarantees (ULSG) model—long-duration product, larger potential for reserve reduction
  - Model office and assumptions same as used in the yearly renewable term (YRT) representative model analysis
  - Lifetime shadow account secondary guarantee
  - No reinsurance in the model

Component	Values
Issue ages	Decennial issue ages 30 – 70
Gender	Male Female
Risk classes	Preferred non-tobacco Standard non-tobacco Standard tobacco
Face bands	Low (\$250,000) High (\$1,000,000)



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# Reserve Impact—NAIC Model Office

- Term Life Insurance Product with 10- and 20-year level premium periods
  - Model office and assumptions same as used in the YRT representative model analysis
  - Mature at age 95
  - 100% shock lapse at end of level term period

Component	Values
Issue ages	Decennial issue ages 20 – 60
Gender	Male Female
Risk classes	Preferred non-tobacco Standard non-tobacco Standard tobacco
Face bands	Low (\$250,000) High (\$1,000,000)
Term lengths	10 year 20 year



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# Reserve Impact Results—ULSG

Mortality Improvement Basis	ULSG	
	Normalized VM-20 Deterministic Reserve (DR)	Percentage Change from Baseline
<b>Baseline:</b> HMI: no change to HMI FMI: zero FMI	\$ 1,000,000.00	----
HMI: Approach 2 FMI: Zero FMI	\$ 1,014,962.02	1.50%
<b>RECOMMENDATION:</b> HMI: Approach 2 FMI: Approach 2	\$ 940,464.62	-5.95%
Sensitivity: HMI: Approach 2 FMI: Approach 3	\$ 938,346.28*	-6.17%*

Approaches to HMI and FMI	
<b>HMI</b>	
<b>Approach 1</b>	= historical average 2009-2019
<b>Approach 2</b>	= historical average 2010-2020 (zero MI in 2020)
<b>FMI</b>	= grades to SSA intermediate projection long-term rate over 10 years
<b>Approach 1</b>	= no FMI deterioration for COVID-19
<b>Approach 2</b>	= apply deterioration due to COVID-19 for first 3 years
<b>Approach 3</b>	= apply greater 50 percent greater deterioration due to COVID-19 for first 3 years (sensitivity)



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\*The slight decrease in reserves for the sensitivity run compared to the recommendation seems counterintuitive given the higher initial mortality deterioration present in the sensitivity. However, specific impacts related to the net-amount-at-risk pattern (decreasing in the initial years due to fund value growth before growing in later years as fund value runs out and the secondary guarantee comes into effect) meant that the shift of death claims to earlier years from later years for the sensitivity run resulted in a slightly reduced deterministic reserve compared to the recommendation. Overall, the conclusion is that the additional margin did not have a material impact on the deterministic reserve calculation for this model office product.

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## Reserve Impact Results—Term

Mortality Improvement Basis	Term	
	VM-20 DR	Reserve Change
<b>Baseline:</b>		
HMI: no change to HMI FMI: zero FMI	\$ (79,846)	----
HMI: Approach 2 FMI: Zero FMI	\$ (50,285)	\$ 29,561
<b>RECOMMENDATION:</b>		
HMI: Approach 2 FMI: Approach 2	\$ (68,968)	\$ 10,878
Sensitivity:		
HMI: Approach 2 FMI: Approach 3	\$ (66,303)	\$ 13,543

**Approaches to HMI and FMI**

**HMI**  
**Approach 1** = historical average 2009-2019  
**Approach 2** = historical average 2010-2020 (zero MI in 2020)

**FMI** - grades to SSA intermediate projection long-term rate over 10 years  
**Approach 1** = no FMI deterioration for COVID-19  
**Approach 2** = apply deterioration due to COVID-19 for first 3 years  
**Approach 3** = apply greater 50 percent greater deterioration due to COVID-19 for first 3 years (sensitivity)



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Note: All of the valuation date deterministic reserves shown on this slide are negative



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## Additional Considerations HMI and FMI

- MI improvement scale annual updates should not create reserve volatility
- Individual companies should also consider their own business and make appropriate additional adjustments



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March 6, 2023

Rachel Hemphill

Chair, NAIC Life Actuarial (A) Task Force (LATF)

Re: APF 2023-03 Parts 3-5

Dear Ms. Hemphill:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit comments on Parts 3-5 of APF 2023-03 (APF), which was exposed by LATF during their meeting on February 2<sup>nd</sup>. While we are generally supportive of the provisions contained within these sections of the APF, we do have some concerns related to the scope of the proposal as well as some technical details that we believe should be addressed before adoption.

Overall, APF 2023-03 includes several potentially material changes that are not related to or dependent on one another, so we would recommend splitting this proposal into multiple APFs so each item can be considered separately. This would likely lead to easier and quicker adoption of the more minor items that are included. In addition, several of the proposed items cite consistency with other sections in the Valuation Manual as rationale for the change. While consistency may be desirable, further explanation of the rationale for the changes would be appreciated for these items.

However, as stated above, our feedback for this round of comments addresses changes proposed in Part 3 of the APF. Particularly, we have concerns surrounding the differences between VM-20 and VM-21 as we feel that the changes do not take into consideration that VM-20 and VM-21 also differ in the discount rates used to calculate scenario reserves. Under the APF, a company that models its actual strategy (rather than the alternative investment strategy) would have to document it as a simplification if borrowing cost being greater than or equal to reinvestment rate isn't true in every period.

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This is especially troublesome when you add the consideration of VM-20 Section 7.E.2 consistent with the VM-21 Section 4.D.4.c requirement on the company's assumed cost of borrowing along with the associated Guidance Note. This consideration adds language requiring that the assumed cost of borrowing is not lower than the rate at which positive cash flows are reinvested in the same time period, taking into account duration, ratings, and other attributes of the borrowing mechanism. While this change does align the assumed cost of borrowing between VM-20 and VM-21, it results in a disconnect between the rate at which deficiencies are accumulated and the scenario discount rate. As stated in each respective VM section:

*VM-20 Section 7.H.4: "The company shall use the path of one-year Treasury interest rates in effect at the beginning of each projection year multiplied by 1.05 for each model segment within each scenario as the discount rates in the SR calculations in Section 5."*

*VM-21 Section 4.B.2: "In determining the scenario reserve, accumulated deficiencies shall be discounted at the NAER on additional assets, as defined in Section 4.B.3". Section 4.B.3 describes an NAER that would be akin to a new money earned rate.*

Furthermore, the disconnect created between the Stochastic Reserve discount rate and borrowing rate could result in infinite SR calculations. For example, suppose that at the end of 50 years in the projection, there is a 1M deficiency and no/few policies remaining. Assuming the net earned rate on positive cash flows = borrowing rate = 5% and the discount rate is =  $1.05 * \text{Treasury} = 2\%$ , letting the projection run another N years would result in the PV of deficiency continuing to grow by  $(1.05/1.02)^N$ . It may be difficult for companies to defend cutting off the projection at 50 years, if running it 100 years causes the scenario reserve to increase by 300%, primarily driven by the disconnect in discounting accumulation rates.

It is our current understanding that these changes are regulators way of saying that companies should not be assuming significant benefits from borrowing, which is a point we agree with at an overarching level. But as we have stated above, if regulators would like to reach this goal as expeditiously as possible, there are several changes that could be made to address both the technical and bureaucratic challenges presented by the APF as it currently stands including dividing the APF into smaller proposals and acknowledging the differences between VM-20 and VM-21 requirements.

Thank you once again for your consideration of our comments and we are looking forward to further conversation and cooperation with regulators on this matter as we work towards compiling feedback on Parts 1 and 2.

cc: Scott O'Neal, NAIC

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force  
 Amendment Proposal Form\***

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

**Identification:**

PBR Staff of Texas Department of Insurance

**Title of the Issue:**

Address several clean-up items for VM-20, as well as related VM-21 and VM-31 Sections.

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

VM- 20 Section 3.B.5.c.ii.4, VM-20 Section 5.B.3, VM-20 Section 7.E.2 and Guidance Note below, VM-21 Section 4.D.4.c, VM-20 Section 7.K.3, VM-31 Section 3.D.6.f, VM-20 Section 9.A.4

January 1, 2023 NAIC Valuation Manual

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

See attached.

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

1. The formula for calculating the NPR for ULSG based on the value of the SG in VM-20 Section 3.B.5.c.ii.4 excludes the EA from the scaling of the NPR. This is inconsistent with the formula for calculating the NPR for ULSG disregarding the SG in VM-20 Section 3.B.5.d.iv. The scale is the prefunding ratio of actual SG (denoted ASG) to fully funded SG (denoted FFSG), and it makes intuitive sense that the NPR would be scaled to decrease or increase relative to the level of funding of the SG.
2. The VM-20 Section 5.B.3 stochastic reserve methodology is missing an aggregate cash surrender value (CSV) floor for scenario reserves before calculating CTE70. This allows scenario reserves that exceed the CSV to be dampened or eliminated by being averaged with scenario reserves. A CSV floor in the NPR does not address this concern, because it does not reflect the scenario reserves in the SR that exceed the CSV. In contrast, in VM-21 Section 4.B.1 scenario reserves are floored at the aggregate CSV as appropriate. Scenario reserves, as the asset requirement for specific scenarios, should be held at or above the CSV.
3. Add consideration to VM-20 Section 7.E.2 consistent with VM-21 Section 4.D.4.c’s requirement on the company’s assumed cost of borrowing along with the associated Guidance Note. Editorial clarifications to the existing Guidance Note in VM-21.
4. VM-20 Section 7.K.3 should clarify the requirement to reflect the hedge modeling error or insufficiency. Related to this change, more discussion about the hedging strategy and hedge modeling should be added to the Life Report section of the VM-31 Section 3.D.6.f report.

5. VM-20 Section 9.A.4 implies companies can elect to stochastically model risk factors other than interest rates & equities. Stochastic assumptions are not subject to the requirements of Section 9 relating to prudent estimate assumptions. Nor are any guidance/specific requirements provided if companies elect to stochastically model other risk factors. Add consideration to VM-20 consistent with VM-21 Section 12.B.4’s requirement about the risk factors other than interest rates & equities that are stochastically modelled, which was added to VM-21 for this same reasoning.

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

NAIC Staff Comments:

<b>Dates: Received</b>	<b>Reviewed by Staff</b>	<b>Distributed</b>	<b>Considered</b>
1/30/23	SO		
<b>Notes:</b> <u>APF 2023-03</u>			

W:\National Meetings\2010\...TF\LHA\

**VM-20 Section 3.B.5.c.ii.4**

- 4) The NPR for an insured age x at issue at time t shall be according to the formula below:

$$\text{Min} \left[ \frac{ASG_{x+t}}{FFSG_{x+t}}, 1 \right] \cdot (NSP_{x+t} - E_{x+t})$$

$$\text{Min} \left[ \frac{ASG_{x+t}}{FFSG_{x+t}}, 1 \right] \cdot (NSP_{x+t} - E_{x+t})$$

**VM-20 Section 5.B.3**

3. Set the scenario reserve equal to the sum of the statement value of the starting assets across all model segments and the maximum of the amounts calculated in Subparagraph 2 above.

The scenario reserve for any given scenario shall not be less than the cash surrender value in aggregate on the valuation date for the group of contracts modeled in the projection.

**VM-20 Section 7.E.2**

2. Model at each projection interval any disinvestment in a manner that is consistent with the company’s investment policy and that reflects the company’s cost of borrowing where applicable, provided that the assumed cost of borrowing is not lower than the rate at which positive cash flows are reinvested in the same time period, taking into account duration, ratings, and other attributes of the borrowing mechanism. Gross asset spreads used in computing market values of assets sold in the model shall be consistent with, but not necessarily the same as, the gross asset spreads in Section 7.E.1.d and Section 7.E.1.f above, recognizing that starting assets may have different characteristics than modeled reinvestment assets.

**Guidance Note:** The simple language above "provided that the assumed cost of borrowing is not lower than the rate at which positive cash flows are reinvested in the same time period" is intended to prevent excessively optimistic borrowing assumptions. If in any case, the assumed cost of borrowing restriction cannot be fully applied or followed precisely, then as with all other simplifications/approximations, the company shall not allow borrowing assumptions to materially reduce the reserve.

**VM-21 Section 4.D.4.c**

**Guidance Note:** The simple language above “provided that the assumed cost of borrowing is not lower than the rate at which positive cash flows are reinvested in the same time period” is intended to prevent excessively optimistic borrowing assumptions. If in any case, the assumed cost of borrowing restriction cannot be fully applied or followed precisely, then as with all other simplifications/approximations, the company shall not allow borrowing assumptions to materially reduce the reserve.

- Deleted:** This limitation is being referred to Life Actuarial (A) Task Force for review.
- Deleted:** not intended to impose a literal requirement. It is
- Deleted:** to reflect a general concept
- Deleted:** It is recognized that borrowing parameters and rules can be complicated, such that modeling limitations may not allow for literal compliance, in every time step, as long as the reserve is not materially affected. However, if
- Deleted:** the company is unable to fully apply this
- Deleted:** prudence dictates that a

**VM-20 Section 7.K.3**



3. In circumstances where one or more material risk factors related to a derivative program are not fully captured within the cash-flow model used to calculate CTE 70, the company shall reflect the approximation, simplification or model limitations in the modeling of such risk factors by increasing the SR as described in Section 5.E. The company shall also be able to justify that the method appropriately reflects the potential error using historical experience, e.g., analysis of historical performance or backtesting.

--

### **VM-31 Section 3.D.6.f**

- f. Risk Management – Detailed description of model risk management strategies, such as hedging and other derivative programs, including any future hedging strategies supporting the policies and any adjustments to the SR pursuant to VM-20, Section 7.K3 and VM-20, Section 7.K.4, specific to the groups of policies covered in this sub-report and not discussed in the Life Summary Section 3.C.5. Documentation of any future hedging strategies should include documentation addressing each of the CDHS documentation attributes. The following should be included in the documentation:
- i. Descriptions of basis risk, gap risk, price risk and assumption risk.
  - ii. Methods and criteria for estimating the a priori effectiveness of the strategy.
  - iii. Results of any reviews of actual historical hedging effectiveness.
  - iv. Strategy Changes – Discussion of any changes to the hedging strategy during the past 12 months, including identification of the change, reasons for the change, and the implementation date of the change.
  - v. Hedge Modeling – Description of how the hedge strategy was incorporated into modeling, including:
    - Differences in timing between model and actual strategy implementation.
    - For a company that does not have a future hedging strategy supporting the contracts, confirmation that currently held hedge assets were included in the starting assets.
    - Evaluations of the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, and other items that are likely to result in materially adverse results.
    - Discussion of the projection horizon for the future hedging strategy as modeled and a comparison to the timeline for any anticipated future changes in the company's hedging strategy.
    - If residual risks and frictional costs are assumed to have a value of zero, a demonstration that a value of zero is an appropriate expectation.
    - Any discontinuous hedging strategies modeled, and where such discontinuous hedging strategies contribute materially to a reduction in the SR, any evaluations of the interaction of future trigger definitions and the discontinuous hedging strategy, including any analyses of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.

- The approach and rationale used to reflect the hedge modeling error(s).

#### **VM-20 Section 9.A.4**

4. If the company elects to stochastically model risk factors in addition to those listed in Section 9.A.3 above, the requirements in this section for determining prudent estimate assumptions for these risk factors do not apply.

It is expected that companies will not stochastically model risk factors other than the economic scenarios, such as policyholder behavior or mortality, until VM-20 has more specific guidance and requirements available. Companies shall discuss with domiciliary regulators if they wish to stochastically model other risk factors.

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force  
 Amendment Proposal Form\***

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

**Identification:**

PBR Staff of Texas Department of Insurance

**Title of the Issue:**

The values of the starting assets defined in the two sentences in VM-21 Section 4.D.1.a are not identical.

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

VM-21 Section 4.D.1.a.iii in January 1, 2023 NAIC Valuation Manual

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

1. Starting Asset Amount

a. For the projections of accumulated deficiencies, the value of assets at the start of the projection shall be set equal to the approximate value of statutory reserves at the start of the projection plus the allocated amount of PIMR attributable to the assets selected. Assets shall be valued consistently with their annual statement values. The amount of such asset values shall equal the sum of the following items, all as of the start of the projection:

- i. All of the separate account assets supporting the contracts;
- ii. Any hedge instruments held in support of the contracts being valued; and
- iii. An amount of assets held in the general account equal to the approximate value of statutory reserves as of the start of the projections plus the allocated amount of PIMR attributable to the assets selected less the amount in (i) and (ii).

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

The edit is necessary to have the identical value of the assets at the start of the projection as in the first sentence (i.e., For the projections of accumulated deficiencies, the value of assets at the start of the projection shall be set equal to the approximate value of statutory reserves at the start of the projection **plus the allocated amount of PIMR attributable to the assets selected**).

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

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
1/9/23, 2/7/23, 3/2/23	SO		
<b>Notes:</b> APF 2023-01 2/23/23 edit was to move the “plus the allocated amount of PIMR attributable to the assets selected” down to 4.D.1.a.iii from 4.D.1.a.			

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

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Draft: 4/4/23

Health Insurance and Managed Care (B) Committee  
Louisville, Kentucky  
March 23, 2023

The Health Insurance and Managed Care (B) Committee met in Louisville, KY, March 23, 2023. The following Committee members participated: Anita G. Fox (MI); Jon Pike, Co-Vice Chair (UT); Mike Kreidler, Co-Vice Chair (WA); John F. King (GA); Dean L. Cameron (ID); Kathleen A. Birrane (MD); Grace Arnold (MN); Chris Nicolopoulos (NH); Glen Mulready (OK); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Alexander S. Adams Vega (PR); and Allan L. McVey represented by Ellen Potter (WV). Also participating were: Lori K. Wing-Heier (AK); Michael Conway (CO); Paul Lombardo (CT); Andria Seip (IA); LeAnn Crow (KS); Cynthia Amann (MO); and Troy Downing (MT).

1. Discussed its 2023 Activities

Director Fox outlined the Committee's activities and focus for 2023. She said that in accordance with its charges, the Committee will continue to monitor the activities of its task forces and be responsive to any health insurance-related federal initiatives. She also noted that the Committee's charges include coordinating with the Market Regulation and Consumer Affairs (D) Committee, chaired by the Health Insurance and Managed Care (B) Committee's co-vice chair, Commissioner Pike. She said such coordination provides an opportunity for the Committee to work, as necessary, with the Market Regulation and Consumer Affairs (D) Committee on health benefit plan and producer enforcement issues and to monitor market conduct trends on non-federal Affordable Care Act (ACA) plans.

Director Fox said she anticipates the Committee working closely with the Special (EX) Committee on Race and Insurance's Health Workstream as that Workstream continues its work this year on health equity issues involving underserved and traditionally underrepresented populations. She noted that Committee members Commissioner Birrane and Commissioner Arnold are co-chairs of the Health Workstream. As such, this is a great opportunity for the Committee to collaborate and work with the Health Workstream as it completes its work this year.

Director Fox explained that she would like the Committee to work together this year to focus on several topics raised by Committee members that have been ranked in order of importance based on a recent survey of the Committee membership. Those topics, in order of importance, are: 1) network adequacy; 2) Medicaid unwinding due to the pending end of the COVID-19 public health emergency (PHE); 3) state-based marketplaces (SBMs); 4) pharmacy benefit manager (PBM) regulation; and 5) essential health benefits (EHBs).

Director Fox said that prior to the Spring National Meeting, the Committee met with the NAIC consumer representatives focused on health. She said this meeting provided an opportunity for the Committee and the NAIC consumer representatives to discuss priorities and focus for 2023. She said she plans to continue such outreach to enable the Committee to hear a consumer point of view, which can often be difficult to obtain without such meetings. Director Fox noted that one result of this interaction was the invitation to the Kaiser Family Foundation (KFF) to discuss one of its recently published issue briefs on claims denials and appeals for ACA marketplace plans in 2021 during today's Committee meeting.

Director Fox said that to ensure Committee members remain current on Committee meetings and other activities, she asked each Committee member to designate staff to act as a point of contact. She said she plans to use this group to preview Committee meeting agendas and other items. This group met prior to the Spring National Meeting and will continue to meet on an as-needed basis throughout the year. Lastly, Director Fox said she is instituting interim regulator-to-regulator meetings to allow Committee members and interested state insurance

regulators to have more in-depth discussions about topics of interest particularly related to presentations the Committee hears during its open meetings. She said the first of these meetings is March 24. During this meeting, KFF representatives will be available to listen and answer questions on claim denials and appeals from an individual state perspective. The Committee will also discuss in more depth its focus for the year.

Director Fox also discussed a meeting with the Center for Insurance Policy and Research (CIPR). She said that during this meeting, she discussed what the CIPR can do to support the Committee’s work this year and learned what research the CIPR has already done or plans to do in the areas Committee members have identified as important topics to focus on this year.

## 2. Adopted 2022 Fall National Meeting Minutes

Commissioner King made a motion, seconded by Commissioner Mulready, to adopt the Committee’s Dec. 14, 2022, minutes (see *NAIC Proceedings – Fall 2022, Health Insurance and Managed Care (B) Committee*). The motion passed unanimously.

## 3. Adopted its Subgroup, Working Group, and Task Force Reports

Commissioner Pike made a motion, seconded by Commissioner King, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its March 2 minutes (Attachment One); 2) the Health Innovations (B) Working Group, including its March 22 minutes (Attachment Two); 3) the Health Actuarial (B) Task Force; 4) the Regulatory Framework (B) Task Force; and 5) the Senior Issues (B) Task Force. The motion passed unanimously.

## 4. Heard a Discussion on the KFF Issue Brief

Karen Pollitz (KFF) and Kaye Pestaina (KFF) discussed findings from the recently published KFF issue brief “Claims Denials and Appeals in ACA Marketplace Plans in 2021.” Pestaina explained that Section 2715A of the ACA requires ACA-compliant plans, including employer-sponsored plans and health insurance marketplace plans, to report certain ACA transparency in coverage data—including data on the number of claims denied—to health insurance marketplace plans, the Secretary of the U.S. Department of Health and Human Services (HHS), and state insurance commissioners, as applicable, and to also make it available to the public. She explained that although the data reporting requirement applies more broadly, to date, the HHS is only requiring federally facilitated marketplace (FFM) plans to submit this data. She said that since 2016, the federal Centers for Medicare & Medicaid Services (CMS) has specifically required only FFM plans to submit a subset of the claims transparency data—claim denials and appeals data—to it. In addition, the data is limited to in-network claims, which combine both medical and pharmaceutical claims. The CMS takes the data submitted and makes it available to the public in public use files (PUFs), which is what the KFF has been examining since 2016.

Pestaina discussed the potential uses of the data, such as using it as a tool for enforcement and oversight. She said that the KFF is not sure if the CMS is using the data for such a purpose. She said some states are using transparency data as part of their oversight responsibilities related to mental health parity plan compliance. Pestaina highlighted other state uses of other non-CMS transparency data, such as the data collected and reported by the NAIC through its Market Conduct Annual Statement (MCAS). She also said that some SBM plans, such as those in California and possibly Minnesota, are collecting claims denial and appeals data.

Pollitz discussed the KFF’s findings from its review of the data reported by insurers for the plan year 2021 and posted in the PUF. She said that across HealthCare.gov insurers, approximately 230 major medical issuers, with complete data, nearly 17% of in-network claims were denied in 2021. Insurer denials rates varied widely around this average, ranging from 2% to 49%. She explained that the CMS requires insurers to report reasons for claims

denials at the plan level. Of in-network claims, about 14% were denied because the claim was for an excluded service, 9% due to lack of preauthorization or referral, and only about 2% based on medical necessity. She highlighted that insurers classified most plan-reported denials (about 82%) as “all other reasons.” She explained that this “all other reasons” category could include claim denials due to billing or coding errors, duplicate claims, or coverage eligibility. Pollitz said that in analyzing the 2021 plan data, as in its previous analyses, the KFF found that consumers rarely appealed their denied claims. In 2021, HealthCare.gov consumers appealed less than two-tenths of 1% of denied in-network claims, which is about only 1 in 500 denied in-network claims. Insurers upheld most denials (around 59%) on appeal.

Director Fox asked Pollitz if she had any thoughts about what the states can do to increase consumer awareness of their rights to appeal claims denials. Pollitz said it is perplexing as to why consumers do not appeal claim denials. She said the KFF recently completed work on a survey targeted at obtaining information from consumers on their experiences with health insurance. One of the questions to be asked is whether consumers understand their appeal rights, how the process works, and/or who or what agency to contact for assistance. She said the KFF plans to release the results of the survey at some point later this year.

Pollitz said she believes there could be other factors beyond consumers being simply overwhelmed and confused about health insurance, such as the fact that because there is a claim, the consumer or a family member is sick and, as such, may not have the wherewithal to investigate next steps and navigate the appeals process. She said that, in addition, the explanation of benefits (EOB) document consumers receive includes information on appeal rights, but it is typically presented in insurance-related jargon and/or found on the last page of a multi-page EOB document. Pollitz said there are consumer assistance programs in many states that could possibly assist consumers in understanding their appeal rights, but the federal government no longer funds these programs. Those programs in existence since 2010, for the most part, still exist due to state funding. She said that state insurance regulators in states that have these programs might want to reach out to them and work together to figure out how to better educate consumers in this area.

Director Fox asked Pollitz if she knew if there ever has been any engagement or ways to engage the provider community to assist consumers in filing appeals of claim denials. Pollitz said she is not aware of any such engagement. However, she believes that the CMS may be engaging with providers as part of implementing the federal No Surprises Act (NSA). Pollitz said that potential insurer engagement with providers could be beneficial in addressing possible issues in the way claims are submitted to insurers for payment, which could be a reason for certain types of denials, and engaging and educating providers on insurer claim submission requirements could resolve some of those issues.

Commissioner Kreidler asked if the KFF knew if SBMs who tracked claim denials and appeals had findings similar to those of the HealthCare.gov insurers. Pollitz said that among the SBMs KFF knows have similar data reporting, Covered California, the findings look roughly the same. She reiterated that she believes the Minnesota SBM may have similar data reporting requirements, but the KFF has not had the opportunity yet to review its data to determine if there are any similarities. Commissioner Kreidler suggested that of those states that have an SBM, the state department of insurance (DOI) may want to reach out to see if the SBM collects this data in order to understand better what is happening in the state as far as the number of claims denials and appeals and whether there is a need to find ways to educate consumers on their appeal rights.

Carl Schmid (HIV+Hepatitis Policy Institute) expressed appreciation for the Committee inviting the KFF to present its findings. He said the KFF findings highlight a number of troubling issues, such as the high percentage of claim denials and how few consumers appeal such denials. He said he hopes state insurance regulators try to address this issue. He offered a few recommendations to address this, such as the NAIC reviewing its appeal models to see if any revisions need to be made or looking at definitions of “medical necessity.”

#### 5. Heard a Discussion on a State Checklist of Actions Related to the Medicaid Unwinding Process

Sabrina Corlette (Georgetown University, Center on Health Insurance Reforms—CHIR) discussed a recently published issue brief from the State Health and Value Strategies (SHVS) titled “Secrets to a Successful Unwinding: Actions State-Based Marketplaces and Insurance Departments Can Take to Improve Coverage Transitions.” She highlighted the extraordinary work state Medicaid agencies will have to undertake over the next year to reassess the eligibility of approximately 95 million people to retake Medicaid coverage because of the impending end of the COVID-19 PHE. She estimated that approximately 15 million to 18 million of these individuals will be terminated from Medicaid coverage, with many of them being eligible for coverage either through ACA marketplace plans or employer-sponsored insurance (ESI). She discussed the steps state DOIs—along with other partners, such as SBMs and carriers—can take to reduce gaps in coverage and avoid disruptions in care.

Corlette provided a timeline for the Medicaid unwinding process, including the dates certain states plan to begin redeterminations of Medicaid coverage eligibility and terminations of coverage for those deemed ineligible for coverage. Also shown was the decrease in the percentage of the enhanced federal Medical Assistance Percentage (eFMAP) during the time of the Medicaid unwinding process. She discussed temporary and/or short-term actions state DOIs can take to ease transitions, including monitoring the cadence of Medicaid renewals, monitoring qualified health plan (QHP) issuers’ financials and network capacity, and guarding against deceptive marketing of unregulated products. Corlette stressed that it is important that state DOIs communicate early and often with their state and federal partners. She also discussed temporary and/or short-term actions SBMs can take.

Corlette discussed actions state DOIs can take to mitigate the ill effects of churn long-term. Those actions include: 1) expanding continuity of care requirements; 2) requiring QHPs to honor prior authorizations and step-therapy/prescription drug formulary exception decisions; 3) considering the pro-ration of deductibles and maximum out-of-pocket (MOOP) for mid-year transitions; and 4) supporting auto or EZ Enroll initiatives. She discussed similar actions that SBMs can take.

Commissioner Kreidler expressed appreciation for the presentation. He asked Corlette if she has any additional recommendations for the states, particularly those that are actively engaged in the process and are already working with their SBM to smooth the transition process. Corlette said she did not, but she urged state insurance regulators to expect that the process will not go smoothly and to be flexible and maintain lines of communication with their sister agencies, such as the state Medicaid agency.

Director Fox asked about any Special Enrollment Periods (SEPs) for Medicaid recipients that became eligible for Medicare. Corlette said the CMS has instituted such an SEP. She also noted that the CMS has established an SEP for “exceptional circumstances” for FFMs from April 2, 2023, to July 31, 2024. Commissioner Mulready noted that each state will have to decide whether to establish an SEP for enrollment into Medicare supplement (Medigap) plans. He said some states might be able to establish an SEP by rule, which is what Oklahoma did.

#### 6. Heard an Update from the CCIIO on its Recent Activities

Jeff Wu (federal Center for Consumer Information and Insurance Oversight—CCIIO) and Jeff Grant (CCIIO) provided an update on activities of interest to the Committee. Grant focused his remarks on the pending released Notice of Benefit and Payment Parameters 2024 proposed rule, which the CCIIO hopes will be finalized soon. He discussed a few of the proposed changes included in the proposed rule, including proposals that expand access to affordable coverage, but in a way designed to improve consumers’ experiences throughout the process of determining eligibility, choosing a plan, and completing enrollment. The goal is to simplify the enrollment process for consumers and improve the quality of care available. A key rationale for many of these proposed policy and operational changes is to enhance health equity and reduce disparities in health coverage and access.



One proposal central to this goal is enhancing network adequacy and essential community provider (ECP) requirements for individual market QHPs, stand-alone dental plans, and small business health options programs (SHOPs) to ensure consumers have access to a sufficient choice of providers. With the goal of expanding access to services for low-income and medically underserved consumers, CMS proposes to add mental health facilities, substance use disorder (SUD) treatment centers, and rural emergency hospitals to the list of current ECPs.

Grant said that as part of this shift, the CMS is proposing to limit the number of non-standardized plan options to streamline consumer plan choices. He said the CMS is proposing two alternative policies to reduce the number of duplicative or very similar plans currently being displayed to marketplace consumers. SBMs are not impacted. One alternative the CMS proposes is to limit the number of plans insurers can offer at each metal level, product type, and service area to two. Alternatively, the CMS proposes to reinstate a requirement that there be a “meaningful difference” between plans offered on the FFM and the state-based marketplace-federal platform (SBM-FP). Grant reiterated that the proposed rule is not final yet, but explained that these proposed changes reflect CMS’ concern with the proliferation of plans consumers are not able to choose from as opposed to the limited number of plan choices when the health insurance marketplaces first became operational.

Grant said this rule proposes to give health insurance marketplaces the option to implement a special rule giving people who lose Medicaid or the federal Children’s Health Insurance Program (CHIP) 90 days, instead of the typical 60 days, to enroll in a QHP. He also referred to the implementation of the network adequacy wait time requirements, noting the concerns expressed by some commenters about the ability and challenges of the states to have the appropriate tools and resources to assess compliance with the requirements and the burden on providers to get information to insurers in a timely manner, along with other operational challenges.

Grant also touched on: 1) the CMS’ work to modernize the QHP certification process; 2) the independent dispute process under the NSA and the impact of the Feb. 6 Texas court ruling on the ability of the CMS to make payment determinations; and 3) the CMS’ work related to Medicaid unwinding, including improving the transition process for consumers and closing the information gap among the federal and state agencies involved. He closed his remarks by discussing the CCIIO’s work related to health equity.

Commissioner Pike asked about the proposal to limit the number of non-standard plan options. He asked whether there is any consideration to provide flexibility for those states that may have only one or two insurers to permit, if the insurer wishes to do so, more than two plan options. Wu noted the issue’s complexity, explaining that the CMS is carefully weighing all the comments it has received. He pointed out that the proposed rule does not limit the number of standardized plans. An insurer can offer an unlimited number of standardized plans. As such, there are multiple ways for insurers to provide robust competition and choice for consumers in the marketplaces through this mechanism.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/2023 Spring National Meeting/03-Bmin.docx

Draft: 3/8/23

Consumer Information (B) Subgroup  
Virtual Meeting  
March 2, 2023

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met March 2, 2023. The following Subgroup members participated: LeAnn Crow, Chair (KS); Debra Judy (CO); Randy Pipal (ID); Alex Peck (IN); Mary Kwei (MD); Carrie Couch (MO); Mike Rhoads and Rebecca Ross (OK); David Buono (PA); Jill Kruger (SD); Vickie Trice (TN); Shelley Wiseman (UT); and Christina Keeley (WI). Also participating were: Susan Brown (MT); and Cynthia Cisneros (NM).

1. Adopted its Jan. 31 Minutes

The Subgroup met Jan. 31 to discuss the results of a survey of states' consumer engagement activities.

Rhoads made a motion, seconded by Trice, to approve the Subgroup's Jan. 31 minutes (Attachment One-A). The motion passed unanimously.

2. Discussed Potential Subgroup Activities

Crow reviewed ideas raised during the last meeting for the Subgroup's next projects. She listed ideas including a resource document on using social media, a guide to forming partnerships with other agencies, methods for measuring the effectiveness of outreach, and creating alternate versions of existing documents. She also raised the idea of an education piece for consumers who may lose Medicaid.

Rhoads said the most pressing issue for Oklahoma and many states is helping consumers find coverage after they come off Medicaid. He said assisting consumers who lose access to Medicaid will be a critical priority in the coming months. Other states agreed that it would be helpful to have something in this area fairly quickly. Cisneros said New Mexico has worked with its state-based Marketplace and Medicaid agency, which has developed a toolkit to guide activities.

Bonnie Burns (California Health Advocates—CHA) said that consumer representatives would be happy to assist in developing a document. She said consumers are looking for answers to questions, so a document should be designed to give answers to specific questions.

Eric Ellsworth (Consumers' Checkbook) said there is a lot of messaging already from the Centers for Medicare & Medicaid Services (CMS) and state-based marketplaces. He said information dilution is a risk. He said state insurance regulators should consider what they can do that is additive to what has been produced already (e.g., compelling insurers to add messages to their websites). Kruger said consumers will be directed to Marketplaces, not individual carrier websites. She said a risk to consider is that consumers may end up on scam websites rather than Marketplace sites. Ellsworth said consumers may or may not read a letter from the Medicaid agency, but they may need help in avoiding scam websites when they seek new coverage. He said state insurance regulators should consider asking Google to mark official government sites so they can be easily distinguished. Burns said consumers have been attracted to health care sharing ministries (HCSMs) because they search for something inexpensive, so consumers should be warned what they should not do in addition to learning about official resources.

Cisneros said New Mexico has been working proactively to steer consumers away from HCSMs and scam plans with webinars and advertising. Crow said consumers may not seek help or information until it is too late.

Couch suggested the Subgroup could consider reworking its older document on shopping for low-cost health plans.

Harry Ting (Health Care Consumer Advocate) said a frequently asked questions (FAQ) document would be a more effective format and said dual eligible individuals should be addressed.

Kris Hathaway (AHIP) said her organization has been spending a lot of time on redeterminations. She said the Subgroup should not reinvent the wheel and instead make use of materials that have already been developed. She said timing and alignment with Medicaid agencies and Marketplaces are concerns, so the Subgroup should consider a library of resources rather than a new document.

Ross said states have navigators involved already and that states should help consumers find navigators.

Crow asked for volunteers to help with the project. Ross, Brown, and Burns said they would help. Burns said the Subgroup could produce multiple documents, one for consumers and one for state insurance regulators.

Ellsworth suggested that the Subgroup later in the year could work to analyze the barriers to consumers getting the information they need. The intention would be to make policy changes (e.g., requiring issuers to include Health Insurance Oversight System [HIOS] identification numbers on the Summary of Benefits and Coverage [SBC]).

Having no further business, the Consumer Information (B) Subgroup adjourned.

SharePoint/Support Staff Hub/Committees/B Committee/National Meetings/2023 Spring National Meeting/Final Minutes/Cons Info 3.2

Draft: 2/8/23

Consumer Information (B) Subgroup  
Virtual Meeting  
January 31, 2023

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Jan. 31, 2023. The following Subgroup members participated: Mary Kwei, Chair, and Joy Hatchette (MD); Tara Smith (CO); Ryan Gillespie (IL); Alex Peck (IN); Carrie Couch (MO); Kathy Shortt (NC); Jennifer Ramcharan (TN); Shelley Wiseman (UT); and Christina Keeley (WI). Also participating were: Cynthia Cisneros and Paige Duhamel (NM).

1. Discussed the Results of a Survey of States' Consumer Engagement Activities

Kwei reminded the Subgroup that members had worked in 2022 to understand better how state departments of insurance (DOIs) engage with consumers on health insurance topics. She said the Subgroup is interested in understanding what states are doing and how the Subgroup can be most helpful. She said that the Subgroup had convened focus groups and conducted a survey of public information officers (PIOs).

Brenda J. Cude (University of Georgia) provided a summary of the findings of the survey. She said 13 individuals from 12 states responded. She said website content, social media, and partnerships with other government agencies were the most commonly mentioned means of outreach. Dr. Cude said participants were asked to rate the effectiveness of different methods of outreach, and those most identified as effective were online public meetings and website content, followed by social media and advertising.

Dr. Cude said Facebook was the social media used most often, followed by Twitter and LinkedIn. She said YouTube, TikTok, and Nextdoor were also mentioned. She said states that use Nextdoor rated it highly effective. She said states evaluate the effectiveness of their methods by using counting, whether of social media engagement, website hits, or event participants. Dr. Cude said counting is not necessarily the best way to rate effectiveness, even though it is the easiest. She said the Subgroup could consider providing tools to states that help in using other ways to evaluate efforts.

Dr. Cude said respondents generally reported using NAIC materials. The one state that did not said the materials were not useful because of cultural and other differences in the state. Dr. Cude said states most commonly link to NAIC documents or adapt them and use them on their own websites. She said that choosing plans and how to use health insurance were the most frequently requested topics for new content.

Kwei said the Subgroup should think through ways to deliver content on choosing and using health plans that are accessible in different ways. Duhamel asked how states use the Nextdoor app. Hatchette said Maryland tried other types of social media, but Nextdoor provides a unique opportunity because it allows government entities to post statewide, rather than in limited neighborhoods. She said Maryland uses it for both property/casualty (P/C) and health. She suggested that states reach out to Nextdoor to be registered as a government entity.

Harry Ting (Health Consumer Advocate) said that he recently calculated the number of complaints and inquiries to state DOIs per population for each state. He said there is a lot that goes into the numbers, but higher rates of complaints and inquiries could indicate more success in engaging consumers who then contact the DOI.

Dr. Cude said states could benefit from education on: ways to evaluate effectiveness; how to use any social media, not just Nextdoor; and how to partner with other organizations. Kwei said the Subgroup could consider how to repurpose and repackage some of the content that has already been developed and find other ways to distribute

it. Bonnie Burns (California Health Advocates—CHA) said consumers are often seeking the answer to a particular question rather than looking for an overall guide. She said a Q&A type of document may be more helpful.

## 2. Discussed Other Matters

Kwei said that this would be her last meeting as Subgroup chair. She said she is proud of the work the Subgroup has accomplished. Members of the Subgroup thanked her for her work. Joe Tuschner (NAIC) said that the role of vice chair is also becoming vacant and encouraged interested state insurance regulators to reach out if they would like to be considered for the role of chair or vice chair.

Kwei said there is a lot of interest in topics around health insurance and that people need information in different ways and at different times. Therefore, she said the Subgroup should continue to work on materials similar to what it has produced in the past.

Having no further business, the Consumer Information (B) Subgroup adjourned.

SharePoint/Support Staff Hub/Committees/B Committee/National Meetings/2023 Spring National Meeting/Final Minutes/Cons Info 1.31

Draft: 4/5/23

Health Innovations (B) Working Group  
Louisville, Kentucky  
March 22, 2023

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Louisville, KY, March 22, 2023. The following Working Group members participated: Nathan Houdek, Chair, Jennifer Stegall, and Sarah Smith (WI); Amy Hoyt, Vice Chair (MO); Sarah Bailey (AK); Kate Harris (CO); Andria Seip (IA); Alex Peck (IN); Julie Holmes and Craig VanAalst (KS); Jamie Sexton (MD); Marti Hooper and Robert Wake (ME); Chad Arnold (MI); Ross Hartley (ND); Jennifer A. Catechis and Paige Duhamel (NM); Daniel Bradford (OH); TK Keen (OR); Rachel Bowden and R. Michael Markham (TX); Mike Kreidler and Lichiou Lee (WA); and Erin K. Hunter (WV). Also participating was: Patrick Smock (RI).

1. Adopted its 2022 Fall National Meeting Minutes

Hoyt made a motion, seconded by Peck, to adopt the Working Group's Dec. 13, 2022, minutes (*see NAIC Proceedings – Fall 2022, Health Insurance and Managed Care (B) Committee, Attachment Four*). The motion passed unanimously.

2. Heard Presentations on EHBs

Commissioner Houdek said essential health benefits (EHBs) are of interest to state insurance regulators because states are interested in updating them, federal officials are considering revising rules, and the defrayal requirement for state-mandated benefits continues to cause concerns.

Harris reviewed Colorado's process for updating its EHB benchmark plan. She said the state started the process in the fall of 2020 using a federal grant. She said three public town halls gathered feedback on what to add or remove from the EHB. Three themes emerged, including improving mental health benefits, improving access to alternatives to opioids for pain management, and adding gender-affirming care for transgender individuals. She said the third was the most important and was driven by both input at the town halls and complaints received by the Division of Insurance. She said services varied from carrier to carrier, but many needed services were excluded as cosmetic. She said major medical associations have classified this care as medically necessary. She said the state worked to satisfy the technical requirements related to the generosity test and the typicality test. The cost for the added benefits was determined to be 64 cents per member per month. She said Colorado was the first state to explicitly include gender-affirming care to treat gender dysphoria in its benchmark plan.

Hoyt asked whether Colorado looked at other benefits before deciding on the three changes to make. Harris said the state considered more than 20 different changes but wanted to narrow the list before completing an actuarial analysis. She said the state used public feedback to help narrow the list. Seip asked if the per member per month figure was informed by the actual costs reported by insurers. Harris said Colorado's actuaries used internal data as well as carrier data. Commissioner Houdek asked how much pressure the state received from stakeholders on what to include. Harris said there were many valid requests to add benefits. She said it was helpful to walk stakeholders through the generosity test to show the guardrails. She said providers, payers, brokers, and advocates participated, and the state asked that attendees participate in all three meetings, which most did.

Wayne Turner (National Health Law Program—NHeLP) presented recommendations for improving EHBs for consumers. He said many plans excluded important benefits before the federal Affordable Care Act (ACA). The ACA establishes a coverage requirement and a cost-sharing requirement. He said the law tasks the Secretary of

the U.S. Department of Health and Human Services (HHS) with defining the 10 categories of EHB. He said it further requires HHS to periodically review and update EHBs. He said EHB compliance and enforcement are up to the states. He said his organization has seen problems, including pharmacy benefit managers (PBMs) declaring some drugs to be non-EHB. He said there is not a loophole in the law that allows this. Instead, it is against the law, and these drugs are still subject to the cost-sharing protections applicable to EHBs. He said benefits must be clinically based to be nondiscriminatory.

Turner said the benchmarking process is not in the statute. Rather, it is a policy decision to give states more flexibility. He said using commercial plans as benchmarks, particularly small group plans, can embed discriminatory provisions in the plans. He said his organization has recommended national standards. He said the defrayal requirement for state-mandated plans is part of the law, so it cannot be avoided entirely. He said adding benefits to comply with federal requirements does not trigger defrayal, so states could make additions to ensure plans are nondiscriminatory or to comply with federal mental health parity standards without requiring defrayal of their cost. He said that changes in cost sharing also do not trigger defrayal.

Turner said updating EHBs is a good use of state flexibility grants. He said many states do not have a formal process for selecting a benchmark plan. He said federal rules require public notice, and he recommends prioritizing health equity and transparency. He said the benchmarking process can be used to address unmet health needs. He said there would be winners and losers in the process, and the winners should not automatically be the best-funded lobbyists. He pushed for full transparency and providing easy ways for consumers to inform the process. He said the NAIC could consider establishing best practices for states in reviewing and updating EHBs.

Hoyt asked what kinds of data states should consider when starting the process. Turner said population-wide health data is a good starting point. He said states could also consult with academic institutions in the state. He warned that some well-funded groups might have good data, but they may leave out important information. Harris asked how long the process generally takes. Turner said there is a range, and it can be difficult when states do not have an existing process in place. He said Oregon has created an ongoing committee to keep the process going between updates. Commissioner Houdek asked about cost-sharing flexibility for states. Turner said states have authority over cost sharing, which does not trigger defrayal. He said preventive services coverage is under legal challenge, but EHBs also include preventive services. He said regulators can require no cost sharing for preventive services in the event the ACA's preventive services coverage requirement is invalidated. Bailey asked what challenges states have encountered in the update process. Turner encouraged talking to other states who have gone through the process. He said Vermont reported difficulties in the application of the typicality test. He said the test is an important consumer protection, but its application should be clarified.

Kris Hathaway (AHIP) discussed AHIP's recommendations to the federal Centers for Medicare & Medicaid Services (CMS) on EHBs. She said AHIP advocated for maintaining the core structure of EHB selection, with an emphasis on state flexibility. She said state insurance regulators should continue to be the primary regulators. She said the current structure meets local needs. She said additional conversations on defrayal would be appreciated and encouraged states to look at updates to their benchmarks every three years. She said telehealth can be a cost-saving tool, and its continued use should be allowed. She said previously controversial definitions, such as for habilitative services and pediatric services, have gone smoothly. She said that in Colorado, health plan actuaries computed different numbers for the cost of added benefits than the state used.

Harris asked whether health plans have measured cost savings due to added benefits. Hathaway said AHIP had looked at cost-saving measures like ending facility fees and improving transparency but not adding benefits. Commissioner Houdek asked about modifications to the update process. Hathaway said her organization is concerned with making updated benchmarks similar in cost to existing plans. She said patients have needs, but care needs to be affordable at the end of the day.

Holmes said Kansas is in the process of updating EHBs and is hoping to submit them to the CMS by the deadline in May. She said one issue was narrowing down what the updated benefits should be, and the state looked at consumer complaints going back 10 years to decide.

Wake said states are frustrated that the temporary concept of requiring defrayal for new mandates was continued. He said this leads to states mandating benefits through sub-regulatory guidance rather than legislation or regulations. He said CMS should recognize that the process for updating EHBs can replace the initial grandfathering standard that discourages new mandates. He said states with lean EHBs should have the opportunity to make their plans more generous rather than tying them to decisions made 20 years ago. He said it is difficult to quantify the generosity of a set of benefits without considering cost sharing.

Jackson Williams (Dialysis Patient Citizens—DPC) said expanding EHBs would not inhibit alternative payment models or value-based insurance design. He said EHB changes would not tie insurers' hands on medical management if they are done in good faith.

Randi Chapman (Blue Cross Blue Shield Association—BCBSA) said her organization supports the current regulatory structure for EHBs. She said it appropriately recognizes local markets and allows states to build on coverage that is already available in the market. She said BCBSA member plans are committed to using telehealth to expand access and to promoting health equity.

### 3. Discussed Potential Topics for Future Meetings

Bowden discussed efforts in Texas to adjust the relative affordability of plans by directing the premium load of cost-sharing reductions (CSRs). She said the legislature directed Texas to begin rate review in 2021 legislation, which also noted that silver plans were priced below the cost of providing CSRs. She said Texas adopted a rule to require plans to apply a uniform CSR to all silver plans in the exchange. She said silver plans, on average, provide an actuarial value of around 80%. She said the rule did not generate controversy, though there was some question of whether enrollment levels would change due to the rule. She said the result of the rule is that gold plans are now 11% less expensive in premium than silver plans, and the share of consumers who can purchase a gold plan with a \$0 premium rose from 43% to 73%. She said there are many policy and actuarial considerations, but the Texas approach was driven by the direction of the legislature. She clarified that issuers apply the silver load only to on-exchange plans, so consumers can purchase silver plans with no CSR load off-exchange. Wake said Maine applies silver loading through rate review and also requires a silver option that does not include a CSR load. Commissioner Houdek asked if a more detailed presentation on this topic at a future meeting would be useful and Working Group members agreed that it would.

Hoyt provided information on Project Extension for Community Healthcare Outcomes (ECHO). She said Missouri has a program called Show Me ECHO based on New Mexico's Project ECHO. She said the original Project ECHO was inspired by poor outcomes for hepatitis C patients. It connected primary care physicians with specialists so the primary care doctor could provide better care rather than the patient waiting eight to 12 months to see the specialist. She said it improved outcomes and changed lives. She said Show Me ECHO offers adult learning for multidisciplinary teams. A hub team participates and provides advice to primary care providers on how to manage patients. She said it is a way to move knowledge rather than patients. She said Medicaid in Missouri has provided incentives to providers to participate in the program. She said every state has an ECHO program devoted to different diseases or treatments. Commissioner Houdek asked if others were interested in learning more about Project ECHO, and Working Group members said they are.



Keen said one topic to keep tabs on is Medicaid redeterminations and whether any innovative practices have emerged from that experience. Harris said looking at continuity of care or pro-rating of deductibles for enrollees who leave Medicaid are other issues of interest.

Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) said that the Working Group should look at what states can do to remove barriers to preventive services.

Eric Ellsworth (Consumers' Checkbook) noted that the CMS has done a great deal of work on the interoperability of healthcare data. He said the Working Group could look at how the oversight of insurers in this area is divided between states and federal agencies as well as look at the level of investment insurers are making to enhance their information systems.

Hathaway said AHIP may have more data to share on value-based care by the Fall National Meeting.

Having no further business, the Health Innovations (B) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/Health Innovations WG/Spring 23/HInnMin3.22.docx

**HEALTH ACTUARIAL (B) TASK FORCE**

Health Actuarial (B) Task Force March 21, 2023, Minutes..... 6-16  
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     Long-Term Care (LTC) Rate Increase Checklist Discussion Document (Attachment One-A) ..... 6-23  
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     (Attachment Three) ..... 6-35

Draft: 3/31/23

Health Actuarial (B) Task Force  
Louisville, Kentucky  
March 21, 2023

The Health Actuarial (B) Task Force met in Louisville, KY, March 21, 2023. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Anita G. Fox, Vice Chair, represented by Kevin Dyke (MI); Mark Fowler represented by Charles Hale (AL); Ricardo Lara represented by Ahmad Kamil (CA); Michael Conway represented by Eric Unger (CO); Karima M. Woods represented by Stephen F. Flick (DC); Gordon I. Ito represented by Kathleen Nakasone (HI); Doug Ommen represented by Klete Geren (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Timothy N. Schott represented by Marti Hooper (ME); Grace Arnold represented by Fred Andersen and Julia Lyng (MN); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Jennifer Catechis represented by Anna Krylova (NM); Judith L. French represented by Craig Kalman (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Jodi Frantz (PA); Cassie Brown represented by Aaron Hodges (TX); Jon Pike represented by Ryan Jubber (UT); and Mike Kreidler represented by Lichiou Lee (WA).

1. Adopted its 2022 Fall National Meeting Minutes

Muldoon made a motion, seconded by Schallhorn, to adopt the Task Force’s Dec. 5, 2022, minutes (*see NAIC Proceedings – Fall 2022, Health Actuarial (B) Task Force*). The motion passed unanimously.

2. Adopted the Report of the Long-Term Care Actuarial (B) Working Group

Andersen said he and Lombardo are now the Working Group’s co-chairs. He said the Working Group met Feb. 17 and took the following action: 1) discussed disbanding the Long-Term Care Pricing (B) Subgroup and the Long-Term Care Valuation (B) Subgroup; 2) exposed a request for comments on a proposal to revise the nationally coordinated long-term care insurance (LTCI) rate increase review checklist; 3) exposed a request for comments on the Minnesota and Texas LTCI rate increase review methodologies, as used in the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework); and 4) heard an update on LTCI valuation issues. He said both requests for comment exposures have a deadline of April 24, and the Working Group plans to meet in May to discuss comments received.

Andersen said any changes that are made to the checklist or either rate increase review methodology could affect the LTCI MSA Framework. He said he believes any changes to the checklist can be completed this year, and any changes to either rate increase review methodology will likely occur next year.

Andersen made a motion, seconded by Muldoon, to adopt the report of the Long-Term Care Actuarial (B) Working Group, including its Feb. 17 minutes (Attachment One). The motion passed unanimously.

3. Disbanded the Long-Term Care Pricing (B) Subgroup and the Long-Term Care Valuation (B) Subgroup

Andersen made a motion, seconded by Muldoon, to disband the Long-Term Care Pricing (B) Subgroup and the Long-Term Care Valuation (B) Subgroup and transfer the functions of the two subgroups to the Long-Term Care Actuarial (B) Working Group. The motion passed unanimously.

#### 4. Heard an Update from the CCIIO

Brent Plemons (federal Center for Consumer Information and Insurance Oversight—CCIIO) said the plan year 2024 Rate Review Timeline Bulletin for federal Affordable Care Act (ACA) rate filing submissions was posted to the federal Centers for Medicare & Medicaid Services (CMS) website on March 15. He said the initial filing submission deadline for states with effective rate review programs, which are all states other than Oklahoma and Wyoming, is the earlier of the date set by the state and July 19. He said the two states without effective rate review programs have a deadline of June 1. He said the CCIIO intends to post initial rate filing information received to its website, *ratereview.healthcare.gov*, on July 26. He said if rate filings contain a qualified health plan (QHP) serviced by the *healthcare.gov* exchange, the filings need to be finalized by Aug. 16; and for states with state-based exchanges or non-QHP off-exchange filings, the finalization deadline is Oct. 16. He said the CCIIO plans to post final rate information no later than Nov. 1.

Plemons said the new Uniform Rate Review Template (URRT) Version 6.0 differs from the previous version (5.4) only in the removal of rounding limitations, the removal of the Actuarial Value (AV) de minimis range validation, and the state and market fields on Worksheet 1 having been moved to the left. He said updated URRT instructions for Version 6.0 will be available soon. He said the instructions do not specify where to enter factors for reinsurance waivers, but it is allowable to enter the factor on Worksheet 1, where a federal reinsurance factor would normally be entered. He said if a reinsurance waiver factor is used, insurers should be mindful of the single risk pool requirement and not apply all the reinsurance to any one plan.

Jeff Wu (CCIIO) said federal guidelines for cost-sharing reduction (CSR) loads are not particularly detailed. He said insurers can and should load for CSR amounts that the federal government will not reimburse. They can do this by spreading all of the load across all plans within the single risk pool or applying the load only to the plans that generate CSR deficiencies. Wu said whichever loading methodology is chosen, the total amount of the load should be actuarially justified, reasonable, and recover any deficiencies.

Lombardo said the transfer of filings from the System for Electronic Rates & Forms Filing (SERFF) into the federal Health Insurance and Oversight System (HIOS) in 2022 worked extremely well for Connecticut, and he has not heard of many instances to the contrary from other states. He asked if it is correct that the CCIIO is leaving the determination of actuarial justification and reasonableness of an insurer's CSR loading methodology to state insurance regulators. Wu said this is correct. Lombardo asked if there is a timeframe for the finalization of the Actuarial Value Calculator. Wu said it will likely be close to the time that the Notice of Benefit and Payment Parameters is finalized, and he believes this will occur soon. He said this will ideally be in early March 2024 for the plan year 2025 guidance. Dyke said it continues to be a challenge for state insurance regulators to determine whether an insurer's CSR loading methodology is actuarially sound and in keeping with the single-risk pool requirements.

Muldoon said regarding the July 26 posting of final rates, there have been instances in prior years where insurers, for various reasons, have not had their rates posted to *ratereview.healthcare.gov* by the federally prescribed date. He asked if there is a way to ensure that all insurers have their rates posted by the July 26 deadline. Plemons said the only recourse the CCIIO has is for its rate review team to contact the insurer and attempt to get its final rates submitted and posted. Wu asked Muldoon if he believes insurers who have not had their rates posted by the deadline are failing to do so deliberately as a strategy or if it is due to mistakes or errors on the insurers' part. He said if it is thought that the former reason is the explanation, the CCIIO needs to be very thoughtful about how to handle such a situation. Muldoon said he assumes the failure to have rates posted by the deadline was due to an error, and he has no indication that it was being used as a competitive strategy. Wu said the CCIIO will monitor the situation for the 2024 plan year and respond accordingly. Plemons said he will consult with CCIIO staff to determine if there is a way to get final rates posted for insurers that do not meet the deadline due to errors or mistakes.

Muldoon said some state insurance regulators have questions concerning the details of what should be considered appropriate for an insurer's CSR loading methodology. Lombardo said a meeting of interested state insurance regulators will be held soon to discuss these issues.

Lombardo said Connecticut has a state-based exchange, and there have been instances where insurers have missed the deadline for posting final rates. He said he does not believe these insurers were attempting to gain a competitive advantage, but other insurers that have met the deadline have concerns that these insurers are waiting to see rates posted by the deadline to modify their own rates in order to gain a competitive advantage. He said to ensure the integrity of the rate filing system, all rates for a given market should be posted and available at the same time. Wu said if an insurer displays a pattern of missing the posting deadline, the matter should be investigated. Lombardo said state insurance regulators are available to assist with the CCIIO's efforts in resolving these issues. Dyke said it is possible that the implementation of the transfer of filings from SERFF into the federal HIOS has created an issue with insurers verifying that their final rates are available for posting, and it may be beneficial for the CCIIO rate review team to encourage insurers to periodically check the HIOS to ensure that their rates are validated.

#### 5. Heard a Presentation from the SOA Research Institute

Dale Hall (Society of Actuaries—SOA) gave a presentation (Attachment Two) on the Research Institute's findings related to social, physical, and cultural determinants of health and their incorporation into actuarial data and workstreams, as well as Research Institute experience studies and other health research activities.

#### 6. Heard a Presentation from the Academy HPC

Barb Klever (Blue Cross Blue Shield Association—BCBSA) gave a presentation (Attachment Three) on American Academy of Actuaries (Academy) Health Practice Council (HPC) activities.

#### 7. Heard an Academy Professionalism Update

Shawna Ackerman (California Earthquake Authority—CEA) said the Actuarial Board for Counseling and Discipline (ABCD) recently published its 2022 annual report, which is available on the ABCD website, [abcdboard.org](http://abcdboard.org). She said the ABCD responded to 96 requests for guidance (RFGs) in 2022, and about one-third of the requests were from the health practice area. She said Precept 1, Professional Integrity, and Precept 2, Qualification Standards, of the Academy's Code of Professional Conduct continue to be popular RFG topics. She said an RFG concerning obtaining organized activity continuing education (CE) credits was received toward the end of 2022. She also encouraged actuaries to accumulate organized activity CE credits earlier rather than later during the year.

Robert Damler (Actuarial Standards Board [ASB]—Retired) said two general Actuarial Standards of Practice (ASOPs) that apply to all practice areas are in the process of being revised. He said ASOP No. 12, Risk Classification (for All Practice Areas), is undergoing revision and review by a task force, and it is anticipated that the revised ASOP No. 12 will be presented to the ASB later this year and then exposed for comment. He said revisions to ASOP No. 41, Actuarial Communications, were exposed for comment in 2022, and these comments are being reviewed by a task force. He said he expects that a second exposure draft of ASOP No. 41 revisions will be published within the next six to 12 months. He said revisions to ASOP No. 10, U.S. GAAP for Long-Duration Life, Annuity, and Health Products, were approved by the ASB in the past few months, and the new version will be effective May 1. He said an old Actuarial Compliance Guideline No. 4, which was the last such guideline in existence, has been converted to ASOP No. 57, Statements of Actuarial Opinion Not Based on an Asset Adequacy Analysis for Life Insurance, Annuity, or Health Insurance Reserves and Related Actuarial Items. He said ASOP No. 57 will become effective June 15.

Damler said there are several ASOPs under development or revision. He said these include ASOP No. 7, Analysis of Life, Health, or Property/Casualty Insurer Cash Flows; ASOP No. 28, Statements of Actuarial Opinion Regarding Health Insurance Assets and Liabilities; ASOP No. 36, Statements of Actuarial Opinion Regarding Property/Casualty Loss and Loss Adjustment Expense Reserves; ASOP No. 45, The Use of Health Status Based Risk Adjustment Methodologies; and ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification.

8. Discussed a Meeting of the Long-Term Care Actuarial (B) Working Group at the Summer National Meeting

Lombardo said he and Andersen intend for the Working Group to meet in person at the Summer National Meeting in Seattle, WA.

Having no further business, the Health Actuarial (B) Task Force adjourned.

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Draft: 3/9/23

Long-Term Care Actuarial (B) Working Group  
Virtual Meeting  
February 17, 2023

The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met Feb. 17, 2023. The following Working Group members participated: Paul Lombardo, Co-Chair (CT); Fred Andersen, Co-Chair (MN); Sanjeev Chaudhuri (AL); Ahmad Kamil (CA); Lilyan Zhang (FL); Nicole Boyd (KS); Marti Hooper (ME); Michael Muldoon (NE); Anna Krylova (NM); Bill Carmello (NY); Craig Kalman (OH); Andrew Schallhorn (OK); Jim Laverty (PA); Andrew Dvorine (SC); Anamaria Burg and R. Michael Markham (TX); and Tomasz Serbinowski (UT).

1. Discussed Disbanding the Long-Term Care Pricing (B) Subgroup and the Long-Term Care Valuation (B) Subgroup

Andersen said Serbinowski will no longer be chair of the Working Group, and he and Lombardo will be co-chairs of the Working Group. Lombardo said the work of the Long-Term Care Pricing (B) Subgroup and the Long-Term Care Valuation (B) Subgroup will now be done by the Working Group, and the Health Actuarial (B) Task Force will consider the proposal to disband the two subgroups during its March 21 meeting. Andersen said that any members of the two subgroups and any other state insurance regulators are welcome to become members of the Working Group if they are not already. Lombardo said that Serbinowski will continue as a member of the Working Group.

2. Exposed a Request for Comments on a Proposal to Revise the Nationally Coordinated LTCI Rate Increase Review Checklist

Andersen said the Working Group, and the Long-Term Care Valuation (B) Subgroup began work approximately five years ago on a project to develop a single checklist that reflects significant aspects of long-term care insurance (LTCI) rate review increase checklists used by all individual states. He said these checklists typically contain questions that states ask insurers at the beginning of an LTCI rate increase request. He said the Nationally Coordinated LTCI Rate Increase Review Checklist (Checklist) that was developed contains aspects of the *Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation* and input from many states' experiences with their individual checklists. He said the intent of creating the Checklist was to move away from having all states using different checklists, and to add efficiency to the overall rate increase review process nationwide. He said it was recognized that some states may still need to request information that is not asked for in the Checklist, but the intent was that approximately 90% of the information that any one state requires would be requested through the Checklist.

Andersen said the Health Actuarial (B) Task Force adopted the Checklist in 2018. He said many states are relying on the Checklist for their LTCI rate increase reviews, but insurers that have filed rate increase requests report that many states are not relying on it. He said that when the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup and Multistate Actuarial Team (MSA Team) began work in 2019, it decided to rely upon the Checklist for its LTCI Multistate Rate Review process. He said after the first few pilot MSA Team rate increase reviews, it was recognized that requests for additional information were similar for each of the pilot reviews, and a supplemental MSA Team checklist was developed. He said the supplemental checklist includes requests for information, including benefit utilization experience, cost of care trends, and waiver of premium treatment. He said the MSA Team has found that when the Checklist was combined with the supplemental checklist (Attachment One-A), the number of reviewer objections and interactions with filers have been greatly reduced, resulting in a more efficient review process. He said the Working Group proposes consideration of revising the Checklist by

adding the supplemental MSA Team checklist to it, and possibly consider adding or deleting requested information as suggested by state insurance regulators and interested parties. He said the proposal will be exposed for public comment until April 24.

Lombardo said it will be helpful if states that do not use the Checklist and the supplemental MSA Team checklist identify specific items that are not included in them that prevent the state from using them for their LTCI rate increase reviews.

### 3. Exposed a Request for Comments on the Minnesota and Texas LTCI Rate Increase Review Methodologies

Andersen said from 2016 to 2019, the Long-Term Care Pricing (B) Subgroup and the Working Group discussed and vetted the LTCI rate increase review methodologies that Minnesota and Texas use. He said appropriate recognition of the shrinking block issue and treatment of past losses were discussed for each of the methodologies. He said the concept of cost-sharing by the insurer as it relates to reducing the burden to policyholders without causing excess financial distress to the insurer was also discussed. He said the decline in interest rates and the impact on available investment returns to support LTCI blocks was also considered. He said the Minnesota and Texas approaches were deemed to be appropriate by most participants in the discussions.

Andersen said at roughly the time that discussions concerning the Minnesota and Texas approaches concluded, the Long-Term Care Insurance (EX) Task Force was created, with its primary mission being increasing uniformity in rate increase approvals among the states. He said this led to greater scrutiny of the Minnesota and Texas approaches, and it was determined that these two methodologies would be used for the LTCI Multistate Rate Review process pilot program. He said the Minnesota and Texas approaches have been codified into the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) that the Executive (EX) Committee and Plenary adopted in April 2022.

Andersen said the MSA Team has applied the Minnesota and Texas methodologies to several LTCI rate increase filings. He said as these blocks have grown older and passed from premium-paying periods to claims-paying periods, more data has become available for evaluation. He said the MSA Team has faced challenges with applying the two methodologies in certain instances, and it wants to determine if the approaches can be improved for future use. He said the most common feedback to date on the Minnesota approach is a potential lack of transparency and that he hopes details available in the Framework can assist in better understanding it. He said he thinks the Minnesota approach achieves an appropriate balance between fairness to consumers and avoiding further insurer financial distress. He said that it is possible that a lack of transparency can be attributed to necessary actuarial judgment that insurers and state insurance regulators apply for assumptions used in premium and claims projections. He said some of the issues the MSA Team has encountered in using the TX methodology are situations where past rate increases were granted prior to the development of the TX methodology, precisely defining what is meant by a past loss, mature blocks of business having high sensitivity to later duration factors while placing less emphasis on past experience, and potential imbalances between fairness to consumers and avoiding further insurer financial distress.

Markham said although he thinks the Texas methodology is fairly transparent, he has found some insurers have difficulty performing the required calculations for rate increase request submittals. Serbinowski said he has seen that insurers easily project future experience for current in-force business using current assumptions, but some have difficulties developing projections using initial filing assumptions because of a lack of initial filing documentation. He said because the Texas approach compares these two different projections, the results of using it can be questionable due to the possible lack of quality in the projection using initial filing assumptions. Lombardo said that some state insurance regulators and insurers have a desire for a one-size-fits-all methodology to be used in the MSA Team reviews, but because different blocks of business have different characteristics, he



does not think the MSA Team is close to being able to develop such a uniform approach. He said the MSA Team is open to finding a uniform approach and is working towards finding a methodology that may be a better fit for the majority of rate increase reviews submitted.

Jan Graeber (American Council of Life Insurers—ACLI) said industry is not necessarily requesting there be a single, uniform methodology that is used, but would like to know what characteristics of a block make the MSA Team determine which of the Minnesota or Texas approaches will be used. Muldoon suggested the MSA Team use a process upon receiving a rate increase request to determine whether the Minnesota or Texas approach is best suited to the block being reviewed, and then base the recommended rate increase on only the methodology that was deemed best. Lombardo said the MSA Team does perform this sort of analysis upon its initial review, and thinks it is a good idea to document a flowchart of the analysis process used. He said there are instances where the MSA Team sees there are benefits to using both approaches, and this results in a rate increase recommendation that is a blend of the two approaches.

Andersen said the Working Group will expose a request for public comment on the Minnesota and Texas actuarial approaches as described in the Framework document until April 24. Muldoon suggested that the MSA Team provide the insurer with a copy of the spreadsheet used with the Minnesota methodology to arrive at the recommended rate increase that was calculated. Andersen said the Working Group will include this suggestion in the set of comments on the Minnesota and Texas approaches.

#### 4. Heard an Update on LTCI Valuation Issues

Andersen said the Long-Term Care Valuation (B) Subgroup has been inactive since the adoption of *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) in 2017. He said many of the members of the Subgroup have been involved with the review of annual AG 51 filings.

Andersen said one of the key trends seen in AG 51 reviews for the past few years is cost of care inflation, particularly for companies with policies that include a 5% inflation protection feature. He said the inflation in the cost of care is creating issues with reserve adequacy observed in AG 51 filings. He said another issue observed is the impact of COVID-19 on LTCI experience data in 2020. He said the impact of COVID-19 on experience data trended closer to normal in 2021, and the expectation was that there would be a negligible COVID-19 effect on 2022 LTCI experience data. He said one of the reviewers' findings is that the COVID-19 impact has leveled off between 2021 and 2022. He said an issue is whether the experience data seen in 2022 will be the new norm, or if there will be delayed COVID-19 impacts to experience in future years. He said the 2022 AG 51 filings are due in approximately six weeks, and the reviewers will report any issues that develop from the reviews to the Working Group.

Lombardo said the Working Group will begin work on incorporating new mortality and lapse tables proposed in American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute's *Final Long-Term Care Insurance Mortality and Lapse Study* into VM-25, Health Insurance Reserves Minimum Reserve Requirements, of the *Valuation Manual*.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.

Meetings/Member Meetings/B CMTE/HATF/2023\_Spring/02-17-23/Minutes\_LTCAWG\_02-17-23.docx

**Three LTC rate increase review “checklists” for discussion – 2/17/23 LTC Actuarial Working Group**

- I. Recommended checklist for each state
  - NAIC Health Actuarial Task Force-adopted document, with the goal for states attaining 90% to 100% of the information necessary to make a decision about determining approvable rate increases.
- II. MSA Supplemental checklist
  - NAIC Health Actuarial Task Force-adopted document, with the goal for states attaining 90% to 100% of the information necessary to make a decision about determining approvable rate increases.
- III. Additional information requested to be included in a 50-state checklist

- I. Recommended checklist for each state

**Consolidated, Most Commonly Asked Questions – States’ LTC Rate Increase Reviews**

Adopted by the NAIC Health Actuarial (B) Task Force on 3/23/18

1. New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
  - A. Provide rate increase percentages by policy form number and clear mapping of these numbers to any alternative terminology describing policies stated in the actuarial memorandum and other supporting documents.
  - B. Provide the cumulative rate change since inception, after the requested rate increase, for each of the rating scenarios.
2. Rate increase history that reflects the filed increase.
  - A. Provide the month, year, and percentage amount of all previous rate revisions.
  - B. Provide the SERFF filing numbers associated with all previous rate revisions.
3. Actuarial Memorandum justifying the new rate schedule, which includes:
  - A. Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
    - i. The projection should be by year.
    - ii. Provide the count of covered lives and count of claims incurred by year.
    - iii. Provide separate experience summaries and projections for significant subsets of policies with substantially different benefit and premium features. Separate projections of costs for significant blocks of paid-up and premium-paying policies should be provided.
    - iv. Provide a comparison of state versus national mix of business. In addition, a state may request separate state and national data and projections. The company should accompany any state-specific information with commentary on credibility, materiality, and impact on requested rate increase.
  - B. Reasons for the rate increase, including which pricing assumptions were not realized & why.
    - i. Attribution analysis - present the portion of the rate increase allocated to and impact on the lifetime loss ratio from each change in assumption.

- ii. Related to the issue of past losses, explain how the requested rate increase covers a policyholder's own past premium deficiencies and/or subsidizes other policyholders' past claims.
  - iii. Provide the original loss ratio target to allow for comparison of initially assumed premiums and claims and actual and projected premiums and claims.
  - iv. Provide commentary and analysis on how credibility of experience contributed to the development of the rate increase request.
- C. Statement that policy design, underwriting, and claims handling practices were considered.
  - i. Show how benefit features, e.g., inflation and length of benefit period, and premium features, e.g., limited pay and lifetime pay, impact requested increases.
  - ii. Specify whether waived premiums are included in earned premiums and incurred claims, including in the loss ratio target calculation; provide the waived premium amounts and impact on requested increase.
  - iii. Describe current practices with dates and quantification of the effect of any underwriting changes. Describe how adjustments to experience from policies with less restrictive underwriting are applied to claims expectations associated with policies with more restrictive underwriting.
- D. A demonstration that actual and projected costs exceed anticipated costs and the margin.
- E. The method and assumptions used in determining projected values should be reviewed in light of reported experience and compared to the original pricing assumptions and current assumptions.
  - i. Provide applicable actual-to-expected ratios regarding key assumptions.
  - ii. Provide justification for any change in assumptions.
- F. Combined morbidity experience from different forms with similar benefits, whether from inside or outside the company, where appropriate to result in more credible historical claims as the basis for future claim costs.
  - i. Explain the relevance of any data sources and resulting adjustments made relevant to the current filing, particularly regarding the morbidity assumption.
  - ii. A comparison of the population or industry study to the in-force related to the filing should be performed, if applicable.
  - iii. Explain how claims cost expectations at older ages and later durations are developed if data is not fully credible at those ages and durations.
  - iv. Provide the year of the most recent morbidity experience study.
- G. Information (from NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation, "Guidance Manual" Q&A): Morbidity, Lapse, Mortality, Interest
  - i. Comparison with asset adequacy testing reserve assumptions
    - a) Explain the consistency regarding actuarial assumptions between the rate increase filing and the most recent asset adequacy (reserve) testing filing.
    - b) Additional reserves that the company is holding above NAIC Model Reg 10 formula reserves should be provided, (such as premium deficiency reserves and Actuarial Guideline 51 reserves).
  - ii. Assumptions Template in Appendix 6 of the *NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation (Guidance Manual)* (for policies issued after 2017, where applicable)
  - iii. Provide actuarial assumptions from original pricing and most recent rate increase filing, and have the original actuarial memorandum available upon request.

- H. Guidance Manual Checklist items: summaries (including past rate adjustments); average premium; distribution of business, including rate increases by state; underwriting; policy design and margins; actuarial assumptions; experience data; loss ratios; rationale for increase; reserve description
  - I. Assert that analysis complies with actuarial standards of practice, including 18 & 41.
  - J. Numerical exhibits should be provided in Excel spreadsheets with active formulas maintained, where possible.
- 4. Rate Comparison Statement of renewal premiums with new business premiums, if applicable.
  - 5. Policyholder notification letter – should be clear and accurate.
    - A. Provide a description of options for policyholders in lieu of or to reduce the increase.
    - B. If inflation protection is removed or reduced, is accumulated inflation protection vested?
    - C. Explain the comparison of value between the rate increase and policyholder options.
    - D. Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
    - E. How are partnership policies addressed?
  - 6. Actuarial certification and rate stabilization information, as described in the Guidance Manual and Contingent benefit upon lapse information, including reserve treatment.
-

Note regarding this document:

Commissioners on the Long-Term Care Insurance (B/E) Task Force requested that the LTC Pricing Subgroup develop a single checklist that reflects significant aspects of LTC rate increase review inquiries from all of the states. In this context, “checklist” means the list of inquiries (often a template) that states typically send at the beginning of reviews of rate increase filings.

This document contains aspects of the NAIC Guidance Manual and checklists developed by several other states. This single checklist is not intended to prevent a state from asking for additional information. The intent is to take a step toward moving away from 50 states having 50 different checklists in order to have a more efficient process nationally to provide the most important information needed to determine an approvable rate increase. To keep the template at a manageable length, it is anticipated that this template will result in states attaining 90 to 100 percent of the information necessary to make a decision about determining approvable rate increases. State and block specifics will generate the other zero to 10 percent of requests.

This consolidated checklist can be presented to the LTC B/E Task Force prior to or at the March 2018 NAIC national meeting. As states apply this checklist, this checklist or an improved version may be considered for future addition to the *Guidance Manual*.

W:\National Meetings\2018\Spring\TF\HA\Conference Calls\3-1 LTCPSG\LTC\_Price\_SG\_Review\_Template\_030118\_Final.docx

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## II. MSA Supplemental checklist

**To assist in the multi-state actuarial (MSA) review, the following, additional information, would be helpful, where applicable:**

1. Benefit utilization:
  - a. Current, prior rate increase, and original assumptions; including first-projection year through ultimate utilization percentages for 5% compound inflation, lesser inflation, and zero inflation cells;
  - b. Explain how benefit utilization assumptions vary by maximum daily benefit;
  - c. Provide the cost of care inflation assumption implied in the benefit utilization assumption.
2. Attribution of rate increase
  - a. Provide the attribution of rate increase by factor: morbidity, mortality, lapse, investment, other;
  - b. For the morbidity factor, break down the attribution by incidence, claim length, benefit utilization, and other.
  - c. Provide information on the assumptions that are especially sensitive to small changes in assumptions.
3. Reduced benefit options (RBOs)
  - a. Provide the history of RBOs offered and accepted for the block.
  - b. Provide a reasonability analysis of the value of each significant type of offered RBO.
4. Investment returns
  - a. Provide original and updated / average investment return assumptions underlying the pricing. Explain how the updated assumption reflects experience.
5. Expected loss ratio
  - a. With respect to the initial rate filing and each subsequent rate increase filing, provide the target loss ratio. Provide separate ratios for lifetime premium periods and non-lifetime premium periods and also for inflation-protected and non-inflation-protected blocks.
6. Shock lapse history
  - a. Provide shock lapse data related to prior rate increases on this block.
7. Waiver of premium handling
  - a. Explain how policies with premiums waived are handled in the exhibits of premiums and incurred claims, and explain how counting is appropriate (as opposed to double counting or undercounting).
8. Actual-to-expected differences
  - a. Explain how differences between actual and expected counts or percentages (in the provided exhibits) are reflected or not reflected in assumptions.
9. Assumption consistency with the most recent asset adequacy testing
  - a. Explain the consistency or any significant differences between assumptions underlying the rate increase request and those included in Actuarial Guideline 51 testing.

### III. Additional information requested to be included in a 50-state checklist

#### **Additional potential information to discuss**

- Actual investment rate earned in historical years
- Nationwide projections of premiums using the rates in effect in the state, as if these rates were in effect in all states
- Premiums by duration in addition to by calendar year
- Loss ratios by duration based on original pricing assumptions
- Add to 3B of the Recommended Checklist For Each State: Clear descriptions of any adversity in experience or expectations for factors since original pricing and since the most recent rate increase filing



# SOCIETY OF ACTUARIES RESEARCH UPDATE TO HATF

March 21, 2023

R. Dale Hall, FSA, MAAA, CERA, CFA  
Managing Director of Research

## Presentation Disclaimer

*The material and information contained in this presentation is for general information only. It does not replace independent professional judgment and should not be used as the basis for making any business, legal or other decisions. The Society of Actuaries assumes no responsibility for the content, accuracy or completeness of the information presented.*





# Social Physical and Cultural Determinants of Health: Their Incorporation into Actuarial Data and Workstreams

Health Care  
Cost Trends

This provides actuaries with guidance on how to use determinants of health (DOH) for actuarial work streams in the health care space.

- DOH data can be used to enrich health care data analysis beyond traditional data elements, such as age, gender, zip code or health diagnosis.
  - Often individuals who share similar traditional data characteristics can have very different DOH's resulting in very different outcomes
  - For example, within a county or a three-digit zip code, you can have completely different living environments and local characteristics, such as provider availability, food availability, income levels, cultural differences resulting in very different outcomes for individuals with similar age, gender, geography and health diagnoses



## SDOH Data Resources

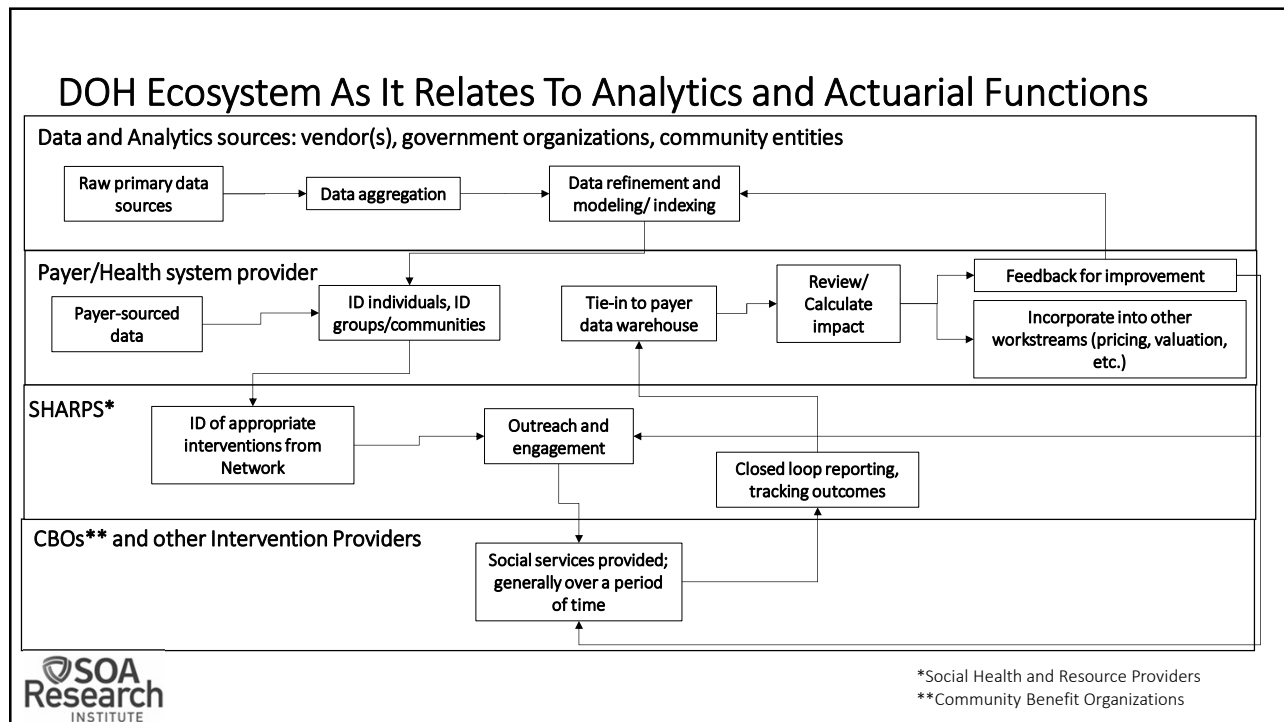
- DOH data is evolving but still fragmented and inconsistent. Can be categorized into Primary and Secondary data
  - Primary Source Characteristics
    - Their use was addressed in the SOA's Quantitative SDOH Paper:
    - Inconsistent definition or coding between different entities
    - Frequently self-reported, resulting in subjectivity and personal perspective
    - Difficult to maintain best practices
  - Secondary Source Derivation
    - Compiles Primary data into global measures of relative DOH intensity
    - Don't tie directly to the claimant, but indirectly to claimant elements (often geographical area)
    - Used as a proxy for member statuses



## SDOH Data Resources

- Secondary Source Characteristics
  - **Consistency** – values of characteristics are relatively stable
  - **Persistency** – production of these data sources is likely to continue over time
  - **Comprehensiveness** – Capture most populations and relevant DOHs
  - **Robustness** – Captures differences and variations (i.e. by geography)
  - **Applicability** – How well does a measure match with populations being analyzed
  - **Neutrality** – Minimizing biases in choice of variables or clustering of results
  - **Version Control** – Being transparent about methodology changes over time
  - **Open and Clear Methodology** – Good documentation of source materials





## Additional Challenges and Considerations with Using DOH Data

- Traditional workstreams such as pricing, reserving, risk adjustment and evaluation may be enhanced by incorporating DOH data
- Traditional models for evaluation, including strict requirements for financial return on investment, may not be appropriate in the context of DOH
- Ethical and Practical Considerations
  - Does the work reflect a fair use of data and modeling
  - Does the work align with existing practice
  - Use of SDOH in models should be easy to integrate, maintain, justify, adapt and simple
  - Avoid being technically correct but ethically problematic



## Additional Health Research

## Experience Studies, Practice Research & Data Driven In-house Research

Project Name	Objective	Expected Completion Date
Risk Adjustment White Paper	Interview Risk Adjustment SMEs and create a white paper that will address recent concerns brought up by political leaders about the use of Risk Adj through an actuarial user's guide to its past and future applications.	<a href="https://www.soa.org/resources/research-reports/2023/risk-adjustment-ma/">https://www.soa.org/resources/research-reports/2023/risk-adjustment-ma/</a>
State Based Public LTC Catastrophic Research	Studies the feasibility, possibilities and potential options for a state specific public product for Catastrophic LTC protection.	<a href="https://www.soa.org/resources/research-reports/2023/ltc-catastrophic-insurance/">https://www.soa.org/resources/research-reports/2023/ltc-catastrophic-insurance/</a>
Social Physical and Cultural Determinants of Health	Qualitative SDOH research project.	3/10/2023
Digital Health	A study focusing on telehealth and other digital communications.	3/31/2023
Emerging Impact of Long COVID on HealthCare Costs and Medical Conditions	A study that will examine the impact of a COVID 19 diagnosis on patient claims and medical conditions.	3/31/2023
Wall Street Journal Health Forum Update	This brief will summarize key takeaways for actuaries in the Health space on emerging topics and technologies discussed at the March 6th Wall Street Journal Health Forum	3/31/2023
Group Life Waiver of Premium Valuation Tables	Develop valuation tables for claim mortality and recovery on Group Term Life policies with Waiver of Premium benefits.	4/30/2023
HCO Quick Hit - Specialty Pharmacy Trends	This research will examine some key specialty drugs to look at how increases in uptake in drugs worth between 10K and 200k are driving current pharmacy trend.	5/31/2023
Health and Health Care Inequalities: Research Challenges and Considerations	A summary of the challenges involved in conducting research that requires health or health care data and protected personal information. Includes considerations for future research.	5/31/2023
Initiative 18/11 - 5/50 Project - Analyzing Characteristics of the top 5% members by cost who drive 50% of Medical Expenses	Validate the 5/50 Premise through % of total costs and average allowed annual cost by percentile grouping. Analyze ability to predict the 5% based on prior claims and risk factors. Calculate Transition probabilities between different groups.	5/31/2023





## **American Academy of Actuaries Health Practice Council—Spring 2023 Updates**

March 21, 2023—National Association of Insurance Commissioners (NAIC)  
Health Actuarial (B) Task Force (HATF) Meeting

Barbara Klever, MAAA, FSA  
Vice President, Health Practice Council  
American Academy of Actuaries

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- The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues.
- The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

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## **Health Practice Council— Key Policy Priorities for 2023**

- Health equity
- COVID-19 and other public health challenges
- Insurance coverage and benefit design
- Health care costs and quality
- Medicare sustainability
- Long-term services and supports (LTSS)
- Financial reporting and solvency
- Professionalism

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## Health Equity

- Issue Briefs:
  - *Data Collection for Measurement of Health Disparities* (forthcoming)
- Events:
  - Health Equity Symposium (TBA)

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## COVID-19 and Other Public Health Challenges

- Webinar: "The Great Unwinding: What's Next for the Medicaid Population?" (March 14, 2023)
  - Topic is included in our *Drivers of 2024 Health Insurance Premium Changes* issue brief (forthcoming)

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## COVID-19 and Other Public Health Challenges: Climate Change and Health

- Climate Change Joint Task Force:
  - In November 2021, the Academy launched the Climate Change Joint Task Force. Membership is comprised of members from the health, casualty, life, and pension practice areas and reports to the Risk Management and Financial Reporting Council (RMFRC).
  - The task force has submitted numerous comment letters to federal agencies, and other stakeholders, on climate-related disclosures and financial risks. For example, the Task Force has submitted a comment letter to the International Sustainability Standards Board.

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## Health Insurance Coverage and Benefit Design

- Issue Brief and Webinar:
  - *Drivers of 2024 Health Insurance Premium Changes* (forthcoming)
- Comment Letters:
  - Comments on proposed rule for the 2024 Notice of Benefit and Payment Parameters (NBPP) (January 2023)
  - Comments on Draft 2024 Actuarial Value (AV) Calculator Methodology (January 2023)

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## Health Care Costs and Quality

- Issue Briefs:
  - *Addressing High Insulin Spending: Moving Beyond Co-pay Caps* (forthcoming)
  - *Gene Therapy Drug Costs* (forthcoming)

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## Medicare Sustainability

- Issue Brief:
  - *Medicare's Financial Condition: Beyond Actuarial Balance* (forthcoming)
- Capitol Forum Webinar:
  - *Medicare Trustees Report: A Deep-Dive Discussion With the Program's Chief Actuary* (forthcoming)

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## Long-Term Services and Supports (LTSS)

- Issue Briefs:
  - Refresh of *Impact of COVID-19 on Long-Term Care Insurance* issue brief (originally published January 2021—forthcoming).
  - Refresh of *Essential Criteria for Long-Term Care Financing Reform Proposals* issue brief (originally published November 2016—forthcoming).
  - *State of Long-term Care and How It Is Evolving* (forthcoming).

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## Financial Reporting and Solvency

- Comment Letters:
  - Comments to the NAIC Health Risk-Based Capital (E) Working Group on Investment Income (February 2023).
  - Comments to the NAIC Long-Term Care Actuarial (B) Working Group on AG 51, Appendix A-010 (LTC reserve adequacy) (February 2023).

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## HPC NAIC Workstreams—HRBC

- Health Risk-Based Capital (E) Working Group (HRBC)
  - Request for comprehensive review of the H2—Underwriting Risk component and managed care credit calculation in the health risk-based capital formula.
    - July 2021—Academy comment letter.
    - January 2022—Academy report.
    - July 2022—Timeline letter.
    - November 2022—Academy Health Underwriting Risk Factors Analysis Work Group commences work.
    - December 2022—Update to the NAIC HRBC Working Group at the Fall National Meeting.
    - February 2023—Comments to the NAIC HRBC Working Group on Investment Income

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## HPC NAIC Workstreams—HRBC

- Health Care Receivables Factors Work Group
  - The work group is completing a review of the current health care receivables factors for the NAIC.
  - Work task 1: Update the chart of health care (HC) receivables (HC Receivables now being reported on the Blue Blank as well as the Orange Blank).
  - Work task 2: Evaluate 2018-2021 NAIC data.

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## HPC NAIC Workstreams—LTCAWG

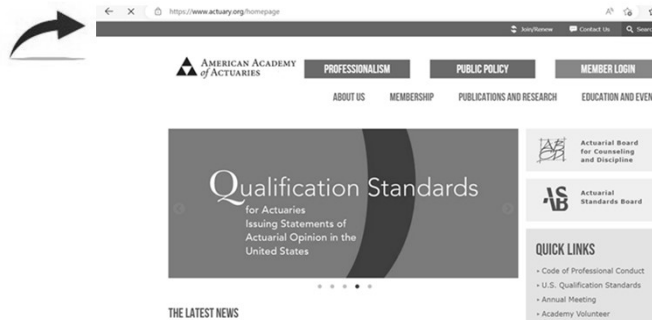
- NAIC Long-Term Care Actuarial (B) Working Group (LTCAWG)
- Long-Term Care Insurance Mortality and Lapse Study
  - Original request from the NAIC LTCAWG
  - Report released November 2021.
    - Developed by the Long-Term Care Valuation Work Group of the Academy and the Society of Actuaries Research Institute (SOARI).
  - Presentation to NAIC HATF in November 2021.
  - Update presentation to NAIC LTCAWG in June 2022.
  - Exposed by the NAIC LTCAWG until Sept. 5, 2022.
  - Status: LTCAWG is to draft changes to VM-25 and to adopt tables within the report (TBD).

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- Testimony



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**Thank You**

Questions?

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**REGULATORY FRAMEWORK (B) TASK FORCE**

Regulatory Framework (B) Task Force March 22, 2023, Minutes ..... 6-45

    Accident and Sickness Insurance Minimum Standards (B) Subgroup March 13, 2023, Minutes  
         (Attachment One)..... 6-49

    Accident and Sickness Insurance Minimum Standards (B) Subgroup Feb. 27, 2023, Minutes  
         (Attachment Two) ..... 6-51

    Accident and Sickness Insurance Minimum Standards (B) Subgroup Feb. 13, 2023, Minutes  
         (Attachment Three)..... 6-54

    Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group Feb. 24, 2023,  
         Minutes (Attachment Four)..... 6-55

    MHPAEA (B) Working Group Dec. 14, 2022, Minutes (Attachment Four-A)..... 6-58

    Pharmacy Benefit Manager Regulatory Issues (B) Subgroup March 22, 2023, Minutes  
         (Attachment Five)..... 6-60

    Pharmacy Benefit Manager Regulatory Issues (B) Subgroup Dec. 15, 2022, Minutes  
         (Attachment Five-A)..... 6-64

    Pharmacy Benefit Manager Regulatory Issues (B) Subgroup Oct. 24, 2022, Minutes  
         (Attachment Five-A1) ..... 6-67

Draft: 3/29/23

Regulatory Framework (B) Task Force  
Louisville, Kentucky  
March 22, 2023

The Regulatory Framework (B) Task Force met in Louisville, KY, March 22, 2023. The following Task Force members participated: Sharon P. Clark, Chair, represented by Shaun Orme (KY); Glen Mulready, Vice Chair, and Andy Schallhorn (OK); Lori K. Wing-Heier represented by Sarah Bailey (AK); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Jared Kosky (CT); Karima M. Woods represented by Howard Liebers (DC); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler and Shannon Hohl (ID); Amy L. Beard represented by Alex Peck (IN); Vicki Schmidt represented by Julie Holmes (KS); Gary D. Anderson represented by Kevin Beagan (MA); Timothy N. Schott represented by Robert Wake (ME); Mike Causey represented by Ted Hamby (NC); Eric Dunning represented by Martin Swanson and Maggie Reinert (NE); Chris Nicolopoulos represented by David Bettencourt (NH); Judith L. French represented by Laura Miller (OH); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys represented by Katie Merritt (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Mike Kreidler represented by Molly Nollette (WA); Nathan Houdek (WI); and Allan L. McVey represented by Erin K. Hunter (WV). Also participating were: Erica Weyhenmeyer (IL); Sarah Wohlford (MI); and Patrick Smock (RI).

1. Adopted its 2022 Fall National Meeting Minutes

Kruger made a motion, seconded by Swanson, to adopt the Task Force’s Dec. 13, 2022, minutes (*see NAIC Proceedings – Fall 2022, Regulatory Framework (B) Task Force*). The motion passed unanimously.

2. Adopted its Subgroup and Working Group Reports

A. Accident and Sickness Insurance Minimum Standards (B) Subgroup

Schallhorn said the Accident and Sickness Insurance Minimum Standards (B) Subgroup met March 13, Feb. 27, and Feb. 13. He said that during these meetings, the Subgroup discussed the comments received on Section 8—Supplementary and Short-Term Health Minimum Standards for Benefits of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)*, specifically, Section 8A—General Rules. He said the Subgroup also discussed its upcoming work to review the remaining provisions in Model #171 in the following order: 1) the remainder of Section 8, including revisiting the proposed new subsection on short-term, limited-duration (STLD) plans to discuss the Feb. 24 comments received on that section; 2) Section 7—Prohibited Policy Provisions; 3) revisit Section 5—Definitions and Section 6—Policy Definitions to reconcile any inconsistencies that may have arisen after the Subgroup’s review of the substantive provisions of Model #171; and 4) Section 9—Required Disclosure Provisions. The Subgroup hopes to finish its work to develop an initial draft of comments on Model #171 for public comment by the end of the year.

Schallhorn said that in discussing the comments on this revised Model #171 draft, which will reflect all the Subgroup’s discussions related to the model revisions, the Subgroup plans to only entertain and consider comments that raise issues not previously discussed. The Subgroup’s goal is to have a revised Model #171 ready for consideration by the Task Force and the Health Insurance and Managed Care (B) Committee by early 2024, before the 2024 Spring National Meeting.



#### B. ERISA (B) Working Group

Wake said the Employee Retirement Income Security Act (ERISA) (B) Working Group will not be meeting during the Spring National Meeting, but he anticipates the Working Group meeting in person at the Summer National Meeting. Wake said the Working Group will most likely meet virtually prior to the Summer National Meeting to complete its work updating the NAIC chart on multiple employer welfare arrangements (MEWAs)/multiple employer trust (MET) and association plans. He said the Working Group continues to serve as a forum and facilitate discussions among state insurance regulators and federal regulators on issues involving ERISA plans and MEWAs. He said the Working Group also stands ready to assist the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup on any issues it encounters related to ERISA preemption issues as the Subgroup works on its white paper concerning pharmacy benefit managers (PBMs) and their business practices, including the implications of the *Rutledge vs. Pharmaceutical Care Management Association (PCMA)* decision and any subsequent decisions on such business practices.

#### C. MHPAEA (B) Working Group

Weyhenmeyer said the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group continues to serve as a forum and an opportunity for Working Group members and interested state insurance regulators to discuss MHPAEA enforcement and compliance issues. She said that since the 2022 Fall National Meeting, the Working Group met in regulator-to-regulator session and Feb. 24 to continue its discussion of parity issues with health insurers.

Weyhenmeyer said the Working Group is also continuing to monitor congressional activity related to mental health parity. She said that last year, the Working Group led the effort to write a letter in support of legislation that would provide grants to the states to assist them with mental health parity plan compliance determination, enforcement, and training. She said the legislation passed, but the U.S. Congress has not yet funded the grant program. She said the Biden Administration has included proposal funds for the grant program in its fiscal year 2024 budget. The Working Group is hopeful that this funding will remain in the final budget. Weyhenmeyer said the Working Group is anticipating an updated proposed rule related to mental health parity from the U.S. Department of Labor (DOL) and the federal Centers for Medicare & Medicaid Services (CMS). Once the proposed rule is published, she hopes to hold a Working Group meeting to discuss it and decide whether the NAIC should comment on it through the Government Relations (EX) Leadership Council.

Weyhenmeyer said the Working Group will meet March 23. During this meeting, the Working Group will hear a discussion of the *Wit v. United Behavioral Health* case, a potential landmark case setting a precedent for how care will be covered for individuals seeking treatment for mental health and addiction.

#### D. Pharmacy Benefit Manager Regulatory Issues (B) Subgroup

Keen said that since his last update, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup released a working draft of the proposed PBM white paper. He said the Subgroup discussed the draft paper's outline during its meeting at the 2022 Fall National Meeting. Keen said the Subgroup is currently working on edits to the working draft, such as adding language to the Recommendation section and making any necessary non-substantive edits. After this is complete, the Subgroup plans to release an official draft of the white paper for public comment by the end of March or early April. Most likely, the Subgroup will set a 45-day public comment period. Keen said that following the end of the public comment period, the Subgroup plans to hold meetings to review the comments received and make changes to the draft based on those discussions. The Subgroup hopes to finish its work on the white paper prior to the 2023 Summer National Meeting and forward it to the Task Force for its consideration.

Keen said that during its March 22 meeting, the Subgroup adopted its 2022 Fall National Meeting minutes. He said the Subgroup heard an update on federal PBM-related legislative and regulatory activities. The Subgroup also heard a legal update on PBM-related litigation.

Keen made a motion, seconded by Nollette, to adopt the following reports: the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its March 13 (Attachment One), Feb. 27 (Attachment Two), and Feb. 13 (Attachment Three) minutes; the ERISA (B) Working Group; the MHPAEA (B) Working Group, including its Feb. 24 (Attachment Four) minutes; and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its March 22 (Attachment Five) minutes. The motion passed unanimously.

### 3. Heard an Update on the CHIR's Work

Maanasa Kona (Center on Health Insurance Reforms—CHIR) provided an update on the CHIR's work and various projects of interest to the Task Force. Kona said that in light of the upcoming end of the COVID-19 public health emergency (PHE) and the resulting Medicaid unwinding process, the CHIR recently released an issue brief called "Secrets to a Successful Unwinding: Actions State-Based Marketplaces and Insurance Departments Can Take to Improve Coverage Transitions." She said a colleague of hers will discuss the issue in more detail during the Health Insurance and Managed Care (B) Committee's March 23 meeting.

Kona said the CHIR has taken on a few projects related to qualified health plan (QHP) federal Affordable Care Act (ACA) marketplace enrollment, including an analysis of state-based marketplace (SBM) outreach strategies for boosting QHP enrollment of the uninsured and the process of implementing the family glitch fix on the ACA's marketplaces. She said the CHIR also is examining state activities, such as those occurring in Washington and Nevada, related to public option programs. The CHIR plans to continue monitoring these activities and new state public option legislation.

Kona said the CHIR is examining what states are doing to improve coverage and recently released a few issue briefs highlighting state efforts in this area. She said the CHIR is continuing to monitor and analyze state action related to health equity. As part of this effort, the CHIR plans to publish a survey of SBMs' language access and policy practices soon.

Kona said the CHIR continues to monitor the implementation of the federal No Surprises Act (NSA) and expects to issue publications soon on several issues related to the implementation process, including a one-year progress report. She said the CHIR recently launched a four-part series studying employer-sponsored insurance (ESI) and cost containment. Kona said the CHIR's future work in this area includes investigating cost containment and outpatient facility fees. Another future CHIR project is a 50-state survey on state protections against medical debt.

Keen said Oregon and other states have encountered an issue with provider contracts expiring in the middle of a policy year, which is very disruptive to consumers. He asked Kona if the CHIR has examined this issue as part of their research and highlighted this as an issue of concern. Kona said the CHIR has researched issues related to provider contracts, but it has not specifically honed in or researched issues related to the mid-year expiration of such contracts. She said she would take this issue back to her colleagues at the CHIR as a potential future research project.

Commissioner Mulready explained that Oklahoma has seen access issues concerning consumers being able to obtain appointments with behavioral health providers in a timely fashion. He asked Kona if the CHIR has looked at this issue and, if so, whether she could recommend any best practices that other states may be doing to address the issue.

Kona said the CHIR has studied the wait time issue with mental health parity as part of comparative analyses of non-quantitative treatment limitations (NQTLs). She said, however, that in examining this issue, it does not seem that any particular state has emerged as a leader in resolving this issue. She noted that California does have certain plan reporting requirements related to wait times for appointments, but the CHIR has not conducted an analysis of how it is working. She said the CHIR could possibly look at this as part of a future project.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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Draft: 3/16/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup  
Virtual Meeting  
March 13, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met March 13, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Chris Struk (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Martin Swanson (NE); Heidi Clausen (UT); Anna Van Fleet, Jamie Gile, and Mary Block (VT); and Ned Gaines (WA).

1. Continued Discussion of Section 8A of Model #171

The Subgroup continued its discussion of the comments received on Section 8A—General Rules of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), beginning with the NAIC consumer representatives' suggestion to delete the language "within a period of less than fourteen (14) days" in Section 8A(7). The Subgroup decided to revise the timeframe to 30 days. The Subgroup also agreed, if necessary, to revisit its decision based on any stakeholder concerns.

2. Discussed Comments Received on Section 7 of Model #171

The Subgroup next discussed the comments received on Section 7—Prohibited Policy Provisions, beginning with the NAIC consumer representatives' comments for Section 7A. Section 7A prohibits specified policies from establishing provisions related to probationary or waiting periods, during which no coverage is provided under the policy under certain circumstances. Section 7A also provides that a policy may contain a probationary or waiting period for certain diseases or conditions. The NAIC consumer representatives suggest numerous revisions to this provision, including adding a provision prohibiting a supplementary or short-term, limited-duration (STLD) health insurance policy from being issued, delivered, or used in the state unless the policy has been filed and approved by the commissioner. The Subgroup discussed the suggested revisions but decided not to accept them. The Subgroup decided to accept the Maine Department of Insurance's (DOI's) suggested revisions to Section 7A, which streamline the existing language and incorporate the language in Section 7C related to preexisting condition exclusion periods. After discussing the Vermont DOI's comments on Section 7A, which question the list of specific conditions described in the provision for which a policy may have a probationary or waiting period, the Subgroup agreed to delete the reference to "appendix" because it appears to be obsolete.

The Subgroup next discussed the comments received on Section 7B. Section 7B prohibits an insurer from issuing a policy or rider for additional coverage as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. The NAIC consumer representatives and the Health Benefits Institute (HBI) suggest deleting the provision because it is not a common provision included in health insurance coverage. The HBI also suggests adding a drafting note that explains why the provision was deleted and suggests that those states where policy dividends are available for policies covered by Model #171 look at how such dividends are treated in life insurance. After discussion, the Subgroup agreed to delete Section 7B and add the HBI's suggested drafting note.

The Subgroup next discussed the Maine DOI's suggestion to delete Section 7C. Section 7C prohibits an insurer from excluding coverage for a loss due to a preexisting condition for a period greater than 12 months following the issuance of the policy or certificate where the application or enrollment form for the insurance does not seek disclosure of prior illness, disease, or physical condition or prior medical care and treatment and the preexisting

condition is not specifically excluded under the terms of the policy or certificate. After discussion, the Subgroup agreed to delete Section 7C because its provisions are folded into the revised language for Section 7A.

The Subgroup next discussed Section 7D. Section 7D describes provisions that may be included in a disability income protection policy. America's Health Insurance Plans (AHIP) suggests adding the word "option" after "cash value benefit." The Subgroup accepted the suggested revision. The Subgroup discussed the NAIC consumer representatives' suggestion to delete the term "suspension" and replace it with "cancellation." The Subgroup decided not to accept the suggested revision because of the different meanings and applications of these terms in accordance with common insurance terminology.

The Subgroup discussed the Texas DOI's suggestion to add language to Section 7, clarifying that, except for STLD plans and limited scope dental and vision plans, the policies covered under Model #171 cannot coordinate because the *Coordination of Benefits Model Regulation* (#120) excludes these types of coverages from the definition of "plan." However, because Model #120 does not technically apply to policies that are not "plans," some insurers attempt to limit coverage to "excess only." After discussion, the Subgroup agreed to consider adding such language. Bowden volunteered to draft language for the Subgroup's consideration.

The Subgroup next discussed the Texas DOI's comments on Section 7E. Section 7E prohibits a hospital confinement indemnity or other fixed indemnity coverage from containing a provision excluding coverage because of confinement in a hospital operated by the federal government. The Subgroup discussed why Section 7E is limited to hospital confinement indemnity, other fixed indemnity coverage, and hospitals operated by the federal government. The Subgroup did not make any decisions on whether to broaden Section 7E to include other coverages and other licensed facilities.

The Subgroup next discussed Section 7F. Section 7F prohibits a policy from limiting or excluding coverage by type of illness, accident, treatment, or medical condition, except as provided in the section. The American Council of Life Insurers (ACLI) and AHIP suggest adding the words "non-commercial or recreational" to clarify Section 7F(4)(c). The Subgroup accepted the suggested revision.

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 7F. The Subgroup did not complete its discussion of the comments, deferring discussion until the Subgroup's next meeting on March 27.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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Draft: 3/15/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup  
Virtual Meeting  
February 27, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Feb. 27, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Chris Struk and Shannon Doheny (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Martin Swanson (NE); Heidi Clausen and Shelley Wiseman (UT); Anna Van Fleet and Jamie Gile (VT); and Ned Gaines (WA).

1. Continued Discussion of Section 8A of Model #171

The Subgroup continued its discussion of the comments received on Section 8A—General Rules of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), beginning with the NAIC consumer representatives' suggestion to delete Section 8A(2)(c), which sets out provisions related to an individual's right to continue a policy up to a specified age under certain circumstances. The Subgroup discussed whether the provision should be retained and revised to delete the references to specific ages, similar to the changes the Subgroup agreed to for Section 8C—Disability Income Protection Coverage. After discussion, the Subgroup decided to delete the references to specific ages and revise the provision based on the Subgroup's preliminary revisions to Section 8C. The Subgroup agreed to revisit this proposed revision after it completes its review of all the comments received on Model #171.

The Subgroup next discussed the NAIC consumer representatives' suggestion to revise Section 8A(3) to delete the reference to "husband and wife" and replace it with "adult members." The NAIC consumer representatives also suggest deleting the references to "spouse" and replacing them with "person." The Subgroup agreed that it would be appropriate to delete the reference to "husband and wife" because it is outdated language. The Subgroup discussed whether replacing that reference with "adult members" would expand the scope of the provision and have unintended consequences. After discussion, the Subgroup decided to accept the Vermont Department of Insurance's (DOI's) suggestion to replace "husband and wife" with "married couple or civil union couple." The Subgroup discussed the appropriateness of adding "civil union" because such a partnership may not be applicable in every state. After discussion, the Subgroup decided to add a drafting note explaining the intent of the language, which it would review later. The Subgroup also agreed to revisit adding "civil union" and make a final decision after it completes its review of all the comments received on Model #171. The Subgroup deferred deciding on whether to delete "spouse" and replace it with "person" because of its concerns about unintentionally expanding the scope of the provision. The Subgroup agreed to revisit this issue later.

The Subgroup next discussed the NAIC consumer representatives' suggestion to delete the language "within a period of less than fourteen (14) days" in Section 8A(7). The Subgroup discussed whether deleting the language would be helpful or harmful to consumers. There also was discussion on whether to delete the provision altogether or change the time frame to 30 days. The Subgroup also discussed whether any changes were necessary because it does not appear that states have been receiving complaints about the 14-day provision. The Subgroup deferred additional discussion of the provision until its next meeting on March 13 to allow Cindy Goff (American Council of Life Insurers—ACLI) to poll ACLI members about this provision, including its 14-day time frame and whether there would be any concerns with revising the time frame to 30 days.

The Subgroup next discussed Section 8A(8). The NAIC consumer representatives and the Vermont DOI both suggest revising this provision to delete outdated language, such as the reference to "mental retardation or

physical handicap” and replacing it with “intellectual or physical disability.” They also suggest deleting the reference to “incapacity” and replacing it with “disability.” After discussion, the Subgroup agreed to accept the suggested revisions.

The Subgroup next discussed the NAIC consumer representatives’ suggestion to delete Section 8A(10). Section 8A(10) provides that a policy may contain a provision related to recurrent disabilities, but such a provision may not specify that a recurrent disability be separated by a period greater than six months. The Subgroup discussed whether deleting this provision would harm consumers. After additional discussion, the Subgroup decided to retain the provision, but consider moving it to Section 8C—Disability Income Protection Coverage.

The Subgroup next discussed the NAIC consumer representatives’ suggestion to add language to Section 8A(12) requiring that an accident-only policy providing benefits that vary according to the type of accidental cause to include in the disclosure materials required under Section 9 of Model #171, in addition to the outline of coverage, specified information on the circumstances when benefits payable under the policy will be lesser than the maximum payable benefit amount. The Subgroup agreed to accept the suggested revision.

Based on its previous discussions, the Subgroup did not accept the NAIC consumer representatives’ suggestion to delete the term “termination” in Section 8A(13) and replace it with the term “cancellation.”

The Subgroup next discussed the Texas DOI’s suggested revision to Section 8A(4) to expand the applicability of the provision to group coverage. The Subgroup discussed the suggested revision. After discussion, the Subgroup decided not to accept the suggested revision.

The Subgroup next discussed the Texas DOI’s suggested revision to Section 8A(5) to possibly expand the military service member protections to other federal or state laws. After discussion, the Subgroup decided to add a drafting note suggesting that the states may want to review other state and federal laws and regulations that may apply to this type of military service member protection.

The Subgroup next discussed the Texas DOI’s suggestion to expand Section 8A(8) to apply to group coverage. Section 8A(8) outlines requirements for continuing coverage for certain dependent children whose coverage would otherwise be terminated under the terms of the policy due to the attainment of a specified age. After discussion, the Subgroup agreed to preliminarily delete the word “individual” and have the provision apply to group coverage. The Subgroup also agreed to revisit its decision subject to industry concern about such a change.

The Subgroup next discussed the Texas DOI’s comments on Section 8A(11), suggesting expanding the time frames for paying accidental death and dismemberment benefits and disability income protection benefits. Bowden asked if Subgroup members and interested regulators took a different approach to this provision related to these time frames. A few states discussed their states’ related provisions. The Subgroup did not decide on whether to revise Section 8A(11) to reflect the Texas DOI’s comments.

The Subgroup reviewed the Texas DOI’s comments on Section 8A(12) and (13), suggesting that the Subgroup may want to move these provisions from Section 8A—General Rules to Section 8D—Accident-Only Coverage because they appear to only apply to accident-only coverage. The Subgroup did not decide whether to move the provisions.

The Subgroup next reviewed the Texas DOI’s comments on Section 8A(14). Bowden said she flagged this provision for the Subgroup for potential future discussion to add definitions for “policy period” and “benefit period” when it revisits Section 5—Definitions.

The Subgroup next discussed the Texas DOI's suggestion to broaden and revise Section 8A(15) as follows: "A policy providing coverage for certain illnesses and injuries may not define covered illnesses and injuries in a way that is misleading or include unfair exclusions. For example, a policy providing coverage for fractures or dislocations may not provide benefits only for 'full or complete' fractures or dislocations." After discussion, the Subgroup agreed to accept the suggested revision.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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Draft: 3/7/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup  
Virtual Meeting  
February 13, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Feb. 13, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Chris Struk and Shannon Doheny (FL); Robert Wake (ME); Shari Miles (SC); Heidi Clausen and Shelley Wiseman (UT); Anna Van Fleet and Jamie Gile (VT); and Ned Gaines (WA).

1. Discussed Proposed Revisions to the Introductory Language for Section 8 and Section 8A of Model #171

Before continuing its discussion of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), Schallhorn welcomed Bowden as the new Subgroup co-chair. He also said that moving forward, the Subgroup plans to meet every other week for 90 minutes in order for the Subgroup to complete its work on revising Model #171 by the end of the year.

The Subgroup discussed America's Health Insurance Plans' (AHIP's) and the American Council of Life Insurers' (ACLI's) suggestion to delete "short-term" in the introductory language for Section 8—Supplementary and Short-Term Health Insurance Minimum Standards for Benefits. Cindy Goff (ACLI) said the ACLI suggests this revision to reflect that provisions of Section 8 do not generally apply to short-term coverage. After discussion, the Subgroup decided not to accept the suggested revision for the introductory paragraph for Section 8, but as the Subgroup reviews the other provisions in Section 8, it will consider deleting the reference to such coverage, as appropriate, such as when the provision would not apply to such coverage. The Subgroup discussed the Texas Department of Insurance's (DOI's) comments suggesting revising the language to clarify that some combinations of products could disqualify a product from being considered an excepted benefit product. After discussion, the Subgroup decided such language was unnecessary because of other revisions the Subgroup has preliminarily agreed to include for this section.

The Subgroup next discussed AHIP's and the ACLI's suggestions to delete the reference to "short-term" in Section 8A—General Rules. After discussion, the Subgroup agreed to delete these references in Section 8A(1), (2), (3), and (4). After discussion, the Subgroup agreed to add AHIP's and the ACLI's suggested language "except for nonpayment of premium" in Section 8A(6). After discussion, the Subgroup did not accept AHIP's and the ACLI's suggestion to delete the reference to "short-term" in Section 8A(8).

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 8A(1) to delete the term "termination" and replace it with the term "cancellation." After discussion, the Subgroup decided not to accept the suggested revisions because of concerns of unintended consequences of such a change to standard insurance terminology. The Subgroup next discussed the NAIC consumer representatives' suggestion to delete Section 8A(2)(c), which sets out provisions related to an individual's right to continue a policy up to a specified age under certain circumstances. The Subgroup discussed whether the provision should be retained and revised to delete the references to specific ages similar to the changes the Subgroup agreed to for Section 8C—Disability Income Protection Coverage. After discussion, the Subgroup deferred deciding until its next meeting on Feb. 27.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/Accident and Sickness Subgrp/Accident and Sickness Ins Min Stds Subgrp 2-13-23MtgMin.docx

Draft: 3/9/23

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group  
Virtual Meeting  
February 24, 2023

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met Feb. 24, 2023. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Jimmy Harris (AR); Erin Klug (AZ); Cara Cheevers (CO); Kurt Swan (CT); Howard Liebers (DC); Elizabeth Nunes (GA); Andria Seip (IA); Julie Holmes (KS); Mary Kwei (MD); Andrew Kleinendorst (MN); Cynthia Amman (MO); David Dachs (MT); Ted Hamby (NC); Chrystal Bartuska (ND); Maureen Belanger (NH); Ralph Boeckman (NJ); Cass Brulotte and Paige Duhamel (NM); Laura Miller (OH); Ashley Scott (OK); Lindsay Swartz (PA); Glynda Daniels (SC); Jill Kruger (SD); Rachel Bowden (TX); Tanji J. Northrup (UT); Brant Lyons (VA); Barbara Belling (WI); Tim Sigman (WV); and Tana Howard (WY).

1. Adopted Its 2022 Fall National Meeting Minutes

Northrup made a motion, seconded by Kruger, to adopt the Working Group's Dec. 14, 2022, minutes (Attachment Four-A). The motion passed unanimously.

2. Discussed Parity Issues with Health Insurers

Weyhenmeyer said the same speakers from America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA) who presented at the 2022 Fall National Meeting were available to respond to follow-up questions from the Working Group.

Meghan Stringer (AHIP) reviewed the results of a survey AHIP conducted with its members on mental health care. She said AHIP's board had made a statement of commitment to expanding access to telehealth services, integrating behavioral health care into primary care, and continuing to provide mental health care at parity. She said AHIP's members have worked to expand access to mental health providers. She said mental health provider networks have grown by 48% and that four out of five plans have increased payments to mental health providers.

Kate Berry (AHIP) described member plans' work on integration of behavioral health care into primary care. She said AHIP's board has identified eight priorities on mental health, including bringing mental health services into primary care. She said AHIP recognizes there are a range of models around collaborative care with a range of payment methods. She said behavioral health care often also should be integrated into specialty care, not just primary care. Berry said integration can expand the workforce, for instance by bringing in social workers in family practice. She said telehealth has been extremely impactful in mental health services, including by increasing access and reducing stigma. She said other considerations are making electronic health records available to mental health providers and adding to the evidence base around mental health services.

Anshu Choudhri (BCBSA) reviewed some of the points from his presentation at the 2022 Fall National Meeting. He said BCBSA plans have prioritized certain areas in behavioral health, including mitigating workforce challenges and trying to drive innovation. He said youth mental health, addressing workforce challenges, and health equity are also key priorities.

Stringer shared an issue brief AHIP published on integrating mental health care.

Weyhenmeyer asked about the increase in the number of mental health providers and whether telehealth providers are included in the cited increase. Stringer said some providers offer a hybrid of telehealth services as well as in person, so she would have to check with the research team to confirm how they are included.

Duhamel brought up pending legislation in New Mexico that AHIP has opposed. She said New Mexico has not seen an increase in mental health provider networks, including psychiatrists, psychologists, and mid-level providers. She said the state has seen drops rather than increases and asked what types of providers have been added. Stringer said AHIP has worked to find a compromise on the legislation. She said the change in the number of mental health providers included 20% growth in psychiatrists, 50% growth in licensed therapists, and more than 80% in psychiatric nurse practitioners. She said the numbers are national.

Amman asked whether plans have the capability to filter out providers who are limited to facilities only and not available for outpatient referrals. She said there has been an increase in network participation by facilities, which is a good thing, but it may hide the number of providers available for patients who are not admitted to facilities. Stringer said AHIP did look at facilities separately from the number of providers. She said provider directory information is only as good as the data offered by providers. She said plans ask providers for information, but it is a challenge when they do not respond. Jen Jones (BCBSA) said some plans have established navigator programs to help patients get connected to the right providers for their care.

Duhamel said providers struggle with prior authorization. She asked what metrics are used by plans to monitor their consumer assistance programs, such as call abandonment, wait times, and successful prior authorization. Berry said prior authorization is burdensome for everyone. She said plans review their prior authorization policies and processes often. She said they are relatively selective in how they use prior authorization, focusing on the most high-volume services where there is variation in how providers practice. Choudhri said metrics on customer service would vary by plan. He said prior authorization is a difficult program to set up in cost and difficulty of administration, so plans focus on variation from clinically accepted guidelines. He said patient safety also factors in to ensure the appropriate course of treatment. He said plans work to make prior authorization more seamless and more transparent in the process.

Duhamel asked what plans are doing to streamline communication between third-party behavioral health administrators and the plans. She said New Mexico has seen breakdowns in communication from these delegated entities and has taken corrective action when there are differences in what is required from the plan and the delegated entity. Choudhri said plans work closely with delegated entities, and the expectation is that they follow plans' policies. He said some plans have moved more services in-house because of these breakdowns in communications.

Stringer said plans track metrics differently, but one plan she interacted with tracks factors like time to appointment, how long to the next appointment, how many appointments a patient has, and ensuring treatment is toward a certain outcome. Duhamel said it is difficult to get such metrics from plans.

Bartuska asked about payment parity for behavioral telehealth. She said a lack of parity in payments could lead some providers to stop offering behavioral treatment. Stringer said it is important to ask whether providers have a brick-and-mortar practice or only provide telehealth services. She said AHIP did a rough calculation that showed payments for telehealth appear to be rising faster than payments for in-person services for certain psychotherapy codes. Bartuska questioned whether telehealth-only practices should be paid the same as those with physical offices. Berry said it can cut both ways; providers want to be paid the same, but many stakeholders want to contain costs. She said many are still evaluating the cost and quality impact of virtual care, so there is not yet a clear answer. Choudhri said the emphasis should be on payment equity rather than payment parity. He said payment

for telehealth services could be paired with additional payment for care coordination. He said there is also difficulty in defining the scope of services, so flexibility is more important than a mandate for parity.

Brulotte said New Mexico prohibits additional barriers for telehealth and requires parity in payment. Berry said telehealth providers should be incorporated into regular networks, which could expand access.

Weyhenmeyer asked how plans have handled concerns from providers about prepayment audits. Choudhri said it varies from plan to plan and that he could not share detailed information without consulting them. Stringer said there is not a substantive difference between audit practices for mental health services and medical or surgical services. She said not all claims that are concerning can be looked at, and audits affect only a small number of claims overall.

Weyhenmeyer asked what contracting strategies have increased the number of participating providers. Berry said plans are doing everything they can, including paying more and reducing administrative burden where possible. Choudhri said administrative burdens can be significant for some providers, and plans are looking at ways to reduce them. He said some plans are setting up referral clinics or connecting small clinics with support services so they can remain viable rather than merging with larger organizations. Jones said plans are working to leverage the networks they have so that primary care providers have the support they need to integrate care. She said this allows behavioral health specialists to be used more effectively. She added that some plans use analytics to identify providers who are underrepresented demographically in the network or identify out-of-network providers who are serving a significant share of members.

Having no further business, the MHPAEA (B) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2023 Spring National Meeting/MHPAEAWG Min 2.24.docx

Draft: 1/5/23

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group  
Tampa, Florida  
December 14, 2022

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met in Tampa, FL, Dec. 14, 2022. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Jane Beyer, Vice Chair (WA); Erin Klug (AZ); Kate Harris (CO); Kurt Swan (CT); Howard Liebers (DC); Andria Seip (IA); LeAnn Crow and Julie Holmes (KS); Mary Kwei (MD); Peter Brickwedde and Paul Hanson (MN); Carrie Couch (MO); David Dachs (MT); Ted Hamby (NC); Rachel Kriege (ND); David Bettencourt (NH); Ralph Boeckman (NJ); Paige Duhamel (NM); Daniel Bradford and Laura Miller (OH); Ashley Scott (OK); Lindsy Swartz (PA); Gwendolyn McGriff (SC); Jill Kruger (SD); R. Michael Markham (TX); Tanji J. Northrup (UT); Julie Fairbanks (VA); Barbara Belling (WI); Erin K. Hunter (WV); and Tana Howard (WY). Also participating were: Chris Struk (FL); and Kevin Beagan (MA).

1. Heard Presentations on Parity Issues from Health Insurers

Anshu Choudhri (Blue Cross Blue Shield Association—BCBSA) spoke about health insurers' opportunities for improving behavioral health access and complying with MHPAEA. He said that insurers face provider shortages in building networks. Nonetheless, he provided examples of insurers in Michigan and North Carolina that have added behavioral health providers to their networks. He said efforts are particularly focused on youth mental health and health equity. He said patient-centered medical homes have been a method for integrating mental health services with primary care.

Choudhri said health insurers are taking steps to address workforce challenges. He said insurers are trying to get creative in contracting by using value-based contracts, changing reimbursement levels, and encouraging contracts with downside risk for providers. He said insurers are working to refine contracts and using vendors to build out networks, as well as adding new provider types, like social workers and counselors, to networks. He said plans are working to support existing providers and to encourage primary care providers to offer mental health treatments.

Choudhri offered suggestions for state and federal regulators to improve MHPAEA reviews. He observed that MHPAEA governs health insurers' processes, not outcomes. He said insurers want additional clarity, consistency, and help in understanding what they should provide to show they are doing the right thing. He requested additional examples of compliance and non-compliance and alignment of compliance practices across state and federal regulations. He said plans would benefit from having a full list of nonquantitative treatment limitations. He said plans are still working to comply with requirements under the federal Consolidated Appropriations Act, 2021, so the time is not right for additional requirements.

Meghan Stringer (AHIP) provided additional perspective from health insurers on improving mental health coverage and access. She said AHIP's board has adopted a set of mental health principles and advocacy priorities. She summarized the results of a survey AHIP conducted among health insurance providers on mental health. She said that mental health provider networks are growing and that reimbursements are rising, with the number of mental health providers increasing by nearly 50% on average over the last three years. She said all plans that responded to the survey offer tele-behavioral health services. She said most plans are training and supporting primary care providers in offering mental health services, assisting enrollees in finding mental health appointments, and using specialized care managers who follow up after emergency or inpatient care.

Stringer said that case management practices differ among insurers and that different regulators have taken different views on whether a particular practice is a non-quantitative treatment limitation. She said an annual list

of non-quantitative treatment limitations (NQTLs) would be helpful, either a full list or a list of all the NQTLs that regulators have requested information on in the prior year. She said this would promote common understanding and collection of the right data.

Stringer emphasized that parity does not require the same treatment limitations, only that the processes to decide the limitations be comparable and no more stringent than those for medical/surgical services. She said prior authorization practices vary by plan and that they consider different factors. She said MHPAEA includes some clear limitations and that plans have altered their requirements in response to the law, including by limiting prior authorization. She said that the process to determine reimbursement rates is governed by MHPAEA, not the rates themselves. She said insurers routinely review their payment rates to gauge compliance with MHPAEA, including measuring against other plans. She said payment audits occur when there is a coding discrepancy or when a service is provided without approval. She said records may be requested to determine if care is appropriate or to check medical management procedures. She said a small number of claims are audited and that plans do not have the capacity to audit every suspicious claim.

Stringer said progress has been made on mental health access, but more needs to be done. She said AHIP is committed to working with regulators and other stakeholders to improve mental health support.

Weyhenmeyer asked the speakers to define fraud, waste, and abuse. Choudhri said that fraud is willfully doing something fraudulent, waste is overusing services or deviating from best practices, and abuse is misrepresenting services. Stringer said it varies by plan, but one example is drug treatment programs that do not meet quality standards.

Brickwedde asked how plans have increased their number of mental health providers. Stringer said plans have focused on using telehealth and that some increase is due to rising payment rates. Brickwedde asked whether network adequacy standards should shift focus from time and distance to appointment wait times if care is shifting to telehealth. Choudhri said it would be interesting to revisit the standards so they are not as dependent on time and distance. Brickwedde and Harris asked how plans are tracking the data needed to measure enrollees' appointment wait times. The speakers said they would have to follow up at a later time.

Beyer asked whether providers in smaller practices have the capacity to participate in value-based payments. Choudhri said contracting models like value-based payments have greater participation from broader health systems rather than small providers. He said behavioral health providers often join when systems of care form, but quality measures for behavioral health are a challenge because they have not been developed.

Weyhenmeyer said releasing an exhaustive list of NQTLs would be difficult because there are many one-off issues that insurers include in their plans. Stringer said regulators should consider releasing a list of the NQTLs they discovered or looked at in the course of a year. Hanson noted that releasing a list could be considered rulemaking under some states' laws.

Having no further business, the MHPAEA (B) Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

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Draft: 4/3/23

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup  
Louisville, Kentucky  
March 22, 2023

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met in Louisville, KY, March 22, 2023. The following Subgroup members participated: TK Keen, Chair (OR); Ashley Scott and Molly Clinkscales, Vice Chair (NE); Kayla Erickson (AK); Jimmy Gunn, Reyn Norman, and Anthony L. Williams (AL); Beth Barrington (AR); Paul Lombardo (CT); Howard Liebers (DC); Andria Seip (IA); Vicki Schmidt (KS); Daniel McIlwain (KY); Frank Opelka (LA); Anita G. Fox and Chad Arnold (MI); Amy Hoyt (MO); Matthew Eberhardt (MT); Ted Hamby (NC); Erin Porter and Ralph Boeckman (NJ); Paige Duhamel and Renee Blechner (NM); David Buono (PA); Scott McAnally (TN); Tanji J. Northrup (UT); Don Beatty (VA); Jennifer Kreitler and Ned Gaines (WA); Jennifer Stegall (WI); Erin K. Hunter (WV); and Jill Reinking (WY). Also participating was: Eamon G. Rock (NY).

1. Adopted its 2022 Fall National Meeting Minutes

Beatty made a motion, seconded by Commissioner Schmidt, to adopt the Subgroup's Dec. 15, 2022, minutes (Attachment Five-A). The motion passed unanimously.

2. Heard an Update on the PBM White Paper Status

Keen said the Subgroup released a working draft of the proposed pharmacy benefit manager (PBM) white paper during its meeting at the 2022 Fall National Meeting. He said the Subgroup is working on edits to the working draft, such as adding language to the Recommendation section and making any necessary non-substantive edits. After this is complete, the Subgroup plans to release an official draft of the white paper for public comment by the end of March or early April. Keen said the Subgroup plans to set a 45-day public comment period. Following the end of the public comment period, the Subgroup plans to hold meetings to review the comments received and update the draft based on those discussions. He said the Subgroup hopes to finish its work on the white paper before the Summer National Meeting and forward it to the Regulatory Framework (B) Task Force for its consideration.

3. Heard an Update on Federal PBM-Related Legislative and Regulatory Activities

Brian R. Webb (NAIC) updated the Subgroup on recent federal PBM-related legislative and regulatory activities. He said the U.S. Senate (Senate) Committee on Commerce, Science, and Transportation passed the Pharmacy Benefit Manager Transparency Act of 2023 (S.127), which was sponsored by U.S. Sen. Maria Cantwell (D-WA) and U.S. Sen. Chuck Grassley (R-IA) on March 22. S.127 generally prohibits PBMs from engaging in certain practices when managing the prescription drug benefits under a health insurance plan, including charging the plan a different amount than the PBM reimburses the pharmacy. The bill also prohibits PBMs from arbitrarily, unfairly, or deceptively: 1) clawing back reimbursement payments; or 2) increasing fees or lowering reimbursements to pharmacies to offset changes to federally funded health plans.

Webb noted that S.127 provides that PBMs are not subject to these prohibitions if they: 1) pass along 100% of any price concession or discount to the health plan; and 2) disclose specified costs, prices, reimbursements, fees, markups, discounts, and aggregate payments received with respect to their PBM services. S.127 further requires PBMs to report annually to the Federal Trade Commission (FTC) certain information about payments received from health plans and fees charged to pharmacies. The FTC and state attorneys general are authorized to enforce the bill's provisions. Webb explained that although this is a bipartisan bill, concerns have been raised by those

accusing it of having the FTC involved in enforcing the legislation. He said he anticipates that S.127 will go to the Senate floor for a vote at some point; although, the exact timeline is unclear. If the Senate passes the bill, it is uncertain what will happen in the U.S. House of Representatives (House).

Webb said another bill of interest is the Prescription Pricing for the People Act of 2023 (S.113) introduced by Sen. Grassley, which passed the Senate Committee on the Judiciary on March 1. The bill requires the FTC to study the role of intermediaries in the pharmaceutical supply chain and merger activity. The FTC also must provide recommendations to increase transparency in the supply chain and prevent anticompetitive practices. Webb noted that like S.127, concerns involving the bill focus on the FTC's role because of a feeling that the FTC is too political and untrustworthy.

Webb said NAIC staff will continue tracking both S.127 and S.113. He explained that because both bills are bipartisan, they could be incorporated into other Senate legislation or passed as standalone bills.

Webb said with respect to federal PBM-regulatory activity, in June 2022, the FTC launched a Section 6(b) of the Federal Trade Commission Act of 1914 (FTC Act) study to inquire into the prescription drug middleman industry, requiring the six largest PBMs to provide information and records regarding their business practices. He said the FTC's investigation will closely examine how vertically integrated PBMs affect the availability and cost of prescription medications. He said as part of this investigation, the FTC issued mandatory orders to the six largest PBMs to submit to provide information and records regarding their business practices.

Webb said the inquiry is aimed at shedding light on several practices that have drawn scrutiny in recent years, including fees and clawbacks charged to unaffiliated pharmacies, methods to steer patients towards PBM-owned pharmacies, and the impact of rebates and fees from drug manufacturers on formulary design and the costs of prescription drugs to payers and patients. He said the FTC gave the PBMs 90 days to respond, but he has not seen any reports from the FTC reflecting the PBM responses. He said NAIC staff are working with FTC staff to see if the FTC would be available to participate in a regulator-to-regulator meeting with the Subgroup to discuss any findings they may have at this point in the study.

Webb said in addition to this Section 6(b) study, in June 2022, the FTC issued a "Policy Statement on Rebates and Fees in Exchange for Excluding Lower Cost Drug Products," in which the FTC said this PBM business practice may violate anti-trust laws and bribery laws. The FTC intends to closely scrutinize the impact of rebates and fees on patients and payers to determine whether any of these provisions have been violated. In addition, it plans to monitor private litigation and file amicus briefs where it can aid courts in analyzing unlawful conduct that may raise drug prices. The FTC also plans to continue to study this issue to understand the full range of practices and implications.

Webb asked which NAIC staff could discuss with relevant Congressional committee staff, given the federal legislation and the recent U.S. Supreme Court decision in *Rutledge vs. Pharmaceutical Care Management Association (PCMA)* if the Subgroup is interested in pursuing trying to codify or clarify some of the issues related to the authority of state insurance regulators to regulate PBMs and their business practices. The Subgroup expressed support for Webb's suggestion.

#### 4. Heard a Legal Update on PBM-Related Litigation

Kay Noonan (NAIC) said as the Subgroup members and other stakeholders know, there has been a lot of PBM-related legislative activity by the states to address rising prescription drug costs. She noted the PCMA's opposition to such legislation, which the PCMA asserts is preempted by the federal Employee Retirement Income Security Act of 1974 (ERISA), Medicare Part C program laws and regulations, and Medicare Part D program laws and



regulations. She explained that the U.S. Supreme Court's *Rutledge* decision potentially opened a pathway for states to regulate PBMs and their business practices. She discussed two major cases still pending in the courts—*PCMA v. Mulready* and *PCMA v. Wehbi*—considering the *Rutledge* decision, including their current litigation status and possible court decisions.

#### 5. Heard a Discussion from the States on Recently Enacted and Pending State PBM Legislation

The Subgroup heard from various members and interested state insurance regulators on recently enacted and pending state PBM legislation. Beatty said in this year's Virginia General Assembly session, two bills were introduced to include all self-funded plans in the definition of "carrier." He said because of this proposed legislation, various stakeholders not previously involved in this issue, raised concerns. After discussion, the Virginia Joint Commission on Health Care (JCHC) was charged with conducting a study generally focusing on the *Rutledge* case and its implications and issuing a report on its findings. Beatty said he believes the idea of having the JCHC conduct this study and issue a report is to better educate legislators on the issues related to the *Rutledge* case and its impact on the ability of states to regulate PBMs and their business practices.

Seip updated the Subgroup on Iowa's recently enacted PBM legislation. In this legislation, Iowa included a requirement that self-funding plans, defined as third-party payors, must comply with its provisions. She said based on this requirement, she has seen a big change in the reporting of information included in Iowa's annual report concerning the collection of rebates and fees by plans, which previously only included such information from fully insured plans. She said this information is not public yet, but there is a big difference in the numbers. She said once the report is public, she would share it with the Subgroup.

Seip said Iowa is beginning to implement provisions of the law, including the provisions requiring the Iowa Department of Insurance (DOI) to collect complaints from pharmacies. She said the Iowa DOI has received many complaints, most focusing on the pharmacy being paid less than its drug acquisition cost. She said they have received a few complaints regarding the fees being charged. She said the Iowa DOI is turning its focus to examinations. She said she would be interested in what other states are doing in this area, how they implement this provision in their laws, and working together to figure out some best practices. Keen agreed and said he would work with NAIC staff to set up a future Subgroup regulator-to-regulator meeting to discuss examinations.

Rock provided an update on New York PBM-related legislation. He said in the Governor's Executive Department proposed budget due April 1, there is a provision to provide the New York DOI with additional authority to regulate/register other prescription drug supply chain participants, such as pharmacy services administrative organizations (PSAOs), pharmacy switch companies, and rebate aggregators, as well as new requirements related to drug price disclosures of prescription drug manufacturers. He said for New York's initial law, an 18-month implementation period was built in to allow time for the New York DOI to promulgate regulations, such as market conduct regulations, to implement its provisions. The New York DOI has had a number of open meetings discussing the proposed regulations and received many comments from stakeholders. He also noted that New York's law gives the New York DOI the authority to conduct examinations. As such, he said he would support Iowa's suggestion that the Subgroup hold a regulator-to-regulator meeting to discuss best practices in this area.

Duhamel discussed legislation just passed in New Mexico, which was introduced as co-payment accumulator legislation but later was amended to include provisions meant to lower the cost of prescription drugs. She said an additional amendment added provisions on federal Section 340B discrimination and new transparency and reporting requirements. She said she has not seen the final bill language, but she knows that based on the latest version of the bill, the New Mexico DOI will be busy this year working to implement the new law. Hoyt said based on Duhamel's description, Missouri is seeing similar legislation being discussed in the state legislature. As such, she plans to follow what is going on in New Mexico as it works to implement the new law.

Lombardo discussed a bill just passed out of one of its committees that requires the Connecticut DOI to analyze the PBM distribution of prescription drugs and practices related to spread pricing, manufacturer rebates, and transparency and accountability. He said the proposed legislation also requires an examination of any impacts of ownership; governance; and vertical integration between PBMs, carriers, and pharmacies with respect to health care costs for consumers and any potential PBM anti-competitive practices in designing prescription drug formularies. He said he would keep the Subgroup apprised of what happens with the bill as it moves through the legislative process. He noted that Connecticut's three largest domestic health insurers own the three largest PBMs. As such, if the bill is enacted, it could have a lot of significant implications. Keen asked about the timeline for the Connecticut DOI to complete its analysis if the bill passed without amendment. Lombardo said the bill requires the Connecticut DOI to finish its analysis and publish a report by Feb. 1, 2024. Beatty asked if the Connecticut DOI has calculated how much it will cost to conduct the analysis. Lombardo said based on internal discussions, the Connecticut DOI anticipates hiring an outside consulting firm to assist in the work, and it is working on developing a fiscal note reflecting this. He said the fiscal note is not intended to "kill" the bill, because the Connecticut DOI wants to conduct the analysis.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

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Draft: 1/4/22

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup  
Tampa, Florida  
December 15, 2022

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met in Tampa, FL, Dec. 15, 2022. The following Subgroup members participated: TK Keen, Chair, Numi Rehfield-Griffith, Doug Hartz, Veronica Murray, and Ralph Magrish (OR); Laura Arp, Vice Chair (NE); Sarah Bailey (AK); Mark Fowler (AL); Crystal Phelps (AR); Paul Lombardo and Jared Kosky (CT); Howard Liebers (DC); Andria Seip (IA); Vicki Schmidt (KS); Daniel McIlwain, Rob Roberts, and Jonathan Abbott (KY); Chad Arnold and Joe Stoddard (MI); Norman Barrett Wiik (MN); Amy Hoyt and Carrie Couch (MO); David Dachs (MT); Robert Croom (NC); Ralph Boeckman and Erin Porter (NJ); Paige Duhamel (NM); Kelli Price (OK); Ana Paulina Gomez (PA); Scott McAnally (TN); Tanji J. Northrup (UT); Don Beatty and Stephen Hogge (VA); Ned Gaines and Molly Nollette (WA); Nathan Houdek, Rachel Cissne Carabell, and Jennifer Stegall (WI); Ellen Potter (WV); and Tana Howard (WY). Also participating were: Chris Struk (FL); Michelle B. Santos (GU); Chris Nicolopoulos (NH); and Cassie Brown (TX).

1. Adopted its Oct. 24 and Summer National Meeting Minutes

The Subgroup met Oct. 24 and Aug. 9. During these meetings, the Subgroup heard presentations from America's Health Insurance Plans (AHIP), the Blue Cross and Blue Shield Association (BCBSA), and the Pharmaceutical Care Management Association (PCMA) on issues from their perspective on the Subgroup's 2022 charge to 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 vs. PCMA* decision on such business practices; and 3) discuss any challenges, if any, the states have encountered in implementing such laws and/or regulations.

Beatty made a motion, seconded by Commissioner Houdek, to adopt the Subgroup's Oct. 24 (Attachment Five-A1) and Aug. 9 (see *NAIC Proceedings – Summer 2022, Regulatory Framework (B) Task Force, Attachment Eight*), minutes. The motion passed unanimously.

2. Discussed its Work to Develop an Initial PBM White Paper Draft

Keen said the Subgroup just released a working draft of the PBM white paper. He said that the Subgroup's aim in developing the white paper was to have it focus on the current state of play as far as PBMs and PBM regulation and business practices are concerned, as well as not have it try to predict any future changes in such regulation or business practices. He said that over the next few months, the Subgroup plans to edit and refine the document before releasing an official draft for a 30-day public comment period, which includes adding language to the introduction and recommendation sections. Keen said the main purpose of this meeting is for the Subgroup to hear from the leaders of each of the white paper section drafting groups on their process for developing an initial draft of their section and its focus.

Gaines discussed Section B—Key Players in the Drug Pricing Ecosystem. He said Section B focuses on the main players in the prescription drug supply chain, including insurers, pharmaceutical manufacturers, PBMs, pharmacists, PSAOs and the interrelation of the parties in the chain and transaction costs. He said with respect to the pharmaceutical manufacturers, Section B describes the various entities within this category—brand drug manufacturers, generic drug manufacturers, and biologic manufacturers. Gains said the subsection on pharmacies

describes both chain pharmacies and independent pharmacies. He explained that there are a few subsections in Section B that the drafting group needs to write, but it plans to complete them soon and have NAIC staff incorporate them into the white paper draft the Subgroup will expose for public comment.

Rehfield-Griffith discussed Section C—Enforcement and Federal Preemption Issues. She said Section C examines the scope of federal preemption of state laws regulating PBMs under the federal Employee Retirement Income Security Act of 1974 (ERISA), Medicare Part D, and Medicaid, including the implications of recent court decisions and ongoing litigation, and implications for states considering enacting similar laws. She said the subsection on ERISA focuses mostly on the recent U.S. Supreme Court decision in *Rutledge* and how that decision provides some leeway for the states to regulate PBMs without being concerned about ERISA preemption, but states need to be careful in crafting such legislation because it is unclear how far the facts of *Rutledge* and the precedent of that case would extend to state laws that may not mirror the Arkansas law that was the subject of that case. Rehfield-Griffith said the Medicare Part D subsection discusses the *Mulready v. PCMA* case extensively and outlines the provisions in the Oklahoma law a federal district court found were preempted by ERISA. She said this subsection concludes that Medicare Part D preemption may remain an obstacle to state insurance regulation and that state insurance regulations are likely going to be preempted in areas where a standard has been directly articulated by the federal government, such as in the provisions related to Medicare Part D.

Rehfield-Griffith said the remaining subsection in Section C, which focuses on Medicaid, does not focus on any court cases because there is little case law or precedent in this area. She said the subsection describes how the Medicaid program is set up as a federal-state partnership, which differs in how both Medicare and ERISA are set up. Because of such a partnership, states have more leeway to regulate PBMs serving Medicaid carriers as long as those regulations do not conflict with the state's Medicaid structure and are consistent with the terms of a state's current Medicaid plan. She said this subsection concludes that unlike the potential for ERISA or Medicare Part D preemption, Medicaid preemption should not be a significant concern for states looking to regulate PBMs that service Medicaid managed care plans or other Medicaid health carriers. However, states should ensure that any changes in PBM regulation in the Medicaid space are consistent with the state's Medicaid plan or seek an appropriate plan amendment if they are not.

Stoddard discussed Section D, which examines PBM functional areas, including formulary design, rebates, pricing and contracting practices, vertical integration and consolidation, pharmacy network adequacy, and the licensing of the different entities involved in the prescription drug supply chain. He discussed the main points of each of these areas as written in the subsection. He explained that the pricing and contracting practices subsection does not include any language related to mandatory arbitration as had been contemplated in the white paper outline because no one in the section drafting group had any information on this. He said the section drafting group is open to including such language if anyone in the Subgroup has this information or could clarify what this means.

Abbott discussed Section E—State Laws that Operate in the Supply Chain. He said Section E discusses the role of PBMs in the prescription drug supply chain and state laws enacted regulating PBMs and PBM business practices because of this expanding and evolving role. He described the Section E drafting group's approach and research used in writing the section, including examining different state laws and recent updates to those laws. He noted that recently there has been a push on both the state and federal level to enact laws requiring PBMs to provide more transparency in their business practices, such as disclosure of prescription drug pricing, cost information related to rebates, payments and fees collected from pharmaceutical manufacturers, insurers, and pharmacies.

Jolie H. Matthews (NAIC) said she would be speaking on behalf of the leader of the Section F drafting group. She said Section F concerns federal interest in PBMs and PBM business practices. The section focuses on the Federal Trade Commission's (FTC's) recently announced study on PBMs. She said the Section F drafting group developed

the language for Section F using information found through targeted online searches for articles on the subject. The Section F drafting group summarized the information found in the articles to include in Section F.

Price discussed Section G—Key Jurisprudence. She said Section G focuses on the three cases, to date, that have shaped state PBM laws and regulations—the *Rutledge* case, the *PCMA v. Wehbi* case, and the *Mulready* case. She explained that to some extent, Section G repeats some of the same information provided in Section C. Price discussed the details, arguments, findings, and key takeaways for each of the cases as detailed in Section G.

Arp reminded the Subgroup members and other stakeholders that the PBM white paper draft is just a draft, not an official draft the Subgroup is exposing for public comment. She said the purpose of providing the draft for this meeting is to let Subgroup members and other stakeholders know that the Subgroup is working diligently to complete its charge and the status of this work now before exposing an official draft for public comment. Keen asked for comments.

Carl Schmid (HIV+Hepatitis Policy Institute) expressed support for the Subgroup’s work to date, particularly the work the Subgroup has been doing to hear from a wide range of stakeholders on issues related to the Subgroup’s work to develop the PBM white paper. He said the NAIC consumer representatives look forward to providing comments on the draft white paper once the Subgroup exposes it for public comment. Schmid noted that the current working draft includes little information on the impact—good or bad—of PBMs and their business practices, such as mail-order service requirements or high cost-sharing requirements on certain prescription drugs for consumers. He reiterated that the NAIC consumer representatives stand ready to assist the Subgroup with addressing these initial concerns. Kris Hathaway (AHIP) also expressed support for the Subgroup’s work to date related to the PBM white paper. She suggested, however, that the Subgroup expand the current working draft to incorporate and examine high prescription drug costs and issues related to such high costs. J.P. Wieske (Horizon Government Affairs) suggested that the Subgroup include a discussion in the white paper on the NAIC’s previous work related to PBMs, such as the work done in revising the *Health Carrier Prescription Drug Benefit Management Model Act (#22)*. Chris Petersen (Arbor Strategies LLC), speaking on behalf of the PCMA, said the PCMA shares some of the concerns of AHIP, particularly with the Subgroup potentially setting a 30-day public comment period for stakeholders to submit comments on the official PBM white paper draft. He suggested a longer public comment period, such as 60 days, would be more appropriate given the white paper’s complexity.

### 3. Discussed Next Steps

Keen reiterated that the Subgroup plans to make additional edits to the PBM white paper working draft. Following this work, the Subgroup will release an official draft for a public comment period. Keen said he anticipates this will happen in January 2023. Noting that it is her last NAIC meeting, he also thanked Arp for her work as the Subgroup’s vice chair.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

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Draft: 11/9/22

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup  
Virtual Meeting  
October 24, 2022

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met Oct. 24, 2022. The following Subgroup members participated: TK Keen, Chair (OR); Laura Arp, Vice Chair (NE); Sarah Bailey (AK); Anthony L. Williams (AL); Beth Barrington (AR); Jessica Ryan (CA); Michael Shanahan and Kathy Belfi (CT); Howard Liebers (DC); Robert Koppin (IA); Craig VanAalst (KS); Sharon P. Clark and Daniel McIlwain (KY); Crystal Lewis (LA); Chad Arnold and Joe Stoddard (MI); Andrew Kleinendorst (MN); Amy Hoyt (MO); David Dachs (MT); Ted Hamby and Robert Croom (NC); Ralph Boeckman and Erin Porter (NJ); Paige Duhamel and Renee Blechner (NM); Kelli Price (OK); Michael Humphreys and Ana Paulina Gomez (PA); Katrina Rodon (SC); Michael Driver and Rhonda Bowling-Black (TN); Shelley Wiseman (UT); Julie Blauvelt (VA); Jennifer Kreitler (WA); Nathan Houdek and Jennifer Stegall (WI); Joylynn Fix (WV); and Bryce Hamilton (WY).

1. Heard a Presentation from AHIP

Kris Hathaway (America's Health Insurance Plans—AHIP) and Sergio Santiviago (AHIP) discussed the role of health insurance providers in keeping prescription drugs affordable. She focused her remarks on prescription drug costs. She explained how prescription drug prices and spending have increased over the years, growing at a rate that AHIP believes is unsustainable. She said an AHIP study found that in 2020, seven of the top 10 largest pharmaceutical companies spent more on marketing than on developing new drugs. She highlighted a 2020 Institute for Clinical and Economic Review (ICER) report, which was updated in 2022, that identified the top 10 drugs causing the greatest increase in drug spending and reviewed them for clinical evidence to justify the increases. She discussed five drugs the ICER reviewed that found no clinical reason for the drug price increase. She said prescription drug costs have decreased overall, but even small net price increases have large impacts on prescription drug spending nationally. She also noted the high costs of new drugs entering the market. She said anecdotally, it seems that recently enacted state prescription drug price transparency laws seem to be having some impact on prescription drug price increases.

Santiviago discussed the value of pharmacy benefit managers (PBMs) to health insurance providers in helping to contain costs. He said health insurance providers use PBMs to help contain costs by: 1) utilizing contract models with administrative fee payment structures and spread pricing; 2) using medication and drug management programs, such as PBM pharmacy and therapeutics (P&T) committees; and 3) developing pharmacy networks that include mail order pharmacy options and specialty pharmacies. He discussed how some of these cost containment tools, such as spread pricing and rebating, work to reduce costs and can reduce premiums in some cases. He also discussed the role of P&T committees in the development of formulary designs to help enrollees obtain safe and effective medications at the best value.

Santiviago discussed how these cost-saving tools are under attack from certain programs, such as drug manufacturer copay coupons. He also discussed how drug manufacturer rebates are not driving higher prescription drug price increases and how rebates benefit all consumers.

The AHIP presentation also included recommendations to the Subgroup related to the development of the white paper on PBM business practices. Those recommendations included suggesting that any policies included in the white paper consider both the individual consumer perspective and the overall cost to all people in the risk pool and health care system. AHIP also recommends the inclusion of all stakeholders in the process and that the white paper provide all perspectives on issues equally because each drug issue has multiple perspectives.

## 2. Heard a Presentation from the BCBSA

Randi Chapman (Blue Cross Blue Shield Association—BCBSA) focused her remarks on the roles of the various entities in the prescription drug supply chain, the BCBSA's policy positions related to prescription drug pricing and prescription drug financial assistance programs, and Blues plan initiatives to provide pharmacy benefits and member access to prescription drugs and affordable medications.

Chapman said the BCBSA agrees with state insurance regulators and many of the stakeholders who have presented to the Subgroup on the need to curb the high cost of prescription drugs. The BCBSA knows that each entity in the prescription drug supply chain, including payers, pharmacies, PBMs, and pharmacy services administrative organizations (PSAOs), play a role and share the responsibility of ensuring that consumers have access to the most effective and affordable medication. Chapman said given this, the BCBSA supports the Subgroup's direction to expand the white paper's scope to include an analysis and assessment of the roles of each supply chain player.

Chapman said the BCBSA supports state departments of insurance (DOIs) having oversight of PBMs rather than state boards of pharmacy or other provider-type state boards. She said the BCBSA also supports state prescription drug transparency laws, and it hopes the white paper includes a robust discussion of such transparency measures.

Chapman said because AHIP has already provided a thorough explanation of prescription drug costs, she would not discuss that issue in any detail. However, she noted that prescription drug manufacturers set the price of prescription drugs and administer patient assistance programs. She said in 2021, prescription drug manufacturers raised prices on 822 brand name drugs by an average of 4.6%. She said a Kaiser Family Foundation (KFF) analysis completed earlier this year showed that between July 2019 and July 2020, half of all Medicare Part D covered drugs and nearly half of the Medicare Part B covered drugs had price increases greater than inflation. She said another study found that 60% of adults between the ages of 18 and 64 recorded being prescribed at least one medication in the previous year, but 29% of them said they were not taking prescribed medication due to cost. She said stories like this one, and many others, show how the consistent rise in prescription drugs has a real and tangible impact on enrollees.

Chapman said because of this, the BCBSA supports improved prescription drug manufacturer price transparency, particularly in patient assistance programs offered by prescription drug manufacturers. She said in addition, the Blues plans and the BCBSA actively support transparency in their practices and are fully compliant with state and federal reporting requirements for claims and discounts. She said as AHIP alluded to, patient assistance programs help individual patients, but in effect, these programs hide the real costs of the drug and can prevent the utilization of generic drugs and spread costs across the system, which ultimately leads to higher premiums and higher costs overall.

Chapman said the Blues plans are looking at and initiating innovative solutions to support community-based approaches to ensure access to affordable medications. She provided examples of these approaches, such as prescription drug transparency with real-time cost information to providers and patients and outcomes-based agreements. She said overall, these approaches are trying to support their members' ability to make educated and informed choices with their providers about the prescription drugs they use and promote the affordability of those medications. She said the BCBSA believes prescription drug price transparency and quality information empowers consumers and ultimately drives larger changes in the prescription drug marketplace.

Chapman discussed the role PBMs play in the prescription drug supply chain, including the tools PBMs use to encourage patients, working with their physicians to select the safest and most effective drugs at the lowest possible price. She also discussed the BCBSA's position related to pharmacies and PSAOs. She said the BCBSA

believes specific types of pharmacy providers should not have financial advantages through mandated contract terms between pharmacies and PBMs or mandated coverage of drugs at acquisition cost. She also said the BCBSA believes further study is necessary to understand how PSAOs affect the prescription drug supply chain and what state actions are needed to lower prescription drug costs, and it urges the Subgroup to do this research when developing the white paper.

Allan Coukell (Civica) discussed how Civica is working with the BCBSA and several Blues plans to bring lower-priced generics to market. He said Civica entered into a partnership in 2020 with the BCBSA to create a new, nonprofit subsidiary, named CivicaScript, dedicated to lowering the cost of select, outpatient generic drugs. He said CivicaScript will develop and manufacture six to 10 common, but high-priced general prescription drug medicines, for which there is not enough market competition to drive down prices. He said Civica has about 10 prescription drug products in development; two of those drugs are expected to be marketed later this year.

Coukell focused his remarks on Civica's work related to generic insulin in both pen and vial form. He said in March 2022, the BCBSA and 12 Blue Cross Blue Shield (BCBS) companies announced a partnership with Civica to increase access to affordable insulin. He said Civica will produce three insulins and biologics corresponding to and interchangeable with brand name insulin. He said the cost of these generics to consumers will be no more than \$30 per vial or \$55 for a box of five pens starting in 2024.

Keen asked if the BCBSA owns Civica. Coukell said Civica is a standalone nonprofit organization. There are no equity owners. Coukell said CivicaScript is also a nonprofit organization, which was capitalized by health plans and other founding members. He said these founding members sit on the board, which also includes a PBM representative, but it is really a mission-driven organization. Keen asked about any hurdles to setting up such nonprofit organizations. Coukell said one major hurdle is obtaining tax-exempt status from the Internal Revenue Service (IRS) as a nonprofit prescription drug manufacturer due to the so-called "commerciality doctrine."

Acting Commissioner Humphreys said the Pennsylvania Capital Blue Cross announced plans to collaborate with the Mark Cuban Cost Plus Drug Company to help bring high-quality, low-cost prescriptions to its members. He asked Chapman if the BCBSA knows of any other companies contemplating such action. She said she would have to reach out to her colleagues to provide an answer, but she said she would be happy to follow up with him later. Santiviago said he believes initiatives and collaborations like Civica and the Mark Cuban Cost Plus Drug Company are a good thing because they bring more competition and supply, which can ultimately drive down prescription drug costs.

#### 4. Heard a Presentation from the PCMA

Casey Mulligan (University of Chicago), presenting on behalf of the Pharmaceutical Care Management Association (PCMA), discussed key findings from his research related to the value of PBMs. He said a managed plan is more valuable than an unmanaged plan. A managed plan provides plan member benefits and net external benefits. He said his research shows that an estimated \$145 billion per year in net value is added by PBM prescription drug plan management. He explained how he arrived at this figure, including how part of this net value is achieved by better drug utilization and inducing providers, such as prescription drug manufacturers and pharmacies, to compete more vigorously. He also explained how prescription drug benefit management reduces drug prices while rewarding drug innovation.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.



**SENIOR ISSUES (B) TASK FORCE**

Senior Issues (B) Task Force March 22, 2023, Minutes ..... 6-71

Draft: 3/23/23

Senior Issues (B) Task Force  
Louisville, Kentucky  
March 22, 2023

The Senior Issues (B) Task Force met in Louisville, KY, March 22, 2023. The following Task Force members participated: Marlene Caride, Chair (NJ); Larry D. Deiter, Vice Chair (SD); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Willard Smith (AL); Barbara D. Richardson represented by Erin Klug (AZ); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Paul Lombardo (CT); Trinidad Navarro represented by Frank Pyle (DE); Michael Yaworsky represented by Bryan Peters (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Vicki Schmidt represented by LeAnn Crow (KS); Sharon P. Clark represented by Angi Raley (KY); James J. Donelon represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Joy Hatchette (MD); Timothy N. Schott represented by Marti Hooper (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by T.J. Patton (MN); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Chaney (MS); Troy Downing represented by Mark Mattioli (MT); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Santana Edison (ND); Eric Dunning represented by Maggie Reinert (NE); Scott Kipper (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys (PA); Jon Pike represented by Tanji J. Northrup and Tomasz Serbinowski (UT); Scott A. White represented by Julie Blauvelt (VA); Kevin Gaffney represented by Anna Van Fleet (VT); Mike Kreidler represented by Todd Dixon (WA); Nathan Houdek represented by Jennifer Stegall (WI); and Allan L. McVey represented by Erin K. Hunter (WV).

1. Adopted its 2022 Fall National Meeting Minutes

Lombardo made a motion, seconded by Dixon, to adopt the Task Force’s Dec. 13, 2022, minutes (see *NAIC Proceedings – Fall 2022, Senior Issues (B) Task Force*). The motion passed unanimously.

2. Discussed the Task Force’s Plans for 2023

Commissioner Caride asked members if they had any comments regarding the materials on the possible issues and topics the Task Force may want to consider in 2023. None were heard. Commissioner Caride asked if any interested state insurance regulators or interested parties had any comments.

Bonnie Burns (California Health Advocates—CHA) said she had two issues of importance. She said the first is an issue she has raised for many years, which is the conflict between Medicare and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) rules that has led to some confusion about which system and set of rules govern eligibility for coverage, as well as how the responsibility for the payment of health care benefits for eligible individuals is determined.

Burns encouraged the Task Force to reconsider editing the *Coordination of Benefits Model Regulation* (#120). She said the exception pertaining to people who are eligible or who could be eligible for Medicare benefits is unfairly discriminatory and makes no sense. She said no one has been able to tell her where this language came from or why it was put into the model.

Burns cited a U.S. Supreme Court case, *Geissal v. Moore Medical Corp.*, 524 U.S. 74 (1998), as where this COBRA and Medicare issue may have begun. She said the Supreme Court held that an employer may not deny continuation coverage under COBRA to a qualified beneficiary who is covered under another group health plan at the time he makes his COBRA election.

Burns said the NAIC should delete the exception for Medicare Part B in Model #120, as there is no rationale for this exception in the NAIC historical record, and it unfairly penalizes and discriminates against Medicare beneficiaries. She said the action specified in the exception, “is or could have been covered” produces a result that is expressly prohibited in the same subsection for any other form of health benefits. She recommended changes to parts of Section 5D of Model #120.

Burns said the second issue is the disbanding of the Long-Term Care Insurance Model Update (B) Subgroup. She said it was disappointing that the Subgroup was disbanded, as there are products in the current marketplace that models do not address. She said the majority of products in the marketplace are now life and annuity plans with long-term care (LTC) components attached. She said these products are complicated and confusing to consumers, and agents and state insurance regulators do not know the pricing of these plans or how these benefits are being used. She said there have to be better disclosures and information about these products.

Burns also suggested that the NAIC needs to have better relationships with State Health Insurance Assistance Program (SHIP) and Senior Medicare Patrol (SMP) offices. She said the SMP was created to empower and assist Medicare beneficiaries, their families, and caregivers in preventing, detecting, and reporting health care fraud, errors, and abuse through outreach, counseling, and education. She said it would be good for state insurance regulators to get to know their SHIPs and SMPs and develop an ongoing relationship.

Commissioner Caride asked if there were any other comments. Serbinowski said the *Long-Term Care Insurance Model Act* (#640) and the *Long-Term Care Insurance Model Regulation* (#641) either need to be opened and edited or a new model needs to be created to address these combo products. He said many filings are likely in violation of laws and regulations, but nothing is being done. He said he has seen filings of life products with attained age ratings and an LTC rider attached, and these products are filed as life, but the LTC models make it clear that an attained age rating is not permissible. He also raised concerns about conversions, suitability, and the fact that the LTC models have zero language about annuities. He said these new products will come to a head within a decade in terms of payouts, and now is the time to address them; thus, this warrants the opening of the LTC models or the creation of a new model.

Commissioner Caride asked for further comments, and none were heard. She asked if anyone had any other issues or matters they wished to discuss or were seeing in their states. None were heard.

Having no further business, the Senior Issues (B) Task Force adjourned.

[SITF 2023 Spring National Minutes](#)

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

Property and Casualty Insurance (C) Committee March 24, 2023, Minutes..... 7-2  
    Catastrophe Insurance (C) Working Group and NAIC/Federal Emergency Management Agency  
    (FEMA) (C) Advisory Group March 21, 2023, Minutes (Attachment One)..... 7-8  
    Transparency and Readability of Consumer Information (C) Working Group March 15, 2023, Minutes  
    (Attachment Two) ..... 7-16  
    Amended *Nonadmitted Insurance Model Act* (#870) (Attachment Three) ..... 7-17

Draft: 4/3/23

Property and Casualty Insurance (C) Committee  
Louisville, Kentucky  
March 24, 2023

The Property and Casualty Insurance (C) Committee met in Louisville, KY, March 24, 2023. The following Committee members participated: Alan McClain, Chair, (AR); Grace Arnold, Co-Vice Chair (MN); Larry D. Deiter, Co-Vice Chair (SD); Mark Fowler (AL); Ricardo Lara represented by Ken Allen (CA); Andrew N. Mais and George Bradner (CT); Gordon I. Ito (HI); Amy L. Beard (IN); James J. Donelon (LA); Chris Nicolopoulos represented by Christian Citarella and Emily Doherty (NH); Jennifer Catechis (NM); Glen Mulready (OK); Kevin Gaffney (VT); and Allan L. McVey (WV). Also participating were: Michael Yaworsky (FL); and Jo LeDuc (MO).

1. Adopted its 2022 Fall National Meeting Minutes

Commissioner Fowler made a motion, seconded by Commissioner Arnold, to adopt the Committee's Dec. 15, 2022, minutes (*see NAIC Proceedings – Fall 2022, Property and Casualty Insurance (C) Committee*). The motion passed unanimously.

2. Adopted the Reports of its Task Forces and Working Groups

Commissioner McClain said the Cannabis Insurance (C) Working Group and the Terrorism Insurance Implementation (C) Working Group have not met this year but will do so soon. He said the Transparency and Readability of Consumer Information (C) Working Group met earlier in regulator-to-regulator session while the other Task Forces and Working Groups met prior to or at the Spring National Meeting.

Citrella said the Casualty Actuarial and Statistical (C) Task Force has been working on making the first-ever updates to the NAIC's loss cost multiplier filing forms. The Task Force has learned much since loss costs first replaced the use of rates filed by advisory organizations. The Task Force has adapted the forms to fit current rate-making methods, combined the separate forms for property/casualty (P/C) and workers' compensation into one form, and eliminated the separate expense constant supplement. Depending on the state, it may need to change regulation or legislation. For states that do not use the NAIC forms, it is still recommended they evaluate the new forms to determine if improvements can be made.

Commissioner Fowler made a motion, seconded by Commissioner McVey, to adopt the following task force and working group reports: Casualty Actuarial and Statistical (C) Task Force; Surplus Lines (C) Task Force; Title Insurance (C) Task Force; Workers' Compensation (C) Task Force; Cannabis Insurance (C) Working Group; Catastrophe Insurance (C) Working Group (Attachment One); Terrorism Insurance Implementation (C) Working Group; and Transparency and Readability of Consumer Information (C) Working Group (Attachment Two). The motion passed unanimously.

3. Adopted the Revised Model #870

Commissioner Donelon said the Surplus Lines (C) Task Force was charged with updating the *Nonadmitted Insurance Model Act (#870)* to conform to the federal Nonadmitted and Reinsurance Reform Act (NRRRA), which was part of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) of 2010. During the 2021 Summer National Meeting, the Surplus Lines (C) Task Force formally developed the Model #870 Drafting Group, which consisted of Colorado, Illinois, Louisiana, Texas, and Washington. The Drafting Group began its work on Model #870 on Aug. 19, 2021, and met 10 times over the next 19 months. The Task Force exposed a draft model three times and discussed comments on each draft. Some of the more significant

amendments dealt with the integration of the “home state” method of tax allocation and the new domestic surplus lines insurer status.

Commissioner Donelon said the Task Force adopted the amended Model #870 during its March 21, 2023, meeting.

Commissioner Donelon made a motion, seconded by Interim Superintendent Catechis, to adopt the amended Model #870 (*see NAIC Proceedings – Spring 2023, Surplus Lines (C) Task Force, Attachment One*). The motion passed unanimously.

#### 4. Heard Presentations from NIA and NAMIC on Insurance Availability and Affordability for Nonprofit Organizations

Commissioner McClain noted that the Committee has a charge related to studying the availability and affordability of liability and property insurance coverage for nonprofit organizations.

Chris Reed (Nonprofits Insurance Alliance—NIA) said NIA has a goal of making sure nonprofits have access to stable insurance coverages. He said the Nonprofit Property Protection Act (NPPA) will allow nonprofits a market-based solution for a market failure at no cost to taxpayers. He said the NPPA contains the narrowest possible language they could find to address the issue. He said NIA continuously hears from nonprofits that they were nonrenewed by admitted carriers over the past three years. He said most had no claims history that would justify nonrenewal.

Reed said the federal Liability Risk Retention Act (LRRA) only allows risk retention groups (RRGs) to offer liability insurance, and it does not allow them to offer the property and auto physical damage coverages. He said NIA receives regular appeals from nonprofits and their brokers in the 18 states they do not serve. He said thousands of nonprofits purchase specialized liability insurance, including tailored risk management services, from RRGs that the nonprofits own and govern. These nonprofits are unable to purchase property coverage on a monoline basis on a Business Owners Policy form and monoline auto physical damage (APD) they need from commercial insurance carriers. Nonprofits’ need for these coverages emerged after commercial insurance companies stopped offering nonprofits the package policies they needed (with the property and liability coverages all bundled together), and nonprofits created their own RRGs.

Reed said only a single carrier ever filed to offer the half business owners policy (BOP) and monoline APD, and only in 32 states and Washington, DC. He said it plans to stop offering that coverage, not because it has a poor claims record, but because it is changing its strategic direction. This would leave tens of thousands of nonprofits that rely on an RRG without the monoline APD and property coverage they need.

Reed said large brokers with access to all admitted markets place coverage for their nonprofit clients with RRGs because there are not admitted sources of the coverage their nonprofit clients need. An effort to remedy this problem has been repeatedly introduced by both parties in Congress as bills and discussion drafts. The latest discussion draft from the 117th Congress was circulated by U.S. Sen. Sherrod Brown (D-OH), chair of the U.S. Senate Committee on Banking, Housing, and Urban Affairs, after his office had reviewed objections that the NAIC raised.

Reed said RRGs are regulated for solvency much like multistate admitted carriers. He said, in 2014, the NAIC imposed significant additional governance standards on RRGs assuring that regulators must apply the same risk-based capital (RBC) standards on RRGs as on commercial carriers. He said state insurance regulators in all states have the same access to solvency information for both RRGs and traditionally regulated insurers. If nondomicile regulators have concerns, they may alert the domicile regulator, much like lead-state regulation. If a domicile

regulator refuses to conduct an examination of an RRG if requested, the nondomicile regulator has the authority to conduct its own examination of that RRG.

He said the total premium of RRGs that have failed after having 10 or more years' experience (the seasoning required by the NPPA) is less than \$200 million nationwide in 40 years. Under the NAIC accreditation program, RRGs, like admitted carriers, must comply with the usual quarterly and annual filing requirements imposed on P/C insurance companies, including financial statements, RBC calculations, audited statements, and actuarial opinions.

He said the NPPA includes the following additional provisions, which would apply to RRGs that would be able to offer property insurance, as well as the liability insurance they already offer: 1) property can only be provided by an RRG to a 501(c)(3) nonprofit; 2) RRGs must have a minimum of \$20 million in surplus; 3) RRGs must have operated as a liability-only RRG for at least 10 years before offering property; 4) RRGs may only offer total insurable value (TIV) limits up to \$50 million to any member; and 5) RRGs may not begin writing property in a state where a regulator has posted the names of three admitted companies writing the monoline property half BOP and auto physical damage.

Reed said an RRG cannot easily become an admitted carrier because in the mid-1990s, Congress created a special tax law to allow 501(c)(3) nonprofit charitable insurers to have the same tax status and same transparency of the nonprofits they insure. He said RRGs have the same cost of capital as admitted carriers, and RRGs pay at least the same or higher premium tax. He said the surplus lines market is not a solution because the nonprofits being nonrenewed or denied coverage outright are not unusual or high risk. They do not have claims histories or risk profiles that would justify relegating them to surplus lines.

Reed said the NPPA lets the states decide if RRGs offering property should be part of the guarantee fund. He said a study of the problem would not produce useful information because there is nobody that can provide such data. He said nonprofits have shown that they can insure the far more challenging liability risks successfully through their own RRGs. Commercial carriers have abandoned nonprofits, nonrenewing thousands of them.

Acting Commissioner Humphreys said the data call Pennsylvania conducted was largely inconclusive. He said the major issues are the rate of the liability coverage going up fairly significantly and the availability of property coverage. He said whether property coverage is available is less conclusive, and a deeper look at the market would be valuable. Acting Commissioner Humphreys said Pennsylvania also reached out to nonprofits, and some of them did not have an issue with or have a need for property coverage. He noted some states make stand-alone property coverage available through an insurer of last resort. He also said foreign RRGs do not always respond to regulator requests for information.

Reed said small nonprofits cannot find the auto physical damage coverage they need. He said NIA has hired Guy Carpenter to look at whether auto physical damage is available to pair with the liability coverage through the RRG. He said state Fair Access to Insurance Requirements (FAIR) plans are not an economical solution for nonprofits.

Commissioner McVey asked whether the RRG had issues with a fronting carrier writing auto physical damage and whether they have tried to market the coverage on the basis of a national program. Reed said most of the nonprofits they work with have small amounts of property and, therefore, a small premium. He said NIA is working through brokers, and they have not found the auto physical damage coverage.

Commissioner Donelon asked whether the nonprofits are associations or those doing charitable work. Reed said the nonprofits they work with are mostly those that represent vulnerable classes of people. He said those types of organizations have the toughest time getting coverage.

Andrew Pauley (National Association of Mutual Insurance Companies—NAMIC) said RRGs have played a role in providing insurance coverage since their inception. He said a tiny fraction of RRGs is seeking to expand its authority into property coverage by asserting there is a crisis in the market. He said NAMIC does not agree that there is a market crisis and an expansion of the LRRRA would be unnecessary and inappropriate, and it would place consumers at risk. He said NAMIC opposes the NPPA and has testified against it before Congress. He said the expansion would circumvent longstanding state insurance regulations and would create an unlevel regulatory playing field. He said the RRG regulatory regime is less rigorous and would put nonprofits at risk. Pauley said states have created more tailored and effective risk transfer mechanisms and alternative solutions.

Pauley said the LRRRA was passed in 1986 in response to a severe disruption in the commercial liability insurance market driven by litigation and oversized verdicts. He said there are nearly 2 million nonprofits in the U.S., and regulators are not seeing a demonstrable number of complaints in the marketplace. He said the NAIC has testified that there is not a crisis in the commercial property insurance market. He said NIA has said nonprofits may be at risk of losing coverage or struggle without adequate coverage, but this does not connote a lack of ability to get coverage.

Pauley said RRGs are not regulated in the same fashion as admitted carriers. RRGs write a majority of their coverage in non-domiciliary states. RRGs are not members of state guaranty funds and do not pay an assessment for any insurer failure. Pauley noted there are inherent advantages to being an RRG. He noted that outside of their domiciliary state, RRGs are not subject to financial examinations unless the domiciliary state has refused to examine the RRG. The question should not be whether the regulatory scheme is sufficient but whether it meets the rigorous standards of state-based regulation for admitted carriers.

Pauley said traditional admitted carriers do offer small and medium-sized nonprofits coverage in the form of BOPs with commercial liability and property coverage. He said manuscript policies are also available. Bundled products are indicative of good risk management and are good for the policyholder. Pauley said simply because there would be a preference for RRGs to underwrite these additional risks does not create a crisis. He said NAMIC members must make operational tradeoffs daily to compete in a highly competitive market within existing regulatory guardrails. He said RRGs can become admitted carriers.

Acting Commissioner Humphreys asked if Pauley could provide the Committee with a list of 10 companies that will write stand-alone businessowners coverage and stand-alone auto physical damage coverage. Pauley said the question allows RRGs to frame the playing field because RRGs would prefer to write the property and liability at the same time, but the admitted market is able to do that. Acting Commissioner Humphreys said he would like to see a list of insurers that write stand-alone coverage for small and medium-sized companies. Pauley said products can be found but are often bundled. Acting Commissioner Humphreys said nonprofits can currently buy the liability coverage due to the LRRRA, so the Committee might wish to look further into the issue to see what is available in the market.

##### 5. Heard from States and the NAIC About Data Sources and Uses

Commissioner McClain said the Committee has a charge to assist state insurance regulators in better assessing their markets by developing property market data intelligence. He said the previous issue looking at the availability of coverage for nonprofits exemplifies the fact that often regulators do not have readily available market data. He also noted that North Dakota recently undertook a pilot where it used blockchain technology to measure the uninsured motorist population.

Commissioner Yaworsky said Florida has a number of data collection techniques and tools it uses to be responsive to market challenges. He said a 2021 statute allows for a property claims reporting tool that collects annual data on all claims that have been closed in the prior calendar year, including the entire life cycle of the claim. He said it



includes the number and type of the policy, the ZIP code of the policy and property, names of vendors used, and dates of claims reported and closed with or without payment. He said this allows Florida to inform policymakers and consumers about trends within the market. The data allows for the identification of trends that may need to be addressed through regulatory action or legislation. He said the first set of data was due on March 1 and that aggregated reports will be released soon.

Commissioner Yaworsky said the annual reinsurance data call allows the Department of Insurance (DOI) to evaluate the adequacy of reinsurance. He said reinsurance data is paired with the capacity stress test to model catastrophe scenarios.

Commissioner Yaworsky said two catastrophe reporting forms are used to track claims-handling experience following hurricanes. The first is more basic and is immediately implemented after a storm. The second, more enhanced survey, measures how quickly claims are closed, whether they are closed without payment, and reasons for nonpayment.

LeDuc said Missouri receives data through text files or through an online submission portal. She said Missouri has a statistical unit dedicated to the data process. She said the state publishes a number of public statistical reports on various lines of business.

LeDuc said an Annual Statement, Page 19 Supplement is based on the State Page but collects at a much more granular level. The private passenger auto (PPA) data is divided between comprehensive and collision.

LeDuc said Missouri has also collected ZIP code data since 1987 for homeowners and auto and other lines since the 1990s. The data call is collected via a statutory requirement, and the data includes premium, exposure, and loss data at a ZIP code level. The data is also broken out by policy type and type of loss and is broken out by insured value ranges.

LeDuc said Missouri creates maps by ZIP code level showing the cost of auto insurance compared to uninsured motorists. Missouri has also created maps showing the number of auto insurance agents per capita to indicate availability. LeDuc said the state publishes reports showing trends related to the type of losses. She also noted Missouri is able to measure average premiums and take-up rates related to earthquake insurance in order to determine why certain counties may be underinsured.

Aaron Brandenburg (NAIC) said the NAIC has assisted states with a number of data calls in recent years. He said states collected ZIP code-level auto insurance data from statistical agents in 2019. This was only aggregated data. He said it allowed a comparison of premiums and losses to demographic data in each ZIP code, and a public report was published in 2020.

Brandenburg said in response to the COVID-19 pandemic, nearly all states issued a data call related to business interruption insurance in 2020. The data was collected through the NAIC's Regulatory Data Collection (RDC) system. The data call collected premium data by size of the policyholder, and it collected claims information on an ongoing basis from insurers. The NAIC aggregated the data and issued reports on its website, which has been helpful in understanding the size of this market and what business interruption claims looked like throughout the pandemic.

The NAIC issued an all-state data call in 2020 to collect 2018 and 2019 private flood insurance data. The data split coverages between commercial and residential, and it collected the number of policies and claims. It was transitioned to the annual statement in 2021. The data is presented through a tool on the NAIC's website so states can better understand the growth of the private flood market. Individual insurer data is reported as well.

Brandenburg said terrorism risk insurance data began being collected by states in 2016 and became a joint data call with the U.S. Department of the Treasury (Treasury Department) in 2018. It requires data to be reported by all insurers subject to the Terrorism Risk Insurance Program (TRIP). Insurers send the data to the state of New York, and the NAIC aggregates data and provides reports on the data through the Terrorism Insurance Implementation (C) Working Group at an aggregated level.

Brandenburg said states also issue post-disaster data calls on an as-needed basis. The NAIC assists many states with these data calls and is able to assist in getting the data call notice and instructions out quickly after a catastrophe. Claims data is collected on a ZIP code level, and the NAIC aggregates the data and provides analytic tools with mapping to states.

Having no further business, the Property and Casualty Insurance (C) Committee adjourned.

[SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2023\\_Spring/National Meeting](#)

Draft: 3/29/23

Catastrophe Insurance (C) Working Group  
and the NAIC/Federal Emergency Management Agency (FEMA) (C) Advisory Group  
Louisville, Kentucky  
March 21, 2023

The Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Working Group met in Louisville, KY, March 21, 2023, in joint session with the NAIC/FEMA (C) Advisory Group of the Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee. The following Working Group members participated: Chlora Lindley-Myers, Chair, represented by Cynthia Amann, Christina Dooley, Teresa Kroll, and Jo LeDuc (MO); Mike Causey, Vice Chair (NC); Kayla Erickson, Sian Ng-Ashcraft, and Shauna Nickel (AK); Brian Powell and Erick Wright (AL); Alan McClain (AR); Ken Allen, Lucy Jabourian, Michelle Lo, Opie Oyewole, Kathryn Taras, and Lynne Wehmuller (CA); George Bradner and Philip Barrett (CT); Dan Applegarth (FL); Zachary Fuentes, Lance Hirano, and Gordon I. Ito (HI); Travis Grassel (IA); Chris Hollenbeck, Jessica Lillibridge, and Levi Nwasoria (KS); James J. Donelon (LA); Jackie Horigan (MA); Joy Hatchette (MD); Andy Case (MS); Jesse Kolodin (NJ); Margaret Pena and Melissa Robertson (NM); Caleb Gruenbaum, Laura Miller, Maureen Motter, and Karen Vourvopoulos (OH); Glen Mulready (OK); Michael Drummonds and Carolyn Kalb (OR); David Buono (PA); Glorimar Santiago (PR); Beth Vollucci (RI); Lindsay Chaffin and Dominic Rovelli (SC); Tony Dorschner (SD); Carter Lawrence (TN); Marianne Baker, J'ne Byckovski, Nicole Elliott, Eric Hintikka, Taryn Lam, Shawn Martin, Elisabeth Ret, and Matthew Richard (TX); and David Forte and Matt Stoutenberg (WA). The following Advisory Group members participated: Glen Mulready, Chair (OK); Carter Lawrence, Vice Chair (TN); Kayla Erickson, Sian Ng-Ashcraft, and Shauna Nickel (AK); Brian Powell and Erick Wright (AL); Ken Allen, Lucy Jabourian, Michelle Lo, Opie Oyewole, Kathryn Taras, and Lynne Wehmuller (CA); George Bradner and Philip Barrett (CT); Dan Applegarth (FL); Patrick O'Connor (IN); Chris Hollenbeck, Jessica Lillibridge, and Levi Nwasoria (KS); James J. Donelon (LA); Joy Hatchette (MD); Cynthia Amann, Christina Dooley, Teresa Kroll, and Jo LeDuc (MO); Margaret Pena and Melissa Robertson (NM); Michael Drummonds and Carolyn Kalb (OR); Dan Bumpus, William Christian, Rebecca Nichols, Marly Santoro, and Garth Shipman (VA); and David Forte and Matt Stoutenberg (WA). Also participating were: Linda Grant (IN); Paige Dickerson (MI); Phil Vigliaturo (MN); Fred Fuller and Timothy Johnson (NC); Kelly Christensen and Tracy Klausmeier (UT); Vanessa Richards (VI); Michael Erdman and Christina Keeley (WI); and Tracy McEwen and Lela Ladd (WY).

1. Adopted its 2022 Fall National Meeting Minutes

Bradner made a motion, seconded by Buono, to adopt the Working Group's Dec. 12, 2022, minutes (*see NAIC Proceedings – Fall 2022, Property and Casualty Insurance (C) Committee, Attachment Two*). The motion passed unanimously.

2. Heard an Update on Federal Legislation

Shana Oppenheim (NAIC) provided an update on federal legislation. The National Flood Insurance Program's (NFIP's) latest extension expires Sept. 30. FEMA recently released data showing a 36% decline in the number of reinsurers participating in the NFIP's reinsurance program as compared to the prior year. According to FEMA, the NFIP's traditional reinsurance placement is indicative of a hard market condition in the catastrophe space and the challenges of securing coverage. Such a decline could also suggest that some notable insurers decided not to write NFIP policies this year or were reluctant to offer these policies at the necessary pricing level.

On March 10, the U.S. House of Representatives (House) Financial Services Subcommittee on Housing and Insurance, led by Chairman Warren Davidson (R-OH), held a hearing entitled, "How Do We Encourage Greater Flood Insurance Coverage in America?"

Republicans were focused on encouraging the private flood insurance market uptake, especially in regions outside of the flood maps, where they believe 20% of floods are occurring. They also expressed interest in examining federal regulatory barriers to private flood insurance. The Democrats wanted a bipartisan, long-term NFIP reauthorization. Notably, the NFIP has had 25 short-term reauthorizations since 2017. Democrats also focused on flood as not just a financial or insurance industry issue, but as an equity, diversity, and inclusion industry issue, as well as encouraging private flood insurance.

U.S. Sen. John Kennedy (R-LA) and U.S. Rep. Blaine Luetkemeyer (R-MO) have introduced bills tackling Risk Rating 2.0 flood insurance affordability and reauthorization.

### 3. Received an Update on the Primer Progress

Amann provided an update on the *Catastrophe Modeling Primer* (Primer). The Primer will replace the NAIC's *Catastrophe Computer Modeling Handbook*. The drafting group has met several times and continues to make progress. Sections that are currently drafted include: 1) Purpose of the Primer; 2) Background Information on Catastrophe Modeling; 3) What is a Catastrophe Model?; 4) Why Use a Catastrophe Model?; 5) Model Components; 6) Key Metrics; and 7) Regulator's Perspectives.

Amann said the Primer is meant to be a regulatory tool to help state insurance regulators understand catastrophe modeling.

The drafting group will meet following the Spring National Meeting to continue its drafting work.

### 4. Heard Updates Regarding the Activities of State and FEMA Regional Workshops

Commissioner Mulready provided updates on the activities of the state and regional FEMA workshops. FEMA Region 1 will meet in Maynard, MA, on the afternoon of May 22 and all day on May 23. Virtual participation will be available for anyone in FEMA Regions 2 or 3 who would like to see how these meetings are conducted, as well as the topics covered. These regions will hold in-person workshops later.

The purpose of these NAIC/FEMA workshops is to help departments of insurance (DOIs) form relationships with their FEMA partners. Oklahoma hosted a workshop for FEMA Region 6 last year and found it to be helpful.

### 5. Heard a Presentation from the Midland Radio Corporation on the NWR

Bruce Jones (Midland Radio Corporation) said the National Oceanic and Atmospheric Administration (NOAA) Weather Radio (NWR) is essentially an indoor tornado siren. The National Weather Service (NWS) started a Weather-Ready Nation Ambassador program. Currently, there are 16,000 Weather-Ready Nation (WRN) Ambassadors. These WRN Ambassadors include businesses, churches, and other groups. The WRN Ambassadors are required to have a plan in place for their organization and staff, including identifying safe places in case of a weather-related event. WRN Ambassadors also teach their staff the principles of weather safety.

Jones said to become a WRN Ambassador, a business or other group can contact their local NWS office and volunteer to become a WRN Ambassador to promote weather safety, preparedness, and resiliency. Every state has a weather awareness week. State insurance regulators could send out a message during the designated week that illustrates weather preparedness.

Jones said one of the main messages from the NWS is that everyone needs to have multiple and redundant ways to receive lifesaving alerts. The NWS is the best in the world at alerting people to severe weather. The six ways

you can receive a warning include: 1) the NWR; 2) local television and radio; 3) wireless emergency alerts and weather apps; 4) outdoor sirens; 5) the *mobile.weather.gov* website; and 6) from your friends, family, and neighbors.

Outdoor warning sirens were created in the 1950s and 1960s, and they could be heard when people had their windows open in the spring and summer. Warning sirens are not meant to be heard inside and wake people up. Hearing a tornado siren is a signal to get indoors and seek additional information. When warning sirens stop, it does not mean the severe weather threat is over. Additionally, the outdoor warning sirens are activated by city or county officials and not the NWS.

If a cell phone tower is destroyed your cell phone will not be able to provide an alert to you. The NWR network is made up of over 1,000 transmitters that send a signal to 95% of the U.S. population. The weather radio is the quickest and most direct way to receive alerts, as the alert goes to the NWR first. The order of alerts are as follows: 1) the NWR; 2) the emergency alert system, which includes television and radio stations; 3) cell phone or wireless emergency alerts; and 4) emergency managers who then send out reverse 911 phone calls or set off their outdoor sirens. The average tornado warning lead time for the NWS is 13 minutes if it receives the warning.

FEMA's Hazard Mitigation Grant Program (HMGP) normally covers up to 75% of the cost of weather radios; however, this year, the HMGP covers 90%. The money is given to states in the aftermath of any presidentially declared disaster, and any county in the state can apply for some of this money regardless of whether their county was included in a weather disaster. The grant must be applied for by the state's emergency management agency. State insurance regulators can remind their emergency management agencies of the HMGP grant and encourage them to apply for it.

Commissioner Mulready asked how long a state has to apply for an HMGP grant. Jones said he believes a state has two years following the presidentially declared disaster to apply for the grant. The state emergency managers control the money and pass it out. Some of the money is also used to build public storm shelters.

Grassel asked if alerts on a cell phone from the NWS are received as quickly as by weather radio. Jones said there has been a failure of the alerting system on cell phones and reverse 911 calls in the past; however, the NWR stayed on the air.

Grassel said in Iowa, it is often challenging to know when a tornado is going to hit. He asked if there is a way to adjust the areas in which the weather radio provides warnings. Jones said the weather radio can be adjusted to just receive a warning pertaining to a particular county or even parts of a county.

#### 6. Held a Panel Discussion on Personal Lines Deductible Trends

Amann said prior to the 2022 Fall National Meeting, the NAIC sent a survey to the states regarding deductibles for homeowners insurance. The Working Group received survey responses from 30 states. Almost half (45%) of the 30 states answering the survey indicated that they are seeing separate roof deductibles in their state. The survey also indicated that at least four non-coastal states are seeing the use of percentage deductibles in their state. While these states are not directly tracking this information, they are noticing an uptick in their complaint data.

Due to the increased severity of storms, the Working Group heard a panel discussion on personal lines homeowners deductible trends due to deductible changes states are seeing. The property/casualty (P/C) market is hardening, causing impacts across all lines of business; however, the focus of the panel was on homeowners insurance. Amann asked the Working Group to think about the impacts across all lines of insurance, including health insurance.

The panel included Amann as moderator, Amy Bach (United Policyholders—UP), David F. Snyder (American Property Casualty Insurance Association—APCIA), and Julia Dreier (MN).

Snyder said the APCIA appreciates the concerns that consumers and state insurance regulators have, as well as the concerns of the insurers the APCIA represents. The term “polycrisis” is defined as a simultaneous occurrence of several catastrophic events, which has been occurring in the U.S.

Snyder indicated that one negative factor includes inflation, which has increased the cost of materials and labor needed to reconstruct homes and businesses. Costs have remained elevated since the beginning of the COVID-19 pandemic. The price of construction materials for a single-family residential home rose by 33.9%. Snyder said the APCIA has seen the deterioration of the combined ratio, as well as an increase in the cost of capital.

Snyder said a second negative factor is made up of natural catastrophe losses and costs. 2022 was the eighth year in a row that the U.S. suffered at least 10 catastrophes causing over \$1 billion in losses. Natural disaster losses from 2020 through 2022 in the U.S. exceeded \$275 billion. Additionally, the U.S. incurred 75% of the global insured losses in 2022. Costs rise from the incidents themselves, as well as the patterns of development and the related costs to deliver the benefits.

Snyder indicated that a third negative factor involves the hardening of the reinsurance market and political polarization.

Snyder said deductibles have been around in one form or another for decades. Deductibles are intended to do two things: 1) provide consumers the ability to manage their risks in a way that works best for them; and 2) make the risk more manageable from the perspective of the insurance industry. Deductibles are currently changing, as they have in the past. It is a competitive market in which each insurer is trying to manage its risks. Snyder said state insurance regulators must decide the appropriateness of the various types of deductibles.

Snyder reiterated that the purpose of the deductibles is, first and foremost, to allow consumers more choice in their ability to manage risk while also providing the insurer the ability to manage its risk while maintaining solvency.

Bach said UP is a national consumer group that does a lot of education and recovery support. Insurance is intended to indemnify the policyholder in the event of a loss. Bach mentioned that the use of percentage deductibles, split deductibles, hail deductibles, etc. brings about a complexity that is challenging for consumers.

Bach said UP was formed because many people who had earthquake damage following the 1989 Loma Prieta, CA, earthquake received estimates that fell just below the \$10,000 deductible and, therefore, did not receive any money toward their loss. She said in the past, consumer advocates advised consumers that the best way to lower the cost of an insurance policy is to increase the deductible. However, that advice was based on the deductible being a flat deductible. However, with percentage deductibles, there is a calculation involved that consumers do not always understand.

Bach said she could understand that insurers see the percentage deductible as risk-sharing, but she does not believe consumers think of it in this way. She indicated that there are at least 19 states with percentage deductibles. She said it is now difficult to tell consumers to increase their deductible to try and save money, as some policyholders are seeing multiple deductibles. For example, they see one for the roof and one for the home.

Dreier said in 2022, Minnesota was hit by six weather disasters exceeding \$1 billion in property damage. Minnesota ranked third in the nation last year for reports of severe hail, following behind only Texas and Nebraska.

Dreier said Minnesota has seen an unprecedented number of rate increases, as they have already seen close to 30 rate increases over 25% this year, keeping in mind that we are only three months into 2023. Since 2020, Minnesota has seen a 55% increase in homeowners insurance complaints. Many of these complaints are from policyholders who are concerned about coverage, denials, and unexpectedly high out-of-pocket costs following damage, particularly from wind and hailstorms.

Dreier said the DOI wants to determine how it can lower overall costs. Borrowing a phrase used by Wisconsin, she said it is cheaper to pre-cover than recover from storm damage. She said Minnesota is proposing to strengthen homes in the state by reducing risk exposure through mitigation. She said Minnesota's proposal would couple grants to retrofit homes with premium reductions and homeowners insurance. This program would require grant recipients to work with contractors trained in the fortified standards, which are based on research by the Insurance Institute for Business and Home Safety (IBHS).

Dreier said Minnesota is also considering the best way to ensure its consumers understand what their policies mean and say, providing an opportunity to work with consumer groups and the insurance industry.

Amann asked Bach what UP is seeing from the consumers' perspective regarding the understanding of their deductibles. She said the American Academy of Actuaries (Academy) recently released a paper about the math of deductibles. The paper addresses deductibles across all lines of business. Bach said consumers have a difficult time understanding deductibles, especially percentage deductibles. She said when a consumer reads an insurance policy, there are many footnotes regarding what will be covered and how much a policyholder will be paid.

Amann said consumers also do not understand that basic maintenance is the responsibility of the policyholder. For example, a policyholder is not going to get a roof replaced just because there was a hailstorm. There may be a problem with the roof.

Amann asked if there is more that needs to be done to help a policyholder understand their insurance policy or if it is sufficient to just tell the policyholder to read their policy and/or declarations page to understand their coverage.

Bach said while she understands the reasoning of the insurer, it is not sufficient to tell the policyholder to read their policy to know what is covered. She believes that oftentimes, at renewal, policyholders are seeing premium increases and are looking for ways to save money on their premiums. She said policyholders do not always understand what will be paid in the event of a loss. She said percentage deductibles are more difficult for consumers to understand than flat deductibles. Bach said insurers have more advanced technology to ascertain the condition of homes than they had in the past, and she is seeing more focus on the condition of the home during claim settlement. She said UP is hearing a lot of reports of insurers denying claims on the basis of wear and tear. She said additionally, insurers have been taking a hard line on the time between when a policyholder observes damage and when they report the damage when deciding if they will pay a claim.

Dreier said the reasons behind implementing building codes are to help buildings better weather storms and minimize the overall risk for individuals. She said Minnesota's proposal would hopefully provide for lower premiums overall, as well as less damage.

Snyder said he believes everyone is struggling with the general public's perception of risk. It is difficult for the government to get the public focused on risk, a challenge for insurers to explain risk and urge consumers to purchase the right type of coverage, and a challenge for consumers to understand the insurance they purchase. The purchase of insurance is not a simple purchase. A policyholder's home includes a variety of variables, such as a roof; a heating, ventilation, and air conditioning (HVAC) system; siding; where the home is located; etc. Snyder

said the question is how insurers can assist consumers in understanding all the variables and make intelligent decisions regarding the best coverage the consumer can afford.

Snyder said he believes insurers are providing good descriptions of deductibles for consumers. He said consumers must want to read the descriptions and better understand the insurance product. He suggested that state insurance regulators work with consumer advocates to come up with questions consumers ought to ask when purchasing a homeowners policy. The NAIC has worked on a *Homeowners Shopping Tool* that provides questions for a homeowner to ask when purchasing a policy. This tool likely needs to be updated with some questions added regarding the understanding of deductibles.

Snyder said there have been changes in the weather that are causing increased volatility, as well as developing homes and businesses in areas that should not have been developed. He said the APCA produced a paper indicating that there are gaps in consumer understanding, and the more complex the product, the more gaps will exist.

Amann asked Dreier if consumers understand a roof claim due to a storm versus a catastrophic event. Dreier said she believes consumers understand more than we give them credit for in many cases. She said as a state insurance regulator, she thinks about what a DOI can do to make sure information is easily accessible to the consumer to inform them about what they are buying and how to best use their insurance coverage. She said this is a difficult task because there is so much variability in the market. She said some consumers understand, and others do not.

Amann asked Bach if she believes there are ways to improve the process of informing the consumer regarding the dollar amount they are ultimately responsible for paying. Bach said high deductibles, multiple deductibles, and percentage deductibles have created more confusion. She said it is still part of UP's standard outreach to make informed decisions and tell consumers to think about their funding plans for repairs that will not be covered if they choose to increase their deductibles.

Bach said she would like to understand more about why insurers are more inclined to raise deductibles than to cap coverage like the NFIP and guaranty associations do. She asked why policyholders are not just told the highest dollar amount the property will be insured for in case of a loss instead of cutting the coverage out on the lower end if the bigger concern is the exposure and these are catastrophic claims.

Snyder said he believes insurers try to tailor the coverage and compete in the market in the best way they can. He said they are not all going to do things the same way. He said he believes insurers see the deductible changes giving them the ability to offer some coverage. He said it is a way for insurers to stay in the market and push toward more high-end coverage, more of what is called the expensive early lower dollars, which is the amount the consumer picks up.

Amann asked how a DOI can encourage insurers to either write more coverage or modify the coverage they offer. Dreier said there is no magic bullet, but she believes the difference being seen in many cases is an effort by several insurers to try and make a product that is more affordable and usable for policyholders.

Commissioner Donelon said he tells consumers to self-insure for whatever they can afford. He said Citizens had a 2% named storm deductible in Louisiana in 2008 after Hurricane Katrina. When Hurricane Gustav went through Baton Rouge, LA, which had been spared by Hurricanes Katrina and Rita, many of the homeowners were not aware that they had the 2% deductible. Insurers then raised deductibles from 2% to 3% to 5%. As the deductibles grew, coverage shrunk. Commissioner Donelon said the deductible is a vehicle around the limitation Louisiana has on insurers from coming and going on coastal exposure and other exposures they no longer want to cover. He



encouraged insurers not to use the split roof deductible because when you are pricing out repairs, this adds more math confusion.

Commissioner Lawrence asked Bach if it would help if the stated amount of the percentage deductible is put on the declarations page if the math is what is confusing the policyholders. Bach said she believes this is important because the policyholder will know the amount of money they will have to pay out of pocket in the event of a claim. She said insurers have always used the argument that a deductible is put into place to help eliminate fraud. She said risk-sharing is having a deductible where the policyholder has a pre-defined deductible, such as \$5,000. Risk-shifting is when most of the losses a policyholder experiences are paid by the policyholder, which she believes is occurring with high percentage deductibles, etc. She said she believes collaborative work amongst the state insurance regulators, such as work resulting in a model law, is timely and required.

Snyder said the market is different today than it was 20 years ago. There have been negative effects from inflation, weather volatility, weather patterns, etc. Some of these negative effects are due to not having up-to-date building codes, and others are due to weather volatility. Snyder said insurers want to sell insurance and take on risk, but they also must manage the risk to maintain their own solvency. Insurers are managing risk in different ways. Snyder said he believes the insurance industry and state insurance regulators need to work together to figure out how to help consumers better understand their risk and what actions to take to reduce risk.

Commissioner Lawrence asked Bach about claims being denied due to the duration of time that passes before a claim is filed. He asked if that is happening within the policy's duration. Bach said she was referring to insurers saying the damage was due to deferred maintenance. An example of this would be an insurer saying the policyholder should have known to take a tree down. Bach said insurers have more technology available now; therefore, they know the condition of a property prior to a claim being filed. She said there are more losses denied due to deferred maintenance, and these losses are not viewed as sudden and accidental.

Nwasoria asked if there is a way state insurance regulators can work with insurers to provide a premium reduction for policyholders that have brought their property up to the current code. Dreier said the insurance community in Minnesota has been engaging in conversations with the DOI regarding premium reductions for mitigation. Snyder believes progress is being made, as there is more community engagement

Nwasoria asked if there is a way to get insurers to visit a home and inform the property owner of the things they can do to improve the insurability of their property. Snyder said he believes improvements in technology, such as the use of drones, may offer a way to make this happen. Bach said there are some important NAIC workstreams looking at ways to provide policyholders with incentives to mitigate damage.

Commissioner Lawrence asked how lenders felt about high deductibles and percentage deductibles. Bach said UP has been working with the Federal National Mortgage Association (FNMA) on a project to improve options for insuring manufactured homes. UP has had conversations with the Federal Reserve Bank about its concern regarding collateral not being insured to replacement value due to the new exclusions they are seeing, as well as higher deductibles. Bach believes the Federal Insurance Office (FIO) is trying to conduct a data call due to the collateral issue.

Amann reminded the Working Group that there are several other NAIC working groups, task forces, and committees experiencing overlap concerning the issues discussed in the panel.

## 7. Discussed Other Matters

Amann asked Working Group members to contact NAIC staff if they wish to see the homeowners survey results.

Amann said in October, Missouri will be hosting the Earthquake Summit tentatively scheduled to be held in St. Louis, MO. There will be seismic experts, disaster preparedness, and response teams presenting at the Summit

Having no further business, the Catastrophe Insurance (C) Working Group and the NAIC/FEMA (C) Advisory Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/C/Catastrophe/Minutes – Joint Meeting CAT\_FEMA.docx

Draft: 3/15/23

Transparency and Readability of Consumer Information (C) Working Group  
E-Vote  
March 15, 2023

The Transparency and Readability of Consumer Information (C) Working Group of the Property and Casualty Insurance (C) Committee conducted an e-vote that concluded March 15, 2023. The following Working Group members participated: Ken Allen (CA); Bobbie Baca (CO); George Bradner (CT); Julie Rachford (IL); Chris Hollenbeck (KS); Ron Henderson (LA); Carrie Couch (MO); Cuc Nguyen (OK); Rachel Chester (RI); Jennifer Ramcharan (TN); and Marianne Baker (TX).

1. Adopted its 2022 Fall National Meeting Minutes

The Working Group considered adoption of its Nov. 15, 2022, minutes.

A majority of the Working Group members voted in favor of adopting its Nov. 15, 2022, minutes (*see NAIC Proceedings – Fall 2022, Property and Casualty Insurance (C) Committee, Attachment Four*). The motion passed.

Having no further business, the Transparency and Readability of Consumer Information (C) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/2023 NAIC Meetings/Spring National Meeting/Committee Meetings/PROPERTY and CASUALTY INS (C) COMMITTEE/Transparency/0315 Transparency Minutes.docx

NAIC Model Laws, Regulations, Guidelines and Other Resources—March 2023

Draft 3/21/23

**Adopted by the Surplus Lines (C) Task Force, March 21, 2023****NONADMITTED INSURANCE MODEL ACT****Table of Contents**

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**Section 1. Short Title**

This Act shall be known and may be cited as “The Nonadmitted Insurance Act.”

**Section 2. Purpose—Necessity for Regulation**

This Act shall be liberally construed and applied to promote its underlying purposes which include:

- A. Protecting persons seeking insurance in this state;
- B. Permitting surplus lines ~~insurance~~ insurance to be placed with reputable and financially sound nonadmitted insurers and exported from this state pursuant to this Act;
- C. Establishing a system of regulation which will permit orderly access to surplus lines insurance in this state and encourage admitted insurers to provide new and innovative types of insurance available to consumers in this state;
- D. Providing a system through which persons may purchase insurance other than surplus lines insurance, from nonadmitted insurers pursuant to this Act;
- E. Protecting revenues of this state; and
- F. Providing a system pursuant to this Act which subjects nonadmitted insurance activities in this state to the jurisdiction of the insurance commissioner and state and federal courts in suits by or on behalf of the state.

**Section 3. Definitions**

As used in this Act:

- A. “Admitted insurer” means an insurer licensed to ~~do engage in~~ ~~an~~ the business of insurance ~~business~~ in this state.
- B. “Affiliate” means, with respect to an insured, any entity that controls, is controlled by, or is under common control with the insured.
- C. “Affiliated group” means any group of entities that are all affiliated. “Capital,” as used in the financial requirements of Section 5, means funds paid in for stock or other evidence of ownership.

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~~D~~E. “Commissioner” means the insurance commissioner of [insert name of state], or the commissioner’s deputies or staff, or the ~~c~~ommissioner, ~~d~~irector or ~~s~~uperintendent of ~~i~~nsurance in any other state.

**Drafting Note:** Insert the title of the chief insurance regulatory official wherever the term “commissioner” appears.

E. “Control” means with respect to an insured:

(1) A person, either directly or indirectly, or acting through one or more other persons, owns, controls, or has the power to vote 25 percent or more of any class of voting securities of the other entity; or

(2) The entity controls in any manner the election of a majority of the directors or trustees of the other entity.

F. [OPTIONAL: ~~“Domestic surplus lines insurer” means a surplus lines insurer domiciled in this state, that which may write insurance in this state on as if it were a surplus lines insurer basis domiciled in another state.~~]

G. “Eligible surplus lines insurer” means a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance pursuant to Section 5 of this Act.

H. “Exempt commercial purchaser” means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

(1) ~~n~~H~~as paid aggregate nationwide commercial property and casualty insurance premiums in excess of \$100,000 in the immediately preceding 12 months; and:~~

(2) (a) ~~The person m~~Meets at least one+ of the following criteria:

(i) ~~The person P~~ossesses a net worth in excess of \$20,000,000;:

(ii) ~~The person G~~enerates annual revenues in excess of \$50,000,000;:

(iii) ~~The person E~~mploys more than 500 full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate;:

(iv) ~~The person I~~s a not-for-profit organization or public entity generating annual budgeted expenditures of at least \$30,000,000; or:

(v) ~~The person i~~s a municipality with a population in excess of 50,000 persons.

(b) Effective on July 21, 2010, every five years and each fifth January 1 occurring thereafter on January 1, the amounts in subsections Items (i), (ii), and (iv) of Subparagraph Section 3H(32)(a) of this Paragraph shall be adjusted to reflect the percentage change for such five- year period in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the Department of Labor.

**Drafting Note:** This definition of “Exempt commercial purchaser” follows the language of the federal Nonadmitted and Reinsurance Reform Act (NRRA). Some states have chosen not to adopt the inflation adjustment. The NRRA uses the term “municipality,” which some states may find limiting. States may choose to use terminology consistent with state law to expand this provision to include counties and other public entities.

~~E~~I. “Export” means to place surplus lines insurance with a nonadmitted insurer.

~~F~~. “Foreign decree” means any decree or order in equity of a court located in any United States jurisdiction, including a federal court of the United States, against any person engaging in the transaction of insurance in this state.

J. “Home state,” ~~means~~with respect to an insured, means:

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- (1) The state in which an insured maintains its principal place of business or, in the case of a natural person, the person’s principal place of residence;
- (2) If 100 percent of the insured risk is located out of the state referred to in ~~subParagraph (1)~~Section 3J(1), the state to which the greatest percentage of the insured’s taxable premium for that insurance contract is allocated; ~~or~~
- (3) If the insured is an affiliated group with more than one member listed as a named insured on a single nonadmitted insurance contract, the home state is the home state of the member of the affiliated group that has the largest percentage of premium attributed to it under the insurance contract. ~~or~~
- ~~(4) [Option 1] In the case of an unaffiliated group policy:~~
- ~~(a) If a group policyholder pays 100% of the premium from its own funds, then the home state is determined according to paragraphs (1) and (2);~~
- ~~(b) If a group policyholder does not pay 100% of the premium from its own funds, then the home state is determined according to paragraphs (1) and (2) for each member of the group;~~
- ~~[Option 2] In the case of an unaffiliated group policy, the home state shall be the home state of the group policyholder as determined by the application of paragraphs (1) and (2);~~

Comment: The NRRA definition of “home state” includes ~~S~~subsections ~~Paragraphs~~ (1), (2), and (3) of Section 3J. The NRRA definition does not expressly cover unaffiliated groups. States have taken different approaches to the taxation of unaffiliated group policies. Some states tax based on the “home state” of the group member or certificate holder under the unaffiliated group policy. Some states assess tax on the “home state” of the person that pays the premium. Not all states have an express provision to address unaffiliated group policies. ~~The Drafting Group could not arrive at language to address each possibility and opted to omit it from the Model, such as risk purchasing groups model language contains two options for addition of that are expressly covering unaffiliated groups treating the members of such a group as individual insureds for purposes of placement and taxation.~~

- ~~K. “Insurer” means any person, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, insurance exchange syndicate, fraternal benefit society, and any other legal entity engaged in the business of insurance.~~
- ~~H. “Kind of insurance” means one of the types of insurance required to be reported in the annual statement which must be filed with the commissioner by admitted insurers.~~
- ~~K. “Nonadmitted insurance” means any insurance written on properties, risks or exposures, located or to be performed in this state, by an insurer not licensed to engage in the ~~transaction~~business of insurance in this state [or a domestic surplus lines insurer].~~
- ~~L.I. “Nonadmitted insurer” means an insurer not licensed to ~~do an~~engage in the ~~transaction~~business of insurance ~~business~~ in this state but does not include a risk retention group pursuant to the federal Liability Risk Retention Act of 1986.~~
- ~~M.J. “Person” means any natural person or ~~other business~~ entity, including, but not limited to, individuals, partnerships, associations, trusts or corporations.”~~
- ~~N. “Premium” means any payment made as consideration for an insurance contract.~~
- ~~N.O. “Principal place of business” means:~~

- ~~(1) The state where a person maintains its headquarters and where the person’s high-level officers direct, control, and coordinate ~~the~~ business activities; or~~
- ~~(2) If the person’s high-level officers direct, control, and coordinate the business activities in more than one state, or if the person’s principal place of business is located outside any state, then it is the state~~

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to which the greatest percentage of the person's taxable premium for that insurance contract is allocated.

PO. “Principal residence” means:

(1) The state where the person resides for the greatest number of days during a calendar year; or

(2) If the person's principal residence is located outside any state, the state to which the greatest percentage of the person's taxable premium for that insurance contract is allocated.

“State” includes any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Northern Mariana Islands, the Virgin Islands, and American Samoa. K. “Policy” or “contract” means any contract of insurance, including but not limited to annuities, indemnity, medical or hospital service, workers' compensation, fidelity or suretyship.

L. “Reciprocal state” means a state that has enacted provisions substantially similar to:

(1) Sections 5F, 5I(5), 5Q(10), 5R(4) and Section 6; and

(2) The allocation schedule and reporting form contained in [cite the regulation on surplus lines taxation].

M. “Surplus,” as used in the financial requirements of Section 5, means funds over and above liabilities and capital of the company for the protection of policyholders.

Q.R.N. “Surplus lines insurance” means any property and casualty insurance in this state on properties, risks or exposures, located or to be performed in this state, permitted to be placed through a surplus lines licensee with an nonadmitted insurer-eligible surplus lines insurer to accept such insurance, pursuant to Section 5 of this Act.

Drafting Note: If a state chooses to adopt the alternative Section 5B, this definition of “surplus lines insurance” should be consistent with the acceptable coverage listed in Section 5B. States may choose to extend the definition of “surplus lines insurance” beyond property/casualty insurance. NAIC.

RS. “Surplus lines insurer” means a nonadmitted [or domestic surplus lines] insurer that is eligible to accept the placement of surplus lines insurance pursuant to Section 5 of this Act.

STO. “Surplus lines licensee” means any person individual, firm or corporation licensed under Section 5 of this Act to place surplus lines insurance on properties, risks or exposures located or to be performed in this state with an nonadmitted insurers-eligible surplus lines insurers to accept such insurance.

TU. “Taxable premium” means any premium less return premium that is not otherwise exempt from tax pursuant to this Act. [OPTIONAL: ++Premium on property risk or exposure that is properly allocated to federal or international waters or is under the jurisdiction of a foreign government is not taxable in this state.]

UVS. “Transaction of insurance”

(b) (1) For purposes of this Act, any of the following acts in this state effected by mail or otherwise by a nonadmitted insurer or by any person acting with the actual or apparent authority of the insurer, on behalf of the insurer, is deemed to constitute the transaction of an insurance business in or from this state:

(a) The making of or proposing to make, as an insurer, an insurance contract;  
(b) The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety;

(c) The taking or receiving of an application for insurance;

(d) The receiving or collection of any premium, commission, membership fees, assessments,

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dues or other consideration for insurance or any part thereof;

- (e) The issuance or delivery in this state of contracts of insurance to residents of this state or to persons authorized to do business in this state;
  - (f) The solicitation, negotiation, procurement or effectuation of insurance or renewals thereof;
  - (g) The dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, the fixing of rates or investigation or adjustment of claims or losses or the transaction of matters subsequent to effectuation of the contract and arising out of it, or any other manner of representing or assisting a person or insurer in the transaction of risks with respect to properties, risks or exposures located or to be performed in this state;
  - (h) The transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of the statutes relating to insurance;
  - (i) The offering of insurance or the transacting of insurance business; or
  - (j) Offering an agreement or contract which purports to alter, amend or void coverage of an insurance contract.
- (2) The provisions of this subsection shall not operate to prohibit employees, officers, directors or partners of a commercial insured from acting in the capacity of an insurance manager or buyer in placing insurance on behalf of the employer, provided that the person’s compensation is not based on buying insurance.
- (3) The venue of an act committed by mail is ~~at the point~~location where the matter transmitted by mail is delivered or issued for delivery or takes effect.

**Drafting Note:** States may need to alter this subsection to reflect their decision as to whether they intend to permit citizens to directly purchase coverage within the state from a nonadmitted insurer, or if self-procurement of coverage will be permitted only when it occurs outside the state. States electing to allow direct procurement will need to insert an appropriate exemption in Section 4A of this Act. Additionally, states should consider whether the preceding definition of “transaction of insurance” is consistent with other statutory definitions of this phrase in the state. Finally, states may want to consider whether group insurance purchases or the maintenance of insurance books and records in this state should fall within the scope of the definition of “transaction of insurance.”

~~Q. “Type of insurance” means coverage afforded under the particular policy that is being placed.~~

~~VI.~~ “Wet marine and transportation insurance” means:

- (1) Insurance upon vessels, crafts, hulls and other interests in them or with relation to them;
- (2) Insurance of marine builder’s risks, marine war risks and contracts of marine protection and indemnity insurance;

~~(1)(3)~~ Insurance of freight and disbursements pertaining to a subject of insurance within the scope of this subsection; and

~~(2)~~

~~(4)~~ Insurance of personal property and interests therein, in the course of exportation from or importation into any country, or in the course of transportation coastwise or on inland waters, including transportation by land, water or air from point of origin to final destination, in connection with any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any incidental delays, transshipment, or reshipment; provided, however, that insurance of personal property and interests therein shall not be considered wet marine and transportation insurance if the property has:



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- (a) Been transported solely by land; or
- (b) Reached its final destination as specified in the bill of lading or other shipping document; or
- (c) The insured no longer has an insurable interest in the property.

**Comment:** The language added in 1994 to the end of the definition of “wet marine and transportation insurance” {Subparagraphs 4(a), 4(b), and 4(c)} is intended to clarify the scope of the definition, which ultimately affects the exemption of certain risks from this Act. The 1994 amendments address current regulatory concerns and concerns raised by those who drafted the 1983 amendments to the Model Surplus Lines Law. The 1983 drafters wrote: “Several [drafters] felt the term ‘storage’ should not appear in... [the wet marine definition] to ensure that warehousemen and other types of insurance covering risks of storage are not interpreted to be within the purview of this definition. The term ‘delays’ is sufficiently broad to cover temporary storage while in the course of transit.”

**Drafting Note:** In addition to the definitions provided in this section, individual states may wish to consider adopting definitions for “agent,” “broker” or “producer” in a manner consistent with its other laws. Additionally, states may want to cross-reference the definition of “insurance” as it appears elsewhere in the state insurance code. The definition of insurance should reach illegal unauthorized activities.

#### Section 4. Placement of Insurance Business

- A. An insurer shall not engage in the transaction of insurance unless authorized by a license in force pursuant to the laws of this state, or exempted by this Act or ~~otherwise exempted by~~ the insurance laws of this state.
- B. A person shall not ~~directly or indirectly~~ engage in a transaction of insurance ~~with or on behalf of or shall in this state directly or indirectly act as agent for, or otherwise represent or aid on behalf of another, a nonadmitted insurer in this state, in the solicitation, negotiation, procurement or effectuation of insurance, or renewals thereof, or forwarding of applications, or delivery of policies or contracts or inspection of risks, or fixing of rates, or investigation or adjustment of claims or losses, or collection or forwarding of premiums, or in any other manner represent or assist the insurer in the transaction of insurance.~~
- C. A person who represents or aids a nonadmitted insurer in violation of this section shall be subject to the penalties set forth in Section 7 of this Act. No insurance contract entered into in violation of this section shall preclude the insured from enforcing his rights under the contract in accordance with the terms and provisions of the contract of insurance and the laws of this state, to the same degree those rights would have been enforceable had the contract been lawfully procured.
- D. If the nonadmitted insurer fails to pay a claim or loss within the provisions of the insurance contract and the laws of this state, a person who assisted or in any manner aided directly or indirectly in the procurement of the insurance contract, shall be liable to the insured for the full amount under the provisions of the insurance contract.
- E. Section 4B or 4D shall not apply to a person in regard to an insured who independently procures insurance as provided under Section 6. This section shall not apply to a person, properly licensed as an agent or broker in this state who, for a fee and pursuant to a written agreement, is engaged solely to offer to the insured advice, counsel or opinion, or service with respect to the benefits, advantages or disadvantages promised under any proposed or in-force policy of insurance if the person does not, directly or indirectly, participate in the solicitation, negotiation or procurement of insurance on behalf of the insured.

**Drafting Note:** If a state collects tax on unlicensed transactions which violate this Act, it may consider imposing liability for payment of those taxes on persons who violate this Act by assisting in the procurement of nonadmitted insurance.

**Drafting Note:** Some states permit other licensed professionals to engage in these activities as provided in their insurance statutes or other state statutes. Those states may want to amend Section 4E to include those professionals, to the extent they act within the scope of their licenses.

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F. This section shall not apply to a person acting in material compliance with the insurance laws of this state in the placement of the types of insurance identified in Paragraphs (1), (2), (3) and (4) below:

- (1) Surplus lines insurance as provided in Section 5. For the purposes of this subsection, a licensee shall be deemed to be in material compliance with the insurance laws of this state, unless the licensee committed a violation of Section 5 that proximately caused loss to the insured;
- (2) Transactions for which a certificate of authority to do business is not required of an insurer under the insurance laws of this state;

~~Drafting Note: A number of states exempt from licensing and premium taxation nonprofit educational insurers insuring only nonprofit educational institutions and their employees. Some states require certificates of authority while others require licensing, and the appropriate language should be used in Paragraph (2) above. Additionally, some states may want to consider adding language to establish an option of allowing persons to file for an exemption with the Department of Insurance.~~

- (3) Reinsurance provided that, unless the commissioner waives the requirements of this subsection:
  - (a) The assuming insurer is authorized to ~~de-engage in the business of an~~ insurance or reinsurance ~~business by~~ its domiciliary jurisdiction and is authorized to write the type of reinsurance in its domiciliary jurisdiction; and
  - (b) The assuming insurer satisfies all legal requirements for such reinsurance in the state of domicile of the ceding insurer;
- (4) The property and operation of railroads or aircraft engaged in interstate or foreign commerce, wet marine and transportation insurance;
- (5) Transactions subsequent to issuance of a policy not covering properties, risks or exposures located, or to be performed in this state at the time of issuance, and lawfully solicited, written or delivered outside this state.

**Drafting Note:** States may also wish to consider exempting from Section 4A of this Act self-procured insurance or industrial insurance purchased by a sophisticated buyer who does not necessarily require the same regulatory protections as an average insurance buyer. Additionally, some states allow other insurance transactions with nonadmitted insurers. Examples include certain aviation and railroad risks. Other states may want to narrow the scope of the exemptions above or reserve the right to approve exemptions on a case-by-case basis.

## Section 5. Surplus Lines Insurance

A. Surplus lines insurance may be placed by a surplus lines licensee if:

- (1) Each insurer is ~~an~~-eligible ~~to write~~ surplus lines ~~insurance~~insurer; and
- (2) Each insurer is authorized to write the type of insurance in its domiciliary jurisdiction; and
- (3) ~~Other than for exempt commercial purchasers, t~~The full amount or type of insurance cannot be obtained from insurers who are admitted to ~~de-engage in the~~ business ~~of insurance~~ in this state. The full amount or type of insurance may be procured from eligible surplus lines insurers, provided that a diligent search is made among the insurers who are admitted to transact and are actually writing the particular type of insurance in this state if any are writing it; and
- (4) All other requirements of this Act are met.

~~Drafting Note: States may prefer to reference “kind of insurance” rather than “type of insurance” in Section 5A(3). The term utilized should be defined within the Act. The diligent search requirement of Section 5A(3) must be satisfied in accordance with the statutes and regulations of the governing state. Such Diligent search statutes and regulations might vary from state to state in terms of the number of declinations required and the person designated to conduct the search. Several states permit surplus lines placement without a diligent search for or without regard to the availability of admitted coverage. States may want to~~

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consider changing diligent search requirements in light of electronic transactions. Section 5A(3) does not prohibit a regulatory system in which a surplus lines licensee may place with an eligible nonadmitted insurer any coverage listed on a current “Export List” maintained by the commissioner. The eExport list would identify types of insurance for which no admitted market exists. The commissioner may waive the diligent search requirement for any such type of insurance.

**Drafting Note:** Utilizing the “full amount” standard in Section 5A(3) of this Act may have certain market implications. An alternative to this approach would be to require that whatever part of the coverage is attainable through the admitted market be placed in the admitted market and only the excess part of the coverage may be exported.

- B. Subject to Section 5A(3) of this Act, a surplus lines licensee may place any coverage with an an nonadmitted eligible surplus lines insurer ~~eligible to accept the insurance~~, unless specifically prohibited by the laws of this state.

[Alternative Subsection B]

- [~~C~~B. Subject to Section 5A(3) of this Act, a surplus lines licensee may place only the following types of coverage with an an nonadmitted eligible surplus lines insurer ~~eligible to accept insurance~~: (list acceptable coverage).]

**Drafting Note:** The two statutory alternatives described in Section 5B represent different regulatory approaches to defining those coverages which may be placed in the nonadmitted market and they would impact the admitted market in different manners.

- C. A surplus lines licensee shall not place ~~surplus lines insurance coverage with a nonadmitted insurer~~, unless, at the time of placement, the surplus lines licensee has determined that the nonadmitted insurer is eligible to write surplus lines insurance under one of the following subsections:

~~(1) Has established satisfactory evidence of good repute and financial integrity; and~~

~~(2) — Qualifies is eligible to write surplus lines insurance under one of the following subparagraphs:~~

1. Drafting Note: Current numbering is retained in this Model to remain consistent with the reference within the NRRA.

2. Is eligible to write surplus lines insurance under one of the following subsections:

(a) For a nonadmitted insurer domiciled in another United States jurisdiction, the insurer shall have both of the following:

~~(ia) i~~ The authority to write the type of insurance in its domiciliary jurisdiction; and

~~(iib) ii~~ Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction ~~which~~ that equals the greater of:

~~(I) (i) — (IA) —~~ The minimum capital and surplus requirements under the law of this state; or

~~(II) (B)~~ \$15,000,000;

Drafting Note: States that have not previously increased capital and surplus requirements may wish to consider implementation of the capital and surplus requirements in this subparagraph in a series of phases over a period of up to three (3) years. In some circumstances, implementation of a \$15,000,000 capital and surplus requirement may represent a dramatic increase over existing requirements. States may wish to allow insurers which are eligible under existing law some period of time to increase their capital and surplus to meet the new standards. Current numbering is retained in this Model to remain consistent with the reference within the NRRA.

~~(iii) III~~ The requirements of Subparagraph (b)(i) may be satisfied by an insurer’s possessing less than the minimum capital and surplus upon an affirmative finding of

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acceptability by the commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability and company record and reputation within the industry. In no event shall the commissioner make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than \$4,500,000; or

~~(a) For a nonadmitted insurer domiciled outside the United States, the insurer shall be listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the National Association of Insurance Commissioners (NAIC); [or]~~

~~(b)~~

~~(c) [(3)e] For an insurer domiciled in this state, the insurer is a domestic surplus lines insurer.]~~

~~(b) In the case of an insurance exchange created by the laws of a state other than this state:~~

~~(i) The syndicates of the exchange shall maintain under terms acceptable to the commissioner capital and surplus, or its equivalent under the laws of its domiciliary jurisdiction, of not less than \$75,000,000 in the aggregate; and~~

~~(ii) The exchange shall maintain under terms acceptable to the commissioner not less than fifty percent (50%) of the policyholder surplus of each syndicate in a custodial account accessible to the exchange or its domiciliary commissioner in the event of insolvency or impairment of the individual syndicate; and~~

~~(iii) In addition, each individual syndicate to be eligible to accept surplus lines insurance placements from this state shall meet either of the following requirements:~~

~~(I) For insurance exchanges which maintain funds in an amount of not less than \$15,000,000 for the protection of all exchange policyholders, the syndicate shall maintain under terms acceptable to the commissioner minimum capital and surplus, or its equivalent under the laws of the domiciliary jurisdiction, of not less than \$5,000,000; or~~

~~(II) For insurance exchanges which do not maintain funds in an amount of not less than \$15,000,000 for the protection of all exchange policyholders, the syndicate shall maintain under terms acceptable to the commissioner minimum capital and surplus, or its equivalent under the laws of its domiciliary jurisdiction, of not less than the minimum capital and surplus requirements under the laws of its domiciliary jurisdiction or \$15,000,000, whichever is greater; or~~

**Drafting Note:** Some states may want to cross-reference statutory provisions in their own states which provide a grandfather clause for syndicates established with a lower capital and surplus requirement.

~~(c) In the case of a Lloyd's plan or other similar group of insurers, which consists of unincorporated individual insurers, or a combination of both unincorporated and incorporated insurers:~~

~~(i) The plan or group maintains a trust fund that shall consist of a trustee account representing the group's liabilities attributable to business written in the United States; and~~

~~(ii) In addition, the group shall establish and maintain in trust a surplus in the amount of \$100,000,000; which shall be available for the benefit of United States surplus lines policyholders of any member of the group.~~

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- ~~(iii) — The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members.~~
- ~~(iv) — The trust funds shall be maintained in an irrevocable trust account in the United States in a qualified financial institution, consisting of cash, securities, letters of credit or investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state and, in addition, the trust required by item (ii) of this paragraph shall satisfy the requirements of the Standard Trust Agreement required for listing with the National Association of Insurance Commissioners (NAIC) International Insurers Department; or~~
- ~~(d) — In the case of a group of incorporated insurers under common administration, which has continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to this time, and which submits to this state's authority to examine its books and records and bears the expense of the examination:~~
- ~~(i) — The group shall maintain an aggregate policyholders' surplus of \$10,000,000,000; and~~
- ~~(ii) — The group shall maintain in trust a surplus in the amount of \$100,000,000; which shall be available for the benefit of United States surplus lines policyholders of any member of the group; and~~
- ~~(iii) — Each insurer shall individually maintain capital and surplus of not less than \$25,000,000 per company.~~
- ~~(iv) — The trust funds shall satisfy the requirements of the Standard Trust Agreement requirement for listing with the NAIC International Insurers Department, and shall be maintained in an irrevocable trust account in the United States in a qualified financial institution, and shall consist of cash, securities, letters of credit or investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state.~~
- ~~(v) — Additionally, each member of the group shall make available to the commissioner an annual certification of the member's solvency by the member's domiciliary regulator and its independent public accountant; or~~
- ~~(e) — Except for an exchange or plan complying with Subparagraph (b), (c) or (d), an insurer not domiciled in one of the United States or its territories shall satisfy the capital and surplus requirements of Subsection C(2)(a) of this section and shall have in force a trust fund of not less than the greater of:~~
- ~~(i) — \$5,400,000; or~~
- ~~(ii) — Thirty percent (30%) of the United States surplus lines gross liabilities, excluding aviation, wet marine and transportation insurance liabilities, not to exceed \$60,000,000, to be determined annually on the basis of accounting practices and procedures substantially equivalent to those promulgated by this state, as of December 31 next preceding the date of determination, where:~~
- ~~(1) — The liabilities are maintained in an irrevocable trust account in the United States in a qualified financial institution, on behalf of U.S. policyholders consisting of cash, securities, letters of credit or other investments of substantially the same character and quality as those which are eligible investments pursuant to [cite insurance investment law] for the capital and statutory reserves of admitted insurers to write~~

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~~like kinds of insurance in this state. The trust fund, which shall be included in any calculation of capital and surplus or its equivalent, shall satisfy the requirements of the Standard Trust Agreement required for listing with the NAIC International Insurers Department; and~~

~~(II) The insurer may request approval from the commissioner to use the trust fund to pay valid surplus lines claims; provided, however, that the balance of the trust fund is never less than the greater of \$5,400,000 or thirty percent (30%) of the insurer's current gross U.S. surplus lines liabilities, excluding aviation, wet marine and transportation insurance liabilities; and~~

~~(III) In calculating the trust fund amount required by this subsection, credit shall be given for surplus lines deposits separately required and maintained for a particular state or U.S. territory, not to exceed the amount of the insurer's loss and loss adjustment reserves in the particular state or territory;~~

~~Drafting Note: The commissioner may wish to establish the authority to set a higher level on a case by case basis.~~

~~(f) An insurer or group of insurers meeting the requirements to do a surplus lines business in this state at the effective date of this law shall have two (2) years from the date of enactment to meet the requirements of Subparagraph (e), as follows:~~

<del>Year Following Enactment</del>	<del>Trust Fund Requirement</del>
<del>1</del>	<del>15% of U.S. surplus lines liabilities, excluding aviation, wet marine and transportation insurance, with a maximum of \$30,000,000</del>
<del>2</del>	<del>30% of U.S. surplus lines liabilities, excluding aviation, wet marine and transportation insurance, with a maximum of \$60,000,000.</del>

~~(g) The commissioner shall have the authority to adjust, in response to inflation, the trust fund amounts required by Subparagraph (e).~~

~~(3) In addition to all of the other requirements of this subsection, an insurer not domiciled in the United States or its territories shall be listed by the NAIC International Insurers Department. The commissioner may waive the requirement in Paragraph (3) or the requirements of Section 5C(2)(e)(ii) may be satisfied by an insurer's possessing less than the trust fund amount specified in Section 5C(2)(e)(ii) upon an affirmative finding of acceptability by the commissioner if the commissioner is satisfied that the placement of insurance with the insurer is necessary and will not be detrimental to the public and the policyholder. In determining whether business may be placed with the insurer, the commissioner may consider such factors as:~~

~~(a) The interests of the public and policyholders;~~

~~(b) The length of time the insurer has been authorized in its domiciliary jurisdiction and elsewhere;~~

~~(c) Unavailability of particular coverages from authorized insurers or unauthorized insurers meeting the requirements of this section;~~

~~(d) The size of the company as measured by its assets, capital and surplus, reserves, premium writings, insurance in force or other appropriate criteria;~~

~~(e) The kinds of business the company writes, its net exposure and the extent to which the company's business is diversified among several lines of insurance and geographic locations; and~~

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- ~~(f) — The past and projected trend in the size of the company’s capital and surplus considering such factors as premium growth, operating history, loss and expense ratios, or other appropriate criteria; and~~
- ~~(4) — Has caused to be provided to the commissioner a copy of its current annual statement certified by the insurer and an actuarial opinion as to the adequacy of, and methodology used to determine, the insurer’s loss reserves. The statement shall be provided at the same time it is provided to the insurer’s domicile, but in no event more than eight (8) months after the close of the period reported upon, and shall be certified as a true and correct copy by an accounting or auditing firm licensed in the jurisdiction of the insurer’s domicile and certified by a senior officer of the nonadmitted insurer as a true and correct copy of the statement filed with the regulatory authority in the domicile of the nonadmitted insurer. In the case of an insurance exchange qualifying under Paragraph (2)(b) of this subsection, the statement may be an aggregate combined statement of all underwriting syndicates operating during the period reported; and~~

**Drafting Note:** The following paragraph is for use by those states which desire to adopt a “white list” for determining the eligibility of nonadmitted insurers to write surplus lines insurance.

- ~~(5) — In addition to meeting the requirements in Paragraphs (1) to (4) of this subsection an insurer shall be an eligible surplus lines insurer if it appears on the most recent list of eligible surplus lines insurers published by the commissioner from time to time but at least semiannually. Nothing in this paragraph shall require the commissioner to place or maintain the name of any nonadmitted insurer on the list of eligible surplus lines insurers.~~
- ~~(6) — Notwithstanding Section 5A, only that portion of any risk eligible for export for which the full amount of coverage is not procurable from listed eligible surplus lines insurers may be placed with any other nonadmitted insurer which does not appear on the list of eligible surplus lines insurers published by the commissioner pursuant to Paragraph (5) of this subsection but nonetheless meets the requirements set forth in Sections 5C(1) and 5C(2) and any regulations of the commissioner. The surplus lines licensee seeking to provide coverage through an unlisted nonadmitted insurer shall make a filing specifying the amounts and percentages of each risk to be placed, and naming the nonadmitted insurers with which placement is intended. Within [insert number] days after placing the coverage, the surplus lines licensee shall also send written notice to the insured or the producing broker that the insurance, or a portion thereof, has been placed with the nonadmitted insurer.~~

D. The placement of surplus lines insurance shall be subject to the statutory and regulatory requirements solely of the insured’s home state.

**Drafting Note:** Section 522(d) of the federal Nonadmitted and Reinsurance Reform Act provides a workers’ compensation exception to home state authority; specifically, that this section may not be construed to preempt any State law, rule, or regulation that restricts the placement of workers’ compensation insurance or excess insurance for self-funded workers’ compensation plans with a nonadmitted insurer. In addition, Section 527(9) of the NRRRA provides that the term “nonadmitted insurance” means any property and casualty insurance permitted to be placed directly or through a surplus lines broker with a nonadmitted insurer eligible to accept such insurance and is not applicable to accident and health insurance. States may consider whether to add language making these exceptions explicit when codifying Section 5D into state law.

~~E.D.~~ Insurance procured under this section shall be valid and enforceable as to all parties.

~~F.E.~~ Withdrawal of Eligibility as a Surplus Lines Insurer

F.

If at any time the commissioner has reason to believe that a surplus lines insurer is no longer eligible under Section 5C,

- ~~(1) — Is in unsound financial condition or has acted in an untrustworthy manner;~~
- ~~(2) — No longer meets standards set forth in Section 5C of this Act;~~
- ~~(3) — Has willfully violated the laws of this state; or~~



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~~(4) — Does not conduct a proper claims practice.~~

~~The~~ commissioner may, after notice and an opportunity for a hearing, declare it ineligible. The commissioner shall promptly ~~mail~~publish notice of all such declarations in a timely manner reasonably calculated to reach to each surplus lines licensee or surplus lines advisory organization, for distribution to all surplus lines licensees.

**Drafting Note:** Individual states should consider whether such declarations of ineligibility are appropriate in view of the state's other due process and administrative procedure requirements. Eligibility criteria are independent of other considerations such as compliance with other laws, for example, 18 USC 1033, relating to felons participating in the insurance business.

GF. Surplus Lines Tax

~~(1) (1) —~~ In addition to the full amount of gross premiums charged by the insurer for the insurance, every person licensed pursuant to Section 5H of this Act shall collect and pay to the commissioner a sum equal to [insert number] percent of the gross premiums charged, less any return premiums, for surplus lines insurance provided by the licensee pursuant to the license. Where the insurance covers properties, risks or exposures located or to be performed both in and out of this state, the sum payable shall be ~~computed on that portion of the gross premiums allocated to this state pursuant to Paragraph (4) of this subsection less the amount of gross premiums allocated to this state and returned to the insured paid entirely to the hHome sState of the insured.~~ The tax on any portion of the premium unearned at termination of insurance having been credited by the state to the licensee shall be returned to the policyholder directly by the surplus lines licensee or through the producing broker, if any. The surplus lines licensee is prohibited from rebating, for any reason, any part of the tax.

(2) At the time of filing the [insert monthly, quarterly, annual] report as set forth in Subsection SR of this section, each surplus lines licensee shall pay the premium tax due for the policies written during the period covered by the report.

~~(3) — If a surplus lines policy procured through a surplus lines licensee covers properties, risks or exposures only partially located or to be performed in this state, the tax due shall be computed on the portions of the premiums which are attributable to the properties, risks or exposures located or to be performed in this state. In determining the amount of premiums taxable in this state, all premiums written, procured or received in this state shall be considered written on properties, risks or exposures located or to be performed in this state, except premiums which are properly allocated or apportioned and reported as taxable premiums of a reciprocal state. In no event shall the tax payable to this state be less than the tax due pursuant to Paragraph (4) of this subsection; provided, however, in the event that the amount of tax due under this provision is less than \$50 in any jurisdiction, it shall be payable in the jurisdiction in which the affidavit required in Subsection K of this section is filed. The commissioner shall, at least annually furnish to the commissioner of a reciprocal state, as defined in Section 3L, a copy of all filings reporting an allocation of taxes as required by this subsection.~~

~~(4) — In determining the amount of gross premiums taxable in this state for a placement of surplus lines insurance covering properties, risks or exposures only partially located or to be performed in this state, the tax due shall be computed on the portions of the premiums which are attributable to properties, risks or exposures located or to be performed in this state and which relates to the kinds of insurance being placed as determined by reference to an allocation schedule duly promulgated in a regulation by the commissioner.~~

~~(a) — If a policy covers more than one classification:~~

~~(i) — For any portion of the coverage identified by a classification on the Allocation Schedule, the tax shall be computed by using the Allocation Schedule for the corresponding portion of the premium;~~

~~(ii) — For any portion of the coverage not identified by a classification on the Allocation Schedule, the tax shall be computed by using an alternative equitable method of~~



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~~allocation for the property or risk;~~

~~(iii) For any portion of the coverage where the premium is indivisible, the tax shall be computed by using the method of allocation which pertains to the classification describing the predominant coverage.~~

~~(b) If the information provided by the surplus lines licensee is insufficient to substantiate the method of allocation used by the surplus lines licensee, or if the commissioner determines that the licensee's method is incorrect, the commissioner shall determine the equitable and appropriate amount of tax due to this state as follows:~~

~~(i) By use of the Allocation Schedule where the risk is appropriately identified in the schedule;~~

~~(ii) Where the Allocation Schedule does not identify a classification appropriate to the coverage, the commissioner may give significant weight to documented evidence of the underwriting bases and other criteria used by the insurer. The commissioner may also consider other available information to the extent sufficient and relevant, including the percentage of the insured's physical assets in this state, the percentage of the insured's sales in this state, the percentage of income or resources derived from this state, and the amount of premium tax paid to another jurisdiction for the policy.~~

~~**Drafting Note:** Subparagraph (b) above may be included in the Act or in a separate regulation at the option of the state. It is highly recommended that the model Allocation Schedule and reporting form be adopted by regulation in conjunction with the adoption of the above language. In order for the model law to work effectively, the allocation schedules used by the states should be as uniform as possible.~~

HG. Collection of Tax

If the tax owed by a surplus lines licensee under this section has been collected and is not paid within the time prescribed, the same shall be recoverable in a suit brought by the commissioner against the surplus lines licensee and the surety on the bond filed under Subsection HI of this section. The commissioner may charge interest at the rate of [insert number] percent per year for the unpaid tax.

HI. Surplus Lines Licenses

(1) A person shall not procure a contract of surplus lines insurance with a ~~nonadmitted~~ surplus lines insurer unless the person possesses a current surplus lines insurance producer license issued by the commissioner.

(2) The commissioner may issue a resident surplus lines license to a qualified holder of ~~a current underlying~~ property and casualty ~~agent's or broker's or general agent's~~ licenses, but only when the ~~broker or agent~~ producer has:

(a) Remitted the \$[insert amount] annual fee to the commissioner;

(b) Submitted a completed license application on a form supplied by the commissioner;

~~(c) Passed a qualifying examination approved by the commissioner, except that all holders of a license prior to the effective date of this Act shall be deemed to have passed such an examination;~~

~~(c)~~ In the case of a resident agent, filed with the commissioner, and continues to maintain during the term of the license, in force and unimpaired, a bond or errors and omissions (E&O) policy in favor of this state in the penal sum of \$[insert amount] aggregate liability, with corporate sureties approved by the commissioner. The bond or E&O policy shall be conditioned that the Surplus Lines Licensee will conduct business in accordance with the provisions of this Act and will promptly remit the taxes as provided by law. No bond or E&O policy shall be terminated unless at least thirty (30) days prior written notice is

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given to the licensee and commissioner;

**Drafting note:** Under Public Law No. 106-102 (the “Gramm-Leach-Bliley Act”), it is believed that a requirement for a nonresident agent to file a bond may contravene the reciprocity provisions. The requirement for a resident agent to file a bond would not, seemingly, contravene these provisions, and there may be methodologies whereby such resident bonds could become reciprocal between states. Some states have expressed concern that their bonding requirements constitute important consumer protections, and that elimination of these simply to comply with Gramm-Leach-Bliley may result in unintended consequences, and a lack of Control over possibly unscrupulous nonresident agents.

- (de) If a resident, established and continues to maintain an office in this state, ~~and~~
- (f) ~~Designated the commissioner as agent for service of process, thereby designating the commissioner to be the licensee’s true and lawful attorney upon whom may be served all lawful process in a proceeding instituted by or on behalf of an insured or beneficiary arising out of any contract of insurance, and shall signify its agreement that such service of process is of the same legal force and validity as personal service of process in this state upon the licensee.~~

- (3) A nonresident person shall receive a nonresident surplus lines license if:
  - (a) The person is currently licensed as a surplus lines licensee and in good standing in his or her home state;
  - (b) The person has submitted the proper request for licensure and has paid the fees required by [insert appropriate reference to state law or regulation];
  - (c) The person has submitted or transmitted to the insurance commissioner the application for licensure that the person submitted to his or her home state, or in lieu of the same, a completed Uniform Application; and
  - (d) The person’s home state awards nonresident surplus lines licenses to residents of this state on the same basis.

**Drafting Note:** In accordance with Public Law No. 106-102 (the “Gramm-Leach-Bliley Act”) states should not require any additional attachments to the Uniform Application or impose any other conditions on applicants that exceed the information requested within the Uniform Application. ~~f~~

- (4) The insurance commissioner may verify the person’s licensing status through the Producer Database maintained by the ~~NAICational Association of Insurance Commissioners~~, its affiliates or subsidiaries. ~~f~~
- (5) A nonresident surplus lines licensee who moves from one state to another state or a resident surplus lines licensee who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty (30) days of the change of legal residence. No fee or license application is required.
- (6) The insurance commissioner shall waive any requirements for a nonresident surplus lines license applicant with a valid license from his or her home state, except the requirements imposed by this subsection, if the applicant’s home state awards nonresident surplus lines licenses to residents of this state on the same basis.
- (7) Each surplus lines license shall expire on [insert date] of each year, and an application for renewal shall be filed before [insert date] of each year upon payment of the annual fee and compliance with other provisions of this section. A surplus lines licensee who fails to apply for renewal of the license

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before [insert date] shall pay a penalty of \$[insert amount] and be subject to penalties provided by law before the license will be renewed.

**Drafting Note:** States may wish to reference their specific licensing statutes in this section.

**Drafting Note:** Some states allow surplus lines licensees to hold binding authorities on behalf of ~~eligible~~ surplus lines insurers. States which allow such binding authorities might want to establish minimum standards for the related agreements. In addition, states might want to consider requiring surplus lines licensees with such binding authorities to submit the related agreements to state regulators for review and approval.

J. Suspension, Revocation or Nonrenewal of Surplus Lines Licensee's License

The commissioner may suspend, revoke or refuse to renew the license of a surplus lines licensee after notice and an opportunity for a hearing as provided under the applicable provision of this state's laws ~~for upon one or more of the following grounds:~~

- ~~(1) Removal of the resident surplus lines licensee's office from this state;~~
- ~~(2) Removal of the resident surplus lines licensee's office accounts and records from this state during the period during which the accounts and records are required to be maintained under Subsection Q of this section;~~
- ~~(3) Closing of the surplus lines licensee's office for a period of more than thirty (30) business days, unless permission is granted by the commissioner;~~
- ~~(4) Failure to make and file required reports;~~
- ~~(5) Failure to transmit required tax on surplus lines premiums to this state or a reciprocal state to which a tax is owing;~~
- ~~(6) Failure to maintain required bond;~~
- ~~(17) Violation of any provision of this Act; or~~
- ~~(28) For any cause for which an insurance license could be denied, revoked, suspended or renewal refused under Sections [insert applicable citation].~~

K. Actions Against Eligible Surplus Lines Insurers Transacting Surplus Lines Business

- (1) An eligible surplus lines insurer may be sued upon a cause of action arising in this state under a surplus lines insurance contract made by it or evidence of insurance issued or delivered by the surplus lines licensee. A policy issued by the eligible surplus lines insurer shall contain a provision stating the substance of this section and designating the person to whom the commissioner shall mail process.
- (2) The remedies provided in this section are in addition to any other methods provided by law for service of process upon insurers.

L. Duty to File Evidence of Insurance and Affidavits

Within [insert number] days after the placing of any surplus lines insurance, each producing broker shall execute and each surplus lines licensee shall execute where appropriate, and file a written report regarding the insurance which shall be kept confidential by the commissioner, including the following:

- (1) The name and address of the insured;
- (2) The identity of the insurer or insurers;
- (3) A description of the subject and location of the risk;

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- (4) The amount of premium charged for the insurance;
- (5) Such other pertinent information as the commissioner may reasonably require; and
- (6) An affidavit on a standardized form promulgated by the commissioner as to the diligent efforts to place the coverage with admitted insurers and the results of that effort or the insured is an exempt commercial purchaser. The affidavit shall be open to public inspection. The affidavit shall affirm that the insured was expressly advised in writing prior to placement of the insurance that:
  - (a) The surplus lines insurer with whom the insurance was to be placed is not licensed in this state and is not subject to its supervision; and
  - (b) In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund.

**Drafting Note:** Surplus lines licensees will frequently communicate with the insured through a producing broker rather than communicate with the insured directly. In preparing affidavit forms, states may wish to recognize that, as a result of communications passing through the producing broker, the surplus lines licensee may not be in a position to affirm, based upon personal knowledge, that the insured received from the producing broker the written information required by this subsection.

M. Surplus Lines Advisory Organizations

- (1) There is hereby created a nonprofit association to be known as the [insert name]. All surplus lines licensees shall be deemed to be members of the association. The association shall perform its functions under the plan of operation established pursuant to Paragraph (3) of this subsection and must exercise its powers through a board of directors established under Paragraph (2) of this subsection. The association shall be supervised by the commissioner. The association shall be authorized and have the duty to:

**Drafting Note:** The preceding paragraph provides that all surplus lines licensees are “deemed” to be members of the association. Some states, however, may choose not to establish a surplus lines advisory organization; in those states Subsection M would not be necessary.

- (a) Receive, record, and subject to Subparagraph (b) of this paragraph, stamp all surplus lines insurance documents which surplus lines brokers are required to file with the association pursuant to the plan of operation;

**Drafting Note:** Subparagraph (a) of this paragraph authorizes the association to receive, record and stamp all surplus lines documents which must be submitted to the association pursuant to the plan of operation. Documents to be submitted to the association for stamping are likely to vary by state.

- (b) Refuse to stamp submitted insurance documents, if the association determines that a nonadmitted insurer does not meet minimum state financial standards of eligibility, or the commissioner orders the association not to stamp insurance documents pursuant to Paragraph (9) of this subsection. The association shall notify the commissioner and provide an explanation for any refusal to stamp submitted insurance documents other than a refusal based upon the order of the commissioner;
- (c) Prepare and deliver annually to each licensee and to the commissioner a report regarding surplus lines business. The report shall include a delineation of the classes of business procured during the preceding calendar year, in the form the board of directors prescribes;
- (d) Encourage compliance by its members with the surplus lines law of this state and the rules and regulations of the commissioner relative to surplus lines insurance;
- (e) Communicate with organizations of agents, brokers and admitted insurers with respect to the proper use of the surplus lines market;

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- (f) Employ and retain persons as necessary to carry out the duties of the association;
  - (g) Borrow money as necessary to effect the purposes of the association;
  - (h) Enter contracts as necessary to effect the purposes of the association; and
  - (i) Provide such other services to its members as are incidental or related to the purposes of the association.
- (2) The association shall function through a board of directors elected by the association members, and officers who shall be elected by the board of directors.
- (a) The board of directors of the association shall consist of not less than five (5) nor more than nine (9) persons serving terms as established in the plan of operation. The plan of operation shall provide for the election of a board of directors by the members of the association from its membership. The plan of operation shall fix the manner of voting and may weigh each member's vote to reflect the annual surplus lines insurance premium written by the member.
  - (b) The board of directors shall elect officers as provided for in the plan of operation.
- (3) The association shall establish a plan of operation. The plan of operation shall provide for the formation, operation and governance of the association. The plan and any amendments shall be effective upon approval by the commissioner, which shall not be unreasonably withheld or delayed. All association members shall comply with the plan of operation or any amendments to it. Failure to comply with the plan of operation or any amendments shall constitute a violation of the insurance law and the commissioner may issue an order requiring discontinuance of the violation.
- (4) The association shall file with the commissioner:
- (a) A copy of its plan of operation and any amendments to it;
  - (b) A current list of its members revised at least annually;
  - (c) The name and address of a resident of this state upon whom notices or orders of the commissioner or processes issued at the direction of the commissioner may be served; and
  - (d) An agreement that the commissioner may examine the association in accordance with the provisions of Paragraph (5) of this subsection.
- (5) The commissioner shall, at least once in [insert number] years, make or cause to be made an examination of the association. The reasonable cost of an examination shall be paid by the association upon presentation to it by the commissioner of a detailed account of each cost. The officers, managers, agents, and employees of the association may be examined at any time, under oath, and shall exhibit all books, records, accounts, documents or agreements governing its method of operation. The commissioner shall furnish a copy of the examination report to the association and shall notify the association that it may request a hearing within thirty (30) days on the report or on any facts or recommendations contained in it. If the commissioner finds the association to be in violation of this section, the commissioner may issue an order requiring the discontinuance of the violation. A director may be removed from the association's board of directors by the commissioner for cause, stated in writing, after an opportunity has been given to the director to be heard.
- (6) There shall be no liability on the part of and no causes of action of any nature shall arise against the association, its directors, officers, agents or employees for any action taken or omitted by them in the performance of their powers and duties under this section, absent gross negligence or willful misconduct.

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- (7) Within [insert number] days after a surplus lines policy is procured, a licensee shall submit to the association for recording and stamping all documents which surplus lines brokers are required to file with the association. Every insurance document submitted to the association pursuant to this subsection shall set forth:
- (a) The name and address of the insured;
  - (b) The gross premium charged;
  - (c) The name of the nonadmitted insurer; and
  - (d) The class of insurance procured.

**Drafting Note:** The appropriate time limits for submitting documents required for stamping will vary by state.

- (8) It shall be unlawful for an insurance agent, broker or surplus lines broker to deliver in this state any insurance document which surplus lines brokers are required to file with the association unless the insurance document is stamped by the association or is exempt from such requirements. However, a licensee's failure to comply with the requirements of this subsection shall not affect the validity of the coverage.
- (9) The services performed by the association shall be funded by a stamping fee assessed for each premium-bearing document submitted to the association. The stamping fee shall be established by the board of directors of the association from time to time. The stamping fee shall be paid by the insured.
- (10) The commissioner may declare a nonadmitted insurer ineligible and order the association not to stamp insurance documents issued by the nonadmitted insurer and issue any other appropriate order.

NM. Evidence of the Insurance and Subsequent Changes to the Insurance

- (1) Upon placing surplus lines insurance, the surplus lines licensee shall promptly deliver to the insured or the producing broker the policy, or if the policy is not then available, a certificate as described in Paragraph (4) of this subsection, cover note, binder or other evidence of insurance. The certificate described in Paragraph (4) of this subsection, cover note, binder or other evidence of insurance shall be executed by the surplus lines licensee and shall show the description and location of the subject of the insurance, coverages including any material limitations other than those in standard forms, a general description of the coverages of the insurance, the premium and rate charged and taxes to be collected from the insured, and the name and address of the insured and surplus lines insurer or insurers and proportion of the entire risk assumed by each, and the name of the surplus lines licensee and the licensee's license number.
- (2) A surplus lines licensee shall not issue or deliver any evidence of insurance or purport to insure or represent that insurance will be or has been written by any ~~eligible~~ surplus lines insurer, or a nonadmitted insurer ~~pursuant to Section 5C(4)~~, unless the licensee has authority from the insurer to cause the risk to be insured or has received information from the insurer in the regular course of business that the insurance has been granted.
- (3) If, after delivery of any evidence of insurance, there is any change in the identity of the insurers, or the proportion of the risk assumed by any insurer, or any other material change in coverage as stated in the surplus lines licensee's original evidence of insurance, or in any other material as to the insurance coverage so evidenced, the surplus lines licensee shall promptly issue and deliver to the insured or the original producing broker an appropriate substitute for, or endorsement of the original document, accurately showing the current status of the coverage and the insurers responsible for the coverage.
- (4) As soon as reasonably possible after the placement of the insurance, the surplus lines licensee shall deliver a copy of the policy or, if not available, a certificate of insurance to the insured or producing broker to replace any evidence of insurance previously issued. Each certificate or policy of insurance

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shall contain or have attached a complete record of all policy insuring agreements, conditions, exclusions, clauses, endorsements or any other material facts that would regularly be included in the policy.

~~(5) A surplus lines licensee who fails to comply with the requirements of this subsection shall be subject to the penalties provided in this Act.~~

(56) The surplus lines licensee shall give the following consumer notice to every person, ~~other than exempt commercial purchasers,~~ applying for insurance with a nonadmitted insurer. The notice shall be printed in 16-point type on a separate document affixed to the application. The applicant shall sign and date a copy of the notice to acknowledge receiving it. The surplus lines licensee shall maintain the signed notice in its file for a period of five (5) years from expiration of the policy. The surplus lines licensee shall tender a copy of the signed notice to the insured at the time of delivery of each policy the licensee transacts with a nonadmitted insurer. The copy shall be a separate document affixed to the policy.

*“Notice: ~~1. A “nonadmitted” or “surplus lines” insurer that is not licensed in this state is issuing the insurance policy that you have applied to purchase. These companies are called “nonadmitted” or “surplus lines” insurers. 2. The insurer is not subject to the financial solvency regulation and enforcement that applies to licensed insurers in this state. 3. These insurers generally do not participate in insurance guaranty funds created by state law. These guaranty funds will not pay your claims or protect your assets if the insurer becomes insolvent and is unable to make payments as promised. 4. Some states maintain lists of approved or eligible surplus lines insurers and surplus lines brokers may use only insurers on the lists. Some states issue orders that particular surplus lines insurers can not be used. 5. For additional information about the above matters and about the insurer, you should ask questions of your insurance agent, broker or surplus lines broker. You may also contact your insurance department consumer help line.”~~*

**Drafting Note:** This notice is intended to inform personal lines customers and smaller commercial risks of the nature of the coverage they are purchasing. A state may wish to add language to this statute providing that this notice need not be given to commercial risks meeting defined criteria for size and insurance expertise.

ON. Licensee’s Duty to Notify Insured

- (1) No contract of insurance placed by a surplus lines licensee under this Act shall be binding upon the insured and no premium charged shall be due and payable until the surplus lines licensee or the producing broker ~~shall have~~ notified the insured in writing, in a form acceptable to the commissioner, a copy of which shall be maintained by the licensee or the producing broker with the records of the contract and available for possible examination, that:
  - (a) The insurer [other than a domestic surplus lines insurer] with which the licensee places the insurance is not licensed by this state and is not subject to its supervision; and
  - (b) In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund.
- (2) Nothing herein contained shall nullify any agreement by any insurer to provide insurance.

**Drafting Note:** To ensure the meaningfulness of the notice required by this subsection, the commissioner might want to establish criteria related to readability, ~~type face~~font, and ~~type~~size of the notice.

PO. Effect of Payment to Surplus Lines Licensee

A payment of premium to a surplus lines licensee acting for a person other than itself in procuring, continuing or renewing any policy of insurance procured under this section shall be deemed to be payment to the insurer, whatever conditions or stipulations may be inserted in the policy or contract notwithstanding.

QP. Surplus Lines Licensees May Accept Business from Other Producers



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A surplus lines licensee may originate surplus lines insurance or accept such insurance from any other producing broker duly licensed as to the kinds of insurance involved, and the surplus lines licensee may compensate the producing broker for the business.

**RE.** Records of Surplus Lines Licensee

(1) Each surplus lines licensee shall keep ~~in this state~~ a full and true record of each surplus lines insurance contract placed by or through the licensee, including a copy of the policy, certificate, cover note or other evidence of insurance showing each of the following items applicable:

- (~~1a~~) Amount of the insurance, risks and perils insured;
- (~~2b~~) Brief description of the property insured and its location;
- (~~3c~~) Gross premium charged;
- (~~4d~~) Any return premium paid;
- (~~5e~~) Rate of premium charged upon the several items of property;
- (~~6f~~) Effective date and terms of the contract;
- (~~7g~~) Name and address of the insured;
- (~~8h~~) Name and address of the insurer;
- (~~9i~~) Amount of tax and other sums to be collected from the insured;
- (~~10~~) ~~Allocation of taxes by state as referred to in Subsection F of this section;~~ and
- (~~11j~~) Identity of the producing broker, any confirming correspondence from the insurer or its representative, and the application.

(2) The record of each contract shall be kept open at all reasonable times to examination by the commissioner without notice for a period not less than five (5) years following termination of the contract. In lieu of maintaining offices in this state, each nonresident surplus lines licensee shall make available to the commissioner any and all records that the commissioner deems necessary for examination.

**Drafting Note:** States may wish to extend the five-year period prescribed for open access to insurance records because of the long-term nature of this business.

**SR.** Reports—Summary of Exported Business

On or before the end of the month following each [insert month, quarter, year], each surplus lines licensee shall file with the commissioner, on forms prescribed by the commissioner, a verified report in duplicate of all surplus lines insurance transacted during the preceding period, showing:

- (1) Aggregate gross premiums written;
- (2) Aggregate return premiums;
- (3) Amount of aggregate tax remitted to this state; and
- (4) Amount of aggregate tax due or remitted to each other state for which an allocation is made pursuant to Subsection ~~GF~~ of this section.

**Drafting Note:** States desiring to have taxes remitted annually may call for more frequent detailed listing of business.



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T. [OPTIONAL: Domestic Surplus Lines Insurers]

- (1) The commissioner may designate a domestic insurer as a domestic surplus lines insurer upon its application, which shall include, as a minimum, an authorizing resolution of the board of directors and evidence to the commissioner's satisfaction that the insurer has capital and surplus of not less than fifteen million dollars.
- (2) A domestic surplus lines insurer:
- (a) ~~(a)~~ Shall be limited in its authority in this state to providing surplus lines insurance.
- ~~(b)~~ May be authorized to write any type of property and casualty [or accident and health] insurance in this state that may be placed with a surplus lines insurer pursuant to this Subpart.
- (c) Be subject to the legal and regulatory requirements applicable to domestic insurers, except for theas following:
- (i) Premium taxes, fees, and assessments applicable to admitted insurance;
- (ii) Regulation of rates and forms requiring the filing of rates and forms for approval;
- (iii) Assessment or coverage by insurance guaranty funds.]

**Section 6. Insurance Independently Procured—Duty to Report and Pay Tax**

- A. Each insured whose home state is in this state, who procures or continues or renews insurance with a nonadmitted insurer ~~on properties, risks or exposures located or to be performed in whole or in part in this state,~~ other than insurance procured through a surplus lines licensee, shall, within [insert number] days after the date the insurance was so procured, continued or renewed, file a written report with the commissioner, upon forms prescribed by the commissioner, showing the name and address of the insured or insureds, name and address of the insurer, the subject of the insurance, a general description of the coverage, the amount of premium currently charged, and additional pertinent information reasonably requested by the commissioner. ~~For the purposes of this subsection, properties, risks or exposures only partially located or to be performed in this state, which are covered under a multistate policy placed by a surplus lines licensee in another state, shall be deemed to be insurance independently procured unless the insurer is an admitted insurer.~~

**Drafting Note:** Subsection A may need to be revised in those states exempting from taxation insurance procured by nonprofit educational institutions and their employers, from nonprofit educational insurers.

- B. ~~Gross~~ Premiums charged for the insurance, less any return premiums, is subject to a tax at the rate of [insert number] percent. At the time of filing the report required in Subsection A of this section, the insured whose home state is this state shall pay the tax on all taxable pPremium to the commissioner, who shall transmit the same for distribution as provided in this Act.

**Drafting Note:** Existing state laws and procedures may require that the tax report be forwarded to another state agency, such as the Department of the Treasury, rather than to the commissioner. In addition, some states may require the tax to be paid on a periodic basis (e.g., annually) rather than at the time of the filing required by Subsection A. Subsections A and B may need to be revised in these states.

- ~~C.~~ If an independently procured policy covers properties, risks or exposures only partially located or to be performed in this state, the tax payable shall be computed on the portion of the premium properly attributable to the properties, risks or exposures located or to be performed in this state, as set forth in Sections 5F(3) and 5F(4) of this Act.
- ~~C.D.~~ Delinquent taxes hereunder shall bear interest at the rate of [insert number] percent per year.
- ~~D.E.~~ This section does not abrogate or modify, and shall not be construed or deemed to abrogate or modify any other provision of this Act.

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**Section 7. Penalties**

- A. A person who in this state represents or aids a nonadmitted insurer in violation of this Act may be found guilty of a criminal act and subject to a fine not in excess of \$[insert amount].

**Drafting Note:** Some states might want to specify “misdemeanor” or “felony” rather than “criminal act” in Section 7A.

- B. In addition to any other penalty provided herein or otherwise provided by law, including any suspension, revocation or refusal to renew a license, any person, firm, association or corporation violating any provision of this Act shall be liable to a civil penalty not exceeding \$[insert amount] for the first offense, and not exceeding \$[insert amount] for each succeeding offense.
- C. The above penalties are not exclusive remedies. Penalties may also be assessed under [insert citation to trade practices and fraud statute] of the insurance code of this state.

**Section 8. Violations**

Whenever there is evidence satisfactory to the commissioner ~~believes, from evidence satisfactory to him or her,~~ that a person is violating or about to violate the provisions of this Act, the commissioner may cause a complaint to be filed in the [insert appropriate court] Court for restitution and to enjoin and restrain the person from continuing the violation or engaging in or doing any act in furtherance thereof. The court shall have jurisdiction of the proceeding and shall have the power to make and enter an order of judgment awarding such preliminary or final injunctive relief and restitution as in its judgment is proper.

**Section 9. Service of Process**

- A. Any act of transacting insurance by an unauthorized person or a nonadmitted insurer is equivalent to and shall constitute an irrevocable appointment by the unauthorized person or insurer, binding upon it, its executor or administrator, or successor in interest of the [insert title of appropriate state official] or his or her successor in office, to be the true and lawful attorney of the unauthorized person or insurer upon whom may be served all lawful process in any action, suit or proceeding in any court by the commissioner or by the state and upon whom may be served any notice, order, pleading or process in any proceeding before the commissioner and which arises out of transacting insurance in this state by the unauthorized person or insurer. Any act of transacting insurance in this state by a nonadmitted insurer shall signify its acceptance of its agreement that any lawful process in such court action, suit or proceeding and any notice, order, pleading or process in such administrative proceeding before the commissioner so served shall be of the same legal force and validity as personal service of process in this state upon the unauthorized person or insurer.
- B. Service of process in the action shall be made by delivering to and leaving with the [insert title of appropriate state official], or some person in apparent charge of the office, two (2) copies thereof and by payment to the [insert title of appropriate state official] of the fee prescribed by law. Service upon the [insert title of appropriate state official] as attorney shall be service upon the principal.

**Drafting Note:** Existing state laws and procedures may require that service of process be made upon either the commissioner or another state official.

- C. The [insert title of appropriate state official] shall forward by certified mail one of the copies of the process or notice, order, pleading or process in proceedings before the commissioner to the defendant in the court proceeding or to whom the notice, order, pleading or process in the administrative proceeding is addressed or directed at its last known principal place of business and shall keep a record of all process so served on the commissioner which shall show the day and hour of service. Service is sufficient, provided:
- (1) Notice of service and a copy of the court process or the notice, order, pleading or process in the administrative proceeding are sent within ten (10) days by certified mail by the plaintiff or the plaintiff's attorney in the court proceeding or by the commissioner in the administrative proceeding to the defendant in the court proceeding or to whom the notice, order, pleading or process in the administrative proceeding is addressed or directed at the last known principal place of business of the defendant in the court or administrative proceeding; and

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- (2) The defendant's receipt or receipts issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person or insurer to whom the letter is addressed, and an affidavit of the plaintiff or the plaintiff's attorney in a court proceeding or of the commissioner in an administrative proceeding, showing compliance are filed with the clerk of the court in which the action, suit or proceeding is pending or with the commissioner in administrative proceedings, on or before the date the defendant in the court or administrative proceeding is required to appear or respond, or within such further time as the court or commissioner may allow.
- D. A plaintiff shall not be entitled to a judgment or a determination by default in any court or administrative proceeding in which court process or notice, order, pleading or process in proceedings before the commissioner is served under this section until the expiration of forty-five (45) days from the date of filing of the affidavit of compliance.
- E. Nothing in this section shall limit or affect the right to serve any process, notice, order or demand upon any person or insurer in any other manner now or hereafter permitted by law.
- F. Each nonadmitted insurer assuming insurance in this state, or relative to property, risks or exposures located or to be performed in this state, shall be deemed to have subjected itself to this Act.
- G. ~~Notwithstanding~~Notwithstanding conditions or stipulations in the policy or contract, a nonadmitted insurer may be sued upon any cause of action arising in this state, or relative to property, risks or exposures located or to be performed in this state, under any insurance contract made by it.
- H. ~~Notwithstanding~~Except with regard to exempt commercial purchasers, independently procured insurance, [aviation], and wet marine and transportation insurance, conditions or stipulations in the policy or contract ~~notwithstanding, a nonadmitted insurer subject to arbitration or other alternative dispute resolution mechanism arising in this state or relative to property, risks or exposures located or to be performed in this state under an insurance contract made by it shall conduct the arbitration or other alternative dispute resolution mechanism in this state in the home state of the insured.~~

**Drafting Note:** Provisions of a state's constitution, statutes, regulations, and public policy may necessitate amendment of the prior ~~sub~~Section 9H. States should consider adoption or modification of priorSection 9H in light of their own laws on arbitration or other alternative dispute resolution in insurance and commercial transactions. States should cross-reference their state insurance code to verify the inclusion of "Aviation" within this provision.

- I. A policy or contract issued by the nonadmitted insurer or one which is otherwise valid and contains a condition or provision not in compliance with the requirements of this Act is not thereby rendered invalid but shall be construed and applied in accordance with the conditions and provisions which would have applied had the policy or contract been issued or delivered in full compliance with this Act.

#### Section 10. Legal or Administrative Procedures

- A. Before any nonadmitted insurer files or causes to be filed any pleading in any court action, suit or proceeding or in any notice, order, pleading or process in an administrative proceeding before the commissioner instituted against the person or insurer, by services made as provided in this Act, the insurer shall either:
- (1) Deposit with the clerk of the court in which the action, suit or proceeding is pending, or with the Commissioner of Insurance in administrative proceedings before the commissioner, cash or securities, or file with the clerk or commissioner a bond with good and sufficient sureties, to be approved by the clerk or commissioner in an amount to be fixed by the court or commissioner sufficient to secure the payment of any final judgment which may be rendered in the action or administrative proceeding; or
- (2) Procure a certificate of authority to transact the business of insurance in this state. In considering the application of an insurer for a certificate of authority, for the purposes of this paragraph the commissioner need not assert the provisions of [insert sections of insurance laws relating to retaliation] against the insurer with respect to its application if the commissioner determines that the company would otherwise comply with the requirements for a certificate of authority.

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- B. The Commissioner of Insurance, in any administrative proceeding in which service is made as provided in this Act, may in the commissioner’s discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of Subsection A of this section and to defend the action.
- C. Nothing in Subsection A of this section shall be construed to prevent a nonadmitted insurer from filing a motion to quash a writ or to set aside service thereof made in the manner provided in this Act, on the ground that the nonadmitted insurer has not done any of the acts enumerated in the pleadings.
- D. Nothing in Subsection A of this section shall apply to placements of insurance which were lawful in the [home state of the insured in which the placement took place](#) and which were not unlawful placements under the laws of this state. Without limiting the generality of the foregoing, nothing in Subsection A shall apply to a placement made pursuant to Section 5 of this Act.

## Section 11. Enforcement

- A. The commissioner shall have the authority to proceed in the courts of this state or any other United States jurisdiction to enforce an order or decision in any court proceeding or in any administrative proceeding before the commissioner of Insurance.

### A. Filing and Status of Foreign Decrees

~~A copy of a foreign decree authenticated in accordance with the statutes of this state may be filed in the office of the clerk of any [insert proper court] Court of this state. The clerk, upon verifying with the commissioner that the decree or order qualifies as a “foreign decree” shall treat the foreign decree in the same manner as a decree of a [insert proper court] Court of this state. A foreign decree so filed has the same effect and shall be deemed a decree of a [insert proper court] Court of this state, and is subject to the same procedures, defenses and proceedings for reopening, vacating or staying as a decree of a [insert proper court] Court of this state and may be enforced or satisfied in like manner.~~

### B. Notice of Filing

- (1) ~~At the time of the filing of the foreign decree, the plaintiff shall make and file with the clerk of the court an affidavit setting forth the name and last known post office address of the defendant.~~
- (2) ~~Promptly upon the filing of the foreign decree and the affidavit, the clerk shall mail notice of the filing of the foreign decree to the defendant at the address given and to the commissioner of this state and shall make a note of the mailing in the docket. In addition, the plaintiff may mail a notice of the filing of the foreign decree to the defendant and to the commissioner of this state and may file proof of mailing with the clerk. Lack of mailing notice of filing by the clerk shall not affect the enforcement proceedings if proof of mailing by the plaintiff has been filed.~~
- (3) ~~No execution or other process for enforcement of a foreign decree filed hereunder shall issue until thirty (30) days after the date the decree is filed.~~

**Drafting Note:** This section presumes that the commissioner has authority to proceed without the cooperation of the state’s attorney general. Governing state laws might require that a person other than the commissioner or the attorney general serve as the plaintiff. The title of that person shall be substituted for “commissioner” or “plaintiff” in Section 11 whenever required by state law.

### C. Stay of the Foreign Decree

- (1) ~~If the defendant shows the [insert proper court] Court that an appeal from the foreign decree is pending or will be taken, or that a stay of execution has been granted, the court shall stay enforcement of the foreign decree until the appeal is concluded, the time for appeal expires, or the stay of execution expires or is vacated, upon proof that the defendant has furnished the security for the satisfaction of the decree required by the state in which it was rendered.~~
- (2) ~~If the defendant shows the [insert proper court] Court any ground upon which enforcement of a~~

## Nonadmitted Insurance Model Act

~~decree of any [insert proper court] Court of this state would be stayed, the court shall stay enforcement of the foreign decree for an appropriate period, upon requiring the same security for satisfaction of the decree which is required in this state.~~

- ~~B. D.~~ It shall be the policy of this state that the insurance commissioner shall cooperate with regulatory officials in other United States jurisdictions to the greatest degree reasonably practicable in enforcing lawfully issued orders of such other officials subject to public policy and the insurance laws of the state. Without limiting the generality of the foregoing, the commissioner may enforce an order lawfully issued by other officials provided the order does not violate the laws or public policy of this state.

**Section 12. Suits by Nonadmitted Insurers**

A nonadmitted insurer may not commence or maintain an action ~~in~~ at law or in equity, including arbitration or any other dispute resolution mechanism, in this state to enforce any right arising out of any insurance transaction except with respect to:

- A. Claims under policies lawfully placed pursuant to the law of the home state of the insured~~written in this state~~;
- B. Liquidation of assets and liabilities of the insurer (other than collection of new premium), resulting from its former authorized operations in this state;
- C. Transactions subsequent to issuance of a policy not covering domestic risks at the time of issuance, and lawfully procured under the laws of the jurisdiction where the transaction took place;
- D. Surplus lines insurance placed by a licensee under authority of Section 5 of this Act;
- E. Reinsurance placed under the authority of [insert citations of state's reinsurance intermediary act and other reinsurance laws];
- F. The continuation and servicing of life insurance, health insurance policies or annuity contracts remaining in force as to residents of this state where the formerly authorized insurer has withdrawn from the state and is not transacting new insurance in the state;
- e G. Servicing of policies written by an admitted insurer in a state to which the insured has moved but in which the company does not have a certificate of authority until the term expires;
- H. Claims under policies covering wet marine and transportation insurance;
- I. Placements of insurance which were lawful in the jurisdiction in which the transaction took place and which were not unlawful placements under the laws of this state.

**Drafting Note:** Provisions of a state's constitution, statutes, regulations, and public policy may necessitate amendment of the opening paragraph of this section.

**Section 13. ~~Separability Severability Clause of Provisions~~**

If any provisions of this Act, or the application of the provision to any person or circumstance, shall be held invalid, the remainder of the Act and the application of the provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

**Section 14. Effective Date**

This Act shall take effect [insert appropriate date].

---

*Chronological Summary of Actions (all references are to the Proceedings of the NAIC).*

1994 Proc. 3<sup>rd</sup> Quarter 14, 16-17, 24, 28-46 (adopted).

1996 Proc. 3<sup>rd</sup> Quarter 9, 42, 1110, 1168, 1169-1173, 1189-1190 (amended).

## NAIC Model Laws, Regulations, Guidelines and Other Resources—March 2023

*1997 Proc. 4<sup>th</sup> Quarter 25, 27-28, 1004, 1029 (amended).*  
*1999 Proc. 3<sup>rd</sup> Quarter 25, 26, 1080, 1135, 1151-1153 (amended).*  
*2002 Proc. 2<sup>nd</sup> Quarter 14, 250-251, 344, 347, 349-350 (amended).*

*This model draws from and replaces three earlier NAIC models:*

*Model Surplus Lines Law*

*1983 Proc. I 6, 36, 834, 900, 913-922 (adopted).*  
*1985 Proc. II 11, 24, 702, 722, 723-724 (amended).*  
*1986 Proc. I 9-10, 24, 799, 813, 814-821 (amended).*  
*1990 Proc. I 6, 30, 840-841, 897-898, 900-901 (amended).*  
*1991 Proc. I 9, 18, 908, 949, 950, 952-961 (amended and reprinted).*

*Unauthorized Insurers Model Act*

*1969 Proc. I 168, 218, 222-227, 271 (adopted).*  
*1978 Proc. I 13, 15, 348, 350 (amended).*  
*1990 Proc. II 7, 13-14, 159-160, 187-191 (amended and reprinted).*

*Model Nonadmitted Insurance Act*

*1983 Proc. I 6, 36, 834, 899-900, 923-926 (adopted).*

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

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Draft: 3/27/23

Casualty Actuarial and Statistical (C) Task Force  
Virtual Meeting (*in lieu of meeting at the 2023 Spring National Meeting*)  
March 7, 2023

The Casualty Actuarial and Statistical (C) Task Force met March 7, 2023. The following Task Force members participated: Chris Nicolopoulos, Chair, represented by Christian Citarella (NH); Chlora Lindley-Myers, Vice Chair, represented by Julie Lederer (MO); Lori K. Wing-Heier represented by Sian Ng-Ashcraft (AK); Mark Fowler represented by Charles Hale (AL); Ricardo Lara represented by Mitra Sanandajifar and Lynne WehmueLLer (CA); Andrew N. Mais represented by Wanchin Chou (CT); Michael Yaworsky represented by Greg Jaynes (FL); Doug Ommen represented by Travis Grassel (IA); Dana Popish Severinghaus represented by Reid McClintock (IL); Amy L. Beard represented by Larry Steinert (IN); Vicki Schmidt represented by Nicole Boyd (KS); James J. Donelon represented by John Sobhanian (LA); Kathleen A. Birrane represented by Walter Dabrowski (MD); Timothy N. Schott represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Phil Vigliaturo (MN); Troy Downing represented by Mari Kindberg (MT); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Carl Sornson (NJ); Jennifer Catechis represented by Anna Krylova (NM); Scott Kipper represented by Gennady Stolyarov (NV); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Kate Yang (OK); Andrew R. Stolfi represented by David Dahl, Brian Fordham, and Ying Liu (OR); Michael Humphreys represented by Michael McKenney (PA); Michael Wise represented by Will Davis (SC); Cassie Brown represented by J'ne Byckovski and Miriam Fisk (TX); Kevin Gaffney represented by Rosemary Raszka (VT); Mike Kreidler represented by Eric Slavich (WA); and Allan L. McVey represented by Juanita Wimmer (WV).

1. Adopted its Jan. 31, 2023; Jan. 27, 2023; Jan. 10, 2023; Jan. 3, 2023; Dec. 9, 2022; and 2022 Fall National Meeting Minutes

Citarella said the Task Force met Jan. 10, 2023, and conducted e-votes that concluded on Jan. 31, 2023; Jan. 27, 2023; Jan. 3, 2023; and Dec. 9, 2022. The Jan. 10 minutes include exposure of the Generalized Additive Model (GAM) Appendix for a 45-day public comment period ending Feb. 24. The e-vote minutes include adoption of the following statistical reports: 2020 *Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance Report* (Homeowner Report); 2021 *Competition Database Report* (Competition Report); 2019/2020 *Auto Insurance Database Report* (Auto Report); and the 2021 *Report on Profitability by Line by State* (Profitability Report).

Botsko made a motion, seconded by Darby, to adopt the Task Force's Jan. 31, 2023 (Attachment One); Jan. 27, 2023 (Attachment Two); Jan. 10, 2023 (Attachment Three); Jan. 3, 2023 (Attachment Four); Dec. 9, 2022 (Attachment Five); and Nov. 8, 2022 (*see NAIC Proceedings – Fall 2022, Casualty Actuarial and Statistical (C) Task Force*) minutes. The motion passed unanimously.

2. Adopted the Report of the Actuarial Opinion (C) Working Group

Fisk said the Actuarial Opinion (C) Working Group met Jan. 26 to discuss draft changes to the 2023 actuarial opinion instructions and a draft response to the referral from the Financial Analysis (E) Working Group on the use of predictive analytics in reserving.

Fisk said the Actuarial Opinion (C) Working Group discussed potential changes to the qualification documentation requirement in the opinion instructions, but it ultimately decided not to propose any substantive changes to the property/casualty (P/C) and title instructions. The Working Group provided two editorial corrections to the 2023



instructions to Blanks (E) Working Group staff. The Actuarial Opinion (C) Working Group plans to meet later this year to discuss potential changes to the 2024 actuarial opinion instructions.

The Working Group discussed a draft response to the referral from the Financial Analysis (E) Working Group regarding the use of predictive analytics in reserving. The Actuarial Opinion (C) Working Group plans to continue the discussion on this topic before responding to the referral later this year.

Fisk made a motion, seconded by Lederer, to adopt the report of the Actuarial Opinion (C) Working Group, including its amended Jan. 26 minutes (Attachment Six). The motion passed unanimously.

### 3. Adopted the Report of the Statistical Data (C) Working Group

Darby said the Statistical Data (C) Working Group met twice since the 2022 Fall National Meeting. The first meeting was a regulator-to-regulator session to review a Tableau dashboard created by NAIC staff based on data from the Profitability Report. Darby said NAIC staff are working to develop similar dashboards using data from the Auto Report and the Homeowners Report. She said the goal of the dashboards is to develop regulatory training on the availability and uses of statistical data by the end of 2023.

The Working Group's second meeting was held Feb. 23. During this meeting, the Working Group adopted a proposal to create an Auto Insurance Average Premium Supplement to fast-track the reporting of average premium data. Darby said the supplement will exist in addition to the full Auto Report. The Working Group also discussed proposed changes to the statistical reports. Darby said these proposed changes, under review since last fall, are prompting interesting discussions on what kinds of data are included in the reports and how that data is presented.

Darby said NAIC staff are currently checking data for the 2021 Homeowners Report and the 2021 Auto Insurance Average Premium Supplement. Both reports are scheduled to be released this spring.

Darby made a motion, seconded by Chou, to adopt the report of the Statistical Data (C) Working Group, including its Feb. 23 minutes (Attachment Seven). The motion passed unanimously.

### 4. Adopted the GAM Regulatory Guidance

Citarella said Sam Kloese (NAIC) presented at the Jan. 10 meeting about GAMs. At that meeting, the Task Force exposed the GAM Regulatory Guidance for a 45-day public comment period ending Feb. 24. Numerous comment letters were received (Attachment Eight). Kloese said he documented the revisions made to the guidance based on comments submitted (Attachment Nine).

Darby made a motion, seconded by Steinert, to adopt the GAM Regulatory Guidance (Attachment Ten). The motion passed unanimously.

### 5. Eliminated the Expense Constant Supplement

Citarella said the Task Force discussed the potential elimination of the NAIC Expense Constant Supplement for a perceived lack of need at the 2022 Fall National Meeting and exposed the idea for a 45-day public comment period ending Dec. 22, 2022. No comments were received. Steinert said the new loss cost multiplier (LCM) forms include the option to use an expense constant, so the separate Expense Constant Supplement is not needed.

Steinert made a motion, seconded by Davis, to eliminate the Expense Constant Supplement. The motion passed unanimously.

#### 6. Discussed a Communication Plan Regarding New LCM Forms

Citarella said the next steps with the LCM forms are to update the NAIC's website and begin communication to state insurance regulators. He said he would expect the Task Force to recommend that states consider implementing the new forms and/or making similar changes to their state forms. He said these types of forms are sometimes in state regulations and laws, where it would take a significant amount of time for implementation. He suggested sending a letter to states, asking for the distribution of the forms in System for Electronic Rates & Forms Filing (SERFF) announcements, and notifying affected committee groups. Wehmueller said it would be unlikely that California can implement the revised forms.

#### 7. Heard Reports from Professional Actuarial Organizations

The American Academy of Actuaries' (Academy's) Committee on Property and Liability Financial Reporting (COPLFR) and Casualty Practice Council (CPC), the Actuarial Board for Counseling and Discipline (ABCD), the Casualty Actuarial Society (CAS), and the Society of Actuaries (SOA) provided reports on current activities.

#### 8. Discussed Other Matters

Lederer will lead a regulatory discussion about the second exposure draft of the Actuarial Standard of Practice (ASOP) 29: Expense Provisions for Prospective Property/Casualty Risk Transfer and Risk Retention. Any state insurance regulator can participate in a March 30 call to evaluate the draft for any regulatory issues. If issues are identified, the Task Force will then discuss and consider sending a comment letter by the May 1 comment deadline.

Citarella asked Task Force members to request Book Club topics by sending those to Kloese.

Citarella said the NAIC is developing new training on the regulatory review of generalized linear models (GLMs). Kris DeFrain (NAIC) said the training will explain what state insurance regulators should look for, how to read the graphs and understand the content, and how to assess the model. Vigliaturo requested that the training also be developed to assist technical staff who are not actuaries.

Citarella said he will arrange an ad hoc meeting of P/C actuaries at the Spring National Meeting. He suggested that the Task Force attend the Big Data and Artificial Intelligence (H) Working Group meeting at the Spring National Meeting or watch it virtually, where modeling questions for all types of company models will be discussed. He said the Working Group's work overlaps with some of the Task Force's work, so it is important to monitor the Working Group's activities related to modeling.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2023\_Spring/CASTF/0307 Min.docx

Draft: 2/2/23

Casualty Actuarial and Statistical (C) Task Force  
E-Vote  
January 31, 2023

The Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded Jan. 31, 2023. The following Task Force members participated: Mike Kreidler, Chair, represented by Eric Slavich (WA); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhlf (DC); TBD represented by Christina Huff (FL); Doug Ommen represented by Travis Grassel (IA); Dana Popish Severinghaus represented by Reid McClintock (IL); Amy L. Beard represented by Larry Steinert (IN); Vicki Schmidt represented by Nicole Boyd (KS); Kathleen A. Birrane represented by Robert Baron (MD); Timothy N. Schott represented by Sandra Darby (ME); Troy Downing represented by Mari Kindberg (MT); Mike Causey represented by Richard Kohan (NC); Eric Dunning represented by Michael Muldoon (NE); Chris Nicolopoulos represented by Christian Citarella (NH); Marlene Caride represented by Carl Sornson (NJ); Jennifer Catechis represented by Anna Krylova (NM); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Wise represented by Will Davis (SC); Cassie Brown represented by J'ne Byckovski (TX); Kevin Gaffney represented by Rosemary Raszka (VT); and Allan L. McVey (WV).

1. Adopted the Competition Report

The Task Force conducted an e-vote to consider adoption of the *2021 Competition Database Report* (Competition Report). The motion passed unanimously.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2023\_Spring/CASTF/013123 Competition evote min.docx

Draft: 1/31/23

Casualty Actuarial and Statistical (C) Task Force  
E-Vote  
January 27, 2023

The Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded Jan. 27, 2023. The following Task Force members participated: Mike Kreidler, Chair, represented by Eric Slavich (WA); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhilf (DC); TBD represented by Christina Huff (FL); Doug Ommen represented by Travis Grassel (IA); Dana Popish Severinghaus represented by Reid McClintock (IL); Amy L. Beard represented by Larry Steinert (IN); Vicki Schmidt represented by Nicole Boyd (KS); James J. Donelon represented by Nichole Torblaa (LA); Kathleen A. Birrane represented by Robert Baron (MD); Timothy N. Schott represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by Julie Lederer (MO); Troy Downing represented by Mari Kindberg (MT); Mike Causey represented by Richard Kohan (NC); Chris Nicolopoulos represented by Christian Citarella (NH); Marlene Caride represented by Carl Sornson (NJ); Jennifer Catechis represented by Anna Krylova (NM); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Cuc Nguyen and Andrew Schallhorn (OK); Andrew R. Stolfi represented by David Dahl (OR); Michael Wise represented by Will Davis (SC); Cassie Brown represented by J'ne Byckovski (TX); Kevin Gaffney represented by Rosemary Raszka (VT); and Allan L. McVey (WV).

1. Adopted the 2019/2020 Auto Report

The Task Force conducted an e-vote to consider adoption of the *2019/2020 Auto Insurance Database Report* (Auto Report). The motion passed unanimously.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2023\_Spring/CASTF/012723 Auto evote min.docx

Draft: 1/23/23

Casualty Actuarial and Statistical (C) Task Force  
Virtual Meeting  
January 10, 2023

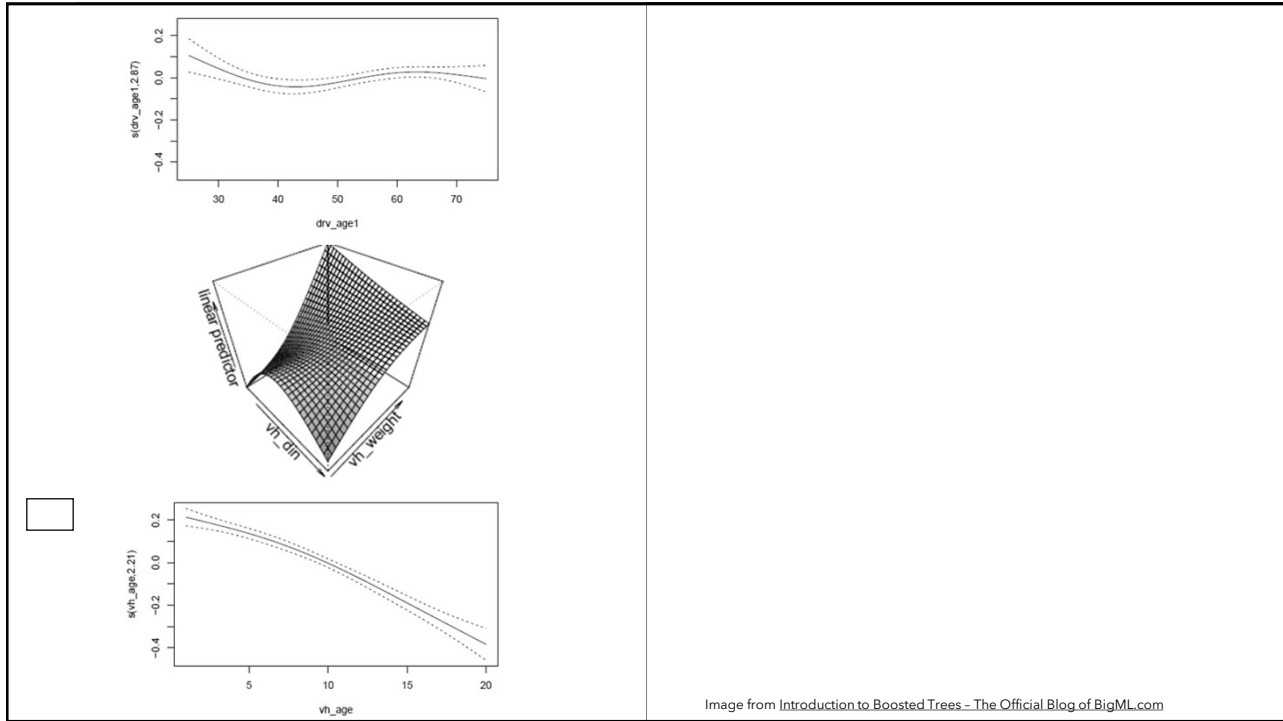
The Casualty Actuarial and Statistical (C) Task Force met Jan. 10, 2023. The following Task Force members participated: Mike Kreidler, Chair, represented by Eric Slavich (WA); Grace Arnold, Vice Chair, represented by Phil Vigliaturo (MN); Mark Fowler represented by Charles Hale (AL); Ricardo Lara represented by Mitra Sanandajifar and Lynne Wehmueller (CA); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou (CT); David Altmaier represented by Greg Jaynes (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Dana Popish Severinghaus represented by Reid McClintock and Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd (KS); James J. Donelon represented by Nichole Torblaa and Arthur Schwartz (LA); Kathleen A. Birrane represented by Walter Dabrowski (MD); Chlora Lindley-Myers represented by Cynthia Amann and Julie Lederer (MO); Chris Nicolopoulos represented by Christian Citarella (NH); Marlene Caride represented by Sam Sackey (NJ); Russell Toal represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew Stolfi represented by David Dahl and Ying Liu (OR); Michael Humphreys represented by Michael McKenney (PA); Michael Wise represented by Will Davis (SC); Cassie Brown represented by J'ne Byckovski (TX); Kevin Gaffney represented by Rosemary Raszka (VT); and Allan L. McVey represented by Juanita Wimmer (WV).

1. Exposed the Draft GAM Appendix

Sam Kloese (NAIC) presented about Generalized Additive Models (GAMs) (Attachment Three-A). He said the draft GAM appendix to the white paper *Regulatory Review of Predictive Models* has tracked changes showing how the GAM appendix would differ from the already-adopted Generalized Linear Model (GLM) appendix (Attachment Three-B). At the chair's request, the appendix was exposed for a 45-day public comment period ending Feb. 24. No members objected.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2023\_Spring/CASTF/011023 min.docx



## Introduction

- GLMs are industry standard
- The CASTF White Paper for Predictive Models is focused primarily on GLM's
- New Appendix for Tree Based Models has already been adopted
- New proposed appendix will cover GAMs
  - GAMs are similar to GLMs with just a few differences
  - The original GLM appendix was used as a starting point

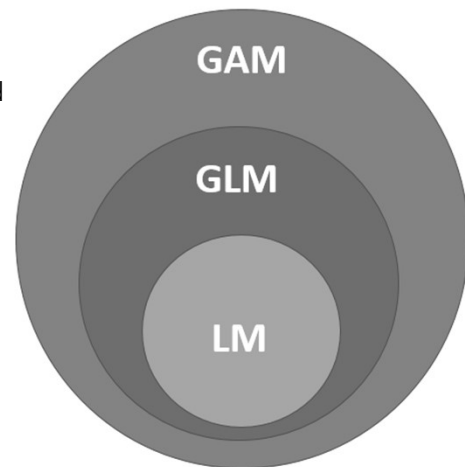
## Similarity to GLM's

- GAMs are an extension of GLMs
- GAMs have many of the same elements
  - Multiple terms in the Regression functions to model the target variable
  - Allows selecting a distribution from the exponential distribution family (Poisson, Gamma, Tweedie...)
  - Link Function defines the relationship between the linear predictor and the mean (log link, logistic link...)
  - Offset terms can be added
  - Records can be weighted (exposures in a frequency model...)

```
gam_final <- gam(claim_count ~ pol_coverage + pol_usage +
  s(drv_age1, k = 4) + s(vh_age, k = 4) +
  te(vh_din, vh_weight, k = 3),
  family = poisson(link = "log"),
  offset = log(exposures),
  data = training_data)
```

## Similarity to GLM's

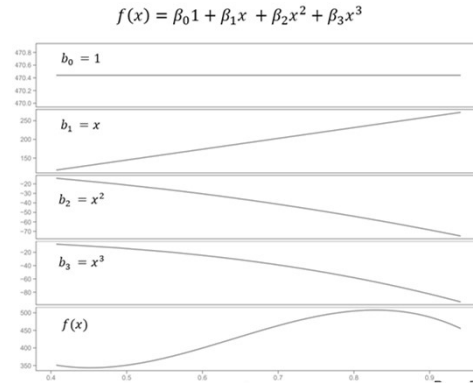
- GAM is like a GLM with the addition of smoothed terms
  - LM (Least squares):  $\mu = \beta_0 + X_1\beta_1 + \dots$
  - GLM:  $g(\mu) = \beta_0 + X_1\beta_1 + \dots$
  - GAM:  $g(\mu) = \beta_0 + X_1\beta_1 + \dots + f_1(X_1) + \dots$
- LM to GLM to GAM
  - A LM is a special case of GLM
    - Distribution: Normal
    - Link Function: Identity
  - A GLM is a special case of GAM
    - No smoothed terms



## Smooth functions

- Smooth functions are comprised of basis functions
- Modeling software allows you to set the type and number of the basis functions
- The overall impact of the smooth can be visualized and analyzed
- There are many types
  - Thin Plate
  - Cubic Splines
  - Random Effect
  - P Splines
  - Factor smooths

## Polynomial Basis Example



## GAM is a type of Penalized Regression

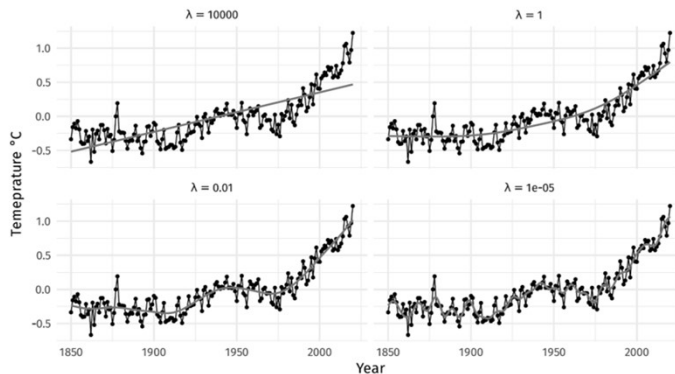
- Other forms of penalized regression
  - Lasso, Ridge, Elastic Net
- GAM Penalized Log-Likelihood
  - The smoothing parameter  $\lambda$  controls the penalty for the wiggleness of the model
  - The  $\lambda$  balances model fit vs. model complexity

$$L_p = \underbrace{L(\beta)}_{\text{Maximum Likelihood as in the GLM}} - \underbrace{\frac{1}{2} \lambda \beta^T S \beta}_{\text{Penalty to discourage overfitting - wiggleness}}$$



## GAM is a type of Penalized Regression

### HadCRUT4 time series



HadCRUT4 is a global temperature dataset, providing gridded temperature anomalies across the world as well as averages for the hemispheres and the globe as a whole.

The smaller the  $\lambda$  the wigglier the fit.

The modeler sets smooths and related  $k$  values, the software typically chooses  $\lambda$ .

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4/3/2023 7

## Complications from Smoothed Terms

- Smoothed terms have multiple beta coefficients
  - Relationship no longer summarized within 1 single number
  - The impact of the smoothed term is hard to interpret without plots
- P-values are less straightforward
  - The calculation changes for penalized regression methods
  - The mgcv package provides p-values, but they are approximate
- Smoothed terms introduce the risk of “concurvity”
  - Concurvity is similar to the concept of collinearity in the parametric (non-smoothed) terms
  - Concurvity is when the smoothed terms move together

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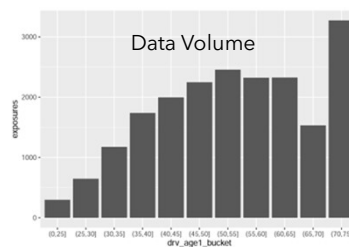
4/3/2023 8

## Recommendations for Smoothed Terms

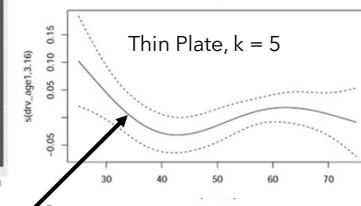
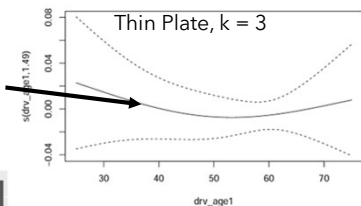
1. Review plots for each smoothed term
2. Review approximate p-value for each smoothed term
3. Review concavity metrics

## Recommendations for Reviewing Plots

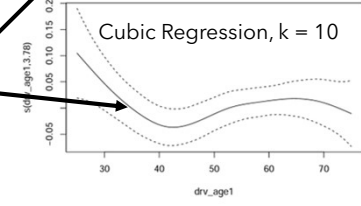
- Focus on the reasonability of the aggregate smooth [Level 1 item]
  - Does the shape match the rational explanation?
- Place less focus on smooth type and underlying basis functions [Level 4 item]
- Consider if the confidence intervals are extremely wide
- Consider if the smooth seems overly noisy or overly smooth
- Consider if the smooth appears like it will extrapolate correctly
  - Look at the far left and far right sides
  - Look at areas with thinner data



Extremely wide confidence intervals  
Fails horizontal line test



Different smooth types or more basis functions are not necessarily materially different



## Recommendations for Reviewing Approximate P-values

- Approximate p-values are provided by the mgcv package in R
- Smoothed term p-values don't account for uncertainty in  $\lambda$
- P-values are biased low, a lower threshold may be appropriate

```
##
## Family: poisson
## Link function: log
##
## Formula:
## claim_count ~ pol_coverage + pol_usage + s(drv_age1, k = 4) +
## s(vh_age, k = 4) + te(vh_din, vh_weight, k = 3)
##
## Parametric coefficients:
##              Estimate Std. Error z value Pr(>|z|)
## (Intercept)  -1.17696    0.18626  -6.319 2.63e-10 ***
## pol_coverageMedian1 -0.05899    0.03944  -1.496 0.134755
## pol_coverageMedian2 -0.13774    0.02885  -4.775 1.80e-06 ***
## pol_coverageMini   -0.59877    0.05396 -11.097 < 2e-16 ***
## pol_usageProfessional -0.40514    0.18800  -2.155 0.031163 *
## pol_usageRetired   -0.71978    0.18835  -3.822 0.000133 ***
## pol_usageWorkPrivate -0.59133    0.18624  -3.175 0.001498 **
## ---
## Signif. codes:  0 '***' 0.001 '**' 0.01 '*' 0.05 '.' 0.1 ' ' 1
##
## Approximate significance of smooth terms:
##              edf Ref.df Chi.sq p-value
## s(drv_age1)    2.870  2.988  11.75 0.00653 **
## s(vh_age)      2.207  2.591 173.96 < 2e-16 ***
## te(vh_din,vh_weight) 6.453  7.073 176.90 < 2e-16 ***
## ---
## Signif. codes:  0 '***' 0.001 '**' 0.01 '*' 0.05 '.' 0.1 ' ' 1
##
## R-sq.(adj) =  0.0156  Deviance explained =  2.9%
## UBRE = -0.36299  Scale est. =  1          n = 79995
```

## Recommendations for Reviewing Concurvity

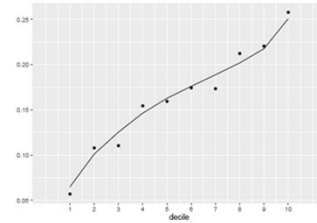
- MgcV provides 3 versions of concurvity metrics: worst, observed, estimate
- Worst is the most pessimistic view
- Rule of thumb, a worst concurvity > 0.8 is too high for a smoothed term

```
concurvity(gam_final, full = TRUE)
```

```
##              para s(drv_age1) s(vh_age) te(vh_din,vh_weight)
## worst  0.9990397  0.64082722  0.5583683  0.2826454
## observed 0.9990397  0.05038042  0.5504003  0.1831978
## estimate 0.9990397  0.42190878  0.5073782  0.1054095
```

## GLM Tests that are still applicable

- Overall model fit tests
  - Quantile Plots (Lift Curves)
  - Lorenz Curves (Measures segmentation power)
- Significance by term
  - (Approximate) P-value
  - Confidence Intervals (within plots)
  - AIC\* would ideally decrease after each term added
  - F nested model test
  - Residual Plots
  - Univariate Observed Average vs. Predicted Average



Formula	Predictors	AIC
~pol_coverage	1	75,573
~pol_coverage + pol_usage	2	75,422
~pol_coverage + pol_usage + s(drv_age1, k = 4)	3	75,406
~pol_coverage + pol_usage + s(drv_age1, k = 4) + s(vh_age, k = 4)	4	75,118
~pol_coverage + pol_usage + s(drv_age1, k = 4) + s(vh_age, k = 4) + te(vh_dln, vh_weight, k = 3)	5	74,955

\*The formula for AIC is different from a GLM, but is still readily available in R

## References

- June 2021 Book Club: Generalized Additive Models GAM
  - <https://www.youtube.com/watch?v=F1fMKy4fMIk>
- April 2021 Book Club: From GLMs to GAMs
  - <https://www.youtube.com/watch?v=vRbHqbNINx8>
- DataCamp R coding course: Nonlinear Modeling with GAMs in R
  - <https://app.datacamp.com/learn/courses/nonlinear-modeling-with-generalized-additive-models-gams-in-r>

**APPENDIX B – INFORMATION ELEMENTS AND GUIDANCE FOR A REGULATOR TO MEET BEST PRACTICES’ OBJECTIVES (WHEN REVIEWING GLMSGAMS)**

This appendix identifies the information a state insurance regulator may need to review a predictive model used by an insurer to support a personal automobile or home insurance rating plan. The list is lengthy but not exhaustive. It is not intended to limit the authority of a regulator to request additional information in support of the model or filed rating plan. Nor is every item on the list intended to be a requirement for every filing. However, the items listed should help guide a regulator to sufficient information that helps determine if the rating plan meets state-specific filing and legal requirements.

Documentation of the design and operational details of the model will help ensure the business continuity and transparency of the models used. Documentation should be sufficiently detailed and complete to enable a qualified third party to form a sound judgment on the suitability of the model for the intended purpose. The theory, assumptions, methodologies, software, and empirical bases should be explained, as well as the data used in developing and implementing the model. Relevant testing and ongoing performance testing need to be documented. Key model limitations and overrides need to be pointed out so that stakeholders understand the circumstances under which the model does not work effectively. End-user documentation should be provided and key reports using the model results described. Major changes to the model need to be documented and shared with regulators in a timely and appropriate manner. Information technology (IT) controls should be in place, such as a record of versions, change control, and access to the model.<sup>1</sup>

Many information elements listed below are probably confidential, proprietary, or trade secret and should be treated as such, in accordance with state laws and/or regulations. Regulators should be aware of their state laws and/or regulations on confidentiality when requesting data from insurers that may be proprietary or trade secret. For example, some proprietary models may have contractual terms (with the insurer) that prevent disclosure to the public. Without clear necessity, exposing this data to additional dissemination may compromise the model’s protection.<sup>2</sup>

Although the list of information is long, the insurer should already have internal documentation on the model for more than half of the information listed. The remaining items on the list require either minimal analysis (approximately 25%) or deeper analysis to generate for a regulator (approximately 25%).

The “Level of Importance to the Regulator’s Review” is a ranking of information a regulator may need to review which is based on the following level criteria:

**Level 1** – This information is necessary to begin the review of a predictive model. These data elements pertain to basic information about the type and structure of the model, the data and variables used, the assumptions made, and the goodness of fit. Ideally, this information would be included in the filing documentation with the initial submission of a filing made based on a predictive model.

**Level 2** – This information is necessary to continue the review of all but the most basic models, such as those based only on the filer’s internal data and only including variables that are in the filed rating plan. These data elements provide more detailed information about the model and address questions arising from review of the information in Level 1. Insurers concerned with speed to market may also want to include this information in the filing documentation.

**Level 3** – This information is necessary to continue the review of a model where concerns have been raised and not resolved based on review of the information in Level 1 and Level 2. These data elements address even more detailed aspects of the model. This information does not necessarily need to be included with the initial submission, unless specifically requested by a particular state, as it is typically requested only if the reviewer has concerns that the model may not comply with state laws and/or regulations.

**Level 4** – This information is necessary to continue the review of a model where concerns have been raised and not resolved based on the information in Level 1, Level 2, and Level 3. This most granular level of detail is addressing the basic building blocks of the model and does not necessarily need to be included by the filer with the initial submission, unless specifically requested by a particular state. It is typically requested only if the reviewer has serious concerns that the model may produce rates or rating factors that are excessive, inadequate, and/or unfairly discriminatory.

Lastly, although the best practices presented in this white paper will readily be transferrable to review of other predictive models, the information elements presented here might be useful only with deeper adaptations when starting to review different types of predictive

<sup>1</sup> Bourdeau, M., 2016. “Model Risk Management: An Overview,” The Modeling Platform, Issue 4, December. Accessed online at <https://www.soa.org/globalassets/assets/library/newsletters/the-modeling-platform/2016/december/mp-2016-iss4.pdf>.

<sup>2</sup> There are some models that are made public by the vendor and would not result in a hindrance of the model’s protection.

models. If the model is not a GLM, some listed items might not apply; e.g., not all predictive models generate p-values or F tests. Depending on the model type, other considerations might be important but are not listed here. When information elements presented in this appendix are applied to lines of business other than personal automobile and home insurance or other type of models, unique considerations may arise. In particular, data volume and credibility may be lower for other lines of business. Regulators should be aware of the context in which a predictive model is deployed, the uses to which the model is proposed to be put, and the potential consequences the model may have on the insurer, its customers, and its competitors. This white paper does not delve into these possible considerations, but regulators should be prepared to address them as they arise.

**A. SELECTING MODEL INPUT**

Section	Information Element	Level of Importance to the Regulator's Review	Comments
<b>1. Available Data Sources</b>			
A.1.a	Review the details of sources for both insurance and non-insurance data used as input to the model (only need sources for filed input characteristics included in the filed model).	1	<p>Request details of data sources, whether internal to the company or from external sources. For insurance experience (policy or claim), determine whether data are aggregated by calendar, accident, fiscal, or policy year and when it was last evaluated. For each data source, get a list of all data elements used as input to the model that came from that source. For insurance data, get a list all companies whose data is included in the datasets.</p> <p>Request details of any non-insurance data used (customer-provided or other), whether the data was collected by use of a questionnaire/checklist, whether data was voluntarily reported by the applicant, and whether any of the data is subject to the federal Fair Credit Reporting Act (FCRA). If the data is from an outside source, find out what steps were taken to verify the data was accurate, complete, and unbiased in terms of relevant and representative time frame, representative of potential exposures, and lacking in obvious correlation to protected classes.</p> <p><b>Note:</b> Reviewing source details should not make a difference when the model is new or refreshed; refreshed models would report the prior version list with the incremental changes due to the refresh.</p>
A.1.b	Reconcile aggregated insurance data underlying the model with available external insurance reports.	4	Accuracy of insurance data should be reviewed. It is assumed that the data in the insurer's data banks is subject to routine internal company audits and reconciliation. "Aggregated data" is straight from the insurer's data banks without further modification (i.e., not scrubbed or transformed for the purposes of modeling). In other words, the data would not have been specifically modified for the purpose of model building. The company should provide some form of reasonability check that the data makes sense when checked against other audited sources.

Section	Information Element	Level of Importance to the Regulator's Review	Comments
A.1.c	Review the geographic scope and geographic exposure distribution of the raw data for relevance to the state where the model is filed.	2	Many models are developed using a countrywide or a regional dataset. The company should explain how the data used to build the model makes sense for a specific state. The regulator should inquire which states were included in the data underlying the model build, testing, and validation. The company should provide an explanation where the data came from geographically and that it is a good representation for a state; i.e., the distribution by state should not introduce a geographic bias. However, there could be a bias by peril or wind-resistant building codes. Evaluate whether the data is relevant to the loss potential for which it is being used. For example, verify that hurricane data is only used where hurricanes can occur.
<b>2. Sub-Models</b>			
A.2.a	Consider the relevance of (i.e., whether there is bias) of overlapping data or variables used in the model and sub-models.	1	Check if the same variables/datasets were used in the model, a sub-model, or as stand-alone rating characteristics. If so, verify the insurance company has processes and procedures in place to assess and address double-counting or redundancy.
A.2.b	Determine if the sub-model was previously approved (or accepted) by the regulatory agency.	1	If the sub-model was previously approved/accepted, that may reduce the extent of the sub-model's review. If approved, obtain the tracking number(s) (e.g., state, SERFF) and verify when and if it was the same model currently under review.  Note: A previous approval does not necessarily confer a guarantee of ongoing approval; e.g., when statutes and/or regulations have changed or if a model's indications have been undermined by subsequent empirical experience. However, knowing whether a model has been previously approved can help focus the regulator's efforts and determine whether the prior decision needs to be revisited. In some circumstances, direct dialogue with the vendor could be quicker and more useful.



Section	Information Element	Level of Importance to the Regulator's Review	Comments
A.2.c	Determine if the sub-model output was used as input to the <b>GEMGAM</b> ; obtain the vendor name, as well as the name and version of the sub-model.	1	<p>To accelerate the review of the filing, it may be desirable to request (from the company), the name and contact information for a vendor representative. The company should provide the name of the third-party vendor and a contact in the event the regulator has questions. The “contact” can be an intermediary at the insurer (e.g., a filing specialist), who can place the regulator in direct contact with a subject-matter expert (SME) at the vendor.</p> <p>Examples of such sub-models include credit/financial scoring algorithms and household composite score models. Sub-models can be evaluated separately and in the same manner as the primary model under evaluation. A sub-model contact for additional information should be provided. Sub-model SMEs may need to be brought into the conversation with regulators (whether in-house or third-party sub-models are used).</p>
A.2.d	If using catastrophe model output, identify the vendor and the model settings/assumptions used when the model was run.	1	<p>To accelerate the review of the filing, get contact information for the SME that ran the model and an SME from the vendor. The “SME” can be an intermediary at the insurer (e.g., a filing specialist), who can place the regulator in direct contact with the appropriate SMEs at the insurer or model vendor.</p> <p>For example, it is important to know hurricane model settings for storm surge, demand surge, and long-term/short-term views.</p>
A.2.e	Obtain an explanation of how catastrophe models are integrated into the model to ensure no double-counting.	1	<p>If a weather-based sub-model is input to the <b>GLM GAM</b> under review, loss data used to develop the model should not include loss experience associated with the weather-based sub-model. Doing so could cause distortions in the modeled results by double-counting such losses when determining relativities or loss loads in the filed rating plan.</p> <p>For example, redundant losses in the data may occur when non-hurricane wind losses are included in the data while also using a severe convective storm model in the actuarial indication. Such redundancy may also occur with the inclusion of fluvial or pluvial flood losses when using a flood model or inclusion of freeze losses when using a winter storm model.</p>
A.2.f	If using output of any scoring algorithms, obtain a list of the variables used to determine the score and provide the source of the data used to calculate the score.	1	Any sub-model should be reviewed in the same manner as the primary model that uses the sub-model's output as input. Depending on the result of item A.2.b, the importance of this item may be decreased.

Section	Information Element	Level of Importance to the Regulator's Review	Comments
<b>3. Adjustments to Data</b>			
A.3.a	Determine if premium, exposure, loss, or expense data were adjusted (e.g., developed, trended, adjusted for catastrophe experience, or capped). If so, how? Do the adjustments vary for different segments of the data? If so, identify the segments and how the data was adjusted.	2	<p>The rating plan or indications underlying the rating plan may provide special treatment of large losses and non-modeled large loss events. If such treatments exist, the company should provide an explanation how they were handled. These treatments need to be identified and the company/regulator needs to determine whether model data needs to be adjusted.</p> <p>For example, should large bodily injury (BI) liability losses in the case of personal automobile insurance be excluded, or should large non-catastrophe wind/hail claims in home insurance be excluded from the model's training, test and validation data? Look for anomalies in the data that should be addressed. For example, is there an extreme loss event in the data? If other processes were used to load rates for specific loss events, how is the impact of those losses considered?</p> <p>Examples of losses that can contribute to anomalies in the data are large losses or flood, hurricane, or severe convective storm losses for personal automobile comprehensive or home insurance.</p>
A.3.b	Identify adjustments that were made to aggregated data (e.g., transformations, binning and/or categorizations). If any, identify the name of the characteristic/variable and obtain a description of the adjustment.	1	
A.3.c	Ask for aggregated data (one dataset of pre-adjusted/scrubbed data and one dataset of post-adjusted/scrubbed data) that allows the regulator to focus on the univariate distributions and compare raw data to adjusted/binning/transformed/etc. data.	4	<p>This is most relevant for variables that have been "scrubbed" or adjusted.</p> <p>Though most regulators may never ask for aggregated data and do not plan to rebuild any models, a regulator may ask for this aggregated data or subsets of it.</p> <p>It would be useful to the regulator if the percentage of exposures and premium for missing information from the model data by category are provided. This data can be displayed in either graphical or tabular formats.</p>
A.3.d	Determine how missing data was handled.	1	<p>This is most relevant for variables that have been "scrubbed" or adjusted. The regulator should be aware of assumptions the modeler made in handling missing, null, or "not available" values in the data.</p> <p>For example, it would be helpful to the reviewer if the modeler were to provide a statement as to whether there is any systemic reason for missing data. If adjustments or recoding of values were made, they should be explained. It may also be useful to the regulator if the percentage of exposures and premium for missing information from the model data are provided. This data can be displayed in either graphical or tabular formats.</p>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
A.3.e	If duplicate records exist, determine how they were handled.	1	
A.3.f	Determine if there were any material outliers identified and subsequently adjusted during the scrubbing process.	3	Look for a discussion of how outliers were handled. If necessary, the regulator may want to investigate further by getting a list (with description) of the types of outliers and determine what adjustments were made to each type of outlier. To understand the filer's response, the regulator should ask for the filer's materiality standard.
<b>4. Data Organization</b>			
A.4.a	Obtain documentation on the methods used to compile and organize data, including procedures to merge data from different sources or filter data based on particular characteristics and a description of any preliminary analyses, data checks, and logical tests performed on the data and the results of those tests.	2	This should explain how data from separate sources was merged and/or how subsets of policies, based on selected characteristics, are filtered to be included in the data underlying the model and the rationale for that filtering.
A.4.b	Obtain documentation on the insurer's process for reviewing the appropriateness, reasonableness, consistency, and comprehensiveness of the data, including a discussion of the rational relationship the data has to the predicted variable.	2	An example is when by-peril or by-coverage modeling is performed; the documentation should be for each peril/coverage and make rational sense. For example, if "murder" or "theft" data are used to predict the wind peril, the company should provide support and a rational explanation for their use.
A.4.c	Identify material findings the company had during its data review and obtain an explanation of any potential material limitations, defects, bias, or unresolved concerns found or believed to exist in the data. If issues or limitations in the data influenced modeling analysis and/or results, obtain a description of those concerns and an explanation of how modeling analysis was adjusted and/or results were impacted.	1	"None" or "N/A" may be an appropriate response.

**B. BUILDING THE MODEL**

Section	Information Element	Level of Importance to the Regulator's Review	Comments
<b>1. High-Level Narrative for Building the Model</b>			
B.1.a	Identify the type of model underlying the rate filing (e.g., <u>GAM</u> , GLM, decision tree, Bayesian GLM, gradient-boosting machine, neural network, etc.). Understand the model's role in the rating system and provide the reasons why that type of model is an appropriate choice for that role.	1	It is important to understand if the model in question is a <u>GLM-GAM</u> and, therefore, these information elements are applicable; or if it is some other model type, in which case other reasonable review approaches may be considered. There should be an explanation of why the model (using the variables included in it) is appropriate for the line of business. If by-peril or by-coverage modeling is used, the explanation should be by-peril/by-coverage. <b>Note:</b> If the model is not a <u>GLM/GAM</u> , the information elements in this white paper may not apply in their entirety.
B.1.b	Identify the software used for model development. Obtain the name of the software vendor/developer, software product, and a software version reference used in model development.	3	Changes in software from one model version to the next may explain if such changes, over time, contribute to changes in the modeled results. The company should provide the name of the third-party vendor and a "contact" in the event the regulator has questions. The "contact" can be an intermediary at the insurer (e.g., a filing specialist) who can place the regulator in direct contact with the appropriate SME at the vendor.  Open-source software/programs used in model development should be identified by name and version the same as if from a vendor.
B.1.c	Obtain a description how the available data was divided between model training, test, and/or validation datasets. The description should include an explanation why the selected approach was deemed most appropriate, whether the company made any further subdivisions of available data, and reasons for the subdivisions (e.g., a portion separated from training data to support testing of components during model building). Determine if the validation data was accessed before model training was completed and, if so, obtain an explanation of why that came to occur. Obtain a discussion of whether the model was rebuilt using all the data or if it was only based on the training data.	1	The reviewer should be aware that modelers may break their data into three or just two datasets. Although the term "training" is used with little ambiguity, "test" and "validation" are terms that are sometimes interchanged, or the word "validation" may not be used at all.  It would be unexpected if validation and/or test data were used for any purpose other than validation and/or test, prior to the selection of the final model. However, according to the CAS monograph, "Generalized Linear Models for Insurance Rating": "Once a final model is chosen, ... we would then go back and rebuild it using all of the data, so that the parameter estimates would be at their most credible."  The reviewer should note whether a company employed cross-validation techniques instead of a training/test/validation dataset approach. If cross-validation techniques were used, the reviewer should request a description of how cross-validation was done and confirm that the final model was not built on any particular subset of the data, but rather the full dataset.

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.1.d	Obtain a brief description of the development process, from initial concept to final model and filed rating plan.	1	The narrative should have the same scope as the filing.
B.1.e	Obtain a narrative on whether loss ratio, pure premium, or frequency/severity analyses were performed and, if separate frequency/severity modeling was performed, how pure premiums were determined.	1	
B.1.f	Identify the model's target variable.	1	A clear description of the target variable is key to understanding the purpose of the model. It may also prove useful to obtain a sample calculation of the target variable in Excel format, starting with the "raw" data for a policy, or a small sample of policies, depending on the complexity of the target variable calculation.
B.1.g	Obtain a description of the variable selection process.	1	The narrative regarding the variable selection process may address matters such as the criteria upon which variables were selected or omitted, identification of the number of preliminary variables considered in developing the model versus the number of variables that remained, and any statutory or regulatory limitations that were taken into account when making the decisions regarding variable selection.  The modeler should comment on the use of automated feature selection algorithms to choose predictor variables and explain how potential overfitting that can arise from these techniques was addressed.
B.1.h	In conjunction with variable selection, obtain a narrative on how the company determined the granularity of the rating variables during model development.	3	The narrative should include discussion of how credibility was considered in the process of determining the level of granularity of the variables selected.
B.1.i	Determine if model input data was segmented in anyway (e.g., by-coverage, by-peril, or by-form basis). If so, obtain a description of data segmentation and the reasons for data segmentation.	1	The regulator would use this to follow the logic of the modeling process.
B.1.j	If adjustments to the model were made based on credibility considerations, obtain an explanation of the credibility considerations and how the adjustments were applied.	2	Adjustments may be needed, given that models do not explicitly consider the credibility of the input data or the model's resulting output; models take input data at face value and assume 100% credibility when producing modeled output.
<b>2. Medium-Level Narrative for Building the Model</b>			
B.2.a	At crucial points in model development, if selections were made among alternatives regarding model assumptions or techniques, obtain a narrative on the judgment used to make those selections.	3	

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.2.b	If post-model adjustments were made to the data and the model was rerun, obtain an explanation on the details and the rationale for those adjustments.	2	Evaluate the addition or removal of variables and the model fitting. It is not necessary for the company to discuss each iteration of adding and subtracting variables, but the regulator should gain a general understanding of how these adjustments were done, including any statistical improvement measures relied upon.
B.2.c	Obtain a description of the testing that was performed during the model-building process, including an explanation of the decision-making process to determine which interactions were included and which were not.	3	<p>There should be a description of the testing that was performed during the model-building process. Examples of tests that may have been performed include univariate testing and review of a correlation matrix.</p> <p>The number of interaction terms that could potentially be included in a model increases far more quickly than the number of "main effect" variables (i.e., the basic predictor variables that can be interacted together). Analyzing each possible interaction term individually can be unwieldy. It is typical for interaction terms to be excluded from the model by default, and only included where they can be shown to be particularly important. So, as a rule of thumb, the regulator's emphasis should be on understanding why the insurer included the interaction terms it did, rather than on why other candidate interactions were excluded.</p> <p>In some cases, however, it could be reasonable to inquire about why a particular interaction term was excluded from a model—for example, if that interaction term was ubiquitous in similar filings and was known to be highly predictive, or if the regulator had reason to believe that the interaction term would help differentiate dissimilar risks within an excessively heterogeneous rating segment.</p>
B.2.d	For the <u>GLM-GAM</u> , identify the link function used. Identify which distribution was used for the model (e.g., Poisson, Gaussian, log-normal, Tweedie). Obtain an explanation of why the link function and distribution were chosen. Obtain the formulas for the distribution and link functions, including specific numerical parameters of the distribution. If changed from the default, obtain a discussion of applicable convergence criterion.	1	Solving the <u>GLM-GAM</u> is iterative and the modeler can check to see if fit is improving. At some point, convergence occurs; however, when it occurs can be subjective or based on threshold criteria. If the software's default convergence criteria were not relied upon, an explanation of any deviation should be provided. <u>If the GAM did not reach convergence, an explanation should be provided.</u>
B.2.e	Obtain a narrative on the formula relationship between the data and the model outputs, with a definition of each model input and output. The narrative should <u>include all coefficients describe all parametric (non-smoothed) and smoothed terms</u> necessary to evaluate the predicted pure premium, relativity, or other value, for any real or hypothetical set of inputs.	2	<u>GAMs can have both parametric terms similar to GLMs and smoothed terms. The smoothed terms are the sum of multiple basis function which can take on a variety of types. The narrative provided should clarify which variables are included as parametric terms (non-smoothed) and which variables are included within a smoothed function.</u>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.2.f	If there were data situations in which <u>GLM-GAM</u> weights were used, obtain an explanation of how and why they were used.	3	Investigate whether identical records were combined to build the model.
<b>3. Predictor Variables</b>			
B.3.a	Obtain a complete data dictionary, including the names, <u>data types</u> , <u>variable fit types</u> , definitions, and uses of each predictor variable, offset variable, control variable, proxy variable, geographic variable, geodemographic variable, and all other variables in the model used on their own or as an interaction with other variables (including sub-models and external models).	1	<u>Data F</u> types of variables might be continuous, discrete, Boolean, etc. Definitions should not use programming language or code. <u>Variable fit types include parametric (non-smoothed) and smoothed</u> . For any variable(s) intended to function as a control or offset, obtain an explanation of its purpose and impact. Also, for any use of interaction between variables, obtain an explanation of its rationale and impact.
B.3.b	Obtain a list of predictor variables considered but not used in the final model, and the rationale for their removal.	4	The purpose of this requirement is to identify variables the company finds to be predictive but ultimately may reject for reasons other than loss-cost considerations (e.g., price optimization). Also, look for variables the company tested and then rejected. This item could help address concerns about data dredging. The reasonableness of including a variable with a given significance level could depend greatly on the other variables the company evaluated for inclusion in the model and the criteria for inclusion or omission.  For instance, if the company tested 1,000 similar variables and selected the one with the lowest p-value of 0.001, this would be a far, far weaker case for statistical significance than if that variable was the only one the company evaluated. <b>Note:</b> Context matters.
B.3.c	Obtain a correlation matrix for all <u>parametric (non-smoothed)</u> predictor variables included in the model and sub-model(s).	3	While <u>GLMs-GAMs</u> accommodate collinearity, the correlation matrix provides more information about the magnitude of correlation between variables. The company should indicate what statistic was used (e.g., Pearson, Cramer's V). The regulatory reviewer should understand what statistic was used to produce the matrix but should not prescribe the statistic.
B.3.d	<u>Obtain concurrency metrics for all smoothed predictor variables included in the model and sub-models.</u>	<u>3</u>	<u>GAMs can suffer from high concurrency in addition to high collinearity. Concurrency is the degree to which the smoothed terms move together. The company should indicate what concurrency metrics were used. The regulatory reviewer should understand what metric was used to produce the concurrency metrics but should not prescribe the type of metrics.</u>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.3.e	Obtain a rational explanation for why an increase in each predictor variable should increase or decrease frequency, severity, loss costs, expenses, or any element or characteristic being predicted.	3	<p>The explanation should go beyond demonstrating correlation. Considering possible causation may be relevant, but proving causation is neither practical nor expected. If no rational explanation can be provided, greater scrutiny may be appropriate.</p> <p>For example, the regulator should look for unfamiliar predictor variables and, if found, the regulator should seek to understand the connection that variable has to increasing or decreasing the target variable.</p>
B.3.f	If the modeler made use of one or more dimensionality reduction techniques, such as a principal component analysis (PCA), obtain a narrative about that process, an explanation why that technique was chosen, and a description of the step-by-step process used to transform observations (usually correlated) into a set of (usually linearly uncorrelated) transformed variables. In each instance, obtain a list of the pre-transformation and post-transformation variable names, as well as an explanation of how the results of the dimensionality reduction technique was used within the model.	2	
<b>4. Adjusting Data, Model Validation, and Goodness-of-Fit Measures</b>			
B.4.a	Obtain a description of the methods used to assess the statistical significance/goodness-of-fit of the model to validation data, such as lift charts and statistical tests. Compare the model's projected results to historical actual results and verify that modeled results are reasonably similar to actual results from validation data.	1	<p>For models that are built using multistate data, validation data for some segments of risk is likely to have low credibility in individual states. Nevertheless, some regulators require model validation on state-only data, especially when analysis using state-only data contradicts the countrywide results. State-only data might be more applicable but could also be impacted by low credibility for some segments of risk.</p> <p><b>Note:</b> It may be useful to consider geographic stability measures for territories within the state.</p>



Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.4.b	<p>For all <u>parametric (non-smoothed)</u> variables (<del>discrete or continuous</del>), review the appropriate parameter values and relevant tests of significance, such as confidence intervals, chi-square tests, p-values, or F tests. Determine if model development data, validation data, test data, or other data was used for these tests.</p>	1	<p>Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.</p> <p>Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values, and any other relevant and material tests.</p> <p>For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; e.g., confidence intervals around each level of an AOI curve might be more than what is needed.</p>
B.4.c	<p><u>For all smoothed variables, review plots representing the smooths and relevant tests of significance, such as approximate confidence intervals, chi-square tests, approximate p-values, or F tests. Determine if model development data, validation data, test data, or other data was used for these tests.</u></p>	1	<p><u>Smoothed terms in a GAM can have many coefficients based on the number of basis functions. It is difficult to interpret the impact of the smoothed term based on the coefficients. Instead, regulators can review plots representing the cumulative effect of smoothed terms. The company could provide variable value on the x-axis and partial effects on the y-axis. The company could alternatively provide variable value on the x-axis and model prediction for the base risk on the y-axis. The company should provide confidence interval lines regardless of the type of plot. The regulatory reviewer should assess whether the plot has an intuitive shape and whether the curve extrapolates well, especially to areas of the curve representing thinner data.</u></p> <p><u>Smoothed interaction terms should also be expressed as plots. Heat map contour plots or 3D perspective plots may be useful.</u></p> <p><u>GAMs are a form of penalized regression which complicates the calculation of p-values. The p-values for the smoothed terms output by the modeling software are generally approximate p-values for GAMs. Approximate p-values should be reviewed at the smoothed variable level. The regulatory reviewer may want to select a smaller threshold for smoothed terms than they used for the parametric term p-value threshold.</u></p>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.4.d	<p><u>For all smoothed variables, request details about the basis functions comprising each smoothed function.</u></p>	4	<p><u>Smooth functions are based on a sum of basis functions. The company should provide the number of basis functions for each smooth and discuss how the number was chosen.</u></p> <p><u>There are many types of smooth functions that can be applied. Examples include thin plate splines, cubic splines, and cyclic splines. The company should provide the type of each smooth and a narrative on why that type of smooth is appropriate for the variable.</u></p>
B.4.e	<p>Identify the threshold for statistical significance and explain why it was selected. Obtain a reasonable and appropriately supported explanation for keeping the variable for each discrete variable level where the p-values were not less than the chosen threshold.</p>	1	<p>The explanation should clearly identify the thresholds for statistical significance used by the modeler. Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.</p> <p>Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter values <u>for parametric terms, plots representing smoothed terms</u>, confidence intervals, chi-square tests, p-values, and any other relevant and material tests.</p>
B.4.f	<p>For overall discrete variables, review type 3 chi-square tests, p-values, F tests and any other relevant and material test. Determine if model development data, validation data, test data, or other data was used for these tests.</p>	2	<p>Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.</p> <p>Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter values <u>for parametric terms, plots representing smoothed terms</u>, confidence intervals, chi-square tests, p-values, and any other relevant and material tests.</p> <p>For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; e.g., confidence intervals around each level of an AOI curve might be more than what is needed.</p>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.4.g	Obtain evidence that the model fits the training data well, for individual variables, for any relevant combinations of variables, and for the overall model.	2	<p>For a <u>GLMGAM</u>, such evidence may be available using chi-square tests, <u>approximate</u> p-values, F tests and/or other means.</p> <p>The steps taken during modeling to achieve goodness-of-fit are likely to be numerous and laborious to describe, but they contribute much of what is generalized about a <u>GLMGAM</u>.</p> <p>The regulator should not assume to know what the company did and ask, "How?" Instead, the regulator should ask what the company did and be prepared to ask follow-up questions.</p>
B.4.h	For continuous variables, provide confidence intervals, chi-square tests, <u>approximate</u> p-values, and any other relevant and material test. Determine if model development data, validation data, test data, or other data was used for these tests.	2	<p>Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.</p> <p>Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter <u>values for parametric terms, plots representing smoothed terms value</u>, confidence intervals, chi-square tests, <u>approximate</u> p-values and any other relevant and material tests.</p> <p>For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an AOI curve might be more than what is needed.</p>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.4.i	Obtain a description how the model was tested for stability over time.	2	<p>Evaluate the build/test/validation datasets for potential time-sensitive model distortions (e.g., a winter storm in year 3 of 5 can distort the model in both the testing and validation datasets).</p> <p>Obsolescence over time is a model risk (e.g., old data for a variable or a variable itself may no longer be relevant). If a model being introduced now is based on losses from years ago, the reviewer should be interested in knowing whether that model would be predictive in the proposed context. Validation using recent data from the proposed context might be requested. Obsolescence is a risk even for a new model based on recent and relevant loss data.</p> <p>The reviewer may want to inquire as to the following: What steps, if any, were taken during modeling to prevent or delay obsolescence? What controls exist to measure the rate of obsolescence? What is the plan and timeline for updating and ultimately replacing the model?</p> <p>The reviewer should also consider that as newer technologies enter the market (e.g., personal automobile) their impact may change claim activity over time (e.g., lower frequency of loss). So, it is not necessarily a bad thing that the results are not stable over time.</p>
B.4.j	Obtain a narrative on how potential concerns with overfitting were addressed.	2	
B.4.k	<u>Obtain the value of the model complexity parameter <math>\lambda</math> and a discussion of how it was chosen.</u>	<u>4</u>	<u>GAMs are a form of penalized regression. Smaller values of <math>\lambda</math> allow the model to increase complexity and fit "wigglier" data. Larger values of <math>\lambda</math> constricts the model and increases smoothness. Multiple automated approaches exist for tuning <math>\lambda</math> including predictive approaches that optimize AIC or Bayesian approaches such as Restricted Maximum Likelihood.</u>
B.4.l	Obtain support demonstrating that the <u>overall GLM GAM</u> assumptions are appropriate.	3	<p>A visual review of plots of actual errors is usually sufficient.</p> <p>The reviewer should look for a conceptual narrative covering these topics: How does this particular <u>GLM GAM</u> work? Why did the rate filer do what it did? Why employ this design instead of alternatives? Why choose this particular distribution function and this particular link function? A company response may be at a fairly high level and reference industry practices.</p> <p>If the reviewer determines that the model makes no assumptions that are considered to be unreasonable, the importance of this item may be reduced.</p>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.4.m	Obtain support demonstrating that the assumptions for each smoothed term are appropriate.	3	<u>The reviewer should look for a narrative on how the fit of the smoothed terms was checked for reasonability.</u> <u>It may be useful to ask for each plot of the smoothed terms to include residuals to ensure that the smoothed line runs through the middle of the residuals.</u> <u>It may be useful for the company to provide tests that each smoothed term is not predictive of residual values (similar to tests achieved in the gam.check() function of the mcgv R package). These tests would ideally demonstrate that the residuals are randomly distributed across all parts of the smoothed term.</u>
B.4.n	Obtain 5-10 sample records with corresponding output from the model for those records.	4	
<b>5. "Old Model" Versus "New Model"</b>			
B.5.a	Obtain an explanation of why this model is an improvement to the current rating plan. If it replaces a previous model, find out why it is better than the one it is replacing; determine how the company reached that conclusion and identify metrics relied on in reaching that conclusion. Look for an explanation of any changes in calculations, assumptions, parameters, <u>changes in smoothed variable plots</u> , and data used to build this model from the previous model.	2	The regulator should expect to see improvement in the new class plan's predictive ability or other sufficient reason for the change.
B.5.b	Determine if two Gini coefficients were compared and obtain a narrative on the conclusion drawn from this comparison.	3	This information element requests a comparison of Gini coefficient from the prior model to the Gini coefficient of proposed model. It is expected that there should be improvement in the Gini coefficient. A higher Gini coefficient indicates greater differentiation produced by the model and how well the model fits that data. This is relevant when one model is being updated or replaced. The regulator should expect to see improvement in the new class plan's predictive ability. One example of a comparison might be sufficient. <b>Note:</b> This comparison is not applicable to initial model introduction. Reviewer can look to CAS monograph, "Generalized Linear Models for Insurance Rating."
B.5.c	Determine if double-lift charts were analyzed and obtain a narrative on the conclusion drawn from this analysis.	3	One example of a comparison might be sufficient. <b>Note:</b> "Not applicable" is an acceptable response.

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.5.d	If replacing an existing model, obtain a list of any predictor variables used in the old model that are not used in the new model. Obtain an explanation of why these variables were dropped from the new model.  Obtain a list of all new predictor variables in the new model that were not in the prior old model.	2	It is useful to differentiate between old and new variables, so the regulator can prioritize more time on variables not yet reviewed.
<b>6. Modeler Software</b>			
B.6.a	Request access to SMEs (e.g., modelers) who led the project, compiled the data, and/or built the model.	4	The filing should contain a contact that can put the regulator in touch with appropriate SMEs and key contributors to the model development to discuss the model.

**C. THE FILED RATING PLAN**

Section	Information Element	Level of Importance to the Regulator's Review	Comments
<b>I. General Impact of Model on Rating Algorithm</b>			
C.1.a	In the actuarial memorandum or explanatory memorandum, for each model and sub-model (including external models), look for a narrative that explains each model and its role (i.e., how it was used) in the rating system.	1	<p>The “role of the model” relates to how the model integrates into the rating plan as a whole and where the effects of the model are manifested within the various components of the rating plan. This is not intended as an overarching statement of the model’s goal, but rather a description of how specifically the model is used.</p> <p>This item is particularly important, if the role of the model cannot be immediately discerned by the reviewer from a quick review of the rate and/or rule pages. (Importance is dependent on state requirements and ease of identification by the first layer of review and escalation to the appropriate review staff.)</p>
C.1.b	Obtain an explanation of how the model was used to adjust the filed rating algorithm.	1	<p>Models are often used to produce factor-based indications, which are then used as the basis for the selected changes to the rating plan. It is the changes to the rating plan that create impacts.</p> <p><u>The regulator should consider asking how the smoothed functions of the GAM will be implemented.</u></p> <p>The regulator should consider asking for an explanation of how the model was used to adjust the rating algorithm.</p>
C.1.c	Obtain a complete list of characteristics/variables used in the proposed rating plan, including those used as input to the model (including sub-models and composite variables) and all other characteristics/variables (not input to the model) used to calculate a premium. For each characteristic/variable, determine if it is only input to the model, whether it is only a separate univariate rating characteristic, or whether it is both input to the model and a separate univariate rating characteristic. The list should include transparent descriptions (in plain language) of each listed characteristic/variable.	1	<p>Examples of variables used as inputs to the model and used as separate univariate rating characteristics might be criteria used to determine a rating tier or household composite characteristic.</p>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
<b>2. Relevance of Variables and Relationship to Risk of Loss</b>			
C.2.a	Obtain a narrative regarding how the characteristics/rating variables included in the filed rating plan relate to the risk of insurance loss(or expense) for the type of insurance productbeing priced.	2	The narrative should include a discussion of the relevance each characteristic/rating variable has on consumer behavior that would lead to a difference in risk of loss (or expense). The narrative should include a rational relationship to cost, and model results should be consistent with the expected direction of the relationship. <b>Note:</b> This explanation would not be needed if the connection between variables and risk of loss (or expense) has already been illustrated.
<b>3. Comparison of Model Outputs to Current and Selected Rating Factors</b>			
C.3.a	Compare relativities indicated by the model to both current relativities and the insurer's selected relativities for each risk characteristic/variable in the rating plan.	1	"Significant difference" may vary based on the risk characteristic/variable and context. However, the movement of a selected relativity should be in the direction of the indicated relativity; if not, an explanation is necessary as to why the movement is logical.
C.3.b	Obtain documentation and support for all calculations, judgments, or adjustments that connect the model's indicated values to the selected relativities filed in the rating plan.	1	The documentation should include explanations for the necessity of any such adjustments and each significantdifference between the model's indicated values and the selected values. This applies even to models that produce scores, tiers, or ranges of values for which indications can be derived. <b>Note:</b> This information is especially important if differences between model-indicated values and selected values are material and/or impact one consumer population more than another.
C.3.c	For each characteristic/variable used as both input to the model (including sub-models and composite variables) and as a separate univariate rating characteristic, obtain a narrative regarding how each characteristic/variable was tempered or adjusted to account for possible overlap or redundancy in what the characteristic/variable measures.	2	Modeling loss ratios with these characteristics/ variables as control variables would account for possible overlap. The insurer should address this possibility or other considerations; e.g., tier placement models often use risk characteristics/ variables that are also used elsewhere inthe rating plan. One way to do this would be to model the loss ratios resulting from a process that already uses univariate rating variables. Then the model/composite variables would be attempting to explain the residuals.
<b>4. Responses to Data, Credibility, and Granularity Issues</b>			
C.4.a	Determine what, if any, consideration was given to the credibility of the output data.	2	The regulator should determine at what level of granularity credibility is applied. If modeling was by-coverage, by-form, or by-peril, the company should explain how these were handled when there was not enough credible data by coverage, form, or peril to model.



Section	Information Element	Level of Importance to the Regulator's Review	Comments
C.4.b	If the rating plan is less granular than the model, obtain an explanation of why.	2	This is applicable if the company had to combine modeled output in order to reduce the granularity of the rating plan.
C.4.c	If the rating plan is more granular than the model, obtain an explanation of why.	2	A more granular rating plan may imply that the company had to extrapolate certain rating treatments, especially at the tails of a distribution of attributes, in a manner not specified by the model indications. It may be necessary to extrapolate due to data availability or other considerations.
<b>5. Definitions of Rating Variables</b>			
C.5.a	Obtain a narrative regarding adjustments made to model output (e.g., transformations, binning and/or categorizations). If adjustments were made, obtain the name of the characteristic/variable and a description of the adjustment.	2	If rating tiers or other intermediate rating categories are created from model output, the rate and/or rule pages should present these rating tiers or categories. The company should provide an explanation of how model output was translated into these rating tiers or intermediate rating categories.
<b>6. Supporting Data</b>			
C.6.a	Obtain aggregated state-specific, book-of-business-specific univariate historical experience data, separately for each year included in the model, consisting of loss ratio or pure premium relativities and the data underlying those calculations for each category of model output(s) proposed to be used within the rating plan. For each data element, obtain an explanation of whether it is raw or adjusted and, if the latter, obtain a detailed explanation for the adjustments.		For example, were losses developed/undeveloped, trended/untrended, capped/uncapped, etc.? Univariate indications should not necessarily be used to override more sophisticated multivariate indications. However, they do provide additional context and may serve as a useful reference.
C.6.b	Obtain an explanation of any material (especially directional) differences between model indications and state-specific univariate indications.	4	Multivariate indications may be reasonable as refinements to univariate indications, but possibly not for bringing about significant reversals of those indications. For instance, if the univariate indicated relativity for an attribute is 1.5 and the multivariate indicated relativity is 1.25, this is potentially a plausible application of the multivariate techniques. If, however, the univariate indicated relativity is 0.7 and the multivariate indicated relativity is 1.25, a regulator may question whether the attribute in question is negatively correlated with other determinants of risk. Credibility of state-level data should be considered when state indications differ from modeled results based on a broader dataset. However, the relevance of the broader dataset to the risks being priced should also be considered. Borderline reversals are not of as much concern. If multivariate indications perform well against the state-level data, this should suffice. However, credibility considerations need to be taken into account as state-level segmentation comparisons may not have enough credibility.

Section	Information Element	Level of Importance to the Regulator's Review	Comments
<b>7. Consumer Impacts</b>			
C.7.a	Obtain a listing of the top five rating variables that contribute the most to large swings in renewal premium, both as increases and decreases, as well as the top five rating variables with the largest spread of impact for both new and renewal business.	4	These rating variables may represent changes to rating factors, be newly introduced to the rating plan, or have been removed from the rating plan.
C.7.b	Determine if the company performed sensitivity testing to identify significant changes in premium due to small or incremental change in a single risk characteristic. If such testing was performed, obtain a narrative that discusses the testing and provides the results of that testing.	3	One way to see sensitivity is to analyze a graph of each risk characteristic's/variable's possible relativities. Look for significant variation between adjacent relativities and evaluate if such variation is reasonable and credible.
C.7.c	For the proposed filing, obtain the impacts on renewal business and describe the process used by management, if any, to mitigate those impacts.	2	Some mitigation efforts may substantially weaken the connection between premium and expected loss and expense and, hence, may be viewed as unfairly discriminatory by some states.
C.7.d	Obtain a rate disruption/dislocation analysis, demonstrating the distribution of percentage and/or dollar impacts on renewal business (created by rerating the current book of business) and sufficient information to explain the disruptions to individual consumers.	2	The analysis should include the largest dollar and percentage impacts arising from the filing, including the impacts arising specifically from the adoption of the model or changes to the model as they translate into the proposed rating plan.  While the default request would typically be for the distribution/dislocation of impacts at the overall filing level, the regulator may need to delve into the more granular variable-specific effects of rate changes if there is concern about particular variables having extreme or disproportionate impacts, or significant impacts that have otherwise yet to be substantiated.  See Appendix D for an example of a disruption analysis.
C.7.e	Obtain exposure distributions for the model's output variables and show the effects of rate changes at granular and summary levels, including the overall impact on the book of business.	3	See Appendix D for an example of an exposure distribution.

Section	Information Element	Level of Importance to the Regulator's Review	Comments
C.7.f	Identify policy characteristics, used as input to a model or sub-model, that remain “static” over a policy’s lifetime versus those that will be updated periodically. Obtain a narrative on how the company handles policy characteristics that are listed as “static,” yet change over time.	3	<p>Some examples of “static” policy characteristics are prior carrier tenure, prior carrier type, prior liability limits, claim history over past X years, or lapse of coverage. These are specific policy characteristics usually set at the time new business is written, used to create an insurance score or to place the business in a rating/underwriting tier, and often fixed for the life of the policy.</p> <p>The reviewer should be aware, and possibly concerned, how the company treats an insured over time when the insured’s risk profile based on “static” variables changes over time but the rate charged, based on a new business insurance score or tier assignment, no longer reflect the insured’s true and current risk profile.</p> <p>A few examples of “non-static” policy characteristics are age of driver, driving record, and credit information (FCRA-related). These are updated automatically by the company on a periodic basis, usually at renewal, with or without the policyholder explicitly informing the company.</p>
C.7.g	Obtain a means to calculate the rate charged a consumer.	3	<p>The filed rating plan should contain enough information for a regulator to be able to validate policy premium. However, for a complex model or rating plan, a score or premium calculator via Excel or similar means would be ideal, but this could be elicited on a case-by-case basis. The ability to calculate the rate charged could allow the regulator to perform sensitivity testing when there are small changes to a risk characteristic/variable. <b>Note:</b> This information may be proprietary.</p> <p>For the rating plan, the rate order of calculation rule may be sufficient. However, it may not be feasible for a regulator to get all the input data necessary to reproduce a model’s output. Credit and telematics models are examples of model types where model output would be readily available, but the input data would not be readily available to the regulator.</p>
C.7.h	In the filed rating plan, be aware of any non-insurance data used as input to the model (customer-provided or other). In order to respond to consumer inquiries, it may be necessary to inquire as to how consumers can verify their data and correct errors.	1	<p>If the data is from a third-party source, the company should provide information on the source. Depending on the nature of the data, it may need to be documented with an overview of who owns it.</p> <p>The topic of consumer verification may also need to be addressed, including how consumers can verify their data and correct errors.</p>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
<b>8. Accurate Translation of Model into a Rating Plan</b>			
C.8.a	Obtain sufficient information to understand how the model outputs are used within the rating system and to verify that the rating plan's manual, in fact, reflects the model output and any adjustments made to the model output.	1	The regulator can review the rating plan's manual to see that modeled output is properly reflected in the manual's rules, rates, factors, etc.
<b>9. Efficient and Effective Review of Rate Filing</b>			
C.9.a	Establish procedures to efficiently review rate filings and models contained therein.	1	<p>“Speed to market” is an important competitive concept for insurers. Although the regulator needs to understand the rate filing before accepting the rate filing, the regulator should not request information that does not increase his/her understanding of the rate filing.</p> <p>The regulator should review the state's rate filing review process and procedures to ensure that they are fair and efficient.</p>
C.9.b	Be knowledgeable of state laws and regulations in order to determine if the proposed rating plan (and models) are compliant with state laws and/or regulations.	1	This is a primary duty of state insurance regulators. The regulator should be knowledgeable of state laws and regulations and apply them to a rate filing fairly and efficiently. The regulator should pay special attention to prohibitions of unfair discrimination.
C.9.c	Be knowledgeable of state laws and regulations in order to determine if any information contained in the rate filing (and models) should be treated as confidential.	1	The regulator should be knowledgeable of state laws and regulations regarding confidentiality of rate filing information and apply them to a rate filing fairly and efficiently. Confidentiality of proprietary information is key to innovation and competitive markets.

**APPENDIX B (Continued)**

**Mapping Best Practices to Information Elements and Information Elements to Best Practices**

Table 1 maps the best practices to each GLM information element. Table 2 maps the GLM information elements to each best practice. With this mapping, a state insurance regulator interested in how to meet the objective of a best practice can consider the information elements associated with the best practice in the table.

Appendix B: Table 1 Best Practices Mapped to Information Element	
Information Element	Selected Best Practices Mapped to Information Element
<b>A. Selecting Model Input</b>	
<b>A.1. Available Data Sources</b>	
A.1.a	1.b, 1.d, 2.a, 2.b, 3.a
A.1.b	2.b, 2.e
A.1.e	1.b
<b>A.2. Sub-Models</b>	
A.2.a	1.b, 1.d, 3.a, 3.e
A.2.b	4.e
A.2.e	2.a, 2.d, 3.a, 4.e
A.2.d	2.a, 2.d, 3.a, 4.e
A.2.e	2.e, 1.d, 2.a, 3.a
A.2.f	1.b, 1.d, 2.a, 3.a
<b>A.3. Adjustments to Data</b>	
A.3.a	1.b, 2.a, 2.b, 2.e
A.3.b	2.a, 2.b, 2.e
A.3.e	2.b, 2.e
A.3.d	2.b, 2.e
A.3.e	2.b, 2.e
A.3.f	2.b, 2.e
<b>A.4. Data Organization</b>	
A.4.a	2.a, 2.b, 2.e, 3.a
A.4.b	1.b, 1.d, 2.b, 2.e
A.4.e	1.d, 2.a, 2.b, 2.e
<b>B. Building the Model</b>	
<b>B.1. High-Level Narrative for Building the Model</b>	
B.1.a	2.a
B.1.b	2.a

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<b>Appendix B: Table 1 Best Practices Mapped to Information Element</b>	
<b>Information Element</b>	<b>Selected Best Practices Mapped to Information Element</b>
B-1.e	2.a
B-1.d	2.a, 3.b
B-1.e	2.a
B-1.f	1.b, 2.a
B-1.g	1.b, 1.d, 2.a, 3.a
B-1.h	2.a, 2.b
B-1.i	1.b, 2.a
B-1.j	2.a, 2.e
<b>B.2. Medium-Level Narrative for Building the Model</b>	
B-2.a	2.a
B-2.b	2.a, 2.e
B-2.c	2.a, 3.b
B-2.d	2.a
B-2.e	2.a, 3.a, 3.b
B-2.f	2.a, 2.e
<b>B.3. Predictor Variables</b>	
B-3.a	1.b, 1.d, 2.a, 3.a
B-3.b	2.a
B-3.c	1.d, 2.a, 3.a
B-3.d	1.b, 1.d, 3.a
B-3.e	2.a, 3.a
<b>B.4. Adjusting Data, Model Validation, and Goodness-of-Fit Measures</b>	
B-4.a	2.a, 3.b
B-4.b	2.a, 3.b
B-4.c	1.b, 2.a
B-4.d	1.b, 2.a, 2.b, 3.b
B-4.e	1.b, 2.a
B-4.f	1.b, 2.a, 3.b
B-4.g	2.a, 2.d, 3.b
B-4.h	2.a
B-4.i	1.b, 2.a

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<b>Appendix B: Table 1 Best Practices Mapped to Information Element</b>	
<b>Information Element</b>	<b>Selected Best Practices Mapped to Information Element</b>
C-7.b	1.a, 1.e
C-7.e	1.a, 1.e, 3.b
C-7.d	1.a, 1.e
C-7.e	1.a, 1.e
C-7.f	2.d
C-7.g	1.e, 3.b
C-7.h	1.d, 2.b, 2.d, 3.b
<b>C.8. Accurate Translation of Model into a Rating Plan</b>	
C-8.a	3.b, 3.e
<b>C.9. Efficient and Effective Review of a Rate Filing</b>	
C-9.a	4.a, 4.b, 4.e
C-9.b	4.a, 4.b, 4.e
C-9.e	4.a, 4.b, 4.e

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Appendix B: Table 2 Information Element Mapped to Best Practices		
Best Practice	Best-Practice Code	Information Element (for GLMs)
1. Ensure that the factors developed based on the model produce rates that are not excessive, inadequate, or unfairly discriminatory:		
a. Review the overall rate level impact of the proposed revisions to rate level indications provided by the filer.	1-a	C.3.a, C.3.b, C.7.a, C.7.b, C.7.e, C.7.d, C.7.e, C.7.d
b. Determine whether individual input characteristics to a predictive model and their resulting rating factors are related to the expected loss or expense differences in risk.	1-b	A.1.a, A.1.e, A.2.a, A.2.f, A.3.a, A.4.b, B.1.f, B.1.g, B.1.i, B.2.a, B.3.d, B.4.e, B.4.d, B.4.e, B.4.f, B.4.i, C.1.e, C.2.a, C.6.b
c. Review the premium disruption for individual policyholders and how the disruptions can be explained to individual consumers.	1-c	C.3.a, C.3.b, C.7.a, C.7.b, C.7.e, C.7.d, C.7.e, C.7.g
d. Review the individual input characteristics to and output factors from the predictive model (and its sub-models), as well as associated selected relativities, to ensure they are compatible with practices allowed in the state and do not reflect prohibited characteristics.	1-d	A.1.a, A.2.a, A.2.e, A.2.f, A.4.b, A.4.e, B.1.g, B.3.a, B.3.e, B.3.d, B.4.j, C.1.e, C.2.a, C.7.h
2. Obtain a clear understanding of the data used to build and validate the model and thoroughly review all aspects of the model, including assumptions, adjustments, variables, sub-models used as input, and resulting output:		
a. Obtain a clear understanding of how the selected predictive model was built.	2-a	A.1.a, A.2.e, A.2.d, A.2.e, A.2.f, A.3.a, A.3.b, A.4.a, A.4.e, B.1.a, B.1.b, B.1.e, B.1.d, B.1.e, B.1.f, B.1.g, B.1.h, B.1.i, B.1.j, B.2.a, B.2.b, B.2.e, B.2.d, B.2.e, B.2.f, B.3.a, B.3.b, B.3.e, B.3.e, B.4.a, B.4.b, B.4.e, B.4.d, B.4.e, B.4.f, B.4.g, B.4.h, B.4.i, B.4.j, B.5.b, B.5.e, B.6.a, C.1.a, C.4.b, C.4.e, C.5.a

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	<p><del>b-Determine whether the data used as input to the predictive model is accurate, including a clear understanding how missing values, erroneous values, and outliers are handled.</del></p>	<p>2.b</p>	<p><del>A.1.a, A.1.b, A.3.a, A.3.b, A.3.c, A.3.d, A.3.e, A.3.f, A.4.a, A.4.b, A.4.c, B.1.h, B.4.d, C.6.a, C.7.h</del></p>
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Appendix B: Table 2 Information Element Mapped to Best Practices		
Best Practice	Best-Practice Code	Information Element (for GLMs)
e. Determine whether any adjustments to the raw data are handled appropriately, including, but not limited to, trending, development, capping, and removal of catastrophes.	2-e	A.1.b, A.2.e, A.3.a, A.3.b, A.3.e, A.3.d, A.3.e, A.3.f, A.4.a, A.4.b, A.4.c, B.1.j, B.2.b, B.2.f, C.5.a, C.6.a
d. Obtain a clear understanding of how often each risk characteristic used as input to the model is updated and whether the model is periodically refreshed, so model output reflects changes to non-static risk characteristics.	2-d	A.2.e, A.2.d, B.4.g, B.5.d, C.7.f, C.7.h
3. Evaluate how the model interacts with and improves the rating plan.		
a. Obtain a clear understanding of the characteristics that are input to a predictive model (and its sub-models).	3-a	A.1.a, A.2.a, A.2.e, A.2.d, A.2.e, A.2.f, A.4.a, B.1.g, B.2.e, B.3.a, B.3.e, B.3.d, B.3.e, B.5.d, C.1.e, C.2.a, C.3.e, C.7.h
b. Obtain a clear understanding of how the insurer integrates the model into the rating plan and how it improves the rating plan.	3-b	B.1.d, B.2.e, B.2.e, B.4.a, B.4.b, B.4.d, B.4.f, B.4.g, B.5.a, B.5.b, B.5.e, B.5.d, C.1.a, C.1.b, C.3.a, C.3.b, C.3.e, C.4.a, C.4.b, C.4.e, C.5.a, C.6.b, C.7.e, C.7.g, C.7.h, C.8.a
c. Obtain a clear understanding of how the model output interacts with non-modeled characteristics/variables used to calculate a risk's premium.	3-e	A.2.a, B.4.j, C.1.b, C.1.e, C.3.e, C.5.a, C.8.a
4. Enable competition and innovation to promote the growth, financial stability, and efficiency of the insurance marketplace.		
a. Enable innovation in the pricing of insurance through acceptance of predictive models, provided they are in compliance with state laws and/or regulations, particularly prohibitions on unfair discrimination.	4-a	C.9.a, C.9.b, C.9.e
b. Protect the confidentiality of filed predictive models and supporting information in accordance with state laws and/or regulations.	4-b	C.9.a, C.9.b, C.9.e

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	<p><del>e. Review predictive models in a timely manner to enable reasonable speed to market.</del></p>	<p>4.e</p>	<p><del>A.2.b, A.2.c, A.2.d, C.9.a, C.9.b, C.9.e</del></p>
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Draft: 1/6/23

Casualty Actuarial and Statistical (C) Task Force  
E-Vote  
January 3, 2023

The Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded Jan. 3, 2023. The following Task Force members participated: Mike Kreidler, Chair, represented by Eric Slavich (WA); Grace Arnold, Vice Chair, represented by Phil Vigliaturo (MN); Ricardo Lara represented by Lynne Wehmueller (CA); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhilf (DC); David Altmaier represented by Christina Huff (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Dana Popish Severinghaus represented by Reid McClintock (IL); Amy L. Beard represented by Larry Steinert (IN); Timothy N. Schott represented by Sandra Darby (ME); Chlora Lindley-Myers and Julie Lederer (MO); Troy Downing represented by Mari Kindberg (MT); Chris Nicolopoulos represented by Christian Citarella (NH); Marlene Caride represented by Carl Sornson (NJ); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Cassie Brown represented by J'ne Byckovski (TX); and Allan L. McVey (WV).

1. Adopted the 2021 Profitability Report

The Task Force conducted an e-vote to consider adoption of the 2021 *Report on Profitability by Line by State* (Profitability Report). The motion passed unanimously.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2023\_Spring/CASTF/010323 evote min.docx

Draft: 1/6/23

Casualty Actuarial and Statistical (C) Task Force  
E-Vote  
December 9, 2022

The Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded Dec. 9, 2022. The following Task Force members participated: Mike Kreidler, Chair, represented by Eric Slavich (WA); Grace Arnold, Vice Chair, represented by Phil Vigliaturo (MN); Ricardo Lara represented by Lynne Wehmuller (CA); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhilf (DC); David Altmaier represented by Christina Huff (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen represented by Travis Grassel (IA); Dana Popish Severinghaus represented by Judy Mottar (IL); Amy L. Beard represented by Larry Steinert (IN); Vicki Schmidt represented by Nicole Boyd (KS); Timothy N. Schott represented by Sandra Darby (ME); Chlora Lindley-Myers represented by Julie Lederer (MO); Troy Downing represented by Mari Kindberg (MT); Russell Toal and Anna Krylova (NM); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by David Dahl (OR); Michael Humphreys represented by Michael McKenney (PA); Michael Wise represented by Will Davis (SC); Cassie Brown represented by J'ne Byckovski (TX); and Allan L. McVey and Juanita Wimmer (WV).

1. Adopted the 2020 Homeowners Report

The Task Force conducted an e-vote to consider adoption of the *2020 Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance Report* (Homeowner Report). The motion passed unanimously.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

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Draft: 3/7/23

Actuarial Opinion (C) Working Group  
Virtual Meeting  
January 26, 2023

The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Jan. 26, 2023. The following Working Group members participated: Miriam Fisk, Chair (TX); Anna Krylova, Vice Chair (NM); Amy Waldhauer (CT); David Christhilf (DC); Chantel Long and Judy Mottar (IL); Sandra Darby (ME); Julie Lederer (MO); Tom Botsko (OH); Andrew Schallhorn (OK); and James DiSanto (PA). Also participating was: Arthur Schwartz (LA).

1. Discussed Draft Changes to the Actuarial Opinion Instructions

Krylova said the Working Group has discussed changing the qualification documentation requirement from annual submission to submission once every five years. Michelle L. Iarkowski (Deloitte Consulting LLP) said feedback at the American Academy of Actuaries' (Academy's) Actuarial Opinion Reserve Seminar was that a change to requiring submission once every five years would increase the administrative burden and that most participants said they would continue to submit it annually.

Ralph Blanchard (The Travelers Companies) said that once every five years might make the Board pay more attention to the document. Long said the regulatory burden of the qualification document has, so far, outweighed the benefit. Iarkowski said seminar participants still do not understand why the requirement to provide qualification documentation to the Board has been imposed and point out that there is no similar requirement for life and health actuaries.

The Working Group suggested two editorial corrections be made by NAIC staff but said that the Working Group would not propose any substantive changes to the 2023 Statement of Actuarial Opinion (SAO) instructions for property/casualty (P/C) and title.

Long gave a preview of some proposed changes for 2024 actuarial opinions: 1) remove the address of the appointed actuary from the signature block. Some actuaries are working from home and may not feel comfortable using their home address and have no other address to provide; and 2) within the "change in actuary" section, add an additional example to encompass disagreements outside of the scope of the opinion.

2. Discussed a Financial Analysis (E) Working Group Referral on Predictive Analytics in Reserving

The Working Group discussed a draft response to a referral from the Financial Analysis (E) Working Group asking for discussion of the use of predictive analytics in reserving and consideration of drafting guidance. Lederer drafted a potential response to the referral, including some potential questions to ask about reserving models.

Long said the proposed response contains a good description of the issues that occurred in the case that prompted the Financial Analysis (E) Working Group's referral. Lederer suggested the Working Group reach out to other actuarial regulators to find someone who has reviewed a reserve model in a financial examination.

Regarding the questions to ask during an exam, Schwartz said he would need more technical information (e.g., goodness of fit metrics for variables and the model as a whole; a list of variables; amount of data on which the model is based) to evaluate the model.

Both Lederer and Krylova said they are concerned that state departments of insurance (DOIs) examiners may not have staff that would be able to evaluate responses to in-depth, technical questions. Fisk offered to share additional resources containing lists of questions that could be applicable.

Having no further business, the Actuarial Opinion (C) Working Group adjourned.

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Draft: 3/1/23

Statistical Data (C) Working Group  
Virtual Meeting  
February 23, 2023

The Statistical Data (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Feb. 23, 2023. The following Working Group members participated: Sandra Darby, Chair (ME); Qing He, Vice Chair, George Bradner, and Wanchin Chou (CT); David Christhlf (DC); Arthur Schwartz and John Sobhanian (LA); Cynthia Amann (MO); Christian Citarella (NH); Alexander Vajda (NY); Tom Botsko (OH); and David Dahl and Ying Liu (OR). Also participating were: Luciano Gobbo (CA); David Dombrowski (MT); and Chris Aufenthie (ND).

1. Adopted the Auto Insurance Average Premium Supplement

Darby said this Working Group adopted a new timeline that would have written premium and exposure data for the *Auto Insurance Database Report* (Auto Report) reported about six months earlier. She said this speeds up the reporting of average premiums, but earned premiums, earned exposures, and loss data cannot be reported on the same faster timeline. She said this would leave a large gap in the years of data provided and that the earned premium and loss data would now be published later than it would have been on the previous timeline.

Justin Cox (NAIC) said the new timeline creates a couple of issues. He said the first issue is that if this Working Group plans to release the full Auto Report in the spring as dictated by the new timeline, the only updates to the report would be the written premium and exposure as the other data would not have changed from the report released in February 2023. He said the second issue is the two-year gap between the reported written premiums and the reported earned premiums going forward. He said the best solution to these issues is to release an Auto Insurance Average Premium Supplement in the spring that would include only the written premium and exposure information that is reported by the statistical agents on Dec. 1 following the end of the data year. Then, the statistical agents would provide the full premium, exposure, and loss data set on the original timeline, with the full Auto Report being released at the end of the year.

Darby asked if the statistical agents that provide the data are agreeable to providing two data sets throughout the year to allow for the release of an average premium supplement. Laura Panesso (Insurance Services Office—ISO), Lori Munn (American Association of Insurance Services—AAISO), Albert Burton (Independent Statistical Service—ISS), and Jeff Patterson (National Independent Statistical Service—NISS) said they would not have a problem providing the data twice during the year.

Amann made a motion, seconded by Citarella, to adopt the creation of the Auto Insurance Average Premium Supplement. The motion passed unanimously.

Cox said NAIC staff are working to draft language to accompany the supplement and that language will be distributed to the Working Group for comment. Amann suggested adding information on the timeline issues to the language to explain the need for the creation of the supplement.

2. Discussed Proposed Changes to NAIC Statistical Reports

Schwartz said his first proposed change to the *Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance Report* (Homeowners Report) is to change the name to the NAIC Home Insurance Database or the NAIC Residential Insurance Database. He said this is similar to his proposals for the other reports and that all of the reports should have common names. He said including the

word database in the report title will give people a better understanding of what is included in the report. He said the current name is too long. Botsko said the word database implies a store of data on which reports can be run. He said he would be hesitant to change the title to include the word database since this is a static report.

Darby agreed that the name was long, and it may be a good idea to change it. She suggested calling it a data report instead of a database. Schwartz said he would like a title that makes it clear that it is a report of the data. Amann said she agrees with streamlining the name of the report, but there should be an indication early in the report of what coverages are included. Birny Birnbaum (Center for Economic Justice—CEJ) said the Homeowners Report title is accurate and provides a complete description.

Schwartz said one of his proposals is also to have all the reports available in a downloadable CSV format. Darby said the CSV versions of the reports are already available to state insurance regulators by requesting access from NAIC staff.

Schwartz said his next proposal is to include a table showing average premium per insurance range. He said the report should also take into consideration the large differences in home prices based on location and other factors. Darby said the data is provided in the buckets shown in the report by the statistical agents, so the table Schwartz is trying to create would not currently be possible. Libby Crews (NAIC) confirmed that the data is aggregated into the buckets before it is sent to the NAIC by statistical agents. Schwartz suggested using the midpoint of each bucket to determine the average premium per insurance range. He said it would also be useful to include the median home price per state. Birnbaum said taking the midpoint of the insurance range would not be accurate and would not be possible for the range of \$500,000 and above.

Darby said she would like to reevaluate the current insurance ranges because home prices, and therefore coverage, have gone up significantly since these ranges were first determined. She said the distribution of premiums and exposures in the lower ranges is significantly less than it was years ago. She said they should also look at adding additional ranges over \$500,000 since many states have large premium and exposure amounts in that range. Dahl said he agrees there should be additional ranges above \$500,000 and that they should also consider breaking some of the current ranges into smaller ranges to get more detail. Brian Sullivan (Risk Information) said it is clear that when the ranges were created, they were trying to capture information about the ranges with the most exposures. He said since then, the lower ranges have had less exposures while the highest ranges have increased. He said the ranges need to be reset so there is granularity in the ranges with the most exposure. He said the reporting of the data should be set up in such a way that it is not difficult to change the ranges in the future if necessary. Qing He asked what the criteria were when the insurance ranges were set up. Crews said she would look into past meeting minutes to determine how the Working Group initially determined the ranges.

Darby asked the participating statistical agents how they currently collect the insurance range information and if they have raw data or if they collect it in the determined insurance ranges. All participating statistical agents said they have the raw data on the insured value, and they map that data to each insurance range that is requested by the NAIC.

Darby said she would create a spreadsheet to gather data from the statistical agents regarding the premiums and exposures for smaller insurance ranges. She said the Working Group would then be able to determine the distribution of exposures at a more granular level and they could then decide which ranges of insurance make sense to publish in the report.

Darby said the Working Group will continue to discuss changes to these reports in future meetings.

### 3. Discussed its 2023 Work Plan

Darby said the Working Group received an initial look at dashboards created by NAIC staff during a regulator-only meeting in January 2023. She said NAIC staff are developing dashboards for the *Report on Profitability by Line by State* (Profitability Report), Homeowners Report, and Auto Report. She said this Working Group will spend the year reviewing and developing these dashboards. She said this will provide a good look at the type of data regulators currently have available, which will inform future discussions about updates to the statistical handbook, including what data regulators need and the most efficient way to collect and analyze that data. She said since these dashboards will be looking at company-level data, as well as data from specific statistical agents, the majority of the Working Group discussions will be regulator-only. She said they will work toward developing training on the use of this data for regulators, which they hope to present at the NAIC Insurance Summit in September. She said once the Working Group has determined how state insurance regulators can use the data currently available, they can pivot into how they can update the statistical handbook to gather data that state insurance regulators are looking for.

Having no further business, the Statistical Data (C) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2023\_Spring/CASTF/SDWG/StatDataWGmin\_0223



**Casualty Actuarial and Statistical Taskforce:**

Thank you for opening the GAM Appendix for comments. Currently, GAMs are largely synonymous with the MGCV package in R. The goal of these comments is to future-proof the GAM appendix by acknowledging the wide definition of a GAM. I recommend this addition to the narrative preceding the requested information elements as part of the future-proofing of this document:

*The definition of GAM is quite broad and the available information elements will differ depending on the basis function used in the GAM as well as the method of penalization.*

*For example, although AGLM is best reviewed through a traditional penalized regression framework, AGLM is considered a GAM by the definition from the original paper by Tibshirani (1990). While the MGCV package uses splines as a basis function combined with ridge-like penalization, the AGLM model uses step functions as a basis function and lasso penalization. These differences mean that metrics provided by the MGCV package such as concavity and approximated p-values, while appropriate for MGCV, would not be appropriate for AGLM.*

*This broad definition of a GAM means that a reviewer should be looking for analogous information in the case where certain necessary information elements are not available. For example, p-values will not be produced for some varieties of GAM. If p-values are being evaluated to confirm the significance of variables included in the model, the reviewer may start a dialogue on how variable significance was evaluated in this particular GAM to obtain the information necessary to satisfy this area of review. In this way, a reviewer can use the information elements below to review wide varieties of GAM.*

Below are recommended changes to the table of information elements to supplement the narrative addition above.

For items B.3.d, B.4.c, B.4.e, B.4.f, B.4.h, B.4.m, I recommend adding a footnote to the following comment:

*Please note that certain statistics such as p-values, confidence intervals, and concavity may not be available or relevant for all varieties of GAM. In these cases, requests should focus on satisfying the purpose of this information element through methodology or metrics supplied by this type of GAM.*



B.4.d

Recommended significance level: 4 or 2

Recommended addition to comments:

*If the GAM is built using a basis function significantly different from those available in the MGCV package in R, this information element may have a higher level of significance (2). The goal of requesting details of the basis function would be to help identify any metrics that may be interpreted similarly to the MGCV package's concavity metrics and gain a better understanding of the GAM building process.*

*In these cases, it is not necessary that a reviewer request the exact mathematical formula for the basis function. Instead, a written or visual example of how the basis function creates a final factor curve for a variable may be requested to aid model review.*

The referenced information elements are included at the end of this document for clarity along with the recommended edits in **bold and colored**.

Thank you for your consideration,

Thomas Holmes - Head of US Actuarial Data Science, Akur8



Section	Information Element	Level of Importance to the Regulator’s Review	Comments
B.3.d	Obtain concurvity metrics for all smoothed predictor variables included in the model and sub-models.	3	GAMs can suffer from high concurvity in addition to high collinearity. Concurvity is the degree to which the smoothed terms move together. The company should indicate what concurvity metrics were used. The regulatory reviewer should understand what metric was used to produce the concurvity metrics but should not prescribe the type of metrics.*
B.4.c	For all smoothed variables, review plots representing the smooths and relevant tests of significance, such as approximate confidence intervals, chi-square tests, approximate p-values, or F tests. Determine if model development data, validation data, test data, or other data was used for these tests.	1	<p>Smoothed terms in a GAM can have many coefficients based on the number of basis functions. It is difficult to interpret the impact of the smoothed term based on the coefficients. Instead, regulators can review plots representing the cumulative effect of smoothed terms. The company could provide variable value on the x-axis and partial effects on the y-axis. The company could alternatively provide variable value on the x-axis and model prediction for the base risk on the y-axis. The company should provide confidence interval lines regardless of the type of plot. The regulatory reviewer should assess whether the plot has an intuitive shape and whether the curve extrapolates well, especially to areas of the curve representing thinner data.</p> <p>Smoothed interaction terms should also be expressed as plots. Heat map contour plots or 3D perspective plots may be useful.</p> <p>GAMs are a form of penalized regression which complicates the calculation of p-values. The p-values for the smoothed terms output by the modeling software are generally approximate p-values for GAMs. Approximate p-values should be reviewed at the smoothed variable level. The regulatory reviewer may want to select a smaller threshold for smoothed terms than they used for the parametric term p-value threshold.*</p>
B.4.e	Identify the threshold for statistical significance and explain why it was selected. Obtain a reasonable and appropriately supported explanation for keeping the variable for each discrete variable level where the p-values were not less than the chosen threshold.	1	<p>The explanation should clearly identify the thresholds for statistical significance used by the modeler. Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p- values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.</p> <p>Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter values for parametric terms, plots representing smoothed terms, confidence intervals, chi-square tests, p-values, and any other relevant and material tests.*</p>



Section	Information Element	Level of Importance to the Regulator’s Review	Comments
B.4.f	For overall discrete variables, review type 3 chi-square tests, p-values, F tests and any other relevant and material test. Determine if model development data, validation data, test data, or other data was used for these tests.	2	<p>Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p- values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.</p> <p>Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter values for parametric terms, plots representing smoothed terms, confidence intervals, chi-square tests, p-values, and any other relevant and material tests.</p> <p>For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; e.g., confidence intervals around each level of an AOI curve might be more than what is needed.*</p>
B.4.h	For continuous variables, provide confidence intervals, chi-square tests, approximate p-values, and any other relevant and material test. Determine if model development data, validation data, test data, or other data was used for these tests.	2	<p>Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p- values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.</p> <p>Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter values for parametric terms, plots representing smoothed termsvalue, confidence intervals, chi-square tests, approximate p-values and any other relevant and material tests.</p> <p>For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an AOI curve might be more than what is needed.*</p>



Section	Information Element	Level of Importance to the Regulator’s Review	Comments
B.4.m	Obtain support demonstrating that the assumptions for each smoothed term are appropriate.	3	<p>The reviewer should look for a narrative on how the fit of the smoothed terms was checked for reasonability.</p> <p>It may be useful to ask for each plot of the smoothed terms to include residuals to ensure that the smoothed line runs through the middle of the residuals.</p> <p>It may be useful for the company to provide tests that each smoothed term is not predictive of residual values (similar to tests achieved in the gam.check() function of the mcgv R package). These tests would ideally demonstrate that the residuals are randomly distributed across all parts of the smoothed term.*</p>
<p><b>*Please note that certain statistics such as p-values, confidence intervals, and concurrency may not be available or relevant for all varieties of GAM. In these cases, requests should focus on satisfying the purpose of this information element through methodology or metrics supplied by this type of GAM.</b></p>			
B.4.d	For all smoothed variables, request details about the basis functions comprising each smoothed function.	4 or 2	<p>Smooth functions are based on a sum of basis functions. The company should provide the number of basis functions for each smooth and discuss how the number was chosen.</p> <p>There are many types of smooth functions that can be applied. Examples include thin plate splines, cubic splines, and cyclic splines. The company should provide the type of each smooth and a narrative on why that type of smooth is appropriate for the variable.</p> <p><b>If the GAM is built using a basis function significantly different from those available in the MGCV package in R, this information element may have a higher level of significance (2). The goal of requesting details of the basis function would be to help identify any metrics that may be interpreted similarly to the MGCV package’s concurrency metrics and gain a better understanding of the GAM building process.</b></p> <p><b>In these cases, it is not necessary that a reviewer request the exact mathematical formula for the basis function. Instead, a written or visual example of how the basis function creates a final factor curve for a variable may be requested to aid model review.</b></p>



Tom Zuppan [Tom.Zuppan@difi.az.gov](mailto:Tom.Zuppan@difi.az.gov)

To: DeFrain, Kris

Cc: Kloese, Sam

Here is a sentence needing correction in B.1.a Comments "It is important to understand if the model in question is a and, therefore, these information elements are applicable; "

Tom F. Zuppan

Property and Casualty Supervisor

Arizona Department of Insurance and Financial Institutions

Product Filing Compliance Division

From: DeFrain, Kris

To: Kloese, Sam

Subject: RE: CASTF Exposure – Regulatory Review of GAMs

When you are preparing your revised version for potential adoption, please spell out G..A...M... in the title and fix the column label “Regulator’ s” to eliminate the extra space. Also, didn’t we modify the introduction for the non-GLM appendices? The introductory paragraphs still focus on GLMs only.

#### APPENDIX B – INFORMATION ELEMENTS AND GUIDANCE FOR A REGULATOR TO MEET BEST PRACTICES’ OBJECTIVES (WHEN REVIEWING GAMS)

This appendix identifies the information a state insurance regulator may need to review a predictive model used by an insurer to support a personal automobile or home insurance rating plan. The list is lengthy but not exhaustive. It is not intended to limit the authority of a regulator to request additional information in support of the model or filed rating plan. Nor is every item on the list intended to be a requirement for every filing. However, the items listed should help guide a regulator to sufficient information that helps determine if the rating plan meets state-specific filing and legal requirements.

Documentation of the design and operational details of the model will help ensure the business continuity and transparency of the models used. Documentation should be sufficiently detailed and complete to enable a qualified third party to form a sound judgment on the suitability of the model for the intended purpose. The theory, assumptions, methodologies, software, and empirical bases should be explained, as well as the data used in developing and implementing the model. Relevant testing and ongoing performance testing need to be documented. Key model limitations and overrides need to be pointed out so that stakeholders understand the circumstances under which the model does not work effectively. End-user documentation should be provided and key reports using the model results described. Major changes to the model need to be documented and shared with regulators in a timely and appropriate manner. Information technology (IT) controls should be in place, such as a record of versions, change control, and access to the model.<sup>1</sup>

Many information elements listed below are probably confidential, proprietary, or trade secret and should be treated as such, in accordance with state laws and/or regulations. Regulators should be aware of their state laws and/or regulations on confidentiality when requesting data from insurers that may be proprietary or trade secret. For example, some proprietary models may have contractual terms (with the insurer) that prevent disclosure to the public. Without clear necessity, exposing this data to additional dissemination may compromise the model’s protection.<sup>2</sup>

Although the list of information is long, the insurer should already have internal documentation on the model for more than half of the information listed. The remaining items on the list require either minimal analysis (approximately 25%) or deeper analysis to generate for a regulator (approximately 25%).

The “Level of Importance to the Regulator’s Review” is a ranking of information a regulator may need to review which is based on the following level criteria:

**Level 1** – This information is necessary to begin the review of a predictive model. These data elements pertain to basic information about the type and structure of the model, the data and variables used, the assumptions made, and the goodness of fit. Ideally, this information would be included in the filing documentation with the initial submission of a filing made based on a predictive model.

**Level 2** – This information is necessary to continue the review of all but the most basic models, such as those based only on the filer’s internal data and only including variables that are in the filed rating plan. These data elements provide more detailed information about the model and address questions arising from review of the information in Level 1. Insurers concerned with speed to market may also want to include this information in the filing documentation.

**Level 3** – This information is necessary to continue the review of a model where concerns have been raised and not resolved based on review of the information in Level 1 and Level 2. These data elements address even more detailed aspects of the model. This information does not necessarily need to be included with the initial submission, unless specifically requested by a particular state, as it is typically requested only if the reviewer has concerns that the model may not comply with state laws and/or regulations.

**Level 4** – This information is necessary to continue the review of a model where concerns have been raised and not resolved based on the information in Level 1, Level 2, and Level 3. This most granular level of detail is addressing the basic building blocks of the model and does not necessarily need to be included by the filer with the initial submission, unless specifically requested by a particular state. It is typically requested only if the reviewer has serious concerns that the model may produce rates or rating factors that are excessive, inadequate, and/or unfairly discriminatory.

Lastly, although the best practices presented in this white paper will readily be transferrable to review of other predictive models, the information elements presented here might be useful only with deeper adaptations when starting to review different types of predictive

<sup>1</sup> Bourdeau, M., 2016. “Model Risk Management: An Overview,” The Modeling Platform, Issue 4, December. Accessed online at <https://www.soa.org/globalassets/assets/library/newsletters/the-modeling-platform/2016/december/mp-2016-iss4.pdf>.

<sup>2</sup> There are some models that are made public by the vendor and would not result in a hindrance of the model’s protection.

models. If the model is not a GAM, some listed items might not apply; e.g., not all predictive models generate p-values or F tests. Depending on the model type, other considerations might be important but are not listed here. When information elements presented in this appendix are applied to lines of business other than personal automobile and home insurance or other type of models, unique considerations may arise. In particular, data volume and credibility may be lower for other lines of business. Regulators should be aware of the context in which a predictive model is deployed, the uses to which the model is proposed to be put, and the potential consequences the model may have on the insurer, its customers, and its competitors. This white paper does not delve into these possible considerations, but regulators should be prepared to address them as they arise.

**A. SELECTING MODEL INPUT**

Section	Information Element	Level of Importance to the Regulator's Review	Comments
<b>I. Available Data Sources</b>			
A.1.a	Review the details of sources for both insurance and non-insurance data used as input to the model (only need sources for filed input characteristics included in the filed model).	1	<p>Request details of data sources, whether internal to the company or from external sources. For insurance experience (policy or claim), determine whether data are aggregated by calendar, accident, fiscal, or policy year and when it was last evaluated. For each data source, get a list of all data elements used as input to the model that came from that source. For insurance data, get a list all companies whose data is included in the datasets.</p> <p>Request details of any non-insurance data used (customer-provided or other), whether the data was collected by use of a questionnaire/checklist, whether data was voluntarily reported by the applicant, and whether any of the data is subject to the federal Fair Credit Reporting Act (FCRA). If the data is from an outside source, find out what steps were taken to verify the data was accurate, complete, and unbiased in terms of relevant and representative time frame, representative of potential exposures, and lacking in obvious correlation to protected classes.</p> <p><b>Note:</b> Reviewing source details should not make a difference when the model is new or refreshed; refreshed models would report the prior version list with the incremental changes due to the refresh.</p>
A.1.b	Reconcile aggregated insurance data underlying the model with available external insurance reports.	4	Accuracy of insurance data should be reviewed. It is assumed that the data in the insurer's data banks is subject to routine internal company audits and reconciliation. "Aggregated data" is straight from the insurer's data banks without further modification (i.e., not scrubbed or transformed for the purposes of modeling). In other words, the data would not have been specifically modified for the purpose of model building. The company should provide some form of reasonability check that the data makes sense when checked against other audited sources.

Section	Information Element	Level of Importance to the Regulator's Review	Comments
A.1.c	Review the geographic scope and geographic exposure distribution of the raw data for relevance to the state where the model is filed.	2	Many models are developed using a countrywide or a regional dataset. The company should explain how the data used to build the model makes sense for a specific state. The regulator should inquire which states were included in the data underlying the model build, testing, and validation. The company should provide an explanation where the data came from geographically and that it is a good representation for a state; i.e., the distribution by state should not introduce a geographic bias. However, there could be a bias by peril or wind-resistant building codes. Evaluate whether the data is relevant to the loss potential for which it is being used. For example, verify that hurricane data is only used where hurricanes can occur.
<b>2. Sub-Models</b>			
A.2.a	Consider the relevance of (i.e., whether there is bias) of overlapping data or variables used in the model and sub-models.	1	Check if the same variables/datasets were used in the model, a sub-model, or as stand-alone rating characteristics. If so, verify the insurance company has processes and procedures in place to assess and address double-counting or redundancy.
A.2.b	Determine if the sub-model was previously approved (or accepted) by the regulatory agency.	1	If the sub-model was previously approved/accepted, that may reduce the extent of the sub-model's review. If approved, obtain the tracking number(s) (e.g., state, SERFF) and verify when and if it was the same model currently under review.  Note: A previous approval does not necessarily confer a guarantee of ongoing approval; e.g., when statutes and/or regulations have changed or if a model's indications have been undermined by subsequent empirical experience. However, knowing whether a model has been previously approved can help focus the regulator's efforts and determine whether the prior decision needs to be revisited. In some circumstances, direct dialogue with the vendor could be quicker and more useful.

Section	Information Element	Level of Importance to the Regulator’s Review	Comments
A.2.c	Determine if the sub-model output was used as input to the GAM; obtain the vendor name, as well as the name and version of the sub-model.	1	<p>To accelerate the review of the filing, it may be desirable to request (from the company), the name and contact information for a vendor representative. The company should provide the name of the third-party vendor and a contact in the event the regulator has questions. The “contact” can be an intermediary at the insurer (e.g., a filing specialist), who can place the regulator in direct contact with a subject-matter expert (SME) at the vendor.</p> <p>Examples of such sub-models include credit/financial scoring algorithms and household composite score models. Sub-models can be evaluated separately and in the same manner as the primary model under evaluation. A sub-model contact for additional information should be provided. Sub-model SMEs may need to be brought into the conversation with regulators (whether in-house or third-party sub-models are used).</p>
A.2.d	If using catastrophe model output, identify the vendor and the model settings/assumptions used when the model was run.	1	<p>To accelerate the review of the filing, get contact information for the SME that ran the model and an SME from the vendor. The “SME” can be an intermediary at the insurer (e.g., a filing specialist), who can place the regulator in direct contact with the appropriate SMEs at the insurer or model vendor.</p> <p>For example, it is important to know hurricane model settings for storm surge, demand surge, and long-term/short-term views.</p>
A.2.e	Obtain an explanation of how catastrophe models are integrated into the model to ensure no double-counting.	1	<p>If a weather-based sub-model is input to the GAM under review, loss data used to develop the model should not include loss experience associated with the weather-based sub-model. Doing so could cause distortions in the modeled results by double-counting such losses when determining relativities or loss loads in the filed rating plan.</p> <p>For example, redundant losses in the data may occur when non-hurricane wind losses are included in the data while also using a severe convective storm model in the actuarial indication. Such redundancy may also occur with the inclusion of fluvial or pluvial flood losses when using a flood model or inclusion of freeze losses when using a winter storm model.</p>
A.2.f	If using output of any scoring algorithms, obtain a list of the variables used to determine the score and provide the source of the data used to calculate the score.	1	<p>Any sub-model should be reviewed in the same manner as the primary model that uses the sub-model’s output as input. Depending on the result of item A.2.b, the importance of this item may be decreased.</p>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
<b>3. Adjustments to Data</b>			
A.3.a	Determine if premium, exposure, loss, or expense data were adjusted (e.g., developed, trended, adjusted for catastrophe experience, or capped). If so, how? Do the adjustments vary for different segments of the data? If so, identify the segments and how the data was adjusted.	2	<p>The rating plan or indications underlying the rating plan may provide special treatment of large losses and non-modeled large loss events. If such treatments exist, the company should provide an explanation how they were handled. These treatments need to be identified and the company/regulator needs to determine whether model data needs to be adjusted.</p> <p>For example, should large bodily injury (BI) liability losses in the case of personal automobile insurance be excluded, or should large non-catastrophe wind/hail claims in home insurance be excluded from the model's training, test and validation data? Look for anomalies in the data that should be addressed. For example, is there an extreme loss event in the data? If other processes were used to load rates for specific loss events, how is the impact of those losses considered?</p> <p>Examples of losses that can contribute to anomalies in the data are large losses or flood, hurricane, or severe convective storm losses for personal automobile comprehensive or home insurance.</p>
A.3.b	Identify adjustments that were made to aggregated data (e.g., transformations, binning and/or categorizations). If any, identify the name of the characteristic/variable and obtain a description of the adjustment.	1	
A.3.c	Ask for aggregated data (one dataset of pre-adjusted/scrubbed data and one dataset of post-adjusted/scrubbed data) that allows the regulator to focus on the univariate distributions and compare raw data to adjusted/binning/transformed/etc. data.	4	<p>This is most relevant for variables that have been "scrubbed" or adjusted.</p> <p>Though most regulators may never ask for aggregated data and do not plan to rebuild any models, a regulator may ask for this aggregated data or subsets of it.</p> <p>It would be useful to the regulator if the percentage of exposures and premium for missing information from the model data by category are provided. This data can be displayed in either graphical or tabular formats.</p>
A.3.d	Determine how missing data was handled.	1	<p>This is most relevant for variables that have been "scrubbed" or adjusted. The regulator should be aware of assumptions the modeler made in handling missing, null, or "not available" values in the data.</p> <p>For example, it would be helpful to the reviewer if the modeler were to provide a statement as to whether there is any systemic reason for missing data. If adjustments or recoding of values were made, they should be explained. It may also be useful to the regulator if the percentage of exposures and premium for missing information from the model data are provided. This data can be displayed in either graphical or tabular formats.</p>



Section	Information Element	Level of Importance to the Regulator's Review	Comments
A.3.e	If duplicate records exist, determine how they were handled.	1	
A.3.f	Determine if there were any material outliers identified and subsequently adjusted during the scrubbing process.	3	Look for a discussion of how outliers were handled. If necessary, the regulator may want to investigate further by getting a list (with description) of the types of outliers and determine what adjustments were made to each type of outlier. To understand the filer's response, the regulator should ask for the filer's materiality standard.
<b>4. Data Organization</b>			
A.4.a	Obtain documentation on the methods used to compile and organize data, including procedures to merge data from different sources or filter data based on particular characteristics and a description of any preliminary analyses, data checks, and logical tests performed on the data and the results of those tests.	2	This should explain how data from separate sources was merged and/or how subsets of policies, based on selected characteristics, are filtered to be included in the data underlying the model and the rationale for that filtering.
A.4.b	Obtain documentation on the insurer's process for reviewing the appropriateness, reasonableness, consistency, and comprehensiveness of the data, including a discussion of the rational relationship the data has to the predicted variable.	2	An example is when by-peril or by-coverage modeling is performed; the documentation should be for each peril/coverage and make rational sense. For example, if "murder" or "theft" data are used to predict the wind peril, the company should provide support and a rational explanation for their use.
A.4.c	Identify material findings the company had during its data review and obtain an explanation of any potential material limitations, defects, bias, or unresolved concerns found or believed to exist in the data. If issues or limitations in the data influenced modeling analysis and/or results, obtain a description of those concerns and an explanation of how modeling analysis was adjusted and/or results were impacted.	1	"None" or "N/A" may be an appropriate response.

**B. BUILDING THE MODEL**

Section	Information Element	Level of Importance to the Regulator's Review	Comments
<b>1. High-Level Narrative for Building the Model</b>			
B.1.a	Identify the type of model underlying the rate filing (e.g., GAM, GLM, decision tree, Bayesian GLM, gradient-boosting machine, neural network, etc.). Understand the model's role in the rating system and provide the reasons why that type of model is an appropriate choice for that role.	1	<p>It is important to understand if the model in question is a GAM and, therefore, these information elements are applicable; or if it is some other model type, in which case other reasonable review approaches may be considered. There should be an explanation of why the model (using the variables included in it) is appropriate for the line of business. If by-peril or by-coverage modeling is used, the explanation should be by-peril/by-coverage.</p> <p><b>Note:</b> If the model is not a GAM, the information elements in this white paper may not apply in their entirety.</p>
B.1.b	Identify the software used for model development. Obtain the name of the software vendor/developer, software product, and a software version reference used in model development.	3	<p>Changes in software from one model version to the next may explain if such changes, over time, contribute to changes in the modeled results. The company should provide the name of the third-party vendor and a "contact" in the event the regulator has questions. The "contact" can be an intermediary at the insurer (e.g., a filing specialist) who can place the regulator in direct contact with the appropriate SME at the vendor.</p> <p>Open-source software/programs used in model development should be identified by name and version the same as if from a vendor.</p>
B.1.c	Obtain a description how the available data was divided between model training, test, and/or validation datasets. The description should include an explanation why the selected approach was deemed most appropriate, whether the company made any further subdivisions of available data, and reasons for the subdivisions (e.g., a portion separated from training data to support testing of components during model building). Determine if the validation data was accessed before model training was completed and, if so, obtain an explanation of why that came to occur. Obtain a discussion of whether the model was rebuilt using all the data or if it was only based on the training data.	1	<p>The reviewer should be aware that modelers may break their data into three or just two datasets. Although the term "training" is used with little ambiguity, "test" and "validation" are terms that are sometimes interchanged, or the word "validation" may not be used at all.</p> <p>It would be unexpected if validation and/or test data were used for any purpose other than validation and/or test, prior to the selection of the final model. However, according to the CAS monograph, "Generalized Linear Models for Insurance Rating": "Once a final model is chosen, ... we would then go back and rebuild it using all of the data, so that the parameter estimates would be at their most credible."</p> <p>The reviewer should note whether a company employed cross-validation techniques instead of a training/test/validation dataset approach. If cross-validation techniques were used, the reviewer should request a description of how cross-validation was done and confirm that the final model was not built on any particular subset of the data, but rather the full dataset.</p>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.1.d	Obtain a brief description of the development process, from initial concept to final model and filed rating plan.	1	The narrative should have the same scope as the filing.
B.1.e	Obtain a narrative on whether loss ratio, pure premium, or frequency/severity analyses were performed and, if separate frequency/severity modeling was performed, how pure premiums were determined.	1	
B.1.f	Identify the model's target variable.	1	A clear description of the target variable is key to understanding the purpose of the model. It may also prove useful to obtain a sample calculation of the target variable in Excel format, starting with the "raw" data for a policy, or a small sample of policies, depending on the complexity of the target variable calculation.
B.1.g	Obtain a description of the variable selection process.	1	The narrative regarding the variable selection process may address matters such as the criteria upon which variables were selected or omitted, identification of the number of preliminary variables considered in developing the model versus the number of variables that remained, and any statutory or regulatory limitations that were taken into account when making the decisions regarding variable selection.  The modeler should comment on the use of automated feature selection algorithms to choose predictor variables and explain how potential overfitting that can arise from these techniques was addressed.
B.1.h	In conjunction with variable selection, obtain a narrative on how the company determined the granularity of the rating variables during model development.	3	The narrative should include discussion of how credibility was considered in the process of determining the level of granularity of the variables selected.
B.1.i	Determine if model input data was segmented in anyway (e.g., by-coverage, by-peril, or by-form basis). If so, obtain a description of data segmentation and the reasons for data segmentation.	1	The regulator would use this to follow the logic of the modeling process.
B.1.j	If adjustments to the model were made based on credibility considerations, obtain an explanation of the credibility considerations and how the adjustments were applied.	2	Adjustments may be needed, given that models do not explicitly consider the credibility of the input data or the model's resulting output; models take input data at face value and assume 100% credibility when producing modeled output.
<b>2. Medium-Level Narrative for Building the Model</b>			
B.2.a	At crucial points in model development, if selections were made among alternatives regarding model assumptions or techniques, obtain a narrative on the judgment used to make those selections.	3	

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.2.b	If post-model adjustments were made to the data and the model was rerun, obtain an explanation on the details and the rationale for those adjustments.	2	Evaluate the addition or removal of variables and the model fitting. It is not necessary for the company to discuss each iteration of adding and subtracting variables, but the regulator should gain a general understanding of how these adjustments were done, including any statistical improvement measures relied upon.
B.2.c	Obtain a description of the testing that was performed during the model-building process, including an explanation of the decision-making process to determine which interactions were included and which were not.	3	There should be a description of the testing that was performed during the model-building process. Examples of tests that may have been performed include univariate testing and review of a correlation matrix.  The number of interaction terms that could potentially be included in a model increases far more quickly than the number of "main effect" variables (i.e., the basic predictor variables that can be interacted together). Analyzing each possible interaction term individually can be unwieldy. It is typical for interaction terms to be excluded from the model by default, and only included where they can be shown to be particularly important. So, as a rule of thumb, the regulator's emphasis should be on understanding why the insurer included the interaction terms it did, rather than on why other candidate interactions were excluded.  In some cases, however, it could be reasonable to inquire about why a particular interaction term was excluded from a model—for example, if that interaction term was ubiquitous in similar filings and was known to be highly predictive, or if the regulator had reason to believe that the interaction term would help differentiate dissimilar risks within an excessively heterogeneous rating segment.
B.2.d	For the GAM, identify the link function used. Identify which distribution was used for the model (e.g., Poisson, Gaussian, log-normal, Tweedie). Obtain an explanation of why the link function and distribution were chosen. Obtain the formulas for the distribution and link functions, including specific numerical parameters of the distribution. If changed from the default, obtain a discussion of applicable convergence criterion.	1	Solving the GAM is iterative and the modeler can check to see if fit is improving. At some point, convergence occurs; however, when it occurs can be subjective or based on threshold criteria. If the software's default convergence criteria were not relied upon, an explanation of any deviation should be provided. If the GAM did not reach convergence, an explanation should be provided.
B.2.e	Obtain a narrative on the formula relationship between the data and the model outputs, with a definition of each model input and output. The narrative should describe all parametric (non-smoothed) and smoothed terms necessary to evaluate the predicted pure premium, relativity, or other value, for any real or hypothetical set of inputs.	2	GAMs can have both parametric terms similar to those available in GLMs (e.g., those terms associated with coefficients) and smoothed terms. The smoothed terms are the sum of multiple basis functions which can take on a variety of types. The narrative provided should clarify which variables are included as parametric terms (non-smoothed) and which variables are included within a smoothed function.

**Commented [W1]:** Is an explanation good enough here? Isn't this a critical error in the model that would preclude its use? What kind of explanation would suffice in determining that the model is allowable?

**Commented [SM2]:** Suggest to change to: "The narrative should include a description of how all parametric (non-smoothed) and non-parametric (smoothed) terms are utilized to evaluate ..."

**Commented [W3]:** Should we leave in "coefficients" as an example of a parametric (non-smoothed) term, as "coefficients" is what most regulators are used to seeing [and many regulators may not understand the "parametric (non-smoothed)" terminology]?

**Commented [SM4]:** Do we want more detailed description of the relationship of the various predictor variables with the output of the model, as opposed to the description of type of variables which is covered in section B.3.a?

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.2.f	If there were data situations in which GAM weights were used, obtain an explanation of how and why they were used.	3	Investigate whether identical records were combined to build the model.
<b>3. Predictor Variables</b>			
B.3.a	Obtain a complete data dictionary, including the names, data types, variable fit types, definitions, and uses of each predictor variable, offset variable, control variable, proxy variable, geographic variable, geodemographic variable, and all other variables in the model used on their own or as an interaction with other variables (including sub-models and external models).	1	Data types of variables might be continuous, discrete, Boolean, etc. Definitions should not use programming language or code. Variable fit types include parametric (non-smoothed) and smoothed. For any variable(s) intended to function as a control or offset, obtain an explanation of its purpose and impact. Also, for any use of interaction between variables, obtain an explanation of its rationale and impact. For smoothed, obtain identification of type of interaction (e.g., bivariate thin plate, tensor, pure, etc.).
B.3.b	Obtain a list of predictor variables considered but not used in the final model, and the rationale for their removal.	4	The purpose of this requirement is to identify variables the company finds to be predictive but ultimately may reject for reasons other than loss-cost considerations (e.g., price optimization). Also, look for variables the company tested and then rejected. This item could help address concerns about data dredging. The reasonableness of including a variable with a given significance level could depend greatly on the other variables the company evaluated for inclusion in the model and the criteria for inclusion or omission.  For instance, if the company tested 1,000 similar variables and selected the one with the lowest p-value of 0.001, this would be a far, far weaker case for statistical significance than if that variable was the only one the company evaluated. <b>Note:</b> Context matters.
B.3.c	Obtain a correlation matrix for all parametric (non-smoothed) predictor variables included in the model and sub-model(s).	3	While GAMs accommodate collinearity, the correlation matrix provides more information about the magnitude of correlation between variables. The company should indicate what statistic was used (e.g., Pearson, Cramer's V). The regulatory reviewer should understand what statistic was used to produce the matrix but should not prescribe the statistic.
B.3.d	Obtain concurrency metrics for all smoothed predictor variables included in the model and sub-models.	3	GAMs can suffer from high concurrency in addition to high collinearity. Concurrency is the degree to which the smoothed terms move together. The company should indicate what concurrency metrics were used. The regulatory reviewer should understand what metric was used to produce the concurrency metrics but should not prescribe the type of metrics.

**Commented [WLS]:** Is there a possibility of a situation where a correlation exists between an unsmoothed and a smoothed predictor variable? If so, how can we address this situation here?

Also, is it possible for different metrics to result in different conclusions? If so, would it be worthwhile to suggest that review of multiple types of concurrency metrics would be beneficial?

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.3.e	Obtain a rational explanation for why an increase in each predictor variable should increase or decrease frequency, severity, loss costs, expenses, or any element or characteristic being predicted.	3	<p>The explanation should go beyond demonstrating correlation. Considering possible causation may be relevant, but proving causation is neither practical nor expected. If no rational explanation can be provided, greater scrutiny may be appropriate.</p> <p>For example, the regulator should look for unfamiliar predictor variables and, if found, the regulator should seek to understand the connection that variable has to increasing or decreasing the target variable.</p>
B.3.f	If the modeler made use of one or more dimensionality reduction techniques, such as a principal component analysis (PCA), obtain a narrative about that process, an explanation why that technique was chosen, and a description of the step-by-step process used to transform observations (usually correlated) into a set of (usually linearly) uncorrelated transformed variables. In each instance, obtain a list of the pre-transformation and post-transformation variable names, as well as an explanation of how the results of the dimensionality reduction technique was used within the model.	2	
<b>4. Adjusting Data, Model Validation, and Goodness-of-Fit Measures</b>			
B.4.a	Obtain a description of the methods used to assess the statistical significance/goodness-of-fit of the model to validation data, such as lift charts and statistical tests. Compare the model's projected results to historical actual results and verify that modeled results are reasonably similar to actual results from validation data.	1	<p>For models that are built using multistate data, validation data for some segments of risk is likely to have low credibility in individual states. Nevertheless, some regulators require model validation on state-only data, especially when analysis using state-only data contradicts the countrywide results. State-only data might be more applicable but could also be impacted by low credibility for some segments of risk.</p> <p><b>Note:</b> It may be useful to consider geographic stability measures for territories within the state.</p>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.4.b	For all parametric (non-smoothed) variables, review the appropriate parameter values and relevant tests of significance, such as confidence intervals, chi-square tests, p-values, or F tests. Determine if model development data, validation data, test data, or other data was used for these tests.	1	<p>Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.</p> <p>Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values, and any other relevant and material tests.</p> <p>For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; e.g., confidence intervals around each level of an AOI curve might be more than what is needed.</p>
B.4.c	For all smoothed variables, including interactions between smoothed variables, review plots representing the smooths and relevant tests of significance, such as approximate confidence intervals, chi-square tests, approximate p-values, or F tests. Determine if model development data, validation data, test data, or other data was used for these tests.	1	<p>Smoothed terms in a GAM can have many coefficients based on the number of basis functions. It is difficult to interpret the impact of the smoothed term based on the coefficients. Instead, regulators can review plots representing the cumulative effect of smoothed terms. The company could provide variable value on the x-axis and partial effects on the y-axis. The company could alternatively provide variable value on the x-axis and model prediction for the base risk on the y-axis. The company should provide confidence interval lines regardless of the type of plot. The regulatory reviewer should assess whether the plot has an intuitive shape and whether the curve extrapolates well, especially to areas of the curve representing thinner data.</p> <p>Smoothed interaction terms should also be expressed as plots. Heat map contour plots or 3D perspective plots may be useful.</p> <p>GAMs are a form of penalized regression which complicates the calculation of p-values. The p-values for the smoothed terms output by the modeling software are generally approximate p-values for GAMs. Approximate p-values should be reviewed at the smoothed variable level. The regulatory reviewer may want to select a smaller threshold for smoothed terms than they used for the parametric term p-value threshold.</p>

**Commented [WL6]:** More explanation of what "base risk" is here?  
Is it worthwhile to add something about the smooth failing the horizontal line test?

**Commented [WL7]:** Is there any guidance as to what that threshold should be? Are there any factors that a regulator should consider in determining the threshold to apply?

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.4.d	For all smoothed variables, request details about the basis functions comprising each smoothed function.	4	Smooth functions are based on a sum of basis functions. The company should provide the number of basis functions for each smooth and discuss how the number was chosen.  There are many types of smooth functions that can be applied. Examples include thin plate splines, cubic splines, and cyclic splines. The company should provide the type of each smooth and a narrative on why that type of smooth is appropriate for the variable.
B.4.e	Identify the threshold for statistical significance and explain why it was selected. Obtain a reasonable and appropriately supported explanation for keeping the variable for each discrete variable level where the p-values were not less than the chosen threshold.	1	The explanation should clearly identify the thresholds for statistical significance used by the modeler. Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.  Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter values for parametric terms, plots representing smoothed terms, confidence intervals, chi-square tests, p-values, and any other relevant and material tests.
B.4.f	For overall discrete variables, review type 3 chi-square tests, approximate p-values, F tests and any other relevant and material test. Determine if model development data, validation data, test data, or other data was used for these tests.	2	Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.  Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter values for parametric terms, plots representing smoothed terms, confidence intervals, chi-square tests, p-values (approximate p-values for smoothed terms), and any other relevant and material tests.  For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; e.g., confidence intervals around each level of an AOI curve might be more than what is needed.

**Commented [WL9]:** Should we add the possibility of a lower threshold when evaluating smoothed terms?

**Commented [WL8]:**  
We are unsure if discrete variables can be smoothed.  
If so, then do we want to add "approximate" here?  
If not, should we eliminate the added language "plots representing smoothed terms" in the Comments section?

**Commented [SM10]:** "Parametric terms" that are modeled continuously?



Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.4.g	Obtain evidence that the model fits the training data well, for individual variables, for any relevant combinations of variables, and for the overall model.	2	<p>For a GAM, such evidence may be available using chi-square tests, approximate p-values, F tests and/or other means.</p> <p>The steps taken during modeling to achieve goodness-of-fit are likely to be numerous and laborious to describe, but they contribute much of what is generalized about a GAM.</p> <p>The regulator should not assume to know what the company did and ask, "How?" Instead, the regulator should ask what the company did and be prepared to ask follow-up questions.</p>
B.4.h	For continuous variables, provide confidence intervals, chi-square tests, approximate p-values, and any other relevant and material test. Determine if model development data, validation data, test data, or other data was used for these tests.	2	<p>Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.</p> <p>Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter values for parametric terms, plots representing smoothed terms confidence intervals, chi-square tests, approximate p-values and any other relevant and material tests.</p> <p>For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an AOI curve might be more than what is needed.</p>

**Commented [SM11]:** "Parametric terms" that are modeled continuously?

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.4.i	Obtain a description how the model was tested for stability over time.	2	<p>Evaluate the build/test/validation datasets for potential time-sensitive model distortions (e.g., a winter storm in year 3 of 5 can distort the model in both the testing and validation datasets).</p> <p>Obsolescence over time is a model risk (e.g., old data for a variable or a variable itself may no longer be relevant). If a model being introduced now is based on losses from years ago, the reviewer should be interested in knowing whether that model would be predictive in the proposed context. Validation using recent data from the proposed context might be requested. Obsolescence is a risk even for a new model based on recent and relevant loss data.</p> <p>The reviewer may want to inquire as to the following: What steps, if any, were taken during modeling to prevent or delay obsolescence? What controls exist to measure the rate of obsolescence? What is the plan and timeline for updating and ultimately replacing the model?</p> <p>The reviewer should also consider that as newer technologies enter the market (e.g., personal automobile) their impact may change claim activity over time (e.g., lower frequency of loss). So, it is not necessarily a bad thing that the results are not stable over time.</p>
B.4.j	Obtain a narrative on how potential concerns with overfitting were addressed.	2	
B.4.k	Obtain the value of the model complexity parameter $\lambda$ and a discussion of how it was chosen.	2	<p>GAMs are a form of penalized regression. Smaller values of <math>\lambda</math> allow the model to increase complexity and fit “wigglier” data. Larger values of <math>\lambda</math> constricts the model and increases smoothness. Multiple automated approaches exist for tuning <math>\lambda</math> including predictive approaches that optimize AIC or Bayesian approaches such as Restricted Maximum Likelihood.</p>
B.4.l	Obtain support demonstrating that the overall GAM assumptions are appropriate.	3	<p>A visual review of plots of actual errors is usually sufficient.</p> <p>The reviewer should look for a conceptual narrative covering these topics: How does this particular GAM work? Why did the rate filer do what it did? Why employ this design instead of alternatives? Why choose this particular distribution function and this particular link function? A company response may be at a fairly high level and reference industry practices.</p> <p>If the reviewer determines that the model makes no assumptions that are considered to be unreasonable, the importance of this item may be reduced.</p>

**Commented [WL12]:** Given that lambda is likely to be readily available from R or other software, should we change the level to 1 or 2?

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.4.m	Obtain support demonstrating that the assumptions for each smoothed term are appropriate.	3	<p>The reviewer should look for a narrative on how the fit of the smoothed terms was checked for reasonableness.</p> <p>It may be useful to ask for each plot of the smoothed terms to include residuals to ensure that the smoothed line runs through the middle of the residuals.</p> <p>It may be useful for the company to provide tests that each smoothed term is not predictive of residual values (similar to tests achieved in the gam.check() function of the mcgv R package). These tests would ideally demonstrate that the residuals are randomly distributed across all parts of the smoothed term.</p>
B.4.n	Obtain 5-10 sample records with corresponding output from the model for those records.	4	
<b>5. "Old Model" Versus "New Model"</b>			
B.5.a	Obtain an explanation of why this model is an improvement to the current rating plan. If it replaces a previous model, find out why it is better than the one it is replacing; determine how the company reached that conclusion and identify metrics relied on in reaching that conclusion. Look for an explanation of any changes in calculations, assumptions, parameters, changes in smoothed variable plots, and data used to build this model from the previous model.	2	The regulator should expect to see improvement in the new class plan's predictive ability or other sufficient reason for the change.
B.5.b	Determine if two Gini coefficients were compared and obtain a narrative on the conclusion drawn from this comparison.	3	<p>This information element requests a comparison of Gini coefficient from the prior model to the Gini coefficient of proposed model. It is expected that there should be improvement in the Gini coefficient. A higher Gini coefficient indicates greater differentiation produced by the model and how well the model fits that data.</p> <p>This is relevant when one model is being updated or replaced. The regulator should expect to see improvement in the new class plan's predictive ability. One example of a comparison might be sufficient.</p> <p><b>Note:</b> This comparison is not applicable to initial model introduction. Reviewer can look to CAS monograph, "Generalized Linear Models for Insurance Rating."</p>
B.5.c	Determine if double-lift charts were analyzed and obtain a narrative on the conclusion drawn from this analysis.	3	<p>One example of a comparison might be sufficient.</p> <p><b>Note:</b> "Not applicable" is an acceptable response.</p>

**Commented [WL13]:** Suggested revision for consistency with remainder of the document.

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.5.d	If replacing an existing model, obtain a list of any predictor variables used in the old model that are not used in the new model. Obtain an explanation of why these variables were dropped from the new model.  Obtain a list of all new predictor variables in the new model that were not in the prior old model.	2	It is useful to differentiate between old and new variables, so the regulator can prioritize more time on variables not yet reviewed.
<b>6. Modeler Software</b>			
B.6.a	Request access to SMEs (e.g., modelers) who led the project, compiled the data, and/or built the model.	4	The filing should contain a contact that can put the regulator in touch with appropriate SMEs and key contributors to the model development to discuss the model.

**C. THE FILED RATING PLAN**

Section	Information Element	Level of Importance to the Regulator's Review	Comments
<b>I. General Impact of Model on Rating Algorithm</b>			
C.1.a	In the actuarial memorandum or explanatory memorandum, for each model and sub-model (including external models), look for a narrative that explains each model and its role (i.e., how it was used) in the rating system.	1	The "role of the model" relates to how the model integrates into the rating plan as a whole and where the effects of the model are manifested within the various components of the rating plan. This is not intended as an overarching statement of the model's goal, but rather a description of how specifically the model is used.  This item is particularly important, if the role of the model cannot be immediately discerned by the reviewer from a quick review of the rate and/or rule pages. (Importance is dependent on state requirements and ease of identification by the first layer of review and escalation to the appropriate review staff.)
C.1.b	Obtain an explanation of how the model was used to adjust the filed rating algorithm.	1	Models are often used to produce factor-based indications, which are then used as the basis for the selected changes to the rating plan. It is the changes to the rating plan that create impacts.  The regulator should consider asking how the smoothed functions of the GAM will be implemented. The regulator should consider asking for an explanation of how the model was used to adjust the rating algorithm.
C.1.c	Obtain a complete list of characteristics/variables used in the proposed rating plan, including those used as input to the model (including sub-models and composite variables) and all other characteristics/variables (not input to the model) used to calculate a premium. For each characteristic/variable, determine if it is only input to the model, whether it is only a separate univariate rating characteristic, or whether it is both input to the model and a separate univariate rating characteristic. The list should include transparent descriptions (in plain language) of each listed characteristic/variable.	1	Examples of variables used as inputs to the model and used as separate univariate rating characteristics might be criteria used to determine a rating tier or household composite characteristic.

**Commented [WL14]:** Smoothed "terms" rather than "functions"?

Section	Information Element	Level of Importance to the Regulator's Review	Comments
<b>2. Relevance of Variables and Relationship to Risk of Loss</b>			
C.2.a	Obtain a narrative regarding how the characteristics/rating variables included in the filed rating plan relate to the risk of insurance loss(or expense) for the type of insurance productbeing priced.	2	The narrative should include a discussion of the relevance each characteristic/rating variable has on consumer behavior that would lead to a difference in risk of loss (or expense). The narrative should include a rational relationship to cost, and model results should be consistent with the expected direction of the relationship. <b>Note:</b> This explanation would not be needed if the connection between variables and risk of loss (or expense) has already been illustrated.
<b>3. Comparison of Model Outputs to Current and Selected Rating Factors</b>			
C.3.a	Compare relativities indicated by the model to both current relativities and the insurer's selected relativities for each risk characteristic/variable in the rating plan.	1	"Significant difference" may vary based on the risk characteristic/variable and context. However, the movement of a selected relativity should be in the direction of the indicated relativity; if not, an explanation is necessary as to why the movement is logical.
C.3.b	Obtain documentation and support for all calculations, judgments, or adjustments that connect the model's indicated values to the selected relativities filed in the rating plan.	1	The documentation should include explanations for the necessity of any such adjustments and each significantdifference between the model's indicated values and the selected values. This applies even to models that produce scores, tiers, or ranges of values for which indications can be derived. <b>Note:</b> This information is especially important if differences between model-indicated values and selected values are material and/or impact one consumer population more than another.
C.3.c	For each characteristic/variable used as both input to the model (including sub-models and composite variables) and as a separate univariate rating characteristic, obtain a narrative regarding how each characteristic/variable was tempered or adjusted to account for possible overlap or redundancy in what the characteristic/variable measures.	2	Modeling loss ratios with these characteristics/ variables as control variables would account for possible overlap. The insurer should address this possibility or other considerations; e.g., tier placement models often use risk characteristics/ variables that are also used elsewhere inthe rating plan. One way to do this would be to model the loss ratios resulting from a process that already uses univariate rating variables. Then the model/composite variables would be attempting to explain the residuals.
<b>4. Responses to Data, Credibility, and Granularity Issues</b>			
C.4.a	Determine what, if any, consideration was given to the credibility of the output data.	2	The regulator should determine at what level of granularity credibility is applied. If modeling was by-coverage, by-form, or by-peril, the company should explain how these were handled when there was not enough credible data by coverage, form, or peril to model.

Section	Information Element	Level of Importance to the Regulator's Review	Comments
C.4.b	If the rating plan is less granular than the model, obtain an explanation of why.	2	This is applicable if the company had to combine modeled output in order to reduce the granularity of the rating plan.
C.4.c	If the rating plan is more granular than the model, obtain an explanation of why.	2	A more granular rating plan may imply that the company had to extrapolate certain rating treatments, especially at the tails of a distribution of attributes, in a manner not specified by the model indications. It may be necessary to extrapolate due to data availability or other considerations.
<b>5. Definitions of Rating Variables</b>			
C.5.a	Obtain a narrative regarding adjustments made to model output (e.g., transformations, binning and/or categorizations). If adjustments were made, obtain the name of the characteristic/variable and a description of the adjustment.	2	If rating tiers or other intermediate rating categories are created from model output, the rate and/or rule pages should present these rating tiers or categories. The company should provide an explanation of how model output was translated into these rating tiers or intermediate rating categories.
<b>6. Supporting Data</b>			
C.6.a	Obtain aggregated state-specific, book-of-business-specific univariate historical experience data, separately for each year included in the model, consisting of loss ratio or pure premium relativities and the data underlying those calculations for each category of model output(s) proposed to be used within the rating plan. For each data element, obtain an explanation of whether it is raw or adjusted and, if the latter, obtain a detailed explanation for the adjustments.		For example, were losses developed/undeveloped, trended/untrended, capped/uncapped, etc.? Univariate indications should not necessarily be used to override more sophisticated multivariate indications. However, they do provide additional context and may serve as a useful reference.
C.6.b	Obtain an explanation of any material (especially directional) differences between model indications and state-specific univariate indications.	4	Multivariate indications may be reasonable as refinements to univariate indications, but possibly not for bringing about significant reversals of those indications. For instance, if the univariate indicated relativity for an attribute is 1.5 and the multivariate indicated relativity is 1.25, this is potentially a plausible application of the multivariate techniques. If, however, the univariate indicated relativity is 0.7 and the multivariate indicated relativity is 1.25, a regulator may question whether the attribute in question is negatively correlated with other determinants of risk. Credibility of state-level data should be considered when state indications differ from modeled results based on a broader dataset. However, the relevance of the broader dataset to the risks being priced should also be considered. Borderline reversals are not of as much concern. If multivariate indications perform well against the state-level data, this should suffice. However, credibility considerations need to be taken into account as state-level segmentation comparisons may not have enough credibility.

Section	Information Element	Level of Importance to the Regulator's Review	Comments
<b>7. Consumer Impacts</b>			
C.7.a	Obtain a listing of the top five rating variables that contribute the most to large swings in renewal premium, both as increases and decreases, as well as the top five rating variables with the largest spread of impact for both new and renewal business.	4	These rating variables may represent changes to rating factors, be newly introduced to the rating plan, or have been removed from the rating plan.
C.7.b	Determine if the company performed sensitivity testing to identify significant changes in premium due to small or incremental change in a single risk characteristic. If such testing was performed, obtain a narrative that discusses the testing and provides the results of that testing.	3	One way to see sensitivity is to analyze a graph of each risk characteristic's/variable's possible relativities. Look for significant variation between adjacent relativities and evaluate if such variation is reasonable and credible.
C.7.c	For the proposed filing, obtain the impacts on renewal business and describe the process used by management, if any, to mitigate those impacts.	2	Some mitigation efforts may substantially weaken the connection between premium and expected loss and expense and, hence, may be viewed as unfairly discriminatory by some states.
C.7.d	Obtain a rate disruption/dislocation analysis, demonstrating the distribution of percentage and/or dollar impacts on renewal business (created by rerating the current book of business) and sufficient information to explain the disruptions to individual consumers.	2	The analysis should include the largest dollar and percentage impacts arising from the filing, including the impacts arising specifically from the adoption of the model or changes to the model as they translate into the proposed rating plan.  While the default request would typically be for the distribution/dislocation of impacts at the overall filing level, the regulator may need to delve into the more granular variable-specific effects of rate changes if there is concern about particular variables having extreme or disproportionate impacts, or significant impacts that have otherwise yet to be substantiated.  See Appendix D for an example of a disruption analysis.
C.7.e	Obtain exposure distributions for the model's output variables and show the effects of rate changes at granular and summary levels, including the overall impact on the book of business.	3	See Appendix D for an example of an exposure distribution.



Section	Information Element	Level of Importance to the Regulator's Review	Comments
C.7.f	Identify policy characteristics, used as input to a model or sub-model, that remain "static" over a policy's lifetime versus those that will be updated periodically. Obtain a narrative on how the company handles policy characteristics that are listed as "static," yet change over time.	3	<p>Some examples of "static" policy characteristics are prior carrier tenure, prior carrier type, prior liability limits, claim history over past X years, or lapse of coverage. These are specific policy characteristics usually set at the time new business is written, used to create an insurance score or to place the business in a rating/underwriting tier, and often fixed for the life of the policy.</p> <p>The reviewer should be aware, and possibly concerned, how the company treats an insured over time when the insured's risk profile based on "static" variables changes over time but the rate charged, based on a new business insurance score or tier assignment, no longer reflect the insured's true and current risk profile.</p> <p>A few examples of "non-static" policy characteristics are age of driver, driving record, and credit information (FCRA-related). These are updated automatically by the company on a periodic basis, usually at renewal, with or without the policyholder explicitly informing the company.</p>
C.7.g	Obtain a means to calculate the rate charged a consumer.	3	<p>The filed rating plan should contain enough information for a regulator to be able to validate policy premium. However, for a complex model or rating plan, a score or premium calculator via Excel or similar means would be ideal, but this could be elicited on a case-by-case basis. The ability to calculate the rate charged could allow the regulator to perform sensitivity testing when there are small changes to a risk characteristic/variable. <b>Note:</b> This information may be proprietary.</p> <p>For the rating plan, the rate order of calculation rule may be sufficient. However, it may not be feasible for a regulator to get all the input data necessary to reproduce a model's output. Credit and telematics models are examples of model types where model output would be readily available, but the input data would not be readily available to the regulator.</p>
C.7.h	In the filed rating plan, be aware of any non-insurance data used as input to the model (customer-provided or other). In order to respond to consumer inquiries, it may be necessary to inquire as to how consumers can verify their data and correct errors.	1	<p>If the data is from a third-party source, the company should provide information on the source. Depending on the nature of the data, it may need to be documented with an overview of who owns it.</p> <p>The topic of consumer verification may also need to be addressed, including how consumers can verify their data and correct errors.</p>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
<b>8. Accurate Translation of Model into a Rating Plan</b>			
C.8.a	Obtain sufficient information to understand how the model outputs are used within the rating system and to verify that the rating plan's manual, in fact, reflects the model output and any adjustments made to the model output.	1	The regulator can review the rating plan's manual to see that modeled output is properly reflected in the manual's rules, rates, factors, etc.
<b>9. Efficient and Effective Review of Rate Filing</b>			
C.9.a	Establish procedures to efficiently review rate filings and models contained therein.	1	<p>“Speed to market” is an important competitive concept for insurers. Although the regulator needs to understand the rate filing before accepting the rate filing, the regulator should not request information that does not increase his/her understanding of the rate filing.</p> <p>The regulator should review the state's rate filing review process and procedures to ensure that they are fair and efficient.</p>
C.9.b	Be knowledgeable of state laws and regulations in order to determine if the proposed rating plan (and models) are compliant with state laws and/or regulations.	1	This is a primary duty of state insurance regulators. The regulator should be knowledgeable of state laws and regulations and apply them to a rate filing fairly and efficiently. The regulator should pay special attention to prohibitions of unfair discrimination.
C.9.c	Be knowledgeable of state laws and regulations in order to determine if any information contained in the rate filing (and models) should be treated as confidential.	1	The regulator should be knowledgeable of state laws and regulations regarding confidentiality of rate filing information and apply them to a rate filing fairly and efficiently. Confidentiality of proprietary information is key to innovation and competitive markets.

## Significant Changes Summary

- 1 The introduction has been clarified to reflect that this appendix is for GAMs only.
  - 2 Information elements discussing p-values and concurvity metrics have an asterisk and a related footnote. The footnote explains that if a certain variety of GAM can't produce these measures, requests should focus on satisfying the purpose of this element through other methods.
  - 3 The correlation matrix information element now requests both the parametric variables and the inputs for the smoothed variables. This is to help identify relationships between the parametric variables and non-parametric variables.
  - 4 The commentary about lower approximate p-value thresholds now includes an example. "For example, if a regulator typically applies a 0.05 threshold to a GLM, they may want to consider applying a 0.03 threshold to the smoothed terms within a GAM."
  - 5 The commentary about evaluating smoothed term plots now discusses the "horizontal line test." The regulatory reviewer should review whether the plot passes the "horizontal line test". The "horizontal line test" checks whether a horizontal line could be drawn in the plot through the confidence intervals. If so, this implies that the smoothed variable is not measuring significant differences across the target variable.
  - 6 Added a statement that the review of multiple concurvity metrics may be beneficial.
- Most of the other changes improve the clarity of the wording without revising the original meaning.

## Comments Received

Organization	Commentor	Comment Regarding	Change
NAIC	Kris DeFrain	Introduction	Yes
AKUR8	Thomas Holmes	Introduction	Yes
		B.3.d B.4.c B.4.e B.4.f B.4.h B.4.m	Yes
		B.4.d	Yes
		B.2.d	No
California Department of Insurance	Lynne Wehmueller Mitra Sanandajifar	B.2.e	Yes
		B.3.c B.3.d	Yes

		B.4.c	Yes
		B.4.f	Yes
		B.4.h	No
		B.4.k	No
		B.4.m	Yes
		C.1.b	Yes
Arizona Department of Insurance and Financial Institutions	Tom Zuppan	B.1.a	Yes

## APPENDIX B-GAM – INFORMATION ELEMENTS AND GUIDANCE FOR A REGULATOR TO MEET BEST PRACTICES’ OBJECTIVES (WHEN REVIEWING GENERALIZED ADDITIVE MODELS)

This appendix identifies the information a state insurance regulator may need to review a Generalized Additive Model (GAM) used by an insurer to support a personal automobile or home insurance rating plan. GAM models are similar to Generalized Linear Models (GLMs) but feature smoothed terms in addition to traditional parametric terms. The list is lengthy but not exhaustive. It is not intended to limit the authority of a regulator to request additional information in support of the model or filed rating plan. Nor is every item on the list intended to be a requirement for every filing. However, the items listed should help guide a regulator to sufficient information that helps determine if the rating plan meets state-specific filing and legal requirements.

Documentation of the design and operational details of the model will help ensure the business continuity and transparency of the models used. Documentation should be sufficiently detailed and complete to enable a qualified third party to form a sound judgment on the suitability of the model for the intended purpose. The theory, assumptions, methodologies, software, and empirical bases should be explained, as well as the data used in developing and implementing the model. Relevant testing and ongoing performance testing need to be documented. Key model limitations and overrides need to be pointed out so that stakeholders understand the circumstances under which the model does not work effectively. End-user documentation should be provided and key reports using the model results described. Major changes to the model need to be documented and shared with regulators in a timely and appropriate manner. Information technology (IT) controls should be in place, such as a record of versions, change control, and access to the model.<sup>1</sup>

Many information elements listed below are probably confidential, proprietary, or trade secret and should be treated as such, in accordance with state laws and/or regulations. Regulators should be aware of their state laws and/or regulations on confidentiality when requesting data from insurers that may be proprietary or trade secret. For example, some proprietary models may have contractual terms (with the insurer) that prevent disclosure to the public. Without clear necessity, exposing this data to additional dissemination may compromise the model’s protection.<sup>2</sup>

Although the list of information is long, the insurer should already have internal documentation on the model for more than half of the information listed. The remaining items on the list require either minimal analysis (approximately 25%) or deeper analysis to generate for a regulator (approximately 25%). The definition of GAM is quite broad and the available information elements will differ depending on the basis functions used in the GAM as well as the method of penalization. This broad definition of a GAM means that a reviewer should be looking for analogous information in the case where certain necessary information elements are not available. For example, p-values will not be produced for some varieties of GAM. If p-values are being evaluated to confirm the significance of variables included in the model, the reviewer may start a dialogue on how variable significance was evaluated in this particular GAM to obtain the information necessary to satisfy this area of review. In this way, a reviewer can use the information elements below to review wide varieties of GAM.

The “Level of Importance to the Regulator’s Review” is a ranking of information a regulator may need to review which is based on the following level criteria:

**Level 1** – This information is necessary to begin the review of a predictive model. These data elements pertain to basic information about the type and structure of the model, the data and variables used, the assumptions made, and the goodness of fit. Ideally, this information would be included in the filing documentation with the initial submission of a filing made based on a predictive model.

**Level 2** – This information is necessary to continue the review of all but the most basic models, such as those based only on the filer’s internal data and only including variables that are in the filed rating plan. These data elements provide more detailed information about the model and address questions arising from review of the information in Level 1. Insurers concerned with speed to market may also want to include this information in the filing documentation.

**Level 3** – This information is necessary to continue the review of a model where concerns have been raised and not resolved based on review of the information in Level 1 and Level 2. These data elements address even more detailed aspects of the model. This information does not necessarily need to be included with the initial submission, unless specifically requested by a particular state, as it is typically requested only if the reviewer has concerns that the model may not comply with state laws and/or regulations.

<sup>1</sup> Bourdeau, M., 2016. “Model Risk Management: An Overview,” The Modeling Platform, Issue 4, December. Accessed online at <https://www.soa.org/globalassets/assets/library/newsletters/the-modeling-platform/2016/december/mp-2016-iss4.pdf>.

<sup>2</sup> There are some models that are made public by the vendor and would not result in a hindrance of the model’s protection.

**Level 4** – This information is necessary to continue the review of a model where concerns have been raised and not resolved based on the information in Level 1, Level 2, and Level 3. This most granular level of detail is addressing the basic building blocks of the model and does not necessarily need to be included by the filer with the initial submission, unless specifically requested by a particular state. It is typically requested only if the reviewer has serious concerns that the model may produce rates or rating factors that are excessive, inadequate, and/or unfairly discriminatory.

Appendix B-GAM is focused on Generalized Additive Models (GAMs). This appendix should not be referenced in the review of other model types. GAMs have significant differences from GLMs. This Appendix B-GAM is intended to provide state guidance for the review of rate filings based on Generalized Additive Models.

**A. SELECTING MODEL INPUT**

Section	Information Element	Level of Importance to the Regulator’s Review	Comments
<b>1. Available Data Sources</b>			
A.1.a	Review the details of sources for both insurance and non-insurance data used as input to the model (only need sources for filed input characteristics included in the filed model).	1	<p>Request details of data sources, whether internal to the company or from external sources. For insurance experience (policy or claim), determine whether data are aggregated by calendar, accident, fiscal, or policy year and when it was last evaluated. For each data source, get a list of all data elements used as input to the model that came from that source. For insurance data, get a list all companies whose data is included in the datasets.</p> <p>Request details of any non-insurance data used (customer-provided or other), whether the data was collected by use of a questionnaire/checklist, whether data was voluntarily reported by the applicant, and whether any of the data is subject to the federal Fair Credit Reporting Act (FCRA). If the data is from an outside source, find out what steps were taken to verify the data was accurate, complete, and unbiased in terms of relevant and representative time frame, representative of potential exposures, and lacking in obvious correlation to protected classes.</p> <p><b>Note:</b> Reviewing source details should not make a difference when the model is new or refreshed; refreshed models would report the prior version list with the incremental changes due to the refresh.</p>
A.1.b	Reconcile aggregated insurance data underlying the model with available external insurance reports.	4	<p>Accuracy of insurance data should be reviewed. It is assumed that the data in the insurer’s data banks is subject to routine internal company audits and reconciliation. “Aggregated data” is straight from the insurer’s data banks without further modification (i.e., not scrubbed or transformed for the purposes of modeling). In other words, the data would not have been specifically modified for the purpose of model building. The company should provide some form of reasonability check that the data makes sense when checked against other audited sources.</p>

Section	Information Element	Level of Importance to the Regulator’s Review	Comments
A.1.c	Review the geographic scope and geographic exposure distribution of the raw data for relevance to the state where the model is filed.	2	Many models are developed using a countrywide or a regional dataset. The company should explain how the data used to build the model makes sense for a specific state. The regulator should inquire which states were included in the data underlying the model build, testing, and validation. The company should provide an explanation where the data came from geographically and that it is a good representation for a state; i.e., the distribution by state should not introduce a geographic bias. However, there could be a bias by peril or wind-resistant building codes. Evaluate whether the data is relevant to the loss potential for which it is being used. For example, verify that hurricane data is only used where hurricanes can occur.
<b>2. Sub-Models</b>			
A.2.a	Consider the relevance of (i.e., whether there is bias) of overlapping data or variables used in the model and sub-models.	1	Check if the same variables/datasets were used in the model, a sub-model, or as stand-alone rating characteristics. If so, verify the insurance company has processes and procedures in place to assess and address double-counting or redundancy.
A.2.b	Determine if the sub-model was previously approved (or accepted) by the regulatory agency.	1	If the sub-model was previously approved/accepted, that may reduce the extent of the sub-model’s review. If approved, obtain the tracking number(s) (e.g., state, SERFF) and verify when and if it was the same model currently under review.  Note: A previous approval does not necessarily confer a guarantee of ongoing approval; e.g., when statutes and/or regulations have changed or if a model’s indications have been undermined by subsequent empirical experience. However, knowing whether a model has been previously approved can help focus the regulator’s efforts and determine whether the prior decision needs to be revisited. In some circumstances, direct dialogue with the vendor could be quicker and more useful.



Section	Information Element	Level of Importance to the Regulator’s Review	Comments
A.2.c	Determine if the sub-model output was used as input to the GAM; obtain the vendor name, as well as the name and version of the sub-model.	1	<p>To accelerate the review of the filing, it may be desirable to request (from the company), the name and contact information for a vendor representative. The company should provide the name of the third-party vendor and a contact in the event the regulator has questions. The “contact” can be an intermediary at the insurer (e.g., a filing specialist), who can place the regulator in direct contact with a subject-matter expert (SME) at the vendor.</p> <p>Examples of such sub-models include credit/financial scoring algorithms and household composite score models. Sub-models can be evaluated separately and in the same manner as the primary model under evaluation. A sub-model contact for additional information should be provided. Sub-model SMEs may need to be brought into the conversation with regulators (whether in-house or third-party sub-models are used).</p>
A.2.d	If using catastrophe model output, identify the vendor and the model settings/assumptions used when the model was run.	1	<p>To accelerate the review of the filing, get contact information for the SME that ran the model and an SME from the vendor. The “SME” can be an intermediary at the insurer (e.g., a filing specialist), who can place the regulator in direct contact with the appropriate SMEs at the insurer or model vendor.</p> <p>For example, it is important to know hurricane model settings for storm surge, demand surge, and long-term/short-term views.</p>
A.2.e	Obtain an explanation of how catastrophe models are integrated into the model to ensure no double-counting.	1	<p>If a weather-based sub-model is input to the GAM under review, loss data used to develop the model should not include loss experience associated with the weather-based sub-model. Doing so could cause distortions in the modeled results by double-counting such losses when determining relativities or loss loads in the filed rating plan.</p> <p>For example, redundant losses in the data may occur when non-hurricane wind losses are included in the data while also using a severe convective storm model in the actuarial indication. Such redundancy may also occur with the inclusion of fluvial or pluvial flood losses when using a flood model or inclusion of freeze losses when using a winter storm model.</p>
A.2.f	If using output of any scoring algorithms, obtain a list of the variables used to determine the score and provide the source of the data used to calculate the score.	1	<p>Any sub-model should be reviewed in the same manner as the primary model that uses the sub-model’s output as input. Depending on the result of item A.2.b, the importance of this item may be decreased.</p>

Section	Information Element	Level of Importance to the Regulator’s Review	Comments
<b>3. Adjustments to Data</b>			
A.3.a	Determine if premium, exposure, loss, or expense data were adjusted (e.g., developed, trended, adjusted for catastrophe experience, or capped). If so, how? Do the adjustments vary for different segments of the data? If so, identify the segments and how the data was adjusted.	2	<p>The rating plan or indications underlying the rating plan may provide special treatment of large losses and non-modeled large loss events. If such treatments exist, the company should provide an explanation how they were handled. These treatments need to be identified and the company/regulator needs to determine whether model data needs to be adjusted.</p> <p>For example, should large bodily injury (BI) liability losses in the case of personal automobile insurance be excluded, or should large non-catastrophe wind/hail claims in home insurance be excluded from the model’s training, test and validation data? Look for anomalies in the data that should be addressed. For example, is there an extreme loss event in the data? If other processes were used to load rates for specific loss events, how is the impact of those losses considered?</p> <p>Examples of losses that can contribute to anomalies in the data are large losses or flood, hurricane, or severe convective storm losses for personal automobile comprehensive or home insurance.</p>
A.3.b	Identify adjustments that were made to aggregated data (e.g., transformations, binning and/or categorizations). If any, identify the name of the characteristic/variable and obtain a description of the adjustment.	1	
A.3.c	Ask for aggregated data (one dataset of pre-adjusted/scrubbed data and one dataset of post-adjusted/scrubbed data) that allows the regulator to focus on the univariate distributions and compare raw data to adjusted/binning/transformed/etc. data.	4	<p>This is most relevant for variables that have been “scrubbed” or adjusted.</p> <p>Though most regulators may never ask for aggregated data and do not plan to rebuild any models, a regulator may ask for this aggregated data or subsets of it.</p> <p>It would be useful to the regulator if the percentage of exposures and premium for missing information from the model data by category are provided. This data can be displayed in either graphical or tabular formats.</p>
A.3.d	Determine how missing data was handled.	1	<p>This is most relevant for variables that have been “scrubbed” or adjusted. The regulator should be aware of assumptions the modeler made in handling missing, null, or “not available” values in the data.</p> <p>For example, it would be helpful to the reviewer if the modeler were to provide a statement as to whether there is any systemic reason for missing data. If adjustments or recoding of values were made, they should be explained. It may also be useful to the regulator if the percentage of exposures and premium for missing information from the model data are provided. This data can be displayed in either graphical or tabular formats.</p>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
A.3.e	If duplicate records exist, determine how they were handled.	1	
A.3.f	Determine if there were any material outliers identified and subsequently adjusted during the scrubbing process.	3	Look for a discussion of how outliers were handled. If necessary, the regulator may want to investigate further by getting a list (with description) of the types of outliers and determine what adjustments were made to each type of outlier. To understand the filer's response, the regulator should ask for the filer's materiality standard.
<b>4. Data Organization</b>			
A.4.a	Obtain documentation on the methods used to compile and organize data, including procedures to merge data from different sources or filter data based on particular characteristics and a description of any preliminary analyses, data checks, and logical tests performed on the data and the results of those tests.	2	This should explain how data from separate sources was merged and/or how subsets of policies, based on selected characteristics, are filtered to be included in the data underlying the model and the rationale for that filtering.
A.4.b	Obtain documentation on the insurer's process for reviewing the appropriateness, reasonableness, consistency, and comprehensiveness of the data, including a discussion of the rational relationship the data has to the predicted variable.	2	An example is when by-peril or by-coverage modeling is performed; the documentation should be for each peril/coverage and make rational sense. For example, if "murder" or "theft" data are used to predict the wind peril, the company should provide support and a rational explanation for their use.
A.4.c	Identify material findings the company had during its data review and obtain an explanation of any potential material limitations, defects, bias, or unresolved concerns found or believed to exist in the data. If issues or limitations in the data influenced modeling analysis and/or results, obtain a description of those concerns and an explanation of how modeling analysis was adjusted and/or results were impacted.	1	"None" or "N/A" may be an appropriate response.

**B. BUILDING THE MODEL**

Section	Information Element	Level of Importance to the Regulator’s Review	Comments
<b>1. High-Level Narrative for Building the Model</b>			
B.1.a	Identify the type of model underlying the rate filing (e.g., GAM, GLM, decision tree, Bayesian GLM, gradient-boosting machine, neural network, etc.). Understand the model’s role in the rating system and provide the reasons why that type of model is an appropriate choice for that role.	1	<p>It is important to understand if the model in question is a GAM and, therefore, these information elements are applicable; or if it is some other model type, in which case other reasonable review approaches may be considered. There should be an explanation of why the model (using the variables included in it) is appropriate for the line of business. If by-peril or by-coverage modeling is used, the explanation should be by-peril/by-coverage.</p> <p><b>Note:</b> If the model is not a GAM, the information elements in this white paper may not apply in their entirety.</p>
B.1.b	Identify the software used for model development. Obtain the name of the software vendor/developer, software product, and a software version reference used in model development.	3	<p>Changes in software from one model version to the next may explain if such changes, over time, contribute to changes in the modeled results. The company should provide the name of the third-party vendor and a “contact” in the event the regulator has questions. The “contact” can be an intermediary at the insurer (e.g., a filing specialist) who can place the regulator in direct contact with the appropriate SME at the vendor.</p> <p>Open-source software/programs used in model development should be identified by name and version the same as if from a vendor.</p>
B.1.c	Obtain a description how the available data was divided between model training, test, and/or validation datasets. The description should include an explanation why the selected approach was deemed most appropriate, whether the company made any further subdivisions of available data, and reasons for the subdivisions (e.g., a portion separated from training data to support testing of components during model building). Determine if the validation data was accessed before model training was completed and, if so, obtain an explanation of why that came to occur. Obtain a discussion of whether the model was rebuilt using all the data or if it was only based on the training data.	1	<p>The reviewer should be aware that modelers may break their data into three or just two datasets. Although the term “training” is used with little ambiguity, “test” and “validation” are terms that are sometimes interchanged, or the word “validation” may not be used at all.</p> <p>It would be unexpected if validation and/or test data were used for any purpose other than validation and/or test, prior to the selection of the final model. However, according to the CAS monograph, “Generalized Linear Models for Insurance Rating”: “Once a final model is chosen, ... we would then go back and rebuild it using all of the data, so that the parameter estimates would be at their most credible.”</p> <p>The reviewer should note whether a company employed cross-validation techniques instead of a training/test/validation dataset approach. If cross-validation techniques were used, the reviewer should request a description of how cross-validation was done and confirm that the final model was not built on any particular subset of the data, but rather the full dataset.</p>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.1.d	Obtain a brief description of the development process, from initial concept to final model and filed rating plan.	1	The narrative should have the same scope as the filing.
B.1.e	Obtain a narrative on whether loss ratio, pure premium, or frequency/severity analyses were performed and, if separate frequency/severity modeling was performed, how pure premiums were determined.	1	
B.1.f	Identify the model's target variable.	1	A clear description of the target variable is key to understanding the purpose of the model. It may also prove useful to obtain a sample calculation of the target variable in Excel format, starting with the "raw" data for a policy, or a small sample of policies, depending on the complexity of the target variable calculation.
B.1.g	Obtain a description of the variable selection process.	1	The narrative regarding the variable selection process may address matters such as the criteria upon which variables were selected or omitted, identification of the number of preliminary variables considered in developing the model versus the number of variables that remained, and any statutory or regulatory limitations that were taken into account when making the decisions regarding variable selection.  The modeler should comment on the use of automated feature selection algorithms to choose predictor variables and explain how potential overfitting that can arise from these techniques was addressed.
B.1.h	In conjunction with variable selection, obtain a narrative on how the company determined the granularity of the rating variables during model development.	3	The narrative should include discussion of how credibility was considered in the process of determining the level of granularity of the variables selected.
B.1.i	Determine if model input data was segmented in anyway (e.g., by-coverage, by-peril, or by-form basis). If so, obtain a description of data segmentation and the reasons for data segmentation.	1	The regulator would use this to follow the logic of the modeling process.
B.1.j	If adjustments to the model were made based on credibility considerations, obtain an explanation of the credibility considerations and how the adjustments were applied.	2	Adjustments may be needed, given that models do not explicitly consider the credibility of the input data or the model's resulting output; models take input data at face value and assume 100% credibility when producing modeled output.
<b>2. Medium-Level Narrative for Building the Model</b>			
B.2.a	At crucial points in model development, if selections were made among alternatives regarding model assumptions or techniques, obtain a narrative on the judgment used to make those selections.	3	

Section	Information Element	Level of Importance to the Regulator’s Review	Comments
B.2.b	If post-model adjustments were made to the data and the model was rerun, obtain an explanation on the details and the rationale for those adjustments.	2	Evaluate the addition or removal of variables and the model fitting. It is not necessary for the company to discuss each iteration of adding and subtracting variables, but the regulator should gain a general understanding of how these adjustments were done, including any statistical improvement measures relied upon.
B.2.c	Obtain a description of the testing that was performed during the model-building process, including an explanation of the decision-making process to determine which interactions were included and which were not.	3	<p>There should be a description of the testing that was performed during the model-building process. Examples of tests that may have been performed include univariate testing and review of a correlation matrix.</p> <p>The number of interaction terms that could potentially be included in a model increases far more quickly than the number of “main effect” variables (i.e., the basic predictor variables that can be interacted together). Analyzing each possible interaction term individually can be unwieldy. It is typical for interaction terms to be excluded from the model by default, and only included where they can be shown to be particularly important. So, as a rule of thumb, the regulator’s emphasis should be on understanding why the insurer included the interaction terms it did, rather than on why other candidate interactions were excluded.</p> <p>In some cases, however, it could be reasonable to inquire about why a particular interaction term was excluded from a model—for example, if that interaction term was ubiquitous in similar filings and was known to be highly predictive, or if the regulator had reason to believe that the interaction term would help differentiate dissimilar risks within an excessively heterogeneous rating segment.</p>
B.2.d	For the GAM, identify the link function used. Identify which distribution was used for the model (e.g., Poisson, Gaussian, log-normal, Tweedie). Obtain an explanation of why the link function and distribution were chosen. Obtain the formulas for the distribution and link functions, including specific numerical parameters of the distribution. If changed from the default, obtain a discussion of applicable convergence criterion.	1	Solving the GAM is iterative and the modeler can check to see if fit is improving. At some point, convergence occurs; however, when it occurs can be subjective or based on threshold criteria. If the software’s default convergence criteria were not relied upon, an explanation of any deviation should be provided. If the GAM did not reach convergence, an explanation should be provided.
B.2.e	Obtain a narrative on the formula relationship between the data and the model outputs, with a definition of each model input and output. The narrative should describe all parametric (non-smoothed terms represented as coefficients) and smoothed terms necessary to evaluate the predicted pure premium, relativity, or other value, for any real or hypothetical set of inputs.	2	GAMs can have both parametric terms similar to those available in GLMs (e.g., those terms associated with coefficients) and smoothed terms. The smoothed terms are the sum of multiple basis functions which can take on a variety of types. The narrative should describe the relationships captured between the terms in the model (parametric and non-parametric) and the model output.

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B.2.f	If there were data situations in which GAM weights were used, obtain an explanation of how and why they were used.	3	Investigate whether identical records were combined to build the model.
<b>3. Predictor Variables</b>			
B.3.a	Obtain a complete data dictionary, including the names, data types, variable fit types, definitions, and uses of each predictor variable, offset variable, control variable, proxy variable, geographic variable, geodemographic variable, and all other variables in the model used on their own or as an interaction with other variables (including sub-models and external models).	1	Data types of variables might be continuous, discrete, Boolean, etc. Definitions should not use programming language or code. Variable fit types include parametric (non-smoothed) and smoothed. For any variable(s) intended to function as a control or offset, obtain an explanation of its purpose and impact. Also, for any use of interaction between variables, obtain an explanation of its rationale and impact.
B.3.b	Obtain a list of predictor variables considered but not used in the final model, and the rationale for their removal.	4	The purpose of this requirement is to identify variables the company finds to be predictive but ultimately may reject for reasons other than loss-cost considerations (e.g., price optimization). Also, look for variables the company tested and then rejected. This item could help address concerns about data dredging. The reasonableness of including a variable with a given significance level could depend greatly on the other variables the company evaluated for inclusion in the model and the criteria for inclusion or omission.  For instance, if the company tested 1,000 similar variables and selected the one with the lowest p-value of 0.001, this would be a far, far weaker case for statistical significance than if that variable was the only one the company evaluated. <b>Note:</b> Context matters.
B.3.c	Obtain a correlation matrix for all predictor variables included in the model and sub-model(s). The variables used as parametric terms and the variables used as inputs to the smooth functions should all be included.	3	While GAMs accommodate collinearity, the correlation matrix provides more information about the magnitude of correlation between variables. The company should indicate what statistic was used (e.g., Pearson, Cramer's V). The regulatory reviewer should understand what statistic was used to produce the matrix but should not prescribe the statistic.
B.3.d	Obtain concurrency metrics for all smoothed predictor variables included in the model and sub-models.	3	GAMs can suffer from high concurrency in addition to high collinearity. Concurrency is the degree to which the smoothed terms move together. The company should indicate what concurrency metrics were used. The regulatory reviewer should understand what metric was used to produce the concurrency metrics but should not prescribe the type of metrics. The review of multiple concurrency metrics may be beneficial.*

Section	Information Element	Level of Importance to the Regulator’s Review	Comments
B.3.e	Obtain a rational explanation for why an increase in each predictor variable should increase or decrease frequency, severity, loss costs, expenses, or any element or characteristic being predicted.	3	<p>The explanation should go beyond demonstrating correlation. Considering possible causation may be relevant, but proving causation is neither practical nor expected. If no rational explanation can be provided, greater scrutiny may be appropriate.</p> <p>For example, the regulator should look for unfamiliar predictor variables and, if found, the regulator should seek to understand the connection that variable has to increasing or decreasing the target variable.</p>
B.3.f	If the modeler made use of one or more dimensionality reduction techniques, such as a principal component analysis (PCA), obtain a narrative about that process, an explanation why that technique was chosen, and a description of the step-by-step process used to transform observations (usually correlated) into a set of (usually linearly uncorrelated) transformed variables. In each instance, obtain a list of the pre-transformation and post-transformation variable names, as well as an explanation of how the results of the dimensionality reduction technique was used within the model.	2	
<b>4. Adjusting Data, Model Validation, and Goodness-of-Fit Measures</b>			
B.4.a	Obtain a description of the methods used to assess the statistical significance/goodness-of-fit of the model to validation data, such as lift charts and statistical tests. Compare the model’s projected results to historical actual results and verify that modeled results are reasonably similar to actual results from validation data.	1	<p>For models that are built using multistate data, validation data for some segments of risk is likely to have low credibility in individual states. Nevertheless, some regulators require model validation on state-only data, especially when analysis using state-only data contradicts the countrywide results. State-only data might be more applicable but could also be impacted by low credibility for some segments of risk.</p> <p><b>Note:</b> It may be useful to consider geographic stability measures for territories within the state.</p>



Section	Information Element	Level of Importance to the Regulator’s Review	Comments
B.4.b	For all parametric (non-smoothed) variables, review the appropriate parameter values and relevant tests of significance, such as confidence intervals, chi-square tests, p-values, or F tests. Determine if model development data, validation data, test data, or other data was used for these tests.	1	<p>Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.</p> <p>Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values, and any other relevant and material tests.</p> <p>For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; e.g., confidence intervals around each level of an AOI curve might be more than what is needed.</p>

Section	Information Element	Level of Importance to the Regulator’s Review	Comments
B.4.c	<p>For all smoothed variables, including interactions between smoothed variables, review plots representing the smooths and relevant tests of significance, such as approximate confidence intervals, chi-square tests, approximate p-values, or F tests. Determine if model development data, validation data, test data, or other data was used for these tests.</p>	1	<p>Smoothed terms in a GAM can have many coefficients based on the number of basis functions. It is difficult to interpret the impact of the smoothed term based on the coefficients. Instead, regulators can review plots representing the cumulative effect of smoothed terms. The company could provide variable value on the x-axis and partial effects on the y-axis. The company could alternatively provide variable value on the x-axis and model prediction for the base risk on the y-axis. A base risk is a specific rating class and is often defined as the risk where each predictor variable is set at the base level (where the indicated factor is 1.000). The company should provide confidence interval lines regardless of the type of plot. The regulatory reviewer should assess whether the plot has an intuitive shape and whether the curve extrapolates well, especially to areas of the curve representing thinner data. The regulatory reviewer should review whether the plot passes the “horizontal line test”. The “horizontal line test” checks whether a horizontal line could be drawn in the plot through the confidence intervals. If so, this implies that the smoothed variable is not measuring significant differences across the target variable.</p> <p>Smoothed interaction terms should also be expressed as plots. Heat map contour plots or 3D perspective plots may be useful.</p> <p>GAMs are a form of penalized regression which complicates the calculation of p-values. The p-values for the smoothed terms output by the modeling software are generally approximate p-values for GAMs. Approximate p-values should be reviewed at the smoothed variable level. The regulatory reviewer may want to select a smaller threshold for smoothed terms than they used for the parametric term p-value threshold. For example, if a regulator typically applies a 0.05 threshold to a GLM, they may want to consider applying a 0.03 threshold to the smoothed terms within a GAM.*</p>

Section	Information Element	Level of Importance to the Regulator’s Review	Comments
B.4.d	For all smoothed variables, request details about the basis functions comprising each smoothed function.	4 or 2	<p>Smooth functions are based on a sum of basis functions. The company should provide the number of basis functions for each smooth and discuss how the number was chosen.</p> <p>There are many types of smooth functions that can be applied. Examples include thin plate splines, cubic splines, and cyclic splines. The company should provide the type of each smooth and a narrative on why that type of smooth is appropriate for the variable.</p> <p>If the GAM is built using a basis function significantly different from those available in the MGCV package in R, this information element may have a higher level of significance (2). The goal of requesting details of the basis function would be to help identify any metrics that may be interpreted similarly to the MGCV package’s concurvity metrics and gain a better understanding of the GAM building process.</p> <p>In these cases, it is not necessary that a reviewer request the exact mathematical formula for the basis function. Instead, a written or visual example of how the basis function creates a final factor curve for a variable may be requested to aid model review.</p>
B.4.e	Identify the threshold for statistical significance and explain why it was selected. Obtain a reasonable and appropriately supported explanation for keeping the variable for each discrete variable level where the p-values were not less than the chosen threshold.	1	<p>The explanation should clearly identify the thresholds for statistical significance used by the modeler. Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.</p> <p>Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter values for parametric terms, plots representing smoothed terms, confidence intervals, chi-square tests, p-values, and any other relevant and material tests.*</p>
B.4.f	For overall discrete variables, review type 3 chi-square tests, p-values for parametric terms, approximate p-values for non-parametric terms, F tests and any other relevant and material test. Determine if model development data, validation data, test data, or other data was used for these tests.	2	<p>Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.</p> <p>Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual</p>

Section	Information Element	Level of Importance to the Regulator’s Review	Comments
			<p>variables, the reviewer may obtain, for each discrete variable level, the parameter values for parametric terms, plots representing smoothed terms, confidence intervals, chi-square tests, p-values, and any other relevant and material tests.</p> <p>For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; e.g., confidence intervals around each level of an AOI curve might be more than what is needed.*</p>
B.4.g	<p>Obtain evidence that the model fits the training data well, for individual variables, for any relevant combinations of variables, and for the overall model.</p>	2	<p>For a GAM, such evidence may be available using chi-square tests, approximate p-values, F tests and/or other means.</p> <p>The steps taken during modeling to achieve goodness-of-fit are likely to be numerous and laborious to describe, but they contribute much of what is generalized about a GAM.</p> <p>The regulator should not assume to know what the company did and ask, “How?” Instead, the regulator should ask what the company did and be prepared to ask follow-up questions.</p>
B.4.h	<p>For continuous variables, provide confidence intervals, chi-square tests, p-values for parametric terms, approximate p-values for non-parametric terms, and any other relevant and material test. Determine if model development data, validation data, test data, or other data was used for these tests.</p>	2	<p>Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model; e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model.</p> <p>Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter values for parametric terms, plots representing smoothed terms confidence intervals, chi-square tests, approximate p-values and any other relevant and material tests.</p> <p>For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an AOI curve might be more than what is needed.*</p>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
B.4.i	Obtain a description how the model was tested for stability over time.	2	<p>Evaluate the build/test/validation datasets for potential time-sensitive model distortions (e.g., a winter storm in year 3 of 5 can distort the model in both the testing and validation datasets).</p> <p>Obsolescence over time is a model risk (e.g., old data for a variable or a variable itself may no longer be relevant). If a model being introduced now is based on losses from years ago, the reviewer should be interested in knowing whether that model would be predictive in the proposed context. Validation using recent data from the proposed context might be requested. Obsolescence is a risk even for a new model based on recent and relevant loss data.</p> <p>The reviewer may want to inquire as to the following: What steps, if any, were taken during modeling to prevent or delay obsolescence? What controls exist to measure the rate of obsolescence? What is the plan and timeline for updating and ultimately replacing the model?</p> <p>The reviewer should also consider that as newer technologies enter the market (e.g., personal automobile) their impact may change claim activity over time (e.g., lower frequency of loss). So, it is not necessarily a bad thing that the results are not stable over time.</p>
B.4.j	Obtain a narrative on how potential concerns with overfitting were addressed.	2	
B.4.k	Obtain the value of the model complexity parameter $\lambda$ and a discussion of how it was chosen.	4	<p>GAMs are a form of penalized regression. Smaller values of <math>\lambda</math> allow the model to increase complexity and fit “wigglier” data. Larger values of <math>\lambda</math> constricts the model and increases smoothness. Multiple automated approaches exist for tuning <math>\lambda</math> including predictive approaches that optimize AIC or Bayesian approaches such as Restricted Maximum Likelihood.</p>
B.4.l	Obtain support demonstrating that the overall GAM assumptions are appropriate.	3	<p>A visual review of plots of actual errors is usually sufficient.</p> <p>The reviewer should look for a conceptual narrative covering these topics: How does this particular GAM work? Why did the rate filer do what it did? Why employ this design instead of alternatives? Why choose this particular distribution function and this particular link function? A company response may be at a fairly high level and reference industry practices.</p> <p>If the reviewer determines that the model makes no assumptions that are considered to be unreasonable, the importance of this item may be reduced.</p>

Section	Information Element	Level of Importance to the Regulator’s Review	Comments
B.4.m	Obtain support demonstrating that the assumptions for each smoothed term are appropriate.	3	<p>The reviewer should look for a narrative on how the fit of the smoothed terms was checked for reasonableness.</p> <p>It may be useful to ask for each plot of the smoothed terms to include residuals to ensure that the smoothed line runs through the middle of the residuals.</p> <p>It may be useful for the company to provide tests that each smoothed term is not predictive of residual values (similar to tests achieved in the gam.check() function of the mcgv R package). These tests would ideally demonstrate that the residuals are randomly distributed across all parts of the smoothed term.*</p>
B.4.n	Obtain 5-10 sample records with corresponding output from the model for those records.	4	
<p>*Please note that certain statistics such as p-values, confidence intervals, and concavity may not be available or relevant for all varieties of GAM. In these cases, requests should focus on satisfying the purpose of this information element through methodology or metrics supplied by this type of GAM.</p>			
<p><b>5. “Old Model” Versus “New Model”</b></p>			
B.5.a	<p>Obtain an explanation of why this model is an improvement to the current rating plan.</p> <p>If it replaces a previous model, find out why it is better than the one it is replacing; determine how the company reached that conclusion and identify metrics relied on in reaching that conclusion. Look for an explanation of any changes in calculations, assumptions, parameters, changes in smoothed variable plots, and data used to build this model from the previous model.</p>	2	<p>The regulator should expect to see improvement in the new class plan’s predictive ability or other sufficient reason for the change.</p>
B.5.b	Determine if two Gini coefficients were compared and obtain a narrative on the conclusion drawn from this comparison.	3	<p>This information element requests a comparison of Gini coefficient from the prior model to the Gini coefficient of proposed model. It is expected that there should be improvement in the Gini coefficient. A higher Gini coefficient indicates greater differentiation produced by the model and how well the model fits that data.</p> <p>This is relevant when one model is being updated or replaced. The regulator should expect to see improvement in the new class plan’s predictive ability. One example of a comparison might be sufficient.</p> <p><b>Note:</b> This comparison is not applicable to initial model introduction. Reviewer can look to CAS monograph, “Generalized Linear Models for Insurance Rating.”</p>
B.5.c	Determine if double-lift charts were analyzed and obtain a narrative on the conclusion drawn from this analysis.	3	<p>One example of a comparison might be sufficient.</p> <p><b>Note:</b> “Not applicable” is an acceptable response.</p>

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B.5.d	If replacing an existing model, obtain a list of any predictor variables used in the old model that are not used in the new model. Obtain an explanation of why these variables were dropped from the new model.  Obtain a list of all new predictor variables in the new model that were not in the prior old model.	2	It is useful to differentiate between old and new variables, so the regulator can prioritize more time on variables not yet reviewed.
<b>6. Modeler Software</b>			
B.6.a	Request access to SMEs (e.g., modelers) who led the project, compiled the data, and/or built the model.	4	The filing should contain a contact that can put the regulator in touch with appropriate SMEs and key contributors to the model development to discuss the model.

**C. THE FILED RATING PLAN**

Section	Information Element	Level of Importance to the Regulator’s Review	Comments
<b>1. General Impact of Model on Rating Algorithm</b>			
C.1.a	In the actuarial memorandum or explanatory memorandum, for each model and sub-model (including external models), look for a narrative that explains each model and its role (i.e., how it was used) in the rating system.	1	<p>The “role of the model” relates to how the model integrates into the rating plan as a whole and where the effects of the model are manifested within the various components of the rating plan. This is not intended as an overarching statement of the model’s goal, but rather a description of how specifically the model is used.</p> <p>This item is particularly important, if the role of the model cannot be immediately discerned by the reviewer from a quick review of the rate and/or rule pages. (Importance is dependent on state requirements and ease of identification by the first layer of review and escalation to the appropriate review staff.)</p>
C.1.b	Obtain an explanation of how the model was used to adjust the filed rating algorithm.	1	<p>Models are often used to produce factor-based indications, which are then used as the basis for the selected changes to the rating plan. It is the changes to the rating plan that create impacts.</p> <p>The regulator should consider asking how the smoothed terms of the GAM will be implemented. The regulator should consider asking for an explanation of how the model was used to adjust the rating algorithm.</p>
C.1.c	Obtain a complete list of characteristics/variables used in the proposed rating plan, including those used as input to the model (including sub-models and composite variables) and all other characteristics/variables (not input to the model) used to calculate a premium. For each characteristic/variable, determine if it is only input to the model, whether it is only a separate univariate rating characteristic, or whether it is both input to the model and a separate univariate rating characteristic. The list should include transparent descriptions (in plain language) of each listed characteristic/variable.	1	<p>Examples of variables used as inputs to the model and used as separate univariate rating characteristics might be criteria used to determine a rating tier or household composite characteristic.</p>



Section	Information Element	Level of Importance to the Regulator's Review	Comments
<b>2. Relevance of Variables and Relationship to Risk of Loss</b>			
C.2.a	Obtain a narrative regarding how the characteristics/rating variables included in the filed rating plan relate to the risk of insurance loss(or expense) for the type of insurance productbeing priced.	2	<p>The narrative should include a discussion of the relevance each characteristic/rating variable has on consumer behavior that would lead to a difference in risk of loss (or expense). The narrative should include a rational relationship to cost, and model results should be consistent with the expected direction of the relationship.</p> <p><b>Note:</b> This explanation would not be needed if the connection between variables and risk of loss (or expense) has already been illustrated.</p>
<b>3. Comparison of Model Outputs to Current and Selected Rating Factors</b>			
C.3.a	Compare relativities indicated by the model to both current relativities and the insurer's selected relativities for each risk characteristic/variable in the rating plan.	1	<p>"Significant difference" may vary based on the risk characteristic/variable and context. However, the movement of a selected relativity should be in the direction of the indicated relativity; if not, an explanation is necessary as to why the movement is logical.</p>
C.3.b	Obtain documentation and support for all calculations, judgments, or adjustments that connect the model's indicated values to the selected relativities filed in the rating plan.	1	<p>The documentation should include explanations for the necessity of any such adjustments and each significantdifference between the model's indicated values and the selected values. This applies even to models that produce scores, tiers, or ranges of values for which indications can be derived.</p> <p><b>Note:</b> This information is especially important if differences between model-indicated values and selected values are material and/or impact one consumer population more than another.</p>
C.3.c	For each characteristic/variable used as both input to the model (including sub-models and composite variables) and as a separate univariate rating characteristic, obtain a narrative regarding how each characteristic/variable was tempered or adjusted to account for possible overlap or redundancy in what the characteristic/variable measures.	2	<p>Modeling loss ratios with these characteristics/variables as control variables would account for possible overlap. The insurer should address this possibility or other considerations; e.g., tier placement models often use risk characteristics/variables that are also used elsewhere inthe rating plan.</p> <p>One way to do this would be to model the loss ratios resulting from a process that already uses univariate rating variables. Then the model/composite variables would be attempting to explain the residuals.</p>
<b>4. Responses to Data, Credibility, and Granularity Issues</b>			
C.4.a	Determine what, if any, consideration was given to the credibility of the output data.	2	<p>The regulator should determine at what level of granularity credibility is applied. If modeling was by-coverage, by-form, or by-peril, the company should explain how these were handled when there was not enough credible data by coverage, form, or peril to model.</p>

Section	Information Element	Level of Importance to the Regulator’s Review	Comments
C.4.b	If the rating plan is less granular than the model, obtain an explanation of why.	2	This is applicable if the company had to combine modeled output in order to reduce the granularity of the rating plan.
C.4.c	If the rating plan is more granular than the model, obtain an explanation of why.	2	A more granular rating plan may imply that the company had to extrapolate certain rating treatments, especially at the tails of a distribution of attributes, in a manner not specified by the model indications. It may be necessary to extrapolate due to data availability or other considerations.
<b>5. Definitions of Rating Variables</b>			
C.5.a	Obtain a narrative regarding adjustments made to model output (e.g., transformations, binning and/or categorizations). If adjustments were made, obtain the name of the characteristic/variable and a description of the adjustment.	2	If rating tiers or other intermediate rating categories are created from model output, the rate and/or rule pages should present these rating tiers or categories. The company should provide an explanation of how model output was translated into these rating tiers or intermediate rating categories.
<b>6. Supporting Data</b>			
C.6.a	Obtain aggregated state-specific, book-of-business-specific univariate historical experience data, separately for each year included in the model, consisting of loss ratio or pure premium relativities and the data underlying those calculations for each category of model output(s) proposed to be used within the rating plan. For each data element, obtain an explanation of whether it is raw or adjusted and, if the latter, obtain a detailed explanation for the adjustments.		<p>For example, were losses developed/undeveloped, trended/untrended, capped/uncapped, etc.?</p> <p>Univariate indications should not necessarily be used to override more sophisticated multivariate indications. However, they do provide additional context and may serve as a useful reference.</p>
C.6.b	Obtain an explanation of any material (especially directional) differences between model indications and state-specific univariate indications.	4	<p>Multivariate indications may be reasonable as refinements to univariate indications, but possibly not for bringing about significant reversals of those indications. For instance, if the univariate indicated relativity for an attribute is 1.5 and the multivariate indicated relativity is 1.25, this is potentially a plausible application of the multivariate techniques. If, however, the univariate indicated relativity is 0.7 and the multivariate indicated relativity is 1.25, a regulator may question whether the attribute in question is negatively correlated with other determinants of risk.</p> <p>Credibility of state-level data should be considered when state indications differ from modeled results based on a broader dataset. However, the relevance of the broader dataset to the risks being priced should also be considered. Borderline reversals are not of as much concern. If multivariate indications perform well against the state-level data, this should suffice. However, credibility considerations need to be taken into account as state-level segmentation comparisons may not have enough credibility.</p>

Section	Information Element	Level of Importance to the Regulator’s Review	Comments
<b>7. Consumer Impacts</b>			
C.7.a	Obtain a listing of the top five rating variables that contribute the most to large swings in renewal premium, both as increases and decreases, as well as the top five rating variables with the largest spread of impact for both new and renewal business.	4	These rating variables may represent changes to rating factors, be newly introduced to the rating plan, or have been removed from the rating plan.
C.7.b	Determine if the company performed sensitivity testing to identify significant changes in premium due to small or incremental change in a single risk characteristic. If such testing was performed, obtain a narrative that discusses the testing and provides the results of that testing.	3	One way to see sensitivity is to analyze a graph of each risk characteristic’s/variable’s possible relativities. Look for significant variation between adjacent relativities and evaluate if such variation is reasonable and credible.
C.7.c	For the proposed filing, obtain the impacts on renewal business and describe the process used by management, if any, to mitigate those impacts.	2	Some mitigation efforts may substantially weaken the connection between premium and expected loss and expense and, hence, may be viewed as unfairly discriminatory by some states.
C.7.d	Obtain a rate disruption/dislocation analysis, demonstrating the distribution of percentage and/or dollar impacts on renewal business (created by rerating the current book of business) and sufficient information to explain the disruptions to individual consumers.	2	The analysis should include the largest dollar and percentage impacts arising from the filing, including the impacts arising specifically from the adoption of the model or changes to the model as they translate into the proposed rating plan.  While the default request would typically be for the distribution/dislocation of impacts at the overall filing level, the regulator may need to delve into the more granular variable-specific effects of rate changes if there is concern about particular variables having extreme or disproportionate impacts, or significant impacts that have otherwise yet to be substantiated.  See Appendix D for an example of a disruption analysis.
C.7.e	Obtain exposure distributions for the model’s output variables and show the effects of rate changes at granular and summary levels, including the overall impact on the book of business.	3	See Appendix D for an example of an exposure distribution.

Section	Information Element	Level of Importance to the Regulator’s Review	Comments
C.7.f	Identify policy characteristics, used as input to a model or sub-model, that remain “static” over a policy’s lifetime versus those that will be updated periodically. Obtain a narrative on how the company handles policy characteristics that are listed as “static,” yet change over time.	3	<p>Some examples of “static” policy characteristics are prior carrier tenure, prior carrier type, prior liability limits, claim history over past X years, or lapse of coverage. These are specific policy characteristics usually set at the time new business is written, used to create an insurance score or to place the business in a rating/underwriting tier, and often fixed for the life of the policy.</p> <p>The reviewer should be aware, and possibly concerned, how the company treats an insured over time when the insured’s risk profile based on “static” variables changes over time but the rate charged, based on a newbusiness insurance score or tier assignment, no longer reflect the insured’s true and current risk profile.</p> <p>A few examples of “non-static” policy characteristics are age of driver, driving record, and credit information (FCRA-related). These are updated automatically by the company on a periodic basis, usually at renewal, with or without the policyholder explicitly informing the company.</p>
C.7.g	Obtain a means to calculate the rate charged a consumer.	3	<p>The filed rating plan should contain enough information for a regulator to be able to validate policy premium. However, for a complex model or rating plan, a score or premium calculator via Excel or similar means would be ideal, but this could be elicited on a case-by-case basis. The ability to calculate the rate charged could allow the regulator to perform sensitivity testing when there are small changes to a risk characteristic/variable. <b>Note:</b> This information may be proprietary.</p> <p>For the rating plan, the rate order of calculation rule may be sufficient. However, it may not be feasible for a regulator to get all the input data necessary to reproduce a model’s output. Credit and telematics models are examples of model types where model output would be readily available, but the input data would not be readily available to the regulator.</p>
C.7.h	In the filed rating plan, be aware of any non-insurance data used as input to the model(customer-provided or other). In order to respond to consumer inquiries, it may be necessary to inquire as to how consumers can verify their data and correct errors.	1	<p>If the data is from a third-party source, the company should provide information on the source. Depending on the nature of the data, it may need to be documented with an overview of who owns it.</p> <p>The topic of consumer verification may also need to be addressed, including how consumers can verify their data and correct errors.</p>

Section	Information Element	Level of Importance to the Regulator's Review	Comments
<b>8. Accurate Translation of Model into a Rating Plan</b>			
C.8.a	Obtain sufficient information to understand how the model outputs are used within the rating system and to verify that the rating plan's manual, in fact, reflects the model output and any adjustments made to the model output.	1	The regulator can review the rating plan's manual to see that modeled output is properly reflected in the manual's rules, rates, factors, etc.
<b>9. Efficient and Effective Review of Rate Filing</b>			
C.9.a	Establish procedures to efficiently review rate filings and models contained therein.	1	<p>“Speed to market” is an important competitive concept for insurers. Although the regulator needs to understand the rate filing before accepting the rate filing, the regulator should not request information that does not increase his/her understanding of the rate filing.</p> <p>The regulator should review the state's rate filing review process and procedures to ensure that they are fair and efficient.</p>
C.9.b	Be knowledgeable of state laws and regulations in order to determine if the proposed rating plan (and models) are compliant with state laws and/or regulations.	1	This is a primary duty of state insurance regulators. The regulator should be knowledgeable of state laws and regulations and apply them to a rate filing fairly and efficiently. The regulator should pay special attention to prohibitions of unfair discrimination.
C.9.c	Be knowledgeable of state laws and regulations in order to determine if any information contained in the rate filing (and models) should be treated as confidential.	1	The regulator should be knowledgeable of state laws and regulations regarding confidentiality of rate filing information and apply them to a rate filing fairly and efficiently. Confidentiality of proprietary information is key to innovation and competitive markets.

**SURPLUS LINES (C) TASK FORCE**

Surplus Lines (C) Task Force March 21, 2023, Minutes..... 7-156  
    *Nonadmitted Insurance Model Act (#870) (Attachment One)* ..... 7-158  
    Model #870 Project History (Attachment Two)..... 7-185

Draft: 3/24/23

Surplus Lines (C) Task Force  
Louisville, Kentucky  
March 21, 2023

The Surplus Lines (C) Task Force met in Louisville, KY, March 21, 2023. The following Task Force members participated: James J. Donelon, Chair, Stewart Guerin, and Tom Travis (LA); Larry D. Deiter, Vice Chair, represented by Tony Dorschner (SD); Lori K. Wing-Heier represented by David Phifer (AK); Mark Fowler represented by Willard Smith (AL); Ricardo Lara represented by Libio Latimer (CA); Michael Conway represented by Rolf Kaumann (CO); Michael Yaworsky represented by Virginia Christy (FL); Doug Ommen represented by Travis Grassel (IA); Dean L. Cameron represented by Randy Pipal (ID); Dana Popish Severinghaus represented by Susan Berry (IL); Vicki Schmidt represented by Jessica Lillibridge (KS); Gary D. Anderson represented by John Turchi (MA); Kathleen A. Birrane represented by Erin Nickles (MD); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Robert Croom (NC); Scott Kipper (NV); Glen Mulready represented by Eli Snowbarger (OK); Michael Humphreys represented by Shannen Logue (PA); Michael Wise represented by Rachel Moore (SC); Carter Lawrence represented by Trey Hancock (TN); and Cassie Brown represented by Jamie Walker (TX). Also participating was: Robert Wake (ME).

1. Adopted its 2022 Fall National Meeting Minutes

Walker made a motion, seconded by Hancock, to adopt the Task Force's Dec. 12, 2022, minutes (see *NAIC Proceedings – Fall 2022, Surplus Lines (C) Task Force*). The motion passed unanimously.

2. Adopted the Report of the Surplus Lines (C) Working Group

Guerin reported that the Surplus Lines (C) Working Group met March 9 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss two applications seeking approval for listing on the NAIC *Quarterly Listing of Alien Insurers*. One application was approved.

Snowbarger made a motion, seconded by Kaumann, to adopt the report of the Surplus Lines (C) Working Group. The motion passed unanimously.

3. Adopted Amendments to Model #870

Commissioner Donelon commented that before considering adoption of the *Nonadmitted Insurance Model Act* (#870) (Attachment One), an update from the drafting group and a summary of the project history would be provided by Travis.

Travis stated that since the 2022 Fall National Meeting, the Model 870 Drafting Group met twice. First, it met Jan. 18 to address comments and expose Model #870 as directed by the Task Force at the 2022 Fall National Meeting. Then, it met Feb. 10 to discuss a few lingering comments received from the exposure. Travis stated that as a result of the exposure, a couple of edits have been made to the draft model. He indicated that those edits are highlighted in yellow in the redlined version. He stated that Section 5D received several comments to remove the statement "with the exception of workers' compensation insurance, excess workers' compensation insurance, and accident and health insurance," and the drafting group concurred with removing it. He said following a discussion with Maine, the drafting group added a drafting note that Daleo circulated to the Task Force. He indicated that the drafting note covers Section 522(d) of the federal Nonadmitted and Reinsurance Reform Act of 2010 (NRRRA) with regard to exceptions to the home state authority. Second, he commented that regarding Section 9H on arbitration,

“Aviation” was added to the draft, bracketed to reflect as optional. He concluded by summarizing the Model #870 project history (Attachment Two).

Wake commented that he believes there was consensus during the last meeting that there would be a carve-out for workers’ compensation and disability regarding Section 5D. He commented that he was surprised to hear that the drafting group had pushback on this and it was removed. He indicated that he would urge the Task Force to reinstate that provision. He stated that if the Task Force thinks that reinstatement is too much of a heavy lift at this late stage, the proposed drafting note is a good compromise. He commented that Lloyd’s summarized it best by stating that the carve out for workers’ compensation, excess workers’ compensation, and accident and health (A&H) is unnecessary because the model law already memorialized that states have the ability to decide for themselves which lines of business are permitted to be placed in surplus lines insurance. He indicated that Congress said 13 years ago that the states no longer have that ability after Section 5D was added as an exception. He stated that if it were not for Section 5D, Section 3 would give states that ability. He commented that within Section 522 of the NRRRA, Congress allowed states to reserve the authority to control, as the non-home state, the placement of workers’ compensation and excess workers’ compensation; and because of the way nonadmitted insurance is defined, the power to control A&H insurance was never taken away. The carve-out would exercise that right; without the carve-out, that right is not being exercised. Wake indicated that that is why the carve-out was proposed; however, he understands that the drafting note may be the best that the Task Force can do at this late date. However, he proposed going back to the carve-out language.

Sabrina Miesowitz (Lloyd’s) commented that Lloyd’s supports the drafting note, and the comment letter indicated that there was some disagreement regarding the interpretation of what the NRRRA says. She said Lloyd’s believes states have the authority to decide whether workers’ compensation or A&H are allowed to be exportable to the surplus lines market. She indicated that that is why Lloyd’s supports preserving that language, so that possibility is not being closed for states where A&H can be exportable.

Commissioner Donelon commented that the Task Force has come a long way with Model #870, and it has reached the finish line. He offered a special thanks to the drafting group, specifically Colorado, Illinois, Louisiana, Texas and Washington, and he commended them on all the hard work. Before moving forward to consider adoption, he inquired about any questions or comments. Given that none were raised, he asked for a motion to adopt the proposed amendments to Model #870, including the drafting note.

Walker made a motion, seconded by Kaumann, to adopt the proposed amendments to Model #870, including the drafting note. The motion passed unanimously.

Having no further business, the Surplus Lines (C) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/SLTF/2023 Spring NM/SLTF Minutes March 21 2023.docx



NAIC Model Laws, Regulations, Guidelines and Other Resources—March 2023

Draft 3/1/23

**NONADMITTED INSURANCE MODEL ACT****Table of Contents**

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**Section 1. Short Title**

This Act shall be known and may be cited as “The Nonadmitted Insurance Act.”

**Section 2. Purpose—Necessity for Regulation**

This Act shall be liberally construed and applied to promote its underlying purposes which include:

- A. Protecting persons seeking insurance in this state;
- B. Permitting surplus lines ~~fi~~insurance to be placed with reputable and financially sound nonadmitted insurers and exported from this state pursuant to this Act;
- C. Establishing a system of regulation which will permit orderly access to surplus lines insurance in this state and encourage admitted insurers to provide new and innovative types of insurance available to consumers in this state;
- D. Providing a system through which persons may purchase insurance other than surplus lines insurance, from nonadmitted insurers pursuant to this Act;
- E. Protecting revenues of this state; and
- F. Providing a system pursuant to this Act which subjects nonadmitted insurance activities in this state to the jurisdiction of the insurance commissioner and state and federal courts in suits by or on behalf of the state.

**Section 3. Definitions**

As used in this Act:

- A. “Admitted insurer” means an insurer licensed to ~~de-engage in an the business of~~ insurance ~~business~~ in this state.
- B. ~~“Affiliate” means, with respect to an insured, any entity that controls, is controlled by, or is under common control with the insured.~~
- C. ~~“Affiliated group” means any group of entities that are all affiliated. “Capital,” as used in the financial requirements of Section 5, means funds paid in for stock or other evidence of ownership.~~

## Nonadmitted Insurance Model Act

~~D~~C. “Commissioner” means the insurance commissioner of [insert name of state], or the commissioner’s deputies or staff, or the ~~c~~Commissioner, ~~d~~Director or ~~s~~Superintendent of insurance in any other state.

**Drafting Note:** Insert the title of the chief insurance regulatory official wherever the term “commissioner” appears.

E. “Control” means with respect to an insured:

- (1) A person, either directly or indirectly, or acting through one or more other persons, owns, controls, or has the power to vote 25 percent or more of any class of voting securities of the other entity; or
- (2) The entity controls in any manner the election of a majority of the directors or trustees of the other entity.

~~F~~. [OPTIONAL: ~~“Domestic surplus lines insurer” means a surplus lines insurer domiciled in this state, that which may write insurance in this state on as if it were a surplus lines insurer-basis domiciled in another state.~~]

G. “Eligible surplus lines insurer” means a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance pursuant to Section 5 of this Act.

H. “Exempt commercial purchaser” means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

- (1) ~~n~~Has paid aggregate nationwide commercial property and casualty insurance premiums in excess of \$100,000 in the immediately preceding 12 months; and:
- (2) (a) ~~The person m~~Meets at least one+ of the following criteria:
  - (i) ~~The person P~~ossesses a net worth in excess of \$20,000,000;:-
  - (ii) ~~The person G~~enerates annual revenues in excess of \$50,000,000;:-
  - (iii) ~~The person E~~mploys more than 500 full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate;:-
  - (iv) ~~The person I~~s a not-for-profit organization or public entity generating annual budgeted expenditures of at least \$30,000,000; or:-
  - (v) ~~The person i~~s a municipality with a population in excess of 50,000 persons.
- (b) Effective on July 21, 2010, every five years and each fifth January 1 occurring thereafter on January 1, the amounts in subsections~~Items~~ (i), (ii), and (iv) of ~~Subparagraph~~Section 3H(32)(a) of this Paragraph shall be adjusted to reflect the percentage change for such ~~five~~5- year period in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the Department of Labor.

**Drafting Note:** This definition of “Exempt commercial purchaser” follows the language of the federal Nonadmitted and Reinsurance Reform Act (NRRA). Some states have chosen not to adopt the inflation adjustment. The NRRA uses the term “municipality,” which some states may find limiting. States may choose to use terminology consistent with state law to expand this provision to include counties and other public entities.

~~E~~I. “Export” means to place surplus lines insurance with a nonadmitted insurer.

~~F~~. “Foreign decree” means any decree or order in equity of a court located in any United States jurisdiction, including a federal court of the United States, against any person engaging in the transaction of insurance in this state.

J. “Home state;” ~~means~~with respect to an insured, means:

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- (1) The state in which an insured maintains its principal place of business or, in the case of a natural person, the person's principal place of residence;
- (2) If 100 percent of the insured risk is located out of the state referred to in ~~subParagraph (1)~~Section 3J(1), the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated; or
- (3) If the insured is an affiliated group with more than one member listed as a named insured on a single nonadmitted insurance contract, the home state is the home state of the member of the affiliated group that has the largest percentage of premium attributed to it under the insurance contract. or
- (4) [Option 1] In the case of an unaffiliated group policy:
- (a) If a group policyholder pays 100% of the premium from its own funds, then the home state is determined according to paragraphs (1) and (2).
- (b) If a group policyholder does not pay 100% of the premium from its own funds, then the home state is determined according to paragraphs (1) and (2) for each member of the group.
- [Option 2] In the case of an unaffiliated group policy, the home state shall be the home state of the group policyholder as determined by the application of paragraphs (1) and (2).

**Comment:** The NRRA definition of “home state” includes ~~subsections Paragraphs (1), (2), and (3) of Section 3J. The NRRA definition does not expressly cover unaffiliated groups. States have taken different approaches to the taxation of unaffiliated group policies. Some states tax based on the “home state” of the group member or certificate holder under the unaffiliated group policy. Some states assess tax on the “home state” of the person that pays the premium. Not all states have an express provision to address unaffiliated group policies. The Drafting Group could not arrive at language to address each possibility and opted to omit it from the Model, such as risk purchasing groups model language contains two options for addition of that are expressly covering unaffiliated group~~ treating the members of such a group as individual insureds for purposes of placement and taxation.

~~K.~~ “Insurer” means any person, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, insurance exchange syndicate, fraternal benefit society, and any other legal entity engaged in the business of insurance.

~~H.~~ “Kind of insurance” means one of the types of insurance required to be reported in the annual statement which must be filed with the commissioner by admitted insurers.

~~K.~~ “Nonadmitted insurance” means any insurance written on properties, risks or exposures, located or to be performed in this state, by an insurer not licensed to engage in the ~~transaction~~ business of insurance in this state [or a domestic surplus lines insurer].

~~L.~~ “Nonadmitted insurer” means an insurer not licensed to ~~do an~~ engage in the ~~transaction~~ business of insurance ~~business~~ in this state but does not include a risk retention group pursuant to the federal Liability Risk Retention Act of 1986.

~~M.~~ “Person” means any natural person or ~~other business~~ entity, including, but not limited to, ~~individuals,~~ partnerships, associations, trusts or corporations.”

~~N.~~ “Premium” means any payment made as consideration for an insurance contract.

~~N.O.~~ “Principal place of business” means:

- (1) The state where a person maintains its headquarters and where the person's high-level officers direct, control, and coordinate ~~the~~ business activities; or
- (2) If the person's high-level officers direct, control, and coordinate the business activities in more than one state, or if the person's principal place of business is located outside any state, then it is the state to which the greatest percentage of the person's taxable premium for that insurance contract is allocated.

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PO. “Principal residence” means:

- (1) ~~The state where the person resides for the greatest number of days during a calendar year; or~~
  - (2) ~~If the person’s principal residence is located outside any state, the state to which the greatest percentage of the person’s taxable premium for that insurance contract is allocated.~~
- ~~“State” includes any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Northern Mariana Islands, the Virgin Islands, and American Samoa. K. “Policy” or “contract” means any contract of insurance, including but not limited to annuities, indemnity, medical or hospital service, workers’ compensation, fidelity or suretyship.~~

~~L. “Reciprocal state” means a state that has enacted provisions substantially similar to:~~

- (1) ~~Sections 5F, 5I(5), 5Q(10), 5R(4) and Section 6; and~~
- (2) ~~The allocation schedule and reporting form contained in [cite the regulation on surplus lines taxation].~~

~~M. “Surplus,” as used in the financial requirements of Section 5, means funds over and above liabilities and capital of the company for the protection of policyholders.~~

~~Q.RN. “Surplus lines insurance” means any property and casualty insurance in this state on properties, risks or exposures, located or to be performed in this state, permitted to be placed through a surplus lines licensee with an nonadmitted insurer eligible surplus lines insurer to accept such insurance, pursuant to Section 5 of this Act.~~

~~**Drafting Note:** If a state chooses to adopt the alternative Section 5B, this definition of “surplus lines insurance” should be consistent with the acceptable coverage listed in Section 5B. States may choose to extend the definition of “surplus lines insurance” beyond property/casualty insurance. NAIC.~~

RS. “Surplus lines insurer” means a nonadmitted [or domestic surplus lines] insurer that is eligible to accept the placement of surplus lines insurance pursuant to Section 5 of this Act.

STO. “Surplus lines licensee” means any person ~~individual, firm or corporation~~ licensed under Section 5 of this Act to place surplus lines insurance ~~on properties, risks or exposures located or to be performed in this state with an nonadmitted insurers eligible surplus lines insurer to accept such insurance.~~

TU. “Taxable premium” means any premium less return premium that is not otherwise exempt from tax pursuant to this Act. [OPTIONAL: ]~~Premium on property risk or exposure that is properly allocated to federal or international waters or is under the jurisdiction of a foreign government is not taxable in this state.]~~

UVS. “Transaction of insurance”

- (~~b~~) (1) For purposes of this Act, any of the following acts in this state effected by mail or otherwise by a nonadmitted insurer or by any person acting with the actual or apparent authority of the insurer, on behalf of the insurer, is deemed to constitute the transaction of an insurance business in or from this state:
  - (a) The making of or proposing to make, as an insurer, an insurance contract;
  - (b) The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety;
  - (c) The taking or receiving of an application for insurance;
  - (d) The receiving or collection of any premium, commission, membership fees, assessments, dues or other consideration for insurance or any part thereof;

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- (e) The issuance or delivery in this state of contracts of insurance to residents of this state or to persons authorized to do business in this state;
  - (f) The solicitation, negotiation, procurement or effectuation of insurance or renewals thereof;
  - (g) The dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, the fixing of rates or investigation or adjustment of claims or losses or the transaction of matters subsequent to effectuation of the contract and arising out of it, or any other manner of representing or assisting a person or insurer in the transaction of risks with respect to properties, risks or exposures located or to be performed in this state;
  - (h) The transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of the statutes relating to insurance;
  - (i) The offering of insurance or the transacting of insurance business; or
  - (j) Offering an agreement or contract which purports to alter, amend or void coverage of an insurance contract.
- (2) The provisions of this subsection shall not operate to prohibit employees, officers, directors or partners of a commercial insured from acting in the capacity of an insurance manager or buyer in placing insurance on behalf of the employer, provided that the person's compensation is not based on buying insurance.
  - (3) The venue of an act committed by mail is ~~at the~~ point/location where the matter transmitted by mail is delivered or issued for delivery or takes effect.

**Drafting Note:** States may need to alter this subsection to reflect their decision as to whether they intend to permit citizens to directly purchase coverage within the state from a nonadmitted insurer, or if self-procurement of coverage will be permitted only when it occurs outside the state. States electing to allow direct procurement will need to insert an appropriate exemption in Section 4A of this Act. Additionally, states should consider whether the preceding definition of “transaction of insurance” is consistent with other statutory definitions of this phrase in the state. Finally, states may want to consider whether group insurance purchases or the maintenance of insurance books and records in this state should fall within the scope of the definition of “transaction of insurance.”

~~Q. “Type of insurance” means coverage afforded under the particular policy that is being placed.~~

~~V.F.~~ “Wet marine and transportation insurance” means:

- (1) Insurance upon vessels, crafts, hulls and other interests in them or with relation to them;
- (2) Insurance of marine builder's risks, marine war risks and contracts of marine protection and indemnity insurance;

~~(3)~~ Insurance of freight and disbursements pertaining to a subject of insurance within the scope of this subsection; and

~~(2)~~

~~(4)~~ Insurance of personal property and interests therein, in the course of exportation from or importation into any country, or in the course of transportation coastwise or on inland waters, including transportation by land, water or air from point of origin to final destination, in connection with any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any incidental delays, transshipment, or reshipment; provided, however, that insurance of personal property and interests therein shall not be considered wet marine and transportation insurance if the property has:

- (a) Been transported solely by land; or

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- (b) Reached its final destination as specified in the bill of lading or other shipping document;  
or
- (c) The insured no longer has an insurable interest in the property.

~~**Comment:** The language added in 1994 to the end of the definition of “wet marine and transportation insurance” (Subparagraphs 4(a), 4(b), and 4(c)) is intended to clarify the scope of the definition, which ultimately affects the exemption of certain risks from this Act. The 1994 amendments address current regulatory concerns and concerns raised by those who drafted the 1983 amendments to the Model Surplus Lines Law. The 1983 drafters wrote: “Several [drafters] felt the term ‘storage’ should not appear in... [the wet marine definition] to ensure that warehousemen and other types of insurance covering risks of storage are not interpreted to be within the purview of this definition. The term ‘delays’ is sufficiently broad to cover temporary storage while in the course of transit.”~~

**Drafting Note:** In addition to the definitions provided in this section, individual states may wish to consider adopting definitions for “agent,” “broker” or “producer” in a manner consistent with its other laws. Additionally, states may want to cross-reference the definition of “insurance” as it appears elsewhere in the state insurance code. The definition of insurance should reach illegal unauthorized activities.

#### Section 4. Placement of Insurance Business

- A. An insurer shall not engage in the transaction of insurance unless authorized by a license in force pursuant to the laws of this state; or exempted by this Act or ~~otherwise exempted by~~ the insurance laws of this state.
- B. A person shall not ~~directly or indirectly~~ engage in a transaction of insurance ~~with or on behalf of or shall in this state directly or indirectly act as agent for, or otherwise represent or aid on behalf of another, a nonadmitted insurer in this state, in the solicitation, negotiation, procurement or effectuation of insurance, or renewals thereof, or forwarding of applications, or delivery of policies or contracts or inspection of risks, or fixing of rates, or investigation or adjustment of claims or losses, or collection or forwarding of premiums, or in any other manner represent or assist the insurer in the transaction of insurance.~~
- C. A person who represents or aids a nonadmitted insurer in violation of this section shall be subject to the penalties set forth in Section 7 of this Act. No insurance contract entered into in violation of this section shall preclude the insured from enforcing his rights under the contract in accordance with the terms and provisions of the contract of insurance and the laws of this state, to the same degree those rights would have been enforceable had the contract been lawfully procured.
- D. If the nonadmitted insurer fails to pay a claim or loss within the provisions of the insurance contract and the laws of this state, a person who assisted or in any manner aided directly or indirectly in the procurement of the insurance contract, shall be liable to the insured for the full amount under the provisions of the insurance contract.
- E. Section 4B or 4D shall not apply to a person in regard to an insured who independently procures insurance as provided under Section 6. This section shall not apply to a person, properly licensed as an agent or broker in this state who, for a fee and pursuant to a written agreement, is engaged solely to offer to the insured advice, counsel or opinion, or service with respect to the benefits, advantages or disadvantages promised under any proposed or in-force policy of insurance if the person does not, directly or indirectly, participate in the solicitation, negotiation or procurement of insurance on behalf of the insured.;

**Drafting Note:** If a state collects tax on unlicensed transactions which violate this Act, it may consider imposing liability for payment of those taxes on persons who violate this Act by assisting in the procurement of nonadmitted insurance.

**Drafting Note:** Some states permit other licensed professionals to engage in these activities as provided in their insurance statutes or other state statutes. Those states may want to amend Section 4E to include those professionals, to the extent they act within the scope of their licenses.

- F. This section shall not apply to a person acting in material compliance with the insurance laws of this state in the placement of the types of insurance identified in Paragraphs (1), (2), (3) and (4) below:

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- (1) Surplus lines insurance as provided in Section 5. For the purposes of this subsection, a licensee shall be deemed to be in material compliance with the insurance laws of this state, unless the licensee committed a violation of Section 5 that proximately caused loss to the insured;
- (2) Transactions for which a certificate of authority to do business is not required of an insurer under the insurance laws of this state;

~~**Drafting Note:** A number of states exempt from licensing and premium taxation nonprofit educational insurers insuring only nonprofit educational institutions and their employees. Some states require certificates of authority while others require licensing, and the appropriate language should be used in Paragraph (2) above. Additionally, some states may want to consider adding language to establish an option of allowing persons to file for an exemption with the Department of Insurance.~~

- (3) Reinsurance provided that, unless the commissioner waives the requirements of this subsection:
  - (a) The assuming insurer is authorized to ~~do engage in the business of an~~ insurance or reinsurance ~~business by in~~ its domiciliary jurisdiction and is authorized to write the type of reinsurance in its domiciliary jurisdiction; and
  - (b) The assuming insurer satisfies all legal requirements for such reinsurance in the state of domicile of the ceding insurer;
- (4) The property and operation of railroads or aircraft engaged in interstate or foreign commerce, wet marine and transportation insurance;
- (5) Transactions subsequent to issuance of a policy not covering properties, risks or exposures located, or to be performed in this state at the time of issuance, and lawfully solicited, written or delivered outside this state.

**Drafting Note:** States may also wish to consider exempting from Section 4A of this Act self-procured insurance or industrial insurance purchased by a sophisticated buyer who does not necessarily require the same regulatory protections as an average insurance buyer. Additionally, some states allow other insurance transactions with nonadmitted insurers. Examples include certain aviation and railroad risks. Other states may want to narrow the scope of the exemptions above or reserve the right to approve exemptions on a case-by-case basis.

## Section 5. Surplus Lines Insurance

- A. Surplus lines insurance may be placed by a surplus lines licensee if:
  - (1) Each insurer is ~~an~~ eligible to write surplus lines ~~insurance~~~~insurer~~; and
  - (2) ~~Each insurer is authorized to write the type of insurance in its domiciliary jurisdiction; and~~
  - (3) ~~Other than for exempt commercial purchasers, t~~The full amount or type of insurance cannot be obtained from insurers who are admitted to ~~do engage in the business of insurance~~ in this state. The full amount or type of insurance may be procured from eligible surplus lines insurers, provided that a diligent search is made among the insurers who are admitted to transact and are actually writing the particular type of insurance in this state if any are writing it; and
  - (4) All other requirements of this Act are met.

~~**Drafting Note:** States may prefer to reference “kind of insurance” rather than “type of insurance” in Section 5A(3). The term utilized should be defined within the Act.~~The diligent search requirement of Section 5A(3) must be satisfied in accordance with the statutes and regulations of the governing state. ~~Such Diligent search~~ statutes and regulations ~~might~~ vary from state to state in terms of the number of declinations required and the person designated to conduct the search. ~~Several states permit surplus lines placement without a diligent search for or without regard to the availability of admitted coverage. States may want to consider changing diligent search requirements in light of electronic transactions.~~ Section 5A(3) does not prohibit a regulatory system in which a surplus lines licensee may place with an eligible nonadmitted insurer any coverage listed on a current



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“~~E~~export ~~L~~ist” maintained by the commissioner. The ~~e~~Export list would identify types of insurance for which no admitted market exists. The commissioner may waive the diligent search requirement for any such type of insurance.

**Drafting Note:** Utilizing the “full amount” standard in Section 5A(3) of this Act may have certain market implications. An alternative to this approach would be to require that whatever part of the coverage is attainable through the admitted market be placed in the admitted market and only the excess part of the coverage may be exported.

- B. Subject to Section 5A(3) of this Act, a surplus lines licensee may place any coverage with an nonadmitted eligible surplus lines insurer ~~eligible to accept the insurance~~, unless specifically prohibited by the laws of this state.

*[Alternative Subsection B]*

- ~~[C]~~B. Subject to Section 5A(3) of this Act, a surplus lines licensee may place only the following types of coverage with an nonadmitted eligible surplus lines insurer ~~eligible to accept insurance~~: (list acceptable coverage).]

**Drafting Note:** The two statutory alternatives described in Section 5B represent different regulatory approaches to defining those coverages which may be placed in the nonadmitted market and they would impact the admitted market in different manners.

- C. A surplus lines licensee shall not place ~~surplus lines insurance coverage with a nonadmitted insurer~~, unless, at the time of placement, the surplus lines licensee has determined that the ~~nonadmitted insurer~~ is eligible to write surplus lines insurance under one of the following subsections:

~~(1) Has established satisfactory evidence of good repute and financial integrity; and~~

~~(2) Qualifies is eligible to write surplus lines insurance under one of the following subparagraphs:~~

1. **Drafting Note:** Current numbering is retained in this Model to remain consistent with the reference within the NRRRA.

2. Is eligible to write surplus lines insurance under one of the following subsections:

(a) For a nonadmitted insurer domiciled in another United States jurisdiction, the insurer shall have both of the following:

~~(i)~~ The authority to write the type of insurance in its domiciliary jurisdiction; and

~~(ii)~~ Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction ~~which~~ that equals the greater of:

~~(I)~~ ~~(i)~~ ~~(I)~~ The minimum capital and surplus requirements under the law of this state; or

~~(II)~~ (B) \$15,000,000;

**Drafting Note:** ~~States that have not previously increased capital and surplus requirements may wish to consider implementation of the capital and surplus requirements in this subparagraph in a series of phases over a period of up to three (3) years. In some circumstances, implementation of a \$15,000,000 capital and surplus requirement may represent a dramatic increase over existing requirements. States may wish to allow insurers which are eligible under existing law some period of time to increase their capital and surplus to meet the new standards. Current numbering is retained in this Model to remain consistent with the reference within the NRRRA.~~

~~(iii)~~ The requirements of Subparagraph (b)(i) may be satisfied by an insurer ~~s~~ possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company



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underwriting profit and investment income trends, market availability and company record and reputation within the industry. In no event shall the commissioner make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than \$4,500,000; or

~~(a) For a nonadmitted insurer domiciled outside the United States, the insurer shall be listed on the *Quarterly Listing of Alien Insurers* maintained by the International Insurers Department of the National Association of Insurance Commissioners (NAIC); [or]~~

~~(b)~~

~~(c) [(3)c] For an insurer domiciled in this state, the insurer is a domestic surplus lines insurer.]~~

~~(b) In the case of an insurance exchange created by the laws of a state other than this state:~~

~~(i) The syndicates of the exchange shall maintain under terms acceptable to the commissioner capital and surplus, or its equivalent under the laws of its domiciliary jurisdiction, of not less than \$75,000,000 in the aggregate; and~~

~~(ii) The exchange shall maintain under terms acceptable to the commissioner not less than fifty percent (50%) of the policyholder surplus of each syndicate in a custodial account accessible to the exchange or its domiciliary commissioner in the event of insolvency or impairment of the individual syndicate; and~~

~~(iii) In addition, each individual syndicate to be eligible to accept surplus lines insurance placements from this state shall meet either of the following requirements:~~

~~(I) For insurance exchanges which maintain funds in an amount of not less than \$15,000,000 for the protection of all exchange policyholders, the syndicate shall maintain under terms acceptable to the commissioner minimum capital and surplus, or its equivalent under the laws of the domiciliary jurisdiction, of not less than \$5,000,000; or~~

~~(II) For insurance exchanges which do not maintain funds in an amount of not less than \$15,000,000 for the protection of all exchange policyholders, the syndicate shall maintain under terms acceptable to the commissioner minimum capital and surplus, or its equivalent under the laws of its domiciliary jurisdiction, of not less than the minimum capital and surplus requirements under the laws of its domiciliary jurisdiction or \$15,000,000, whichever is greater; or~~

**Drafting Note:** Some states may want to cross reference statutory provisions in their own states which provide a grandfather clause for syndicates established with a lower capital and surplus requirement.

~~(e) In the case of a Lloyd's plan or other similar group of insurers, which consists of unincorporated individual insurers, or a combination of both unincorporated and incorporated insurers:~~

~~(i) The plan or group maintains a trust fund that shall consist of a trustee account representing the group's liabilities attributable to business written in the United States; and~~

~~(ii) In addition, the group shall establish and maintain in trust a surplus in the amount of \$100,000,000; which shall be available for the benefit of United States surplus lines policyholders of any member of the group.~~

~~(iii) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level~~

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~~of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members.~~

- ~~(iv) — The trust funds shall be maintained in an irrevocable trust account in the United States in a qualified financial institution, consisting of cash, securities, letters of credit or investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state and, in addition, the trust required by item (ii) of this paragraph shall satisfy the requirements of the Standard Trust Agreement required for listing with the National Association of Insurance Commissioners (NAIC) International Insurers Department; or~~
- ~~(d) — In the case of a group of incorporated insurers under common administration, which has continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to this time, and which submits to this state's authority to examine its books and records and bears the expense of the examination:~~
- ~~(i) — The group shall maintain an aggregate policyholders' surplus of \$10,000,000,000; and~~
- ~~(ii) — The group shall maintain in trust a surplus in the amount of \$100,000,000; which shall be available for the benefit of United States surplus lines policyholders of any member of the group; and~~
- ~~(iii) — Each insurer shall individually maintain capital and surplus of not less than \$25,000,000 per company.~~
- ~~(iv) — The trust funds shall satisfy the requirements of the Standard Trust Agreement requirement for listing with the NAIC International Insurers Department, and shall be maintained in an irrevocable trust account in the United States in a qualified financial institution, and shall consist of cash, securities, letters of credit or investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state.~~
- ~~(v) — Additionally, each member of the group shall make available to the commissioner an annual certification of the member's solvency by the member's domiciliary regulator and its independent public accountant; or~~
- ~~(e) — Except for an exchange or plan complying with Subparagraph (b), (c) or (d), an insurer not domiciled in one of the United States or its territories shall satisfy the capital and surplus requirements of Subsection C(2)(a) of this section and shall have in force a trust fund of not less than the greater of:~~
- ~~(i) — \$5,400,000; or~~
- ~~(ii) — Thirty percent (30%) of the United States surplus lines gross liabilities, excluding aviation, wet marine and transportation insurance liabilities, not to exceed \$60,000,000, to be determined annually on the basis of accounting practices and procedures substantially equivalent to those promulgated by this state, as of December 31 next preceding the date of determination, where:~~
- ~~(1) — The liabilities are maintained in an irrevocable trust account in the United States in a qualified financial institution, on behalf of U.S. policyholders consisting of cash, securities, letters of credit or other investments of substantially the same character and quality as those which are eligible investments pursuant to [cite insurance investment law] for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state. The trust fund, which shall be included in any calculation of capital and surplus or its equivalent, shall~~

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- ~~(H) — The insurer may request approval from the commissioner to use the trust fund to pay valid surplus lines claims; provided, however, that the balance of the trust fund is never less than the greater of \$5,400,000 or thirty percent (30%) of the insurer’s current gross U.S. surplus lines liabilities, excluding aviation, wet marine and transportation insurance liabilities; and~~
- ~~(II) — In calculating the trust fund amount required by this subsection, credit shall be given for surplus lines deposits separately required and maintained for a particular state or U.S. territory, not to exceed the amount of the insurer’s loss and loss adjustment reserves in the particular state or territory;~~

**Drafting Note:** The commissioner may wish to establish the authority to set a higher level on a case-by-case basis.

- ~~(f) — An insurer or group of insurers meeting the requirements to do a surplus lines business in this state at the effective date of this law shall have two (2) years from the date of enactment to meet the requirements of Subparagraph (e), as follows:~~

<b>Year Following Enactment</b>	<b>Trust Fund Requirement</b>
1	15% of U.S. surplus lines liabilities, excluding aviation, wet marine and transportation insurance, with a maximum of \$30,000,000
2	30% of U.S. surplus lines liabilities, excluding aviation, wet marine and transportation insurance, with a maximum of \$60,000,000.

- ~~(g) — The commissioner shall have the authority to adjust, in response to inflation, the trust fund amounts required by Subparagraph (e).~~
- ~~(3) — In addition to all of the other requirements of this subsection, an insurer not domiciled in the United States or its territories shall be listed by the NAIC International Insurers Department. The commissioner may waive the requirement in Paragraph (3) or the requirements of Section 5C(2)(e)(ii) may be satisfied by an insurer’s possessing less than the trust fund amount specified in Section 5C(2)(e)(ii) upon an affirmative finding of acceptability by the commissioner if the commissioner is satisfied that the placement of insurance with the insurer is necessary and will not be detrimental to the public and the policyholder. In determining whether business may be placed with the insurer, the commissioner may consider such factors as:~~
  - ~~(a) — The interests of the public and policyholders;~~
  - ~~(b) — The length of time the insurer has been authorized in its domiciliary jurisdiction and elsewhere;~~
  - ~~(c) — Unavailability of particular coverages from authorized insurers or unauthorized insurers meeting the requirements of this section;~~
  - ~~(d) — The size of the company as measured by its assets, capital and surplus, reserves, premium writings, insurance in force or other appropriate criteria;~~
  - ~~(e) — The kinds of business the company writes, its net exposure and the extent to which the company’s business is diversified among several lines of insurance and geographic locations; and~~
  - ~~(f) — The past and projected trend in the size of the company’s capital and surplus considering such factors as premium growth, operating history, loss and expense ratios, or other appropriate criteria; and~~

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~~(4) — Has caused to be provided to the commissioner a copy of its current annual statement certified by the insurer and an actuarial opinion as to the adequacy of, and methodology used to determine, the insurer's loss reserves. The statement shall be provided at the same time it is provided to the insurer's domicile, but in no event more than eight (8) months after the close of the period reported upon, and shall be certified as a true and correct copy by an accounting or auditing firm licensed in the jurisdiction of the insurer's domicile and certified by a senior officer of the nonadmitted insurer as a true and correct copy of the statement filed with the regulatory authority in the domicile of the nonadmitted insurer. In the case of an insurance exchange qualifying under Paragraph (2)(b) of this subsection, the statement may be an aggregate combined statement of all underwriting syndicates operating during the period reported; and~~

**Drafting Note:** The following paragraph is for use by those states which desire to adopt a “white list” for determining the eligibility of nonadmitted insurers to write surplus lines insurance.

~~(5) — In addition to meeting the requirements in Paragraphs (1) to (4) of this subsection an insurer shall be an eligible surplus lines insurer if it appears on the most recent list of eligible surplus lines insurers published by the commissioner from time to time but at least semiannually. Nothing in this paragraph shall require the commissioner to place or maintain the name of any nonadmitted insurer on the list of eligible surplus lines insurers.~~

~~(6) — Notwithstanding Section 5A, only that portion of any risk eligible for export for which the full amount of coverage is not procurable from listed eligible surplus lines insurers may be placed with any other nonadmitted insurer which does not appear on the list of eligible surplus lines insurers published by the commissioner pursuant to Paragraph (5) of this subsection but nonetheless meets the requirements set forth in Sections 5C(1) and 5C(2) and any regulations of the commissioner. The surplus lines licensee seeking to provide coverage through an unlisted nonadmitted insurer shall make a filing specifying the amounts and percentages of each risk to be placed, and naming the nonadmitted insurers with which placement is intended. Within [insert number] days after placing the coverage, the surplus lines licensee shall also send written notice to the insured or the producing broker that the insurance, or a portion thereof, has been placed with the nonadmitted insurer.~~

~~D. The placement of surplus lines insurance shall be subject to the statutory and regulatory requirements solely of the insured's home state.~~

~~ED.~~ Insurance procured under this section shall be valid and enforceable as to all parties.

~~FE.~~ Withdrawal of Eligibility as a Surplus Lines Insurer

F.

If at any time the commissioner has reason to believe that a surplus lines insurer is no longer eligible under Section 5C,

~~(1) — Is in unsound financial condition or has acted in an untrustworthy manner;~~

~~(2) — No longer meets standards set forth in Section 5C of this Act;~~

~~(3) — Has willfully violated the laws of this state; or~~

~~(4) — Does not conduct a proper claims practice.~~

~~The~~the commissioner may, after notice and an opportunity for a hearing, declare it ineligible. The commissioner shall promptly ~~mail~~publish notice of all such declarations in a timely manner reasonably calculated to reach to each surplus lines licensee or surplus lines advisory organization, for distribution to all surplus lines licensees.

**Drafting Note:** Individual states should consider whether such declarations of ineligibility are appropriate in view of the state's other due process and administrative procedure requirements. Eligibility criteria are independent of other considerations such as compliance with other laws, for example, 18 USC 1033, relating to felons participating in the insurance business.

~~GF.~~ Surplus Lines Tax

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- ~~(1) (4)~~—In addition to the full amount of gross premiums charged by the insurer for the insurance, every person licensed pursuant to Section 5~~H~~ of this Act shall collect and pay to the commissioner a sum equal to [insert number] percent of the gross premiums charged, less any return premiums, for surplus lines insurance provided by the licensee pursuant to the license. Where the insurance covers properties, risks or exposures located or to be performed both in and out of this state, the sum payable shall be ~~computed on that portion of the gross premiums allocated to this state pursuant to Paragraph (4) of this subsection less the amount of gross premiums allocated to this state and returned to the insured~~ paid entirely to the hHome sState of the insured. The tax on any portion of the premium unearned at termination of insurance having been credited by the state to the licensee shall be returned to the policyholder directly by the surplus lines licensee or through the producing broker, if any. The surplus lines licensee is prohibited from rebating, for any reason, any part of the tax.
- (2) At the time of filing the [insert monthly, quarterly, annual] report as set forth in Subsection ~~S~~R of this section, each surplus lines licensee shall pay the premium tax due for the policies written during the period covered by the report.
- ~~(3)~~—~~If a surplus lines policy procured through a surplus lines licensee covers properties, risks or exposures only partially located or to be performed in this state, the tax due shall be computed on the portions of the premiums which are attributable to the properties, risks or exposures located or to be performed in this state. In determining the amount of premiums taxable in this state, all premiums written, procured or received in this state shall be considered written on properties, risks or exposures located or to be performed in this state, except premiums which are properly allocated or apportioned and reported as taxable premiums of a reciprocal state. In no event shall the tax payable to this state be less than the tax due pursuant to Paragraph (4) of this subsection; provided, however, in the event that the amount of tax due under this provision is less than \$50 in any jurisdiction, it shall be payable in the jurisdiction in which the affidavit required in Subsection K of this section is filed. The commissioner shall, at least annually furnish to the commissioner of a reciprocal state, as defined in Section 3L, a copy of all filings reporting an allocation of taxes as required by this subsection.~~
- ~~(4)~~—~~In determining the amount of gross premiums taxable in this state for a placement of surplus lines insurance covering properties, risks or exposures only partially located or to be performed in this state, the tax due shall be computed on the portions of the premiums which are attributable to properties, risks or exposures located or to be performed in this state and which relates to the kinds of insurance being placed as determined by reference to an allocation schedule duly promulgated in a regulation by the commissioner.~~
- ~~(a)~~—~~If a policy covers more than one classification:~~
- ~~(i)~~—~~For any portion of the coverage identified by a classification on the Allocation Schedule, the tax shall be computed by using the Allocation Schedule for the corresponding portion of the premium;~~
- ~~(ii)~~—~~For any portion of the coverage not identified by a classification on the Allocation Schedule, the tax shall be computed by using an alternative equitable method of allocation for the property or risk;~~
- ~~(iii)~~—~~For any portion of the coverage where the premium is indivisible, the tax shall be computed by using the method of allocation which pertains to the classification describing the predominant coverage.~~
- ~~(b)~~—~~If the information provided by the surplus lines licensee is insufficient to substantiate the method of allocation used by the surplus lines licensee, or if the commissioner determines that the licensee's method is incorrect, the commissioner shall determine the equitable and appropriate amount of tax due to this state as follows:~~

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- ~~(i) By use of the Allocation Schedule where the risk is appropriately identified in the schedule;~~
- ~~(ii) Where the Allocation Schedule does not identify a classification appropriate to the coverage, the commissioner may give significant weight to documented evidence of the underwriting bases and other criteria used by the insurer. The commissioner may also consider other available information to the extent sufficient and relevant, including the percentage of the insured's physical assets in this state, the percentage of the insured's sales in this state, the percentage of income or resources derived from this state, and the amount of premium tax paid to another jurisdiction for the policy.~~

**Drafting Note:** Subparagraph (b) above may be included in the Act or in a separate regulation at the option of the state. It is highly recommended that the model Allocation Schedule and reporting form be adopted by regulation in conjunction with the adoption of the above language. In order for the model law to work effectively, the allocation schedules used by the states should be as uniform as possible.

HG. Collection of Tax

If the tax owed by a surplus lines licensee under this section has been collected and is not paid within the time prescribed, the same shall be recoverable in a suit brought by the commissioner against the surplus lines licensee and the surety on the bond filed under Subsection HI of this section. The commissioner may charge interest at the rate of [insert number] percent per year for the unpaid tax.

HH. Surplus Lines Licenses

- (1) A person shall not procure a contract of surplus lines insurance with a ~~nonadmitted surplus lines~~ insurer unless the person possesses a current surplus lines insurance producer license issued by the commissioner.
- (2) The commissioner may issue a resident surplus lines license to a qualified holder of ~~a current underlying property and casualty agent's or broker's or general agent's licenses,~~ but only when the ~~broker or agent~~ producer has:
- (a) Remitted the \$[insert amount] annual fee to the commissioner;
- (b) Submitted a completed license application on a form supplied by the commissioner;
- ~~(c) Passed a qualifying examination approved by the commissioner, except that all holders of a license prior to the effective date of this Act shall be deemed to have passed such an examination;~~
- ~~(cd)~~ In the case of a resident agent, filed with the commissioner, and continues to maintain during the term of the license, in force and unimpaired, a bond or errors and omissions (E&O) policy in favor of this state in the penal sum of \$[insert amount] aggregate liability, with corporate sureties approved by the commissioner. The bond or E&O policy shall be conditioned that the Surplus Lines Licensee will conduct business in accordance with the provisions of this Act and will promptly remit the taxes as provided by law. No bond or E&O policy shall be terminated unless at least thirty (30) days prior written notice is given to the licensee and commissioner;

**Drafting note:** Under Public Law No. 106-102 (the "Gramm-Leach-Bliley Act"), it is believed that a requirement for a nonresident agent to file a bond may contravene the reciprocity provisions. The requirement for a resident agent to file a bond would not, seemingly, contravene these provisions, and there may be methodologies whereby such resident bonds could become reciprocal between states. Some states have expressed concern that their bonding requirements constitute important consumer protections, and that elimination of these simply to comply with Gramm-Leach-Bliley may result in unintended consequences, and a lack of Ceontrol over possibly unscrupulous nonresident agents.

- ~~(de)~~ If a resident, established and continues to maintain an office in this state, ~~;~~ and

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~~(f) Designated the commissioner as agent for service of process, thereby designating the commissioner to be the licensee's true and lawful attorney upon whom may be served all lawful process in a proceeding instituted by or on behalf of an insured or beneficiary arising out of any contract of insurance, and shall signify its agreement that such service of process is of the same legal force and validity as personal service of process in this state upon the licensee.~~

- (3) A nonresident person shall receive a nonresident surplus lines license if:
- (a) The person is currently licensed as a surplus lines licensee and in good standing in his or her home state;
  - (b) The person has submitted the proper request for licensure and has paid the fees required by [insert appropriate reference to state law or regulation];
  - (c) The person has submitted or transmitted to the insurance commissioner the application for licensure that the person submitted to his or her home state, or in lieu of the same, a completed Uniform Application; and
  - (d) The person's home state awards nonresident surplus lines licenses to residents of this state on the same basis.

**Drafting Note:** In accordance with Public Law No. 106-102 (the "Gramm-Leach-Bliley Act") states should not require any additional attachments to the Uniform Application or impose any other conditions on applicants that exceed the information requested within the Uniform Application.

- (4) The insurance commissioner may verify the person's licensing status through the Producer Database maintained by the ~~NAICational Association of Insurance Commissioners~~, its affiliates or subsidiaries.
- (5) A nonresident surplus lines licensee who moves from one state to another state or a resident surplus lines licensee who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty (30) days of the change of legal residence. No fee or license application is required.
- (6) The insurance commissioner shall waive any requirements for a nonresident surplus lines license applicant with a valid license from his or her home state, except the requirements imposed by this subsection, if the applicant's home state awards nonresident surplus lines licenses to residents of this state on the same basis.
- ~~(7)~~ Each surplus lines license shall expire on [insert date] of each year, and an application for renewal shall be filed before [insert date] of each year upon payment of the annual fee and compliance with other provisions of this section. A surplus lines licensee who fails to apply for renewal of the license before [insert date] shall pay a penalty of \$[insert amount] and be subject to penalties provided by law before the license will be renewed.

**Drafting Note:** States may wish to reference their specific licensing statutes in this section.

**Drafting Note:** Some states allow surplus lines licensees to hold binding authorities on behalf of ~~eligible~~ surplus lines insurers. States which allow such binding authorities might want to establish minimum standards for the related agreements. In addition, states might want to consider requiring surplus lines licensees with such binding authorities to submit the related agreements to state regulators for review and approval.

#### II. Suspension, Revocation or Nonrenewal of Surplus Lines Licensee's License



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The commissioner may suspend, revoke or refuse to renew the license of a surplus lines licensee after notice and an opportunity for a hearing as provided under the applicable provision of this state's laws ~~for upon one or more of the following grounds:~~

- ~~(1) Removal of the resident surplus lines licensee's office from this state;~~
- ~~(2) Removal of the resident surplus lines licensee's office accounts and records from this state during the period during which the accounts and records are required to be maintained under Subsection Q of this section;~~
- ~~(3) Closing of the surplus lines licensee's office for a period of more than thirty (30) business days, unless permission is granted by the commissioner;~~
- ~~(4) Failure to make and file required reports;~~
- ~~(5) Failure to transmit required tax on surplus lines premiums to this state or a reciprocal state to which a tax is owing;~~
- ~~(6) Failure to maintain required bond;~~
- ~~(17)~~ Violation of any provision of this Act; or
- ~~(28)~~ For any cause for which an insurance license could be denied, revoked, suspended or renewal refused under Sections [insert applicable citation].

K.J. Actions Against Eligible Surplus Lines Insurers Transacting Surplus Lines Business

- (1) An eligible surplus lines insurer may be sued upon a cause of action arising in this state under a surplus lines insurance contract made by it or evidence of insurance issued or delivered by the surplus lines licensee. A policy issued by the eligible surplus lines insurer shall contain a provision stating the substance of this section and designating the person to whom the commissioner shall mail process.
- (2) The remedies provided in this section are in addition to any other methods provided by law for service of process upon insurers.

L.K. Duty to File Evidence of Insurance and Affidavits

Within [insert number] days after the placing of any surplus lines insurance, each producing broker shall execute and each surplus lines licensee shall execute where appropriate, and file a written report regarding the insurance which shall be kept confidential by the commissioner, including the following:

- (1) The name and address of the insured;
- (2) The identity of the insurer or insurers;
- (3) A description of the subject and location of the risk;
- (4) The amount of premium charged for the insurance;
- (5) Such other pertinent information as the commissioner may reasonably require; and
- (6) An affidavit on a standardized form promulgated by the commissioner as to the diligent efforts to place the coverage with admitted insurers and the results of that effort or the insured is an exempt commercial purchaser. The affidavit shall be open to public inspection. The affidavit shall affirm that the insured was expressly advised in writing prior to placement of the insurance that:
  - (a) The surplus lines insurer with whom the insurance was to be placed is not licensed in this state and is not subject to its supervision; and



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- (b) In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund.

**Drafting Note:** Surplus lines licensees will frequently communicate with the insured through a producing broker rather than communicate with the insured directly. In preparing affidavit forms, states may wish to recognize that, as a result of communications passing through the producing broker, the surplus lines licensee may not be in a position to affirm, based upon personal knowledge, that the insured received from the producing broker the written information required by this subsection.

ML. Surplus Lines Advisory Organizations

- (1) There is hereby created a nonprofit association to be known as the [insert name]. All surplus lines licensees shall be deemed to be members of the association. The association shall perform its functions under the plan of operation established pursuant to Paragraph (3) of this subsection and must exercise its powers through a board of directors established under Paragraph (2) of this subsection. The association shall be supervised by the commissioner. The association shall be authorized and have the duty to:

**Drafting Note:** The preceding paragraph provides that all surplus lines licensees are “deemed” to be members of the association. Some states, however, may choose not to establish a surplus lines advisory organization; in those states Subsection M would not be necessary.

- (a) Receive, record, and subject to Subparagraph (b) of this paragraph, stamp all surplus lines insurance documents which surplus lines brokers are required to file with the association pursuant to the plan of operation;

**Drafting Note:** Subparagraph (a) of this paragraph authorizes the association to receive, record and stamp all surplus lines documents which must be submitted to the association pursuant to the plan of operation. Documents to be submitted to the association for stamping are likely to vary by state.

- (b) Refuse to stamp submitted insurance documents, if the association determines that a nonadmitted insurer does not meet minimum state financial standards of eligibility, or the commissioner orders the association not to stamp insurance documents pursuant to Paragraph (9) of this subsection. The association shall notify the commissioner and provide an explanation for any refusal to stamp submitted insurance documents other than a refusal based upon the order of the commissioner;
- (c) Prepare and deliver annually to each licensee and to the commissioner a report regarding surplus lines business. The report shall include a delineation of the classes of business procured during the preceding calendar year, in the form the board of directors prescribes;
- (d) Encourage compliance by its members with the surplus lines law of this state and the rules and regulations of the commissioner relative to surplus lines insurance;
- (e) Communicate with organizations of agents, brokers and admitted insurers with respect to the proper use of the surplus lines market;
- (f) Employ and retain persons as necessary to carry out the duties of the association;
- (g) Borrow money as necessary to effect the purposes of the association;
- (h) Enter contracts as necessary to effect the purposes of the association; and
- (i) Provide such other services to its members as are incidental or related to the purposes of the association.
- (2) The association shall function through a board of directors elected by the association members, and officers who shall be elected by the board of directors.

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- (a) The board of directors of the association shall consist of not less than five (5) nor more than nine (9) persons serving terms as established in the plan of operation. The plan of operation shall provide for the election of a board of directors by the members of the association from its membership. The plan of operation shall fix the manner of voting and may weigh each member's vote to reflect the annual surplus lines insurance premium written by the member.
- (b) The board of directors shall elect officers as provided for in the plan of operation.
- (3) The association shall establish a plan of operation. The plan of operation shall provide for the formation, operation and governance of the association. The plan and any amendments shall be effective upon approval by the commissioner, which shall not be unreasonably withheld or delayed. All association members shall comply with the plan of operation or any amendments to it. Failure to comply with the plan of operation or any amendments shall constitute a violation of the insurance law and the commissioner may issue an order requiring discontinuance of the violation.
- (4) The association shall file with the commissioner:
  - (a) A copy of its plan of operation and any amendments to it;
  - (b) A current list of its members revised at least annually;
  - (c) The name and address of a resident of this state upon whom notices or orders of the commissioner or processes issued at the direction of the commissioner may be served; and
  - (d) An agreement that the commissioner may examine the association in accordance with the provisions of Paragraph (5) of this subsection.
- (5) The commissioner shall, at least once in [insert number] years, make or cause to be made an examination of the association. The reasonable cost of an examination shall be paid by the association upon presentation to it by the commissioner of a detailed account of each cost. The officers, managers, agents, and employees of the association may be examined at any time, under oath, and shall exhibit all books, records, accounts, documents or agreements governing its method of operation. The commissioner shall furnish a copy of the examination report to the association and shall notify the association that it may request a hearing within thirty (30) days on the report or on any facts or recommendations contained in it. If the commissioner finds the association to be in violation of this section, the commissioner may issue an order requiring the discontinuance of the violation. A director may be removed from the association's board of directors by the commissioner for cause, stated in writing, after an opportunity has been given to the director to be heard.
- (6) There shall be no liability on the part of and no causes of action of any nature shall arise against the association, its directors, officers, agents or employees for any action taken or omitted by them in the performance of their powers and duties under this section, absent gross negligence or willful misconduct.
- (7) Within [insert number] days after a surplus lines policy is procured, a licensee shall submit to the association for recording and stamping all documents which surplus lines brokers are required to file with the association. Every insurance document submitted to the association pursuant to this subsection shall set forth:
  - (a) The name and address of the insured;
  - (b) The gross premium charged;
  - (c) The name of the nonadmitted insurer; and

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- (d) The class of insurance procured.

**Drafting Note:** The appropriate time limits for submitting documents required for stamping will vary by state.

- (8) It shall be unlawful for an insurance agent, broker or surplus lines broker to deliver in this state any insurance document which surplus lines brokers are required to file with the association unless the insurance document is stamped by the association or is exempt from such requirements. However, a licensee's failure to comply with the requirements of this subsection shall not affect the validity of the coverage.
- (9) The services performed by the association shall be funded by a stamping fee assessed for each premium-bearing document submitted to the association. The stamping fee shall be established by the board of directors of the association from time to time. The stamping fee shall be paid by the insured.
- (10) The commissioner may declare a nonadmitted insurer ineligible and order the association not to stamp insurance documents issued by the nonadmitted insurer and issue any other appropriate order.

~~NM.~~ Evidence of the Insurance and Subsequent Changes to the Insurance

- (1) Upon placing surplus lines insurance, the surplus lines licensee shall promptly deliver to the insured or the producing broker the policy, or if the policy is not then available, a certificate as described in Paragraph (4) of this subsection, cover note, binder or other evidence of insurance. The certificate described in Paragraph (4) of this subsection, cover note, binder or other evidence of insurance shall be executed by the surplus lines licensee and shall show the description and location of the subject of the insurance, coverages including any material limitations other than those in standard forms, a general description of the coverages of the insurance, the premium and rate charged and taxes to be collected from the insured, and the name and address of the insured and surplus lines insurer or insurers and proportion of the entire risk assumed by each, and the name of the surplus lines licensee and the licensee's license number.
- (2) A surplus lines licensee shall not issue or deliver any evidence of insurance or purport to insure or represent that insurance will be or has been written by any ~~eligible~~ surplus lines insurer, or a nonadmitted insurer ~~pursuant to Section 5C(4)~~, unless the licensee has authority from the insurer to cause the risk to be insured or has received information from the insurer in the regular course of business that the insurance has been granted.
- (3) If, after delivery of any evidence of insurance, there is any change in the identity of the insurers, or the proportion of the risk assumed by any insurer, or any other material change in coverage as stated in the surplus lines licensee's original evidence of insurance, or in any other material as to the insurance coverage so evidenced, the surplus lines licensee shall promptly issue and deliver to the insured or the original producing broker an appropriate substitute for, or endorsement of the original document, accurately showing the current status of the coverage and the insurers responsible for the coverage.
- (4) As soon as reasonably possible after the placement of the insurance, the surplus lines licensee shall deliver a copy of the policy or, if not available, a certificate of insurance to the insured or producing broker to replace any evidence of insurance previously issued. Each certificate or policy of insurance shall contain or have attached a complete record of all policy insuring agreements, conditions, exclusions, clauses, endorsements or any other material facts that would regularly be included in the policy.
- ~~(5) A surplus lines licensee who fails to comply with the requirements of this subsection shall be subject to the penalties provided in this Act.~~
- ~~(5)~~ (6) The surplus lines licensee shall give the following consumer notice to every person, ~~other than exempt commercial purchasers~~, applying for insurance with a nonadmitted insurer. The notice shall be printed in 16-point type on a separate document affixed to the application. The applicant shall sign and date a copy of the notice to acknowledge receiving it. The surplus lines licensee shall maintain

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the signed notice in its file for a period of five (5) years from expiration of the policy. The surplus lines licensee shall tender a copy of the signed notice to the insured at the time of delivery of each policy the licensee transacts with a nonadmitted insurer. The copy shall be a separate document affixed to the policy.

*“Notice: ~~1. A “nonadmitted” or “surplus lines” insurer that is not licensed in this state is issuing the insurance policy that you have applied to purchase. These companies are called “nonadmitted” or “surplus lines” insurers. 2. The insurer is not subject to the financial solvency regulation and enforcement that applies to licensed insurers in this state. 3. These insurers generally do not participate in insurance guaranty funds created by state law. These guaranty funds will not pay your claims or protect your assets if the insurer becomes insolvent and is unable to make payments as promised. 4. Some states maintain lists of approved or eligible surplus lines insurers and surplus lines brokers may use only insurers on the lists. Some states issue orders that particular surplus lines insurers can not be used. 5. For additional information about the above matters and about the insurer, you should ask questions of your insurance agent, broker or surplus lines broker. You may also contact your insurance department consumer help line.”~~*

**Drafting Note:** This notice is intended to inform personal lines customers and smaller commercial risks of the nature of the coverage they are purchasing. A state may wish to add language to this statute providing that this notice need not be given to commercial risks meeting defined criteria for size and insurance expertise.

QN. Licensee’s Duty to Notify Insured

- (1) No contract of insurance placed by a surplus lines licensee under this Act shall be binding upon the insured and no premium charged shall be due and payable until the surplus lines licensee or the producing broker ~~shall have~~has notified the insured in writing, in a form acceptable to the commissioner, a copy of which shall be maintained by the licensee or the producing broker with the records of the contract and available for possible examination, that:
  - (a) The insurer [other than a domestic surplus lines insurer] with which the licensee places the insurance is not licensed by this state and is not subject to its supervision; and
  - (b) In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund.
- (2) Nothing herein contained shall nullify any agreement by any insurer to provide insurance.

**Drafting Note:** To ensure the meaningfulness of the notice required by this subsection, the commissioner might want to establish criteria related to readability, ~~type face~~font, and ~~type~~ size of the notice.

PQ. Effect of Payment to Surplus Lines Licensee

A payment of premium to a surplus lines licensee acting for a person other than itself in procuring, continuing or renewing any policy of insurance procured under this section shall be deemed to be payment to the insurer, whatever conditions or stipulations may be inserted in the policy or contract notwithstanding.

QP. Surplus Lines Licensees May Accept Business from Other Producers

A surplus lines licensee may originate surplus lines insurance or accept such insurance from any other producing broker duly licensed as to the kinds of insurance involved, and the surplus lines licensee may compensate the producing broker for the business.

RQ. Records of Surplus Lines Licensee

(1) Each surplus lines licensee shall keep ~~in this state~~ a full and true record of each surplus lines insurance contract placed by or through the licensee, including a copy of the policy, certificate, cover note or other evidence of insurance showing each of the following items applicable:

- ~~(+a)~~ Amount of the insurance, risks and perils insured;

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- ~~(2b)~~ Brief description of the property insured and its location;
  - ~~(3c)~~ Gross premium charged;
  - ~~(4d)~~ Any return premium paid;
  - ~~(5e)~~ Rate of premium charged upon the several items of property;
  - ~~(6f)~~ Effective date and terms of the contract;
  - ~~(7g)~~ Name and address of the insured;
  - ~~(8h)~~ Name and address of the insurer;
  - ~~(9i)~~ Amount of tax and other sums to be collected from the insured;
  - ~~(10)~~ ~~Allocation of taxes by state as referred to in Subsection F of this section;~~ and
  - ~~(11j)~~ Identity of the producing broker, any confirming correspondence from the insurer or its representative, and the application.
- ~~(2)~~ The record of each contract shall be kept open at all reasonable times to examination by the commissioner without notice for a period not less than five (5) years following termination of the contract. In lieu of maintaining offices in this state, each nonresident surplus lines licensee shall make available to the commissioner any and all records that the commissioner deems necessary for examination.

**Drafting Note:** States may wish to extend the five-year period prescribed for open access to insurance records because of the long-term nature of this business.

SR. Reports—Summary of Exported Business

On or before the end of the month following each [insert month, quarter, year], each surplus lines licensee shall file with the commissioner, on forms prescribed by the commissioner, a verified report in duplicate of all surplus lines insurance transacted during the preceding period, showing:

- (1) Aggregate gross premiums written;
- (2) Aggregate return premiums;
- (3) Amount of aggregate tax remitted to this state; and
- (4) Amount of aggregate tax due or remitted to each other state for which an allocation is made pursuant to Subsection ~~GF~~ of this section.

**Drafting Note:** States desiring to have taxes remitted annually may call for more frequent detailed listing of business.

T. [OPTIONAL: Domestic Surplus Lines Insurers]

- ~~(1)~~ The commissioner may designate a domestic insurer as a domestic surplus lines insurer upon its application, which shall include, as a minimum, an authorizing resolution of the board of directors and evidence to the commissioner's satisfaction that the insurer has capital and surplus of not less than fifteen million dollars.
- ~~(2)~~ A domestic surplus lines insurer:
  - ~~(a)~~ ~~(a)~~ Shall be limited in its authority in this state to providing surplus lines insurance.

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~~(b) May be authorized to write any type of property and casualty [or accident and health] insurance in this state that may be placed with a surplus lines insurer pursuant to this Subpart.~~

~~(c) Be subject to the legal and regulatory requirements applicable to domestic insurers, except for theas following:~~

~~(i) Premium taxes, fees, and assessments applicable to admitted insurance;~~

~~(ii) Regulation of rates and formss requiring the filing of rates and forms for approval;~~

~~(iii) Assessment or coverage by insurance guaranty funds.]~~

**Section 6. Insurance Independently Procured—Duty to Report and Pay Tax**

- A. Each insured ~~whose home state is in~~ this state, who procures or continues or renews insurance with a nonadmitted insurer ~~on properties, risks or exposures located or to be performed in whole or in part in this state~~, other than insurance procured through a surplus lines licensee, shall, within [insert number] days after the date the insurance was so procured, continued or renewed, file a written report with the commissioner, upon forms prescribed by the commissioner, showing the name and address of the insured or insureds, name and address of the insurer, the subject of the insurance, a general description of the coverage, the amount of premium currently charged, and additional pertinent information reasonably requested by the commissioner. ~~For the purposes of this subsection, properties, risks or exposures only partially located or to be performed in this state, which are covered under a multistate policy placed by a surplus lines licensee in another state, shall be deemed to be insurance independently procured unless the insurer is an admitted insurer.~~

**Drafting Note:** Subsection A may need to be revised in those states exempting from taxation insurance procured by nonprofit educational institutions and their employers, from nonprofit educational insurers.

- B. ~~Gross~~ Premiums charged for the insurance, less any return premiums, is subject to a tax at the rate of [insert number] percent. At the time of filing the report required in Subsection A of this section, the insured ~~whose home state is this~~ state shall pay the tax ~~on all taxable p~~Premium to the commissioner, who shall transmit the same for distribution as provided in this Act.

**Drafting Note:** Existing state laws and procedures may require that the tax report be forwarded to another state agency, such as the Department of the Treasury, rather than to the commissioner. In addition, some states may require the tax to be paid on a periodic basis (e.g., annually) rather than at the time of the filing required by Subsection A. Subsections A and B may need to be revised in these states.

~~C. If an independently procured policy covers properties, risks or exposures only partially located or to be performed in this state, the tax payable shall be computed on the portion of the premium properly attributable to the properties, risks or exposures located or to be performed in this state, as set forth in Sections 5F(3) and 5F(4) of this Act.~~

~~C.D.~~ Delinquent taxes hereunder shall bear interest at the rate of [insert number] percent per year.

~~D.E.~~ This section does not abrogate or modify, and shall not be construed or deemed to abrogate or modify any other provision of this Act.

**Section 7. Penalties**

- A. A person who in this state represents or aids a nonadmitted insurer in violation of this Act may be found guilty of a criminal act and subject to a fine not in excess of \$[insert amount].

**Drafting Note:** Some states might want to specify “misdemeanor” or “felony” rather than “criminal act” in Section 7A.

- B. In addition to any other penalty provided herein or otherwise provided by law, including any suspension, revocation or refusal to renew a license, any person, firm, association or corporation violating any provision

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of this Act shall be liable to a civil penalty not exceeding \$[insert amount] for the first offense, and not exceeding \$[insert amount] for each succeeding offense.

- C. The above penalties are not exclusive remedies. Penalties may also be assessed under [insert citation to trade practices and fraud statute] of the insurance code of this state.

## Section 8. Violations

Whenever there is evidence satisfactory to the commissioner ~~believes, from evidence satisfactory to him or her,~~ that a person is violating or about to violate the provisions of this Act, the commissioner may cause a complaint to be filed in the [insert appropriate court] Court for restitution and to enjoin and restrain the person from continuing the violation or engaging in or doing any act in furtherance thereof. The court shall have jurisdiction of the proceeding and shall have the power to make and enter an order of judgment awarding such preliminary or final injunctive relief and restitution as in its judgment is proper.

## Section 9. Service of Process

- A. Any act of transacting insurance by an unauthorized person or a nonadmitted insurer is equivalent to and shall constitute an irrevocable appointment by the unauthorized person or insurer, binding upon it, its executor or administrator, or successor in interest of the [insert title of appropriate state official] or his or her successor in office, to be the true and lawful attorney of the unauthorized person or insurer upon whom may be served all lawful process in any action, suit or proceeding in any court by the commissioner or by the state and upon whom may be served any notice, order, pleading or process in any proceeding before the commissioner and which arises out of transacting insurance in this state by the unauthorized person or insurer. Any act of transacting insurance in this state by a nonadmitted insurer shall signify its acceptance of its agreement that any lawful process in such court action, suit or proceeding and any notice, order, pleading or process in such administrative proceeding before the commissioner so served shall be of the same legal force and validity as personal service of process in this state upon the unauthorized person or insurer.
- B. Service of process in the action shall be made by delivering to and leaving with the [insert title of appropriate state official], or some person in apparent charge of the office, two (2) copies thereof and by payment to the [insert title of appropriate state official] of the fee prescribed by law. Service upon the [insert title of appropriate state official] as attorney shall be service upon the principal.

**Drafting Note:** Existing state laws and procedures may require that service of process be made upon either the commissioner or another state official.

- C. The [insert title of appropriate state official] shall forward by certified mail one of the copies of the process or notice, order, pleading or process in proceedings before the commissioner to the defendant in the court proceeding or to whom the notice, order, pleading or process in the administrative proceeding is addressed or directed at its last known principal place of business and shall keep a record of all process so served on the commissioner which shall show the day and hour of service. Service is sufficient, provided:
- (1) Notice of service and a copy of the court process or the notice, order, pleading or process in the administrative proceeding are sent within ten (10) days by certified mail by the plaintiff or the plaintiff's attorney in the court proceeding or by the commissioner in the administrative proceeding to the defendant in the court proceeding or to whom the notice, order, pleading or process in the administrative proceeding is addressed or directed at the last known principal place of business of the defendant in the court or administrative proceeding; and
  - (2) The defendant's receipt or receipts issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person or insurer to whom the letter is addressed, and an affidavit of the plaintiff or the plaintiff's attorney in a court proceeding or of the commissioner in an administrative proceeding, showing compliance are filed with the clerk of the court in which the action, suit or proceeding is pending or with the commissioner in administrative proceedings, on or before the date the defendant in the court or administrative proceeding is required to appear or respond, or within such further time as the court or commissioner may allow.



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- D. A plaintiff shall not be entitled to a judgment or a determination by default in any court or administrative proceeding in which court process or notice, order, pleading or process in proceedings before the commissioner is served under this section until the expiration of forty-five (45) days from the date of filing of the affidavit of compliance.
- E. Nothing in this section shall limit or affect the right to serve any process, notice, order or demand upon any person or insurer in any other manner now or hereafter permitted by law.
- F. Each nonadmitted insurer assuming insurance in this state, or relative to property, risks or exposures located or to be performed in this state, shall be deemed to have subjected itself to this Act.
- G. ~~Notwithstanding~~Notwithstanding conditions or stipulations in the policy or contract, a nonadmitted insurer may be sued upon any cause of action arising in this state, or relative to property, risks or exposures located or to be performed in this state, under any insurance contract made by it.
- H. ~~Notwithstanding~~Except with regard to exempt commercial purchasers, independently procured insurance, [aviation], and wet marine and transportation insurance, conditions or stipulations in the policy or contract ~~notwithstanding~~, a nonadmitted insurer subject to arbitration or other alternative dispute resolution mechanism ~~arising in this state or relative to property, risks or exposures located or to be performed in this state under an insurance contract made by it~~ shall conduct the arbitration or other alternative dispute resolution mechanism ~~in this state in the home state of the insured.~~

**Drafting Note:** Provisions of a state’s constitution, statutes, regulations, and public policy may necessitate amendment of the prior ~~sub~~Section 9H. States should consider adoption or modification of priorSection 9H in light of their own laws on arbitration or other alternative dispute resolution in insurance and commercial transactions. States should cross-reference their state insurance code to verify the inclusion of “Aviation” within this provision.

- I. A policy or contract issued by the nonadmitted insurer or one which is otherwise valid and contains a condition or provision not in compliance with the requirements of this Act is not thereby rendered invalid but shall be construed and applied in accordance with the conditions and provisions which would have applied had the policy or contract been issued or delivered in full compliance with this Act.

**Section 10. Legal or Administrative Procedures**

- A. Before any nonadmitted insurer files or causes to be filed any pleading in any court action, suit or proceeding or in any notice, order, pleading or process in an administrative proceeding before the commissioner instituted against the person or insurer, by services made as provided in this Act, the insurer shall either:
  - (1) Deposit with the clerk of the court in which the action, suit or proceeding is pending, or with the Commissioner of Insurance in administrative proceedings before the commissioner, cash or securities, or file with the clerk or commissioner a bond with good and sufficient sureties, to be approved by the clerk or commissioner in an amount to be fixed by the court or commissioner sufficient to secure the payment of any final judgment which may be rendered in the action or administrative proceeding; or
  - (2) Procure a certificate of authority to transact the business of insurance in this state. In considering the application of an insurer for a certificate of authority, for the purposes of this paragraph the commissioner need not assert the provisions of [insert sections of insurance laws relating to retaliation] against the insurer with respect to its application if the commissioner determines that the company would otherwise comply with the requirements for a certificate of authority.
- B. The Commissioner of Insurance, in any administrative proceeding in which service is made as provided in this Act, may in the commissioner’s discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of Subsection A of this section and to defend the action.
- C. Nothing in Subsection A of this section shall be construed to prevent a nonadmitted insurer from filing a motion to quash a writ or to set aside service thereof made in the manner provided in this Act, on the ground that the nonadmitted insurer has not done any of the acts enumerated in the pleadings.



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- D. Nothing in Subsection A of this section shall apply to placements of insurance which were lawful in the home state of the insured in which the placement took place and which were not unlawful placements under the laws of this state. Without limiting the generality of the foregoing, nothing in Subsection A shall apply to a placement made pursuant to Section 5 of this Act.

## Section 11. Enforcement

- ~~A. The commissioner shall have the authority to proceed in the courts of this state or any other United States jurisdiction to enforce an order or decision in any court proceeding or in any administrative proceeding before the commissioner of Insurance.~~

### ~~A. Filing and Status of Foreign Decrees~~

~~A copy of a foreign decree authenticated in accordance with the statutes of this state may be filed in the office of the clerk of any [insert proper court] Court of this state. The clerk, upon verifying with the commissioner that the decree or order qualifies as a “foreign decree” shall treat the foreign decree in the same manner as a decree of a [insert proper court] Court of this state. A foreign decree so filed has the same effect and shall be deemed a decree of a [insert proper court] Court of this state, and is subject to the same procedures, defenses and proceedings for reopening, vacating or staying as a decree of a [insert proper court] Court of this state and may be enforced or satisfied in like manner.~~

### ~~B. Notice of Filing~~

- ~~(1) At the time of the filing of the foreign decree, the plaintiff shall make and file with the clerk of the court an affidavit setting forth the name and last known post office address of the defendant.~~
- ~~(2) Promptly upon the filing of the foreign decree and the affidavit, the clerk shall mail notice of the filing of the foreign decree to the defendant at the address given and to the commissioner of this state and shall make a note of the mailing in the docket. In addition, the plaintiff may mail a notice of the filing of the foreign decree to the defendant and to the commissioner of this state and may file proof of mailing with the clerk. Lack of mailing notice of filing by the clerk shall not affect the enforcement proceedings if proof of mailing by the plaintiff has been filed.~~
- ~~(3) No execution or other process for enforcement of a foreign decree filed hereunder shall issue until thirty (30) days after the date the decree is filed.~~

**Drafting Note:** This section presumes that the commissioner has authority to proceed without the cooperation of the state’s attorney general. Governing state laws might require that a person other than the commissioner or the attorney general serve as the plaintiff. The title of that person shall be substituted for “commissioner” or “plaintiff” in Section 11 whenever required by state law.

### ~~C. Stay of the Foreign Decree~~

- ~~(1) If the defendant shows the [insert proper court] Court that an appeal from the foreign decree is pending or will be taken, or that a stay of execution has been granted, the court shall stay enforcement of the foreign decree until the appeal is concluded, the time for appeal expires, or the stay of execution expires or is vacated, upon proof that the defendant has furnished the security for the satisfaction of the decree required by the state in which it was rendered.~~
- ~~(2) If the defendant shows the [insert proper court] Court any ground upon which enforcement of a decree of any [insert proper court] Court of this state would be stayed, the court shall stay enforcement of the foreign decree for an appropriate period, upon requiring the same security for satisfaction of the decree which is required in this state.~~

- ~~B. D.~~ It shall be the policy of this state that the insurance commissioner shall cooperate with regulatory officials in other United States jurisdictions to the greatest degree reasonably practicable in enforcing lawfully issued orders of such other officials subject to public policy and the insurance laws of the state. Without limiting the generality of the foregoing, the commissioner may enforce an order lawfully issued by other officials provided the order does not violate the laws or public policy of this state.

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**Section 12. Suits by Nonadmitted Insurers**

A nonadmitted insurer may not commence or maintain an action ~~in~~ at law or in equity, including arbitration or any other dispute resolution mechanism, in this state to enforce any right arising out of any insurance transaction except with respect to:

- A. Claims under policies lawfully ~~placed pursuant to the law of the home state of the insured~~ written in this state;
- B. Liquidation of assets and liabilities of the insurer (other than collection of new premium), resulting from its former authorized operations in this state;
- C. Transactions subsequent to issuance of a policy not covering domestic risks at the time of issuance, and lawfully procured under the laws of the jurisdiction where the transaction took place;
- D. Surplus lines insurance placed by a licensee under authority of Section 5 of this Act;
- E. Reinsurance placed under the authority of [insert citations of state’s reinsurance intermediary act and other reinsurance laws];
- F. The continuation and servicing of life insurance, health insurance policies or annuity contracts remaining in force as to residents of this state where the formerly authorized insurer has withdrawn from the state and is not transacting new insurance in the state;
- G. Servicing of policies written by an admitted insurer in a state to which the insured has moved but in which the company does not have a certificate of authority until the term expires;
- H. Claims under policies covering wet marine and transportation insurance;
- I. Placements of insurance which were lawful in the jurisdiction in which the transaction took place and which were not unlawful placements under the laws of this state.

**Drafting Note:** Provisions of a state’s constitution, statutes, regulations, and public policy may necessitate amendment of the opening paragraph of this section.

**Section 13. ~~Separability~~ Severability Clause of Provisions**

If any provisions of this Act, or the application of the provision to any person or circumstance, shall be held invalid, the remainder of the Act and the application of the provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

**Section 14. Effective Date**

This Act shall take effect [insert appropriate date].

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*Chronological Summary of Actions (all references are to the Proceedings of the NAIC).*

1994 Proc. 3<sup>rd</sup> Quarter 14, 16-17, 24, 28-46 (adopted).  
 1996 Proc. 3<sup>rd</sup> Quarter 9, 42, 1110, 1168, 1169-1173, 1189-1190 (amended).  
 1997 Proc. 4<sup>th</sup> Quarter 25, 27-28, 1004, 1029 (amended).  
 1999 Proc. 3<sup>rd</sup> Quarter 25, 26, 1080, 1135, 1151-1153 (amended).  
 2002 Proc. 2<sup>nd</sup> Quarter 14, 250-251, 344, 347, 349-350 (amended).

*This model draws from and replaces three earlier NAIC models:*

*Model Surplus Lines Law*

1983 Proc. I 6, 36, 834, 900, 913-922 (adopted).  
 1985 Proc. II 11, 24, 702, 722, 723-724 (amended).  
 1986 Proc. I 9-10, 24, 799, 813, 814-821 (amended).

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*1990 Proc. I 6, 30, 840-841, 897-898, 900-901 (amended).*

*1991 Proc. I 9, 18, 908, 949, 950, 952-961 (amended and reprinted).*

*Unauthorized Insurers Model Act*

*1969 Proc. I 168, 218, 222-227, 271 (adopted).*

*1978 Proc. I 13, 15, 348, 350 (amended).*

*1990 Proc. II 7, 13-14, 159-160, 187-191 (amended and reprinted).*

*Model Nonadmitted Insurance Act*

*1983 Proc. I 6, 36, 834, 899-900, 923-926 (adopted).*

**PROJECT HISTORY*****NONADMITTED INSURANCE MODEL ACT (#870)*****1. Description of the Project, Issues Addressed, etc.**

The 2023 revisions to the NAIC *Nonadmitted Insurance Model Act (#870)* are intended to conform Model #870 to the federal Nonadmitted and Reinsurance Reform Act of 2010 (NRRRA), which was part of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act). The current Model #870 was adopted in 1994 to combine three NAIC models that date as far back as 1969: 1) the Unauthorized Insurers Model Act; 2) the Model Surplus Lines Law; and 3) the Model Nonadmitted Insurance Act. Since the adoption of Model #870 on Sept. 18, 1994, the NAIC has amended it on the following dates: 1) Dec. 16, 1996; 2) March 18, 1998; 3) Dec. 6, 1999; and 4) Sept. 10, 2002. The 2002 modifications resulted from the passage of the federal Gramm-Leach-Bliley Act (GLBA) by the U.S. Congress (Congress). Currently, 31 states have adopted Model #870.

The most recent activity regarding Model #870 is related to the NRRRA. Model #870 was not modified as a result of the implementation of the NRRRA. On Oct. 11, 2011, the *Nonadmitted Insurance Reform Sample Bulletin* (Bulletin), which was distributed to the state insurance departments, was adopted by the Executive (EX) Committee and Plenary. The Bulletin outlined federally mandated regulatory changes that affect the placement of nonadmitted insurance. Specifically, the Bulletin addressed the scope of the NRRRA, the application of “Home State” for the purposes of jurisdictional authority and paying premium tax, licensure requirements for brokers, diligent search requirements, and eligibility requirements for nonadmitted insurers.

During the implementation of the NRRRA, the Surplus Lines (C) Task Force and NAIC staff were working on state tax allocation proposals. The leading proposals were the Surplus Lines Insurance Multistate Compliance Compact (SLIMPACT), which pre-dated the NRRRA, and the Nonadmitted Insurance Multistate Agreement (NIMA), which was developed by the Task Force in response to the NRRRA. The SLIMPACT failed to obtain the 10 states needed to become operative. The NIMA clearinghouse operated for only a few years before the NIMA was dissolved in 2016. With the focus on achieving a system of tax allocation before the NRRRA deadline in July 2012, the decision was made to draft the Bulletin rather than amend Model #870.

During the 2020 Summer National Meeting of the Task Force, the chair directed staff to develop a drafting group to produce a summary document that outlined significant updates needed to modernize Model #870 and present a recommendation to the Task Force at a future national meeting. The drafting group consisted of Tom Travis (LA), Jeff Baughman (WA), Eli Snowbarger (OK), Andy Daleo (NAIC), and Dan Schelp (NAIC). The drafting group met Sept. 30 and Oct. 27, 2020. As a result of those meetings, the drafting group outlined numerous proposed revisions to Model #870.

During the 2020 Fall National Meeting, the Task Force adopted the Request for NAIC Model Law Development. During the 2021 Spring National Meeting, the Executive (EX) Committee approved the Request for NAIC Model Law Development.

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

The Surplus Lines (C) Task Force and the drafting group consisting of Louisiana, Chair; Colorado; Illinois; Texas; and Washington.

**Nonadmitted Insurance Model Act (#870)**Project History

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

The charges of the Surplus Lines (C) Task Force state, “Develop or amend relevant NAIC model laws, regulations, and/or guidelines.” Also, as described in charge #1, the Request for NAIC Model Law Development was approved by the Executive (EX) Committee during the 2021 Spring National Meeting.

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

During the 2021 Summer National Meeting, the Surplus Lines (C) Task Force formally developed the Model #870 Drafting Group that consisted of Travis, chair; Rolf Kaumann (CO); Marcy Savage (IL); Jamie Walker (TX); and Jeff Baughman (WA). The Drafting Group began its work on Model #870 on Aug. 19, 2021. During that call the Drafting Group discussed the overall approach to updating the model, initial comments received, and a timeline.

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

The Drafting Group met Aug. 19, 2021, for a regulator-only planning session. Following the initial meeting, the Drafting Group met in open session Sept. 28, Oct. 20, Nov. 4, and Dec. 1, 2021. During these sessions, interested state insurance regulators and parties submitted comment letters to the Drafting Group. The Drafting Group held regulator-only discussion and planning calls on Jan. 10, March 15, and May 3, 2022. During a Surplus Lines (C) Task Force call on May 23, 2022, Model #870 was exposed for a 60-day public comment period. Comments were received from the American Property Casualty Insurance Association (APCIA), CRC Group: Wholesale and Specialty Insurance; Lloyd’s of London; McDermott Will & Emery; the National Risk Retention Association (NRRRA); Surplus Line Association of Illinois (SLAI); the Council of Insurance Agents & Brokers (CIAB); and the Wholesale & Specialty Insurance Association (WSIA). The Drafting Group held a regulator-only discussion and planning call on Aug. 3, 2022 and the Task Force held a call on Oct. 17 to discuss the comments received and on Oct. 27, 2022 it exposed Model #870 for a 30-day public comment period. Comments were received from the Maine Bureau of Insurance; the APCIA; Lloyd’s of London; and the WSIA. During the Fall National Meeting, the Task Force heard a summary of the comments received. The Drafting Group held a regulator-only discussion and planning call on Jan. 18, 2023 to discuss comments received and on Jan. 23 exposed a new draft of Model #870 for a 14-day public comment period. Comments were received from the California Department of Insurance; the APCIA; the CIAB; Lloyd’s of London; McDermott Will & Emery; and the WSIA. On Feb. 10 the drafting group held a regulatory-only discussion and planning call and integrated edits into Model #870.

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

The most significant issue raised was related to the methodology of determining the “Home State” for unaffiliated groups as outlined within Section 2 of the model. Following comments from various interested parties and discussion among Drafting Group members, an agreed-upon revision resulted in clarification via a drafting note.

**7. List the Key Provisions of the Model (e.g., sections considered most essential to state adoption)**

Section 5C(2)(b) – Non-U.S. Insurers

**Nonadmitted Insurance Model Act (#870)**Project History

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- For a Nonadmitted Insurer domiciled outside the U.S., the insurer shall be listed on the *Quarterly Listing of Alien Insurers* maintained by the International Insurers Department (IID) of the NAIC.

## Section 5G – Surplus Lines Tax

- In addition to the full amount of gross Premium charged by the insurer for the insurance, every Person licensed pursuant to Section 5J of this Act shall collect and pay to the commissioner a sum equal to [insert number] percent of the gross Premium charged, less any return Premium, for Surplus Lines Insurance provided by the licensee pursuant to the license. Where the insurance covers properties, risks or exposures located or to be performed both in and out of this state, the sum payable shall be paid entirely to the Home State of the insured. The tax on any portion of the Premium unearned at the termination of insurance having been credited by the state to the licensee shall be returned to the policyholder directly by the Surplus Lines Licensee or through the producing broker, if any. The Surplus Lines Licensee is prohibited from rebating, for any reason, any part of the tax.

## Section 5T – Domestic Surplus Lines Insurer

- The commissioner may designate a domestic insurer as a domestic Surplus Lines Insurer upon its application, which shall include, as a minimum, an authorizing resolution of the board of directors and evidence to the commissioner's satisfaction that the insurer has capital and surplus of not less than \$15 million. (Although this was added to the model as optional, it remains an important part of the model.)

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

There were no discussions held regarding making Model #870 an accreditation standard.

**TITLE INSURANCE (C) TASK FORCE**

Title Insurance (C) Task Force March 23, 2023, Minutes ..... 7-189

Draft: 3/28/23

Title Insurance (C) Task Force  
Louisville, Kentucky  
March 23, 2023

The Title Insurance (C) Task Force met in Louisville, KY, March 23, 2023. The following Task Force members participated: Eric Dunning, Chair, and Connie Van Slyke (NE); Kevin Gaffney, Vice Chair, and Emily Brown (VT); Mark Fowler represented by Jimmy Gunn (AL); Michael Yaworsky represented by Anoush Brangaccio (FL); Doug Ommen represented by Travis Grassel (IA); Vicki Schmidt represented by Monica Richmeier (KS); James J. Donelon represented by Chuck Meyers (LA); Kathleen A. Birrane represented by Mary Kwei (MD); Grace Arnold represented by Paul Hanson (MN); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Tracy Biehn, Timothy Johnson, and Angela Hatchell (NC); Judith L. French represented by Maureen Motter (OH); Glen Mulready represented by Erin Wainner (OK); Michael Humphreys represented by Michael McKenney (PA); Elizabeth Kelleher Dwyer represented by Patrick Smock (RI); Michael Wise represented by Melissa Manning (SC); and Larry D. Deiter represented by Tony Dorschner (SD). Also participating was Michael Conway represented by Peg Brown (CO) and Amy Beard represented by Pat O'Connor (IN).

1. Adopted its 2022 Fall National Meeting Minutes

Commissioner Gaffney made a motion, seconded by Hatchell, to adopt the Task Force's Dec. 14, 2022, minutes (see *NAIC Proceedings – Fall 2022, Title Insurance (C) Task Force*). The motion passed unanimously.

2. Discussed its Charge to Open Model #628

Director Dunning stated that the Task Force is charged to review the *Title Insurers Model Act (#628)*, Section 15C to determine if a request should be made to remove the requirement for the on-site review of underwriting and claims practices. As the pandemic demonstrated, on-site reviews are not always practical. However, based on research done by NAIC legal staff, only eight states adopted the model. Only three of these states still require on-site review. An additional two states require on-site review, but they did not adopt the NAIC model. As a result of the low adoption, Model #628 will be put on the list of models to be reviewed for the Model Law Review Initiative this year. The initiative deals with retention/archiving models, but the full process for this has not yet been finalized. Given this new information, he recommended that the Task Force postpone reviewing Model #628 pending the outcome of its review under the Model Law Review Initiative.

Commissioner Gaffney stated that he supports postponing the review of Model #628. Director Dunning stated that given that there were no objections, the Task Force has a consensus to postpone reviewing Model #628 pending the outcome of its review under the Model Law Review Initiative.

3. Heard an Update on Requested Information from Voxtur

Director Dunning stated that Stacy Mestayer (Voxtur) presented to the Task Force during the 2022 Fall National Meeting on Voxtur's attorney opinion letter (AOL). Following her presentation, the Task Force requested that Voxtur share information on: 1) its operations; 2) whether it has a prominent notice that it does not participate in the guarantee fund in states where applicable; 3) how its carriers are reserving; 4) what due diligence was performed to try and obtain admitted coverage before going to the nonadmitted market; 5) its standard letters and policy; 6) the release of its white paper addressing conflicting characterizations of the Voxtur AOL; and 7) a comparison of the Voxtur AOL and title insurance.



On March 14, Commissioner Gaffney, Director Dunning, and NAIC staff met on a background call with Mestayer to discuss the requested items. Mestayer stated that Voxtur relied on its insurance broker for coverage, and it is working on connecting the Task Force with the broker and carriers for direct communications on insurance questions. She is discussing with Voxtur leadership if there are methods of sharing the other requested information that they are comfortable with, as they have confidentiality concerns.

4. Heard a Presentation on UWM’s Alternative to the Traditional Lender Title Process and the FNMA’s Pilot Program on Title Insurance Requirements

Steve Gottheim (American Land Title Association—ALTA) said the new alternatives to title insurance on the market are meant to provide more affordable options to homeowners. However, ALTA worries that the lack of transparency on these products is confusing homeowners’ understanding of what they will be protected on. On April 6, 2022, the Federal National Mortgage Association (FNMA) updated its selling guidance on AOLs to permit lenders to obtain either a lender’s title insurance policy or, in limited circumstances, an attorney title opinion letter. Shortly thereafter, Voxtur announced that it would be selling an AOL on FNMA loans. In June 2022, the FNMA and the Federal Home Loan Mortgage Corporation (FHLMC) issued their government-sponsored enterprise (GSE) equitable housing finance plans. These plans were requested of them to help support low- and moderate-income homeownership, especially for minorities. In October 2022, United Wholesale Mortgage (UWM), the largest U.S. mortgage finance company, announced that it would be entering the space through its title review and closing (TRAC) product. While Voxtur’s AOL purports to offer owners’ coverage, the UWM only offers lenders coverage. In February 2023, there was an article in Politico stating that the FNMA is rumored to be looking at forgoing title insurance. It would serve as a default insurer by waiving the title insurance requirement from lenders and reserving funds for claims related to title matters.

ALTA proposes the following questions to guide the Task Force in its discussions on these topics: 1) how these products are marketed to consumers; 2) what type of title search and curative work is done with these alternatives; 3) what the differences are in coverage and who takes on the additional risk; 4) whether owners’ coverage is provided and how it compares to title insurance; 5) whether there is a duty of defense; 6) whether these products are being sold in the market; 7) how these products are licensed; 8) whether their coverage and forms are filed publicly; 9) what level of reserves for future loss the insurer holds; and 10) how these reserves are actuarially determined.

The actual underwriting that goes into these products is critical. About 70% of the cost of title insurance comes from underwriting costs (e.g., search, examination, and curative efforts to ensure a clean record). The potential for an increase in title consumer complaints from insufficient underwriting should be examined. Duty to defense is also critical, as most consumers view title insurance as litigation insurance. Model #628 defines the business of title insurance as “guarantying, warranting, or insuring searches or examinations of title to real property or any interest in real property; or guaranteeing or warranting the status of title as to ownership of or liens on real property and personal property by any person other than the principals to the transaction; or doing or proposing to do any business substantially equivalent to any of the activities listed in this subsection in a manner designed to evade the provisions of this Act.”

This is not the first time alternative lighter search products have entered the market stating that they are not title insurance and therefore do not need to be regulated as such. Norwest Mortgage, now Wells Fargo Home Mortgage, offered a similar product to the alternatives entering the market now. In *Norwest Corp. v. State, Dept. of Ins.*, 253 Neb. 574, 571 N.W.2d 628 (1997) and *State, Division of Insurance v. Norwest Corp.*, 1998 S.D. 61, 581 N.W.2d 158, the Court found an alternative product involving a title search and representation that the loan that was in first lien position was title insurance because representation involved a transfer of risk.

The UWM partners with brokers rather than having its own mortgage originators. TRAC products provide lenders' with coverage only, and in-house attorneys write the opinions, creating a question on moral hazard. The purchase price is based on a certain basis point of the loan amount as is owed from the broker to the UWM. This purchase price is not necessarily the price charged from the brokerage company to the consumer. TRAC products are available in Arizona; California; Colorado; Connecticut; Delaware; Florida; Georgia; Illinois; Massachusetts; Michigan; Nevada; New Hampshire; New Jersey; New York; Ohio; Pennsylvania; Rhode Island; Texas; Utah; Virginia; Washington; and Washington, DC.

Per frequently asked questions (FAQ) issued to mortgage brokers, the UWM will take on the risk of title defects and issue an AOL. The FNMA is believed to be the sole secondary market purchaser for these products. Despite these products being designed for cost effectiveness, ALTA believes they are more expensive than title insurance in most circumstances. This is particularly true because of the number of states where it is customary for sellers to pay for an owner's policy. There is usually a discount when the loan and owner's policy are purchased together because the underwriting work overlaps. The UWM requires settlement agents to sign a closing indemnification letter, which is a rearranged version of a standard ALTA closing protection letter (CPL). ALTA has concerns about another set of closing letters that only place the agent at risk, instead of an insurer.

ALTA has been engaging directly with the FNMA and the FHLMC to help support the mission of more affordable homeownership. There has been some success with ALTA members offering newer or discounted products to help meet the need for lower closing costs. These include first-time homebuyer discounts, community reinvestment rates, special purpose credit programs, and partnering with state housing agencies.

Commissioner Gaffney asked for more information on the first-time homebuyer discounts and whether there are any regulatory barriers. He also asked what percentage of purchasers purchase an owner's policy versus a lender's policy. Gottheim stated these are rates title companies have filed in a handful of states to offer discounted rates to first-time homebuyers. Occasionally, states will have laws that state that rates cannot be discriminatory, excessive, or unfair, which make it difficult to get a lower rate for first-time homeowners approved. Due to FNMA and FHLMC guidelines, 99% of homebuyers purchase a lender's policy. ALTA national member data indicates that about 75% of homebuyers purchase an owner's policy. The uptake rate for owner's policies is consistent between low-, middle-, and upper-income homebuyers. Commissioner Gaffney stated that he would be interested in seeing ALTA's national data on take-up rates.

McKenney stated that he is concerned that if these alternative products do not include the same extensive search and curative work as occurs with title insurers, there would be an increase in unclean titles that would then increase the price of title insurance.

Gottheim stated that ALTA believes the curative work done with the alternative products is not as detailed. ALTA is concerned that if more loans are going through these processes, there will be less of an incentive to fix a legal description issue or an issue with the satisfaction of the loan from two owners that never got recorded. If there is a large enough uptake in these alternative products, title insurers may have to pick up an additional expense item, stemming from the lack of diligence done with the alternative products.

Hanson stated that the \$370,000 mortgage amount used in the example to illustrate the UWM's pricing seems excessive for a product meant to save lower-income buyers money. Gottheim stated that the \$370,000 mortgage pricing example came from the UWM's marketing. The national sales price of a home is \$375,000. ALTA is concerned that these programs are set up to help cherry-pick higher income products. There is a rumor that the FNMA will be taking on title insurance risks only for homes with a 20% down payment. The median down payment for a first-time homebuyer is 7%.

Birny Birnbaum (Center for Economic Justice—CEJ) stated that the cost of title insurance is significant for first-time homebuyers, and while required to purchase it, they have little understanding of it. His daughter purchased a home in Texas for \$225,000, and she was asked to pay several thousands of dollars for title insurance. In Texas, title insurance includes the search, underwriting, and portions of the closing. The title agent also wanted an additional \$700 for title and escrow. Eventually, the \$700 was removed, as the title insurance policy was supposed to include it. However, most consumers would not have known that they could negotiate its removal. The automated underwriting process includes pulling information from a database, running it through an algorithm, and developing a score that indicates whether the policy is issued automatically. This is a similar process to getting a credit score for a loan. However, a credit score is \$25, and a title insurance policy is \$2,500. Mortgage lenders set up affiliated title agencies or title insurers to monetize access to the consumer. Title insurance is ripe for innovation, disruption, and consumer protection. Iowa guarantees titles, but it does not allow title insurance. A title insurance policy does not guarantee a title; it provides a marketable title.

Gottheim stated that those offering alternative products are asserting that they are not subject to state regulation, despite offering similar products to title insurers. This should concern state insurance regulators. Automated title insurance engines are in their infancy and used in refinancing. Otherwise, the underwriting process is still a very paper and labor-intensive process.

Birnbaum stated that the FNMA's *Barriers to Entry: Closing Costs for First-Time and Low-Income Homebuyers* report was issued Dec. 2, 2021. The report found that closing costs are a meaningful obstacle to sustainable homeownership for first-time and low-income first-time homebuyers, including Black and Hispanic borrowers. Within the low-income first-time homebuyers in the study, 21% of African American and 19% of Hispanic buyers paid closing costs equal to or greater than their down payment. Title insurance is an expensive proposition for first-time homebuyers.

5. Discussed if Additional Questions Should be Added to the Survey of State Laws Before it is Distributed for Update

Director Dunning stated that the Task Force is charged to administer the *Survey of State Insurance Laws Regarding Title Data and Title Matters* (Survey of State Laws) this year. It was last administered in 2018 and published in 2019. Task Force members were asked to email NAIC staff with any questions they believed should be added to the Survey of State Laws. Additional questions proposed were submitted by Louisiana and Rhode Island, and they are included in the materials. Under the Data Reporting section, Rhode Island proposed adding, "If the number of policies issued is collected, is the number separated by standard title policies and enhanced title policies?" after question 9. Under the Policy Rate and Form Regulation section, Rhode Island proposed adding, "Does the department set requirements for standard title policies? For enhanced title policies?" after question 12. Under the Procedural Regulation section, Louisiana proposed adding two questions: 1) "Is there a statutory requirement for an attorney opinion letter concerning the title examination for the issuance of a title insurance policy?"; and 2) "Is there a statutory standard for the information contained in: a title examination? A title opinion letter?" Under the Insurer-Agent Relationship section, Rhode Island proposed adding, "What are the requirements for title insurers to confirm/verify valid license status of title agents? How often is confirmation/ verification completed?" after question 47. Rhode Island also proposed adding a new category for Title Opinion Letters, with the following questions: "1) Does the state department regulate title opinion letters?"; 2) "Does the state department regulate the pricing of title opinion letters?"; 3) "Does the state license the entity that generates the title opinion letters?"; 4) "What license is required?"; and 5) "Are title opinion letter forms and rates filed with the state department?"

Smock stated that he is supportive of all the questions, and he particularly liked the ones suggested by Louisiana. Birnbaum stated that the CEJ appreciates the proposed questions, and he has no further questions to propose.

Commissioner Gaffney made a motion, seconded by McKenney, to add the proposed questions to the Survey of State Laws. The motion passed unanimously.

Having no further business, the Title Insurance (C) Task Force adjourned.

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**WORKERS' COMPENSATION (C) TASK FORCE**

Workers' Compensation (C) Task Force March 6, 2023, Minutes..... 7-195

Draft: 3/15/23

Workers' Compensation (C) Task Force  
Virtual Meeting (*in lieu of meeting at the 2023 Spring National Meeting*)  
March 6, 2023

The Workers' Compensation (C) Task Force met March 6, 2023. The following Task Force members participated: Alan McClain, Chair (AR); John F. King, Vice Chair, and Steve Manders (GA); Mark Fowler represented by Jimmy Gunn, Yada Horace, and Erick Wright (AL); Lori K. Wing-Heier represented by Alex Reno (AK); Ricardo Lara represented by Yvonne Hauscarriague, Giovanni Muzzarelli, Mitra Sanandajifar, and Sarah Ye (CA); Andrew N. Mais represented by George Bradner, Wanchin Chou, and Bridget Lamagdelaine (CT); Karima M. Woods represented by David Christhilf (DC); Gordon I. Ito represented by Randy Jacobson, Kathleen Nakasone, and Roland Teruya (HI); Doug Ommen represented by Mathew Cunningham (IA); Dean L. Cameron represented by Randy Pipal (ID); Vicki Schmidt represented by Chris Hollenbeck, Julie Holmes, Sara Hurtado, and Cassandra McCall (KS); Sharon P. Clark represented by Sue Hicks (KY); James J. Donelon represented by Tom Travis (LA); Gary D. Anderson represented by Bashiru Abubakare, Caleb Huntington, and Matthew Mancini (MA); Timothy N. Schott, Brock Bubar, Sandra Darby, and Robert Wake (ME); Grace Arnold represented by Sandra Anderson, Tammy Lohmann, and Phil Vigliaturo (MN); Chlora Lindley-Myers represented by Jo LeDuc (MO); Mike Causey represented by Tracy Biehn and Fred Fuller (NC); Marlene Caride represented by Carl Sornson (NJ); Scott Kipper represented by Gennady Stolyarov (NV); Glen Mulready, Kim Hunter and Cuc Nguyen (OK); Andrew R. Stolfi represented by Alex Cheng and TK Keen (OR); Michael Humphreys, Mark Lersch, Lu Xiaofeng (PA); Shannon Kost, Michael McKenney, Dennis Sloand, and Eric Zhou (PA); Elizabeth Kelleher Dwyer represented by Beth Vollucci (RI); Larry D. Deiter and Tony Dorschner (SD); Kevin Gaffney, Rosemary Raszka, and Mary Richter (VT); and Allan L. McVey represented by Juanita Wimmer (WV). Also participating were: Kaylee Baumstark and Tom Zuppan (AZ); Lucretia Prince, Frank Pyle, and Jeffry Schott (DE); Patrick O'Connor (IN); Chris Arth, Paige Dickerson, Robyn Lowes, Tina Nancy, and Mandi Whinnie (MI); Bob Biskupiak (MT); Christian Citarella (NH); Anna Krylova (NM); Jessica Thomas (TN); Marianne Baker and Nicole Elliott (TX); Tracy Klausmeier (UT); and Rebecca Nichols (VA).

1. Adopted its 2022 Fall National Meeting Minutes

Sanandajifar said she had a couple of corrections to the Fall National Meeting minutes. The first item was to replace the word "depended" with "dependent" on page 2 in the third paragraph. The second item was to replace "combined ratio" with "premium" on page 2 in the last paragraph.

Commissioner King made a motion, seconded by Keen, to adopt the Task Force's Nov. 15, 2022, minutes as amended (*see NAIC Proceedings – Fall 2022, Workers' Compensation (C) Task Force*). The motion passed unanimously.

2. Heard a Presentation from the IAIABC on Telework and how it is Affecting Workers' Compensation

Heather Lore (International Association of Industrial Accident Boards and Commissions—IAIABC) said she reached out to several state workers' compensation administrators to ask how their jurisdictions are tracking teleworking injuries. She asked about injury frequencies, severity, premium, class codes, etc. Lore said of all those she talked to, no one is tracking information regarding workers' compensation injuries experienced by teleworkers, making it challenging to understand the impact of telework on workers' compensation.

Lore said telework will continue. She said McKinsey & Company's study this spring estimated that 35% of job holders in the U.S. were offered the option to work from home full-time, and 58% of these workers can work from home at least part-time. Prior to the pandemic, approximately 6% of workers were able to work from home on a full-time basis.

Lore said the IAABC has been teleworking on a full-time basis since March 2020 and does not plan to return to the office. She said prior to this time, all but one of the IAABC staff worked full-time in the office. Lore asked the state insurance regulators on the call to share whether they allow telework and who determines the ability to telework.

O'Connor said the state of Indiana allows telework two days a week.

Gaffney said the state of Vermont had a well-established telework policy prior to the pandemic. He said in the past, it was mainly financial examiners who took advantage of teleworking, but others were also able to telework. The governor leaves the telework decision to the department heads to determine the level of telework. Gaffney said jobs might require more in-office and manual processes, so it is not a one size fits all solution. He said he leaves it up to each division to determine the telework processes, so it varies by team. Gaffney believes the implementation of telework has allowed the department to attract talent they would not otherwise have been able to attract. He said some needs still occur in the office, such as cross-training staff, skills training, and meeting with industry and other interested parties. Gaffney believes there are hazards that come with remote work that will need to be tracked as well.

King said he has broad authority regarding work schedules. He believes it is not a one size fits all solution, and each of the activities in the agencies requires tailoring and assessments. King said in the instance of brand-new employees, they need to start in the office to understand the culture and be trained. He said Georgia has a mechanism in place to track the performance of teleworkers.

The following states responded in the WebEx chat box:

- The Iowa Department of Insurance (DOI) allows teleworking for all employees, which was the commissioner's decision based on what the governor has allowed for state employees.
- The Kansas DOI allows two remote workdays per week as approved by the division directors.
- The Kentucky DOI allows two days per week to telework, and the governor dictates the policy.
- The Missouri DOI allows limited remote work on a part-time basis for no more than two days per week.
- The Nevada DOI allows remote work for unclassified employees but not for classified employees. The new governor, Joe Lombardo, recently issued an order for state offices to return to "pre-pandemic working conditions" by July 1, 2023, but it is not certain whether this will alter the current arrangement in which classified employees need to work from the office, while unclassified employees have more flexibility.
- The Pennsylvania DOI allows telework two days a week for management and leadership, while the civil service and union are allowed to continue full-time telework.
- The South Dakota DOI has a few telework options, and division directors weigh each situation case by case.
- The Virginia DOI allows teleworking up to three days per week, and its agency decides the teleworking policy.
- The West Virginia Offices of the Insurance Commissioner (OIC) do not allow telework. The governor left these decisions to each cabinet secretary, and they have determined that no remote or hybrid options will apply to the OIC.

Lore said it is difficult to discuss the frequency of workers' compensation claims that occur while an employee is teleworking because jurisdictions are not actually tracking those employees who are teleworkers. She said none of the states she reached out to had plans to add new class codes. However, California did add a new class code for clerical teleworking employees in 2021. Lore said she was going to try and see what data California has available regarding this new class code.

Lore said loss costs were generally higher for jobs that are unable to telecommute, such as retail, construction, transportation, and manufacturing. These jobs have higher claims frequency in general than telecommuting-optional clerical jobs. Lore said the hazards are likely not a lot different when an employee is working in the office or when they are working from home. In an office, employees might be getting up more from their desks to go to a conference room for a meeting, or getting up to talk to a colleague, but functionally the work itself is really the same.

Lore said several states mentioned they have concerns about the psychological issues of telecommuting employees, and while it is not something that is showing up in the data yet, it may be a lagging issue. She said we might see more psychological issues arise as people might be feeling more disconnected from the workplace, which may cause anxiety and depression to set in, particularly for people who are working full-time from home and do not have the same connections to their colleagues that they did when they were working in the office. Lore said most jurisdictions do not allow for mental-only claims, but it is possible we will start to see an increase in disputes regarding these types of injuries.

Lore asked if any of the states were seeing any frequency or severity trends they could report on for workers' compensation or anything in states regarding premiums being affected. She asked if, anecdotally, states had seen any psychological impacts on their teleworking employees.

Stolyarov said in Nevada, they have seen a significant decrease in the loss costs for workers' compensation since the beginning of the pandemic. He said he believes the shift to telework for many occupations has contributed to this decrease. Stolyarov said it is not a matter of work being different, but it could be a matter of the workplace setting being different. He said, understandably, there are some hazards at home as well as in the office, but from an intuitive standpoint there are less hazards because the worker has more control over the environment. He said someone in an office could put a cord somewhere in the hallway that creates a tripping hazard, whereas that likely would not happen in someone's own home.

Lore said a couple of employees in her office did not have an office in their home, and therefore their ethernet port was on the opposite side of the home from their desk. She asked how we encourage employees to set up their home offices safely. Lore said while an employee does not have to set up an office per se, their workspace needs to be safe.

McKenney said he was hoping to discuss this topic in a meeting because the data is many years behind in workers' compensation. He said Pennsylvania just got the most recent loss cost filing from their independent bureau, and it takes effect on April 1, 2023. McKenney said the most recent year in the experience was the policy year 2020, so he does not know what is happening and does not like the idea that he must wait for the results to come through the data.

McKenney said a lot of workers' compensation is returned to work, as you are paying an injured person's salary while they are not working, and it may be easier for a person to return to work if they are working from home. He said he is concerned that we are not getting, and taking account of, any of the positive impacts we are gaining from telework.

Lore said workers' compensation data is slower to get, and therefore, it is a challenge that the data is not available.

Lore asked the various states what insurers require when writing a workers' compensation policy. She asked if agencies require their employees to have a desk that is at a proper height, etc. Lore said she knows that one jurisdiction does conduct home office visits in which a safety coordinator goes to the teleworker's home to make sure they have a safe and ergonomic workspace. She said that while this is not practical for all employers, some are having their employees send in pictures of their home workspace to make needed suggestions.



Lore said items to take into consideration regarding injuries at home include:

1. Is going to the kitchen to get lunch considered to be in the course of work?
2. Does the lack of witnesses to an injury cause potential friction?
3. Many jurisdictions have a coming-and-going rule, so a commute would generally not be covered. But if coming and going is covered, and a person falls down the stairs walking into their home office, is that covered?

Lore asked the Task Force if they have seen any compensability challenges in court regarding teleworking or denials specifically for teleworking injuries.

Lore said there is a lack of data and information regarding workers' compensation injuries occurring in the course of telework. She said as an employer, she is looking at the requirements her business should begin complying with, including developing specific telework policies that provide necessary equipment lists and safety standards to ensure employees are working in a safe work environment. Lore asked the Task Force if their agencies have safety and equipment requirements for teleworking employees, how they are monitoring these requirements, if insurers require their policyholders to develop these written policies, and how else they might be mitigating the risk for teleworking employees. Answers in the chat included states having checklists for teleworkers and teleworking agreements.

Lore said there needs to be some data collected to better understand the impacts. She said the NAIC and the IAABC have discussed the opportunity to collaborate on a paper that could dive deeper into this issue. McClain said he liked the idea of a collaborative white paper. King said Georgia is still assessing the data, and it is hard to predict when more data will be available, as it could be a year or longer before data is available.

King said telework will likely continue at the current rates because productivity is not being affected. He said they are not seeing a surge in claims but believes it is likely too early to tell what will transpire.

### 3. Heard a Presentation from the NCCI Regarding Presumptive Workers' Compensation Benefits for Firefighters and Other First Responders

Jeff Eddinger (National Council of Compensation Insurance—NCCI) said numerous studies have examined the relationship between the job duties of firefighters and the contraction of certain diseases. He said these studies have provided varying conclusions, and the NCCI does not take a position on whether there is an actual correlation between the job duties of firefighters and these types of injuries.

Over the last decade, many states have enacted presumption laws for firefighters and other first responders. When a statutory presumption exists, and a worker meets certain requirements, the injury is presumed to have arisen out of and in the course of employment. More than a dozen states have introduced bills this year that would add some more types of cancers to the list of comprehensive injuries for first responders, such as police, firefighters, and emergency medical personnel. This has been a legislative trend in recent years as more states seek to expand benefits.

Eddinger said over the years, the NCCI has produced a white paper to provide information and insights on this topic to various stakeholders. This white paper was recently updated. The white paper outlines the different varieties of firefighter bills and some of the issues associated with them. The bills generally vary in two major respects, namely, the specific diseases that are covered and how certain restrictions may apply.

One of the diseases included in most of the firefighter bills is cancer. There can be either a broad definition of cancer or a specific list of cancers that would be covered. One of the issues with cancer is that it is a relatively

common disease in the U.S., as well as being among one of the most expensive medical conditions. Another issue with cancer is that it tends to have a long latency period, so it may be difficult to tie back to a prior employment period.

A second common disease found in firefighter bills includes respiratory conditions. Chronic respiratory diseases are relatively common diseases, as they are the sixth leading cause of death in the U.S. Smoking can contribute to respiratory conditions and some states include a non-smokers clause in their legislation.

A third type of disease found in firefighter bills includes blood and infectious diseases. First responders often come into contact with diseases like HIV, AIDS, hepatitis, tuberculosis, and recently COVID-19. These diseases have a shorter latency period, so theoretically, there would be less of an impact for these types of diseases due to a presumption law because it might be easier to track when the exposure occurred.

A fourth type of disease found in the firefighter bills includes heart and vascular conditions, including high blood pressure and heart disease. Heart disease is prevalent among firefighters, and sudden cardiac arrest accounts for half of all on-the-job fatalities for firefighters. It is difficult to prove a link because lifestyle and family history play a large role in heart disease. Additionally, there could be some heart-related presumptions that have time restrictions, so there could be a minimum amount of time between the firefighter's service and the episode for it to be eligible for a presumption.

Finally, the presumption being discussed most recently is mental injuries, which may expand to include things like Post-traumatic Stress Disorder (PTSD). At least 25 states recognize mental injuries, which are defined as mental injuries that arise without physical injuries. The NCCI is tracking this topic.

The other variabilities in these bills deal with different types of restrictions. Many times, these restrictions are service restrictions and time limitations, meaning that in order to qualify for a presumption, the employee must have served a minimum number of years to qualify. There may also be a limitation on the time after retirement or termination and could also be age restrictions. These presumptions may require health evaluations so that a pre-employment exam shows no pre-existing conditions for the types of diseases we have been discussing.

Furthermore, these presumption bills generally have wording on rebuttal presumptions. These presumptions are usually rebuttable presumptions that may be rebutted by a preponderance of the evidence.

Some additional considerations include voluntary firefighters. Some state statutes specifically exclude voluntary firefighters versus full-time firefighters. In those states where voluntary firefighters are included, it makes it more difficult to estimate the potential impact of one of these bills. A voluntary firefighter does not have set hours and there can be a variation of how much time they might actually spend being a firefighter.

Another issue is the potential shifts to coverage. Sometimes when these presumptions are put into place, there is a fear that the presumptions might open up or increase claims activity. Firefighters who do not self-insure may have difficulty finding workers' compensation coverage in the voluntary market.

If a presumption is passed, there is also an unexpected impact on the judicial environment, meaning that just because of the uncertainty, there could be an increase in litigation.

Another important impact to consider is the retroactive impact. Once a presumption bill is put into place, any claims that are filed could end up coming from years prior to the effective date of that presumption, so there was no premium collected to cover past injuries.

The final issue the NCCI discusses in its white paper is the issue of estimating the impact of the proposed bills. The availability of data is one issue that makes it hard to estimate the impact of firefighter bills. Most firefighters are employed by municipalities or other entities that self-insure, and this data is not reported to the NCCI. Additionally, there is the issue of the long latency of some of the diseases, meaning the data will not be available for many years. Even when the data does exist, it is impossible to differentiate between claims that were compensable under presumption versus just general standards.

The NCCI will continue to track these bills. The NCCI's newly updated white paper that includes additional information can be found on the NCCI's website.

Having no further business, the Workers' Compensation (C) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2023\_Spring/WCTF/Minutes – WCTF\_3\_6 SprNM 2023.docx

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

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Draft: 3/29/23

Market Regulation and Consumer Affairs (D) Committee  
Louisville, Kentucky  
March 24, 2023

The Market Regulation and Consumer Affairs (D) Committee met in Louisville, KY, March 24, 2023. The following Committee members participated: Jon Pike, Chair (UT); Mike Causey, Co-Vice Chair, represented by Tracy Biehn (NC); Michael Humphreys, Co-Vice Chair, and David Buono (PA); Peni Itula Sapini Teo represented by Elizabeth Perri (AS); Karima M. Woods and Sharon Shipp (DC); Trinidad Navarro and Susan Jennette (DE); Sharon P. Clark (KY); Chlora Lindley-Myers, Cynthia Amann, and Jo LeDuc (MO); Jon Godfread represented by John Arnold (ND); Michael Wise (SC); Cassie Brown represented by Jessica Barta, Matthew Tarpley, and Jamie Walker (TX); Kevin Gaffney represented by Karla Nuisl (VT); and Jeff Rude (WY). Also participating were: Erica Weyhenmeyer (IL); Matt Gendron (RI); Rebecca Nichols (VA); and John Haworth (WA).

1. Adopted its 2022 Fall National Meeting Minutes

Biehn made a motion, seconded by Commissioner Navarro, to adopt the Committee's Dec. 15, 2022, minutes (see *NAIC Proceedings – Fall 2022, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

2. Heard a Presentation on the Emerging Cyberthreat of Technology-Enabled Claims Instigation

Joseph Petrelli (Demotech) said multiple insurers in Florida have become insolvent in the last few years. Research by Demotech and 4Warn has shown a disproportionate increase in litigation in Florida, and they have tied this increase in litigation to the insolvencies. Petrelli said law firms have targeted the insurance companies. He said Demotech asked Todd Kozikowski (4Warn) to investigate the reasons for the insolvencies.

Kozikowski said Google sells keywords, which are used by its search engine to prioritize results obtained in searches. Entities that pay for the keywords that are used in the searches will appear as the first results for a search. Buying keywords to push up the prioritization of an entity's advertisement is called search engine optimization (SEO). He said an analysis of the keywords and the sites that own them show that the keywords include insurance company names; public adjuster names; and generic searches, such as "public insurance adjusters near me" or "claims department." The keywords will be purchased just prior to a National Oceanic and Atmospheric Administration (NOAA) named storm arriving along an affected path. Kozikowski said average monthly spending on SEO keywords by six major multinational companies—McDonald's, Ford Motor Company, Starbucks, Nestle, Costco, and Anthem Blue Cross Blue Shield—was \$296,000. He said the average monthly spending by one substantial law firm was \$741,000. He noted that one Florida public adjuster paid an average of \$57,000 per month, or about \$650,000 per year, to buy keywords. The 1,200 paid keywords generated 3,700 clicks compared to 1,200 clicks from 2,600 organic searches that did not use paid keywords.

Petrelli said six Florida insurance companies failed due to a significant increase in new lawsuits that often exceeded the number of lawsuits in entire states. He said law firms used Litify to increase lawsuit filings by 480%. He said litigation financing outperformed investments in private equity (PE), real estate, and hedge funds. He noted that the Louisiana Department of Insurance (DOI) issued a cease and desist on one law firm for fraudulent activity related to marketing practices related to promising large recoveries before a claim is investigated.

Kozikowski said he monitored search activities and the purchase of keywords prior to the landfall of Hurricane Ian. There was a substantial increase in the purchase of keywords to elevate the results for law firms and public adjusters when consumers searched for information on their insurance companies and claims information. He

said one law firm has targeted more than 90 insurance companies by buying keywords, including the company name, such as “Travelers insurance personal injury settlement” and “Travelers insurance claims.”

Commissioner Clark asked if there was evidence of public adjusters and litigators collaborating. Petrelli said there is no direct evidence, but he believes it is occurring. He said it would be necessary to coordinate with companies to see their claims files to know if there is collaboration. He said he believes litigators have carved up the Florida insurance marketplace.

Commissioner Navarro asked if the law firms and public adjusters were intercepting calls intended for the insurance companies. Kozikowski said by using SEO, a Google search will show as a top result the telephone number for a public adjuster or litigator who purchased keywords using the insurance company’s name. Commissioner Navarro said everyone assumed that the reason the companies went insolvent in Florida was because of the cost of the hurricane-related losses. He asked if Petrelli and Kozikowski believe the companies went insolvent because of lawsuits. Petrelli said it was death by litigation.

Arnold asked if other industries and regions of the country have the same SEO issues that 4Warn is noticing in the insurance industry. Kozikowski said other industries are experiencing the same, but he has no analysis on them. There are increased litigation levels in Chicago, San Francisco, and Florida. Gendron asked why no upticks are indicated in cities other than Chicago, San Francisco, and Miami. Kozikowski said the lawsuits are targeted at specified insurers, and the upticks would be in the cities where those companies have the most losses.

Birny Birnbaum (Center for Economic Justice—CEJ) said he would like to have an opportunity to present a rebuttal to the presentation by Petrelli and Kozikowski. He said he was outraged that the Committee provided a platform for this conspiracy theory.

Ken Klein (California Western School of Law) noted that regulatory and legislative efforts to reduce litigation reduce both frivolous and meritorious lawsuits. He asked if Kozikowski or Petrelli can identify how many of the lawsuits were frivolous or meritorious. Shipp asked how many of the litigated claims resulted in payments, and Petrelli said that is information that would have to be gathered from the insurance companies.

### 3. Adopted its Task Force and Working Group Reports

#### a. Antifraud (D) Task Force

Commissioner Navarro said the Antifraud (D) Task Force met March 23 to adopt its 2022 Fall National Meeting minutes and discuss its charges and priorities for the year. He said the Task Force received an update from the Improper Marketing of Health Insurance (D) Working Group. He said the Working Group holds monthly regulator-only conference calls to discuss ongoing investigations and state efforts concerning lead generators. The Working Group is also continuing to work on its charge to “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.” He said in 2022, the Working Group started reviewing the *Unfair Trade Practices Act* (#880) for potential amendments. The Working Group is finalizing the draft amendments. Commissioner Navarro said following the Spring National Meeting, the Working Group will distribute an updated draft for review and hold an open conference call in April to review and potentially adopt the amendments.

Commissioner Navarro said the Task Force received an update on the NAIC’s Online Fraud Reporting System (OFRS) redesign. He said the implementation process will include collaboration with the National Insurance Crime Bureau (NICB), the National Health Care Anti-Fraud Association (NHCAA), and state vendors. He said the Antifraud Technology (D) Working Group will begin reviewing suggested enhancements for OFRS moving forward. He said

the Task Force concluded its meeting with reports on matters of interest from the Coalition Against Insurance Fraud (CAIF), the Healthcare Fraud Prevention Partnership (HFPP), and the NICB.

b. Producer Licensing (D) Task Force

Commissioner Clark said the Producer Licensing (D) Task Force has not met this year. She said the Task Force will have three working groups in 2023. The Adjuster Licensing (D) Working Group will be chaired by Rachel Chester (RI). The Uniform Education (D) Working Group will be chaired by Richard Tozer (VA). The Producer Licensing Uniformity (D) Working Group will be chaired by Bryan Stevens (WY).

Commissioner Clark said last year, the Task Force circulated a draft template on the 1033 waiver process. She said following the 2022 Fall National Meeting, the draft was circulated for comment to the Producer Licensing (D) Task Force, the Antifraud (D) Task Force, and all interested parties with a comment deadline of Jan. 31. She said there were 17 comments submitted from both state insurance regulators and industry, and NAIC staff are reviewing and summarizing the comments. She said the comments will also be posted to the Producer Licensing (D) Task Force web page for further consideration prior to the Summer National Meeting.

Commissioner Clark said Commissioner Navarro will lead a new workstream on public adjusters for the Adjuster Licensing (D) Working Group. She said the National Association of Public Insurance Adjusters (NAPIA) has requested the following four items to be addressed: 1) unlicensed public adjusters; 2) contractors who are also acting as public adjusters on the same claims; 3) the assignment of benefit rights to contractors; and 4) the general claims appraisal process.

Commissioner Clark said with last year's adoption by the Executive (EX) Committee and Plenary of the "Guidelines for Amending the Uniform Producer Licensing Applications," NAIC staff will begin coordinating with the National Insurance Producer Registry (NIPR) and states, including any back-office system support vendors, to conduct an analysis of how long it will take to implement a proposed change and the cost to implement it.

c. Market Analysis Procedures (D) Working Group

LeDuc said the Market Analysis Procedures (D) Working Group will meet April 10.

LeDuc said during its April 10 meeting, the Working Group will discuss its charges for 2023, which include a new charge to assess the current market analysis data in the NAIC Market Information Systems (MIS) and identify needed improvements in the effectiveness of the data and the predictive abilities of the scoring systems that utilize the data. She said the Working Group will begin by identifying the data that is available in the MIS and how the states are using the data.

d. Market Conduct Examination Guidelines (D) Working Group

Tarpley said he and Market Conduct Examination Guidelines (D) Working Group vice chair Weyhenmeyer met Feb. 1, Feb. 7, Feb. 27, and March 15 to discuss the Working Group's 2023 charges and topics continuing from last year. He said last year's continuing topics include a new travel insurance policy in-force standardized data request (SDR), a new travel insurance claims SDR, revisions to Chapter 23—Conducting the Life and Annuity Examination of the *Market Regulation Handbook*. The revision to the chapter is to the best interest provisions of the *Suitability in Annuity Transactions Model Regulation* (#275).

Tarpley said he and the Working Group vice chair are monitoring the work of the Accelerated Underwriting (A) Working Group and the Innovation, Cybersecurity, and Technology (H) Committee to prepare for the Market Conduct Examination Guidelines (D) Working Group's first meeting on March 28.

e. Market Regulation Certification (D) Working Group

Haworth said the Market Regulation Certification (D) Working Group met Feb. 27. He said during the meeting, the Working Group discussed its charges for 2023 and received an update on the revisions to the Voluntary Market Regulation Certification Program requirements, checklist, and guidelines. He said the work of the subject matter expert (SME) group revising the certification program requirements, checklist, guidelines, and scoring matrix is nearly complete. He said once the drafting group completes its final review of the revisions, the redline and clean versions of all these documents will be posted to the Working Group's web page in preparation for the Working Group's consideration and adoption.

Haworth provided an overview of the draft certification program for new members of the Market Regulation and Consumer Affairs (D) Committee. He said the current work on putting together a certification program for state market regulation departments differs from previous attempts in not insisting upon domestic deference. He noted that after the original drafting of this certification program, the Working Group oversaw a pilot of the certification program with 18 states. The states applied the certification standards to their departments and came up with a number of suggestions to improve the program prior to adoption. Haworth said the draft certification program consists of 11 requirements that a department would be expected to achieve. The 11 requirements are broken into five broad categories covering: 1) the available statutory authorities; 2) use the *Market Regulation Handbook*; 3) staffing resources and qualifications; 4) use of NAIC MIS databases and the Market Conduct Annual Statement (MCAS); and 5) collaboration with other departments.

Haworth said the proposed implementation plan for the program anticipates an initial period where jurisdictions will be encouraged to self-certify that they meet the requirements and be provided with peer review, guidance, and training. After the initial self-certification period, jurisdictions can choose to continue to self-certify or seek full certification. Full certification would be measured by an independent panel appointed by the Working Group. A fully certified jurisdiction would submit annual self-assessments and be re-certified every five years. Haworth said the Working Group should have the entire certification program ready for Committee consideration by the Summer National Meeting.

f. Speed to Market (D) Working Group

Nichols said the Speed to Market (D) Working Group has not met yet this year, but it is continuing its work on the revisions to the *Product Filing Review Handbook*. She said the *Product Filing Review Handbook* revisions are near completion, and the Working Group expects to have the exposure draft posted to its web page by late May or early June. She said the Working Group will consider the changes in three segments, and it anticipates having the entirety of the *Product Filing Review Handbook* changes adopted prior to the Fall National Meeting.

Additionally, Nichols said in June and July, the Working Group will conduct its annual consideration of suggestions for the product coding matrices (PCMs). The Market Information Systems (D) Task Force and the Market Conduct Annual Statement Blanks (D) Working Group did not meet prior to the Spring National Meeting, and they did not report.

Commissioner Navarro made a motion, seconded by Biehn, to adopt the following reports: 1) the Antifraud (D) Task Force; 2) the Producer Licensing (D) Task Force; 3) the Market Analysis Procedures (D) Working Group; 4) the Market Conduct Examination Guidelines (D) Working Group; 5) the Market Regulation Certification (D) Working Group (Attachment One); and 6) the Speed to Market (D) Working Group. The motion passed unanimously.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

SharePoint/NAIC Support Staff Hub/Committees ...



Draft: 3/6/23

Market Regulation Certification (D) Working Group  
Virtual Meeting (*in lieu of meeting at the 2023 Spring National Meeting*)  
February 27, 2023

The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Feb. 27, 2023. The following Working Group members participated: Mike Kreidler, Chair, represented by John Haworth (WA); Bill Cole, Vice Chair (WY); Lori K. Wing-Heier represented by Chelsy Maller (AK); Erica Weyhenmeyer (IL); Kathleen A. Birrane represented by Mary Kwei (MD); Chlora Lindley-Myers represented by Jo LeDuc (MO); Mike Causey represented by Tracy Biehn (NC); Robert McCollough (NE); Marlene Caride represented by Ralph Boeckman and Erin Porter (NJ); Judith L. French represented by Don Layson (OH); Glen Mulready represented by Landon Hubbart (OK); Michael Wise represented by Rachel Moore (NC); Tanji J. Northrup (UT); Don Beatty (VA); and Kevin Gaffney represented by Marcia Violette (VT).

1. Adopted its Dec. 9, 2022, and 2022 Fall National Meeting Minutes

Haworth said the Working Group conducted an e-vote that concluded Dec. 9, 2022, to adopt the revisions to the Market Regulation Certification Program implementation plan.

Cole made a motion, seconded by Biehn, to adopt the Working Group's Dec. 9, 2022, (Attachment One-A) and Nov. 28, 2022 (*see NAIC Proceedings – Fall 2022, Market Regulation and Consumer Affairs (D) Committee, Attachment Six*) minutes. The motion passed unanimously.

2. Discussed its Charges and Goals for 2023

Haworth said the only charge for the Working Group is to develop a formal market regulation certification proposal for consideration by the NAIC members. He said this has five parts.

Haworth said the first part is for the Working Group to develop the certification standards that a state's insurance department should or must meet to be certified. He said this, for the most part, has been achieved. He noted that 12 requirements were originally drafted into the certification program covering staffing, use of the NAIC Market Information Systems (MIS), participation in Market Regulation and Consumer Affairs (D) Committee Working Groups, participation in the Market Conduct Annual Statement (MCAS), collaboration with other departments, and the ability to enforce compliance of regulated entities to market conduct laws and regulations.

Haworth said the Working Group is currently assessing the recommendations made by a group of 18 states that volunteered to certify themselves with the original certification program requirements.

Haworth said the second part of the charge is to develop an implementation plan for the certification program. He said this is finished and that on Dec. 9, 2022, the Working Group adopted the Market Regulation Certification Program implementation plan.

Haworth said the third part tasks the Working Group with developing a process for measuring a jurisdiction's compliance to the standards. He said this was completed in 2022, but the scoring matrix is currently being updated as revisions are being recommended by the drafting group that is reviewing the requirements.

Haworth said the fourth part of the charge is to create a process for future revisions to the certification standards. He said this was included in the implementation plan that was adopted in December.

Haworth said the final part of the charge is the Working Group's ongoing activity once a certification program is approved to assist jurisdictions in achieving certification.

Haworth said his goal is for the Working Group to have the complete package of the requirements, scoring matrix, and implementation plan to the Market Regulation and Consumer Affairs (D) Committee by the Summer National Meeting.

### 3. Reviewed the Pilot Program Suggested Revisions to the Market Regulation Certification Program

Haworth said the drafting group did not meet in January but met twice in February. He said the drafting group has completed going through the requirements. He said the group has reviewed all the requirements and is now doing one final close look to be sure the wording in the program is consistent, clear, and logical and that the scoring matrix is aligned with the requirements guidelines, measurements, and checklists.

Haworth said the revisions were primarily in line with recommendations received by the jurisdictions that piloted the Market Regulation Certification Program. However, the drafting group also came up with some revisions it felt were important.

Haworth said among the revisions and suggestions are:

- 1) The drafting group added an "Objective" and a "Measurement" section to each requirement. Much of the redline is simply cutting paragraphs from the "Guidelines" section to the new sections.
- 2) On requirements 3 and 4, the drafting group clarified that requirement 3 measures staffing resources and requirement 4 measures staffing qualifications. He said requirement 4 was rewritten to be clearer and to match the formatting of the requirements. He noted that the requirements originally were written by different individuals, so there were many inconsistencies that needed to be cleaned up.
- 3) The drafting group believes the requirement 4 measurements of "unqualified pass" and "provisional pass" create confusion. The drafting group will be asking the Working Group to decide whether those measurements should be replaced with a simple description of what is required to pass.
- 4) Recognizing that employees often have multiple responsibilities, the drafting group changed "full-time employee" to "full-time equivalent employee."
- 5) The drafting group will also be proposing to the Working Group that requirements 6 and 11 should be merged. Requirement 6 concerns collaboration, and requirement 11 concerns the Market Actions (D) Working Group's national analysis process. Because national analysis is a collaborative process, the drafting group believes it should be included with requirement 6. Also, because the national analysis process itself changes frequently, as the Working Group tries to make it more effective, it should not be its own requirement within the Market Regulation Certification Program.
- 6) For requirement 7 regarding the MCAS, the drafting group removed question 7c about requiring companies to file using a format acceptable to the NAIC. There are really no alternatives.
- 7) Requirement 8 concerns electronic data entry with the NAIC. The drafting group will be asking the Working Group to consider simplifying the requirement to only the actual submission of Complaints Database System (CDS), Regulatory Information Retrieval System (RIRS), and data to the NAIC. The

drafting group will be suggesting that the timeliness of the submissions be moved from the requirement itself to the checklist and measurement sections of the requirement.

- 8) For requirement 8, the drafting group will be asking the Working Group to consider building in tolerances (e.g., a jurisdiction could fulfill the requirement if it submits data in a timely manner 75% of the time).
- 9) In requirement 10 regarding Collaborative Action Designees (CADs), the drafting group will be asking that the Working Group alter the language of the requirement slightly to make it clear that the CAD needs to attend only 50% of the Market Actions (D) Working Group meetings they are eligible to attend because there are Working Group meetings that are only open to the Working Group members.

Haworth said the drafting group stopped at requirement 6 and that he is confident it will complete its review by the Spring National Meeting.

Having no further business, the Market Regulation Certification (D) Working Group adjourned.

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Draft: 2/22/23

Market Regulation Certification (D) Working Group  
E-Vote  
December 9, 2022

The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee conducted an e-vote that concluded Dec. 9, 2023. The following Working Group members participated: Russell Toal, Chair (NM); John Haworth, Vice Chair (WA); Lori K. Wing-Heier (AK); Kathleen A. Birrane (MD); Grace Arnold (MN); Chlora Lindley-Myers (MO); Mike Causey (NC); Martin Swanson (NE); Chris Nicolopoulos (NH); Michael Humphreys (PA); Michael Wise (SC); Tanji J. Northrup (UT); Don Beatty (VA); Kevin Gaffney (VT); Allan L. McVey (WV); and Bill Cole (WY).

1. Adopted the Market Regulation Certification Program Implementation Plan

The Working Group considered adoption of the Market Regulation Certification Program Implementation Plan.

A majority of the Working Group members voted in favor of adopting the implementation plan (Attachment One-A1). The motion passed.

Having no further business, the Market Regulation Certification (D) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Meetings/D CMTE/2023 Spring /MRCWG/1209/12-MRCWG T.docx

Draft: 12/2/22

*Implementation Plan adopted Market Regulation and Consumer Affairs (D) Committee –  
Implementation Plan adopted by the Market Regulation Certification (D) Working Group*

## **Voluntary Market Regulation Certification Program Proposal for Implementation**

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### **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 –  
Implementation Plan adopted by the Market Regulation Certification (D) Working Group –*

- 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 Committee 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 Committee prior to the Fall National Meeting of the same calendar year. The Market Regulation Standards and Certification Committee 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 –  
Implementation Plan adopted by the Market Regulation Certification (D) Working Group –*

- 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.

**ANTIFRAUD (D) TASK FORCE**

Antifraud (D) Task Force March 23, 2023, Minutes ..... 8-14



Draft: 4/4/23

Antifraud (D) Task Force  
Louisville, Kentucky  
March 23, 2023

The Antifraud (D) Task Force met in Louisville, KY, March 23, 2023. The following Task Force members participated: Trinidad Navarro, Chair (DE); John F. King, Vice Chair (GA); Lori K. Wing-Heier represented by Alex Romero (AK); Alan McClain represented by Crystal Phelps (AR); Barbara D. Richardson represented by Maria Ailor (AZ); Andrew N. Mais represented by Kurt Swan (CT); Doug Ommen represented by Andria Seip and Jared Kirby (IA); Dean L. Cameron represented by Randy Pipal (ID); Vicki Schmidt represented by John Eichkorn (KS); Sharon P. Clark represented by Rob Roberts (KY); Kathleen A. Birrane represented by Mary Kwei (MD); Anita G. Fox represented by Joseph Garcia (MI); Grace Arnold represented by Paul Hanson (MN); Chlora Lindley-Myers represented by Carrie Couch and Marjorie Thompson (MO); Mike Chaney represented by John Hornback (MS); Troy Downing represented by Steve Matthews (MT); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by Dale Pittman (ND); Eric Dunning represented by Laura Arp and Martin Swanson (NE); Chris Nicolopoulos represented by Heather Silverstein (NH); Jennifer A. Catechis represented by Leatrice Geckler (NM); Judith L. French represented by Michelle Brugh Rafeld (OH); Glen Mulready represented by Rick Wagnon (OK); Andrew R. Stolfi represented by Dorothy Bean and Stephanie Noren (OR); Michael Wise (SC); Larry D. Deiter represented by Melissa Manning and Travis Jordan (SD); Jon Pike represented by Randy Overstreet, Tanji J. Northrup, and Tracy Klausmeier (UT); Scott A. White represented by Juan A. Rodriguez Jr. and Richard Tozer (VA); Kevin Gaffney (VT); and Allan L. McVey represented by Erin K. Hunter (WV).

1. Adopted its 2022 Fall National Meeting Minutes

Commissioner King made a motion, seconded by Mueller, to adopt the Task Force’s Dec. 14, 2022, minutes (see *NAIC Proceedings – Fall 2022, Antifraud (D) Task Force*). The motion passed unanimously.

2. Discussed its 2023 Charges and Priorities

Commissioner Navarro said the Task Force discussed its 2023 proposed charges during the 2022 Fall National Meeting. Commissioner Navarro said those proposed charges were officially adopted by full NAIC Membership. He said the Task Force will be focusing on additional priorities, including; 1) the creation of a Producer Portal, which will be a centralized portal that would allow consumers to find licensing information on insurance producers; 2) an Antifraud Plan Repository, which will assist with streamlining the process of submitting and collecting companies’ antifraud plans; and 3) the implementation of the Online Fraud Reporting System (OFRS) redesign. Commissioner Navarro said the Task Force will also be assisting the Improper Marketing of Health Insurance (D) Working Group’s review of the *Unfair Trade Practices Act* (#880) for potential amendments to address current marketplace activities and the Antifraud Technology (D) Working Group’s work on the implementation of an OFRS redesign and future enhancements.

3. Received an Update from the Improper Marketing of Health Insurance (D) Working Group

Frank Pyle, Vice Chair of the Improper Marketing of Health Insurance (D) Working Group, said the Working Group held its first regulator-to-regulator meeting of the year on Feb. 23. Pyle said the Working Group will continue to meet in regulator-to-regulator session on the fourth Thursday of the month. He said that last year, the Working Group began working on its charge to “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.” Pyle said the Working Group started reviewing Model #880. He said the Working Group will be continuing its work on this charge and is on a path to finalizing the review of

the model in April and May. Pyle said the Working Group will continue with its regulator-to-regulator meetings and will be adding public meetings as necessary to complete its charges and goals for 2023. The Working Group will meet this afternoon on March 23 following the Task Force.

#### 4. Discussed the NAIC OFRS

Greg Welker (NAIC) said that during the 2022 Fall National Meeting, the Task Force briefly discussed the completion of the OFRS redesign. Welker said that notifications have been sent out. However, he wanted to follow up during the Task Force meeting to announce to those who have not heard that the OFRS redesign is completed and live. Welker said if they have not already, he encourages state insurance regulators to review the redesign. He said the purpose behind the redesign was to update an out-of-date system being used, provide the necessary cyber security required, and add specific enhancements like attachments. Welker said that at this time, an individual submitting a potential fraud referral has the ability to submit attachments directly to the OFRS. He also said that, at this time, the attachment enhancement feature is not set up with the National Insurance Crime Bureau (NICB), the National Health Care Anti-Fraud Association (NHCAA), or state vendors. The NAIC will need to work with each to implement the attachment enhancement. Welker said the NAIC is currently working with the NICB and the NHCAA. The next step will be to work with individual states. Welker said the Antifraud Technology (D) Working Group, chaired by Armand Glick (UT), will be taking back its responsibility to review requested enhancements for OFRS. Welker said the Working Group will meet after the Spring National Meeting to specifically discuss the OFRS and the next steps to fully integrate the redesigned system for everyone.

Glick said he has had discussions with Welker and others at the NAIC. Prior to the redesign project, the Working Group was responsible for reviewing all suggested enhancements and approving them before taking them to NAIC staff to update OFRS. Glick said the Working Group will be taking that responsibility again and will also be involved in the implementation of the redesign. Glick said he will work with Welker to schedule a meeting for April.

#### 5. Heard Reports from Interested Parties

##### A. Coalition Against Insurance Fraud

Matthew Smith (Coalition Against Insurance Fraud) said this will be the Coalition's 30-year anniversary. Smith said if there are states that are not familiar with the Coalition or its services available, he would encourage them to reach out. The Coalition distributes its Fraud News Weekly report, which provides comments on what is being seen from different geographic locations. Smith said that this is a free newsletter and that those not already subscribed could enroll on the Coalition's web page.

Smith said that with the continued growth of the Coalition, it is adding staff. He said the Coalition hired Tracy Thompson, former New Jersey state insurance fraud prosecutor, and Brady Bell as a second full-time communications staff member. The Coalition is also interviewing for a full-time government affairs position that will be announced at the end of April.

Smith said the Coalition has continued to work on its research studies, which assist the states in fighting against insurance fraud. He said it has completed a data ethics study that provides a detailed view of the good and bad taking place in insurance fraud. Smith said the data from this study shows that 85% of consumers support the appropriate use of data to fight insurance fraud. He said another study is being completed in partnership with Verisk. Smith said this study will be a psychology fraud study. The analysis will show consumers' perceptions of insurance fraud. Smith said the last study will be with PricewaterhouseCoopers (PWC) on the keys to unlocking special investigation unit (SIU) success.

Smith said the Coalition’s legislative advocacy program has been busy, with 165 legislative bills being introduced. He said a new bill is being introduced that provides an incentive for reporting insurance fraud. Smith said the bill states that anyone who reports potential fraud that leads to an investigation in which there is a conviction and money recovered will receive 40% of the recovered amount.

Smith said other items to announce on behalf of the Coalition include its efforts to work with Glick for the Utah Insurance Department to host the 2023 Annual Fraud Directors Meeting and its plans to host a webinar in April on litigation finances. The Coalition’s midyear meeting will be June 5–6, and the year-end meeting will be held in December.

#### B. NICB

Patrick Martin (National Insurance Crime Bureau—NICB) said he is filling in for Rich DiZinno, who could not attend due to weather. Martin said that the NICB fully supports the OFRS redesign, which provides an avenue to report fraud to the states. The NICB has a similar reporting system, and they complement each other. As the NAIC implements the redesign, the NICB will be 100% behind the implementation. The NICB and NAIC are working together with quarterly calls to help with any implementation issues.

#### 6. Discussed Other Matters

Glick said the Utah Insurance Department has the privilege of hosting the Annual Fraud Directors Conference in October. Glick said this will be the largest gathering of state fraud directors. The NAIC will be assisting with the contracts and funding in addition to the Coalition and NICB. Glick said the conference will take place Oct. 3–5 in St. George, UT.

Having no further business, the Antifraud (D) Task Force adjourned.

[AFTF Minutes 3.23.23](#)

## **MARKET INFORMATION SYSTEMS (D) TASK FORCE**

The Market Information Systems (D) Task Force did not meet at the Spring National Meeting.

**PRODUCER LICENSING (D) TASK FORCE**

The Producer Licensing (D) Task Force did not meet at the Spring National Meeting.

## FINANCIAL CONDITION (E) COMMITTEE

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Draft: 3/28/23

Financial Condition (E) Committee  
Louisville, Kentucky  
March 24, 2023

The Financial Condition (E) Committee met in Louisville, KY, March 24, 2023. The following Committee members participated: Elizabeth Kelleher Dwyer, Chair (RI); Nathan Houdek, Vice Chair, and Amy Malm (WI); Mark Fowler (AL); Michael Conway represented by Keith Warburton (CO); Michael Yaworsky represented by Jane Nelson (FL); Amy L. Beard and Roy Eft (IN); Doug Ommen and Carrie Mears (IA); Timothy N. Schott (ME); Chlora Lindley-Myers represented by John Rehagen and Danielle Smith (MO); Marlene Caride (NJ); Adrienne A. Harris represented by John Finston and Bob Kasinow (NY); Michael Wise (SC); Cassie Brown represented by Jamie Walker and Jessica Barta (TX); and Scott A. White (VA).

1. Adopted its 2022 Fall National Meeting Minutes

Commissioner Caride made a motion, seconded by Commissioner Houdek, to adopt the Committee's Dec. 15, 2022, minutes (*see NAIC Proceedings – Fall 2022, Financial Condition (E) Committee*). The motion passed unanimously.

2. Adopted the Reports of its Task Forces and Working Groups

Superintendent Dwyer stated that the Committee usually takes one motion to adopt its 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. He reminded Committee members that after the Committee's adoption of its votes, all the technical items included within the reports adopted will be sent to the NAIC Members for review shortly after the conclusion of the Summer National Meeting as part of the Financial Condition (E) Committee Technical Changes report. Pursuant to the technical changes report process previously adopted by the Executive (EX) Committee and Plenary, the members will have 10 days to comment. Otherwise, the technical changes will be considered adopted by the NAIC and effective immediately. With respect to the task force and working group reports, Superintendent Dwyer asked the Committee: 1) whether there were any items that should be discussed further before being considered for adoption and sent to the Members for consideration as part of the technical changes; and 2) whether there were other issues not up for adoption that are currently being considered by task forces or working groups reporting to this Committee that require further discussion. The response to both questions was no.

In addition to presenting the reports for adoption, Superintendent Dwyer noted that the Financial Analysis (E) Working Group met March 21, Feb. 15, and Jan. 19 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss letter responses and financial results. Additionally, the Valuation Analysis (E) Working Group met March 21 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss valuation items related to specific companies.

Finston made a motion, seconded by Superintendent Schott, to adopt the following task force and working group reports: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Financial Stability (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Valuation of Securities (E) Task Force; Mortgage Guaranty Insurance (E) Working Group (Attachment One); National Treatment and Coordination (E) Working Group (Attachment Two), and Risk-Focused Surveillance (E) Working Group (Attachment Three). The motion passed unanimously.

### 3. Received a Referral from the Valuation of Securities (E) Task Force

Mears said that there was a need identified within the Valuation of Securities (E) Task Force pertaining to its role in assessing investment risk and how it would benefit from different data points that are currently not available. She noted that most of these data points were market value-based, and the original proposal to address this was to add columns to some of the annual reporting schedules. However, it was quickly realized that this was not efficient. Mears noted how that method would result in outdated data by the time it was received. She noted it might not be consistently completed, and many times the insurers and their accounting systems were not matched up with their investment systems to allow this to be data captured as easily as one would expect. Consequently, the industry challenged the proposal, and the general consensus was that a different method and platform were needed to modernize the ability to access this kind of information. Mears said that part of this referral was trying to establish whether that was a valid way forward. Mears requested that the Committee members think about data points around investments that would be valuable and helpful to the process and make a laundry list of requests. She cited as an example how perhaps with more data, actuaries could more easily look at asset duration or other metrics when reviewing and comparing to what is delivered for asset adequacy testing. She asked that a response be provided by May 15. Superintendent Dwyer asked that each of the Committee members review the referral from the Valuation of Securities (E) Task Force (Attachment Four) and develop their own lists, as Mears requested.

### 4. Adopted the Securities Valuation Office's (SVO's) Modeling of CLOs for NAIC Designations

Superintendent Dwyer stated that the Valuation of Securities (E) Task Force had recently adopted an amendment (Attachment Five) to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) to include collateralized loan obligations (CLOs) as a financially modeled security under the responsibility of the NAIC's Structured Securities Group (SSG). She explained that CLOs are a type of structured security backed by a pool of debt, typically corporate loans with low credit ratings. She noted that this amendment makes this asset class ineligible to use credit rating provider ratings to determine an NAIC designation if the SSG can model the security. She noted that the NAIC's Investment Analysis Office (IAO) had identified that securities within this asset class had inconsistently assigned NAIC designations when relying upon credit rating provider ratings and had recommended this change to the Task Force to ensure reporting equivalency for NAIC regulatory purposes. The amendment is effective as of Jan. 1, 2024, with insurers first reporting the financially modeled NAIC designations for CLOs with their year-end 2024 financial statement filings.

Mears made a motion, seconded by Finston, to adopt the action taken by the Valuation of Securities (E) Task Force on this item. The motion passed unanimously.

### 5. Adopted a Request for NAIC Model Law Development Extension from the Mortgage Guaranty Insurance (E) Working Group

Superintendent Dwyer noted that a memorandum from the Mortgage Guaranty Insurance (E) Working Group was included in the materials, requesting an extension on making revisions to the *Mortgage Guaranty Insurance Model Act* (#630). She noted that she believed they had made good progress and, while they are close to finalizing, they are requesting an extension until the Fall National Meeting. Commissioner Houdek stated he supports the work, as Wisconsin was a former chair of the Working Group.

Rehagen made a motion, seconded by Finston, to adopt the request (Attachment Six). The motion passed unanimously.



## 6. Discussed Other Matters

Superintendent Dwyer stated that each year the commissioners gather in early February for a Commissioners' Conference. For the last few years, each of the committees has held a short session at that conference to get acclimated with each other and to briefly discuss some of the key regulatory objectives and projects for the year. She stated that during this year's session, the Committee members agreed that one of its priorities was the work of the Restructuring Mechanisms (E) Working Group and Restructuring Mechanisms (E) Subgroup. Further to that point, they agreed to roll the charges and members of the Subgroup into the Working Group (Attachment Seven). No objections were raised to the change, and she asked that NAIC staff update the web pages of both groups to reflect that change.

Having no further business, the Financial Condition (E) Committee adjourned.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/2022-3-Fall/121522 E Minutes.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/2022-3-Fall/121522%20E%20Minutes.docx)

Draft: 3/28/23

Mortgage Guaranty Insurance (E) Working Group  
Louisville, Kentucky  
March 22, 2023

The Mortgage Guaranty Insurance (E) Working Group of the Financial Condition (E) Committee met March 22, 2023. The following Working Group members participated: Jackie Obusek, Chair (NC); Kurt Regner (AZ); Monica Macaluso (CA); Virginia Christy (FL); John Rehagen (MO); Margot Small (NY); Melissa Greiner and Michael McKenney (PA); Amy Garcia (TX); and Amy Malm and Levi Olson (WI).

1. Adopted its 2022 Fall National Meeting Minutes

Malm made a motion, seconded by Rehagen, to adopt the Working Group's Dec. 13, 2022, minutes (*see NAIC Proceedings – Fall 2022, Financial Condition (E) Committee, Attachment Three*). The motion passed unanimously.

2. Discussed Comments Received on the Exposure Draft of Model #630

Obusek commented that during the 2022 Fall National Meeting, the Working Group discussed draft revisions to the *Mortgage Guaranty Insurance Model Act (#630)* (Attachment One-A). Following this discussion, the Drafting Group met and integrated revisions to the draft and re-exposed Model #630 for a 15-day public comment period that ended March 14. As a result of the exposure, a letter was received from the Mortgage Guaranty Insurance Corporation (MGIC), the Reinsurance Association of America (RAA), and the Center for Economic Justice (CEJ) (Attachment One-B). Obusek stated that the goal is to hear from those who submitted comments and allow Working Group members and others an opportunity to ask questions.

Benjamin Schmidt (Radian Guaranty Inc.) commented that within Section 10B(1) when an insurer establishes its contingency reserve in a segregated account or collateral in a trust that serves the same function as a contingency reserve in the case of a reinsurer. The reinsurers are not filing statutory financial statements and would not have the ability to establish a contingency reserve. The MGC asked for clarification on this provision. Malm asked for clarification regarding who has control of the trust if the reinsurer establishes it. Schmidt commented that it is clarified in the reinsurance agreement that if the reinsurer does not pay its obligations, the mortgage insurer would have access to pay from that account. Heidi Heyrman (Mortgage Guaranty Insurance Corporation) commented that the reinsurers would have no ability to transfer or withdraw money from the trust account. Malm questioned whether it would be possible for other states to not have that requirement and the reinsurance agreement to be set up without that type of collateral. Schmidt indicated that it would be possible; in that case, there would not be credit for the contingency reserve, and that company would set up a contingency reserve. He indicated that the concern with the current language is that only a mortgage insurer would be able to establish that contingency reserve.

Schmidt commented that Section 12D(1) referenced the chief executive officer (CEO) and the chief financial officer (CFO), and some mortgage insurers do not have those positions. Those titles would be at the parent level. The MGC recommends using the term "highest ranking officer" or "highest ranking financial officer."

Schmidt stated that within Section 14 on policy forms and policy rates filed, the July 2000 version of the model has a note on open rating states that would allow a state that adopts the model to delete a portion of the provision and insert its own rating law. He indicated that in certain states, they would want mortgage insurance to be treated as any other line in their state. He commented that this flexibility might allow for more states to adopt the model.

Schmidt commented that regarding to Section 21, the inclusion would allow for less frivolous lawsuits, and there are means for redress if warranted. He stated that frivolous lawsuits weaken the financial condition of companies due to the significant legal fees. There is the risk of plaintiffs' attorneys misconstruing the regulatory intent of these provisions. Schmidt stated that the comment letter regarding this section stated that the state insurance regulators do not have an adequate track record of bringing mortgage insurer enforcement actions. He stated that this accretion overlooks that insurance departments have mechanisms for the enforcement of their laws other than litigation, such as periodic market examinations and desk reviews. Further, he indicated that the no private right of action does not preempt other remedial statutes and causes of action that could apply to the same underlying conduct. He stated that it is not an immunity provision for the mortgage insurers, and it would not insulate the mortgage insurer from being sued for breach of contract of the insurance policy, bad faith, separate federal and state remedial statutes, or common law claims.

Debra Darcy (Consumer Representative) indicated that she would speak on behalf of the comment letter submitted by the CEJ. She commented that Section 21 should be deleted due to the structure of the market, the history of practices that the model law addresses, and the role that some institutions played in the Great Recession. She stated that the structure of the private mortgage insurance market, in which private mortgage insurers sell their product to lenders rather than directly to consumers, meets the NAIC's definition of reverse competition. As such, there need to be extra prohibitions to ensure that there are adequate economic incentives for insurers to follow the provisions in the model law. Darcy further stated that without a private right of action, there could be new tools to sell products in the future that are now not specifically prohibited in the model law. A private right of action ensures that a private mortgage insurer can be held liable when they utilize a practice that is not specifically prohibited in the model but would ultimately harm consumers, the housing market, or the economy. Darcy stated that Section 21 is one-sided; i.e., lenders and consumers cannot sue the private mortgage insurer. However, insurers can sue and have sued lenders and consumers. Darcy also indicated that the assertion that Section 21 will stop frivolous lawsuits neglects the fact that cases have been brought against private mortgage insurers in the past that have not been frivolous. Those cases resulted in penalties and practices that have been changed due to the lawsuits.

Amy Bach (United Policyholders) also spoke on behalf of the comment letter submitted by the CEJ. Regarding Section 21, she commented that curtailing a right that exists in the law today would strain state insurance regulator resources as regulatory agencies do not have the ability to prosecute every consumer violation reported. Bach indicated that the fact that there is another channel of enforcement provides a critical source of consumer protection.

Birny Birnbaum (CEJ) commented that there is no other personal lines model law that has a provision barring a private right of action. He indicated that is because consumers of personal line products need to have some sort of recourse. He stated that the personal lines markets are expansive, further supporting that state insurance regulators need assistance in monitoring these markets.

Obusek indicated that the Drafting Group will reconvene in the coming weeks to arrive at a third and final draft of Model #630. She stated that it is anticipated that a new draft will be available by the end of April, with the intent to hold an open Working Group call in either late April or early May.

### 3. Discussed Other Matters

Theresa Cameron (Arch Mortgage Insurance Company) summarized a comment letter from mortgage insurers regarding a new proposed U.S. Securities and Exchange Commission (SEC) rule that seeks to prevent conflicts of interest in conjunction with synthetic asset-backed securities (ABS). She indicated that the SEC rule could inadvertently prohibit mortgage insurers from utilizing mortgage insurance-linked notes (MILNs) because

synthetic ABS are not explicitly defined. Since 2015, mortgage insurers have used MILNs as a reinsurance mechanism to disperse and mitigate risks in the ordinary course of business. She requested that the NAIC support that MILNs are an important risk management tool and are encouraged by state insurance regulators to manage risk, provide protection, and enhance mortgage insurers' capital position.

Obusek indicated that the mortgage insurers' comment letter regarding the concerns about the SEC rule has been sent to the appropriate NAIC staff and will be presented to the Government Relations (EX) Leadership Council to coordinate communication with the SEC.

Having no further business, the Mortgage Guaranty Insurance (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/E CMTE/MGIWG/2023 Spring NM/MGIWG Minutes March 22 2023.docx

NAIC Model Laws, Regulations, Guidelines and Other Resources—February 2023

**MORTGAGE GUARANTY INSURANCE MODEL ACT****Table of Contents**

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**Section 1. Title**

This Act may be cited as the Mortgage Guaranty Insurance Act.

**Section 2. Definitions**

The definitions set forth in this Act shall govern the construction of the terms used in this Act but shall not affect any other provisions of the code.

~~A.~~ A. “Authorized ~~real estate security,~~” ~~for the purpose of this Act,~~ Real Estate Security” means ~~an:~~

~~(1)~~ An amortized note, bond or other ~~evidence~~ instrument of indebtedness, ~~except for reverse mortgage loans made pursuant to [insert citation of state law that authorizes reverse mortgages] of the real property law, evidencing a loan,~~ not exceeding ~~ninety-five~~ one hundred three percent (~~95~~ 103%) of the fair market value of the real estate, secured by a mortgage, deed of trust, or other instrument that constitutes, or is equivalent to, a first lien or junior lien or charge on real estate, with any percentage in excess of one hundred percent (100%) being used to finance the fees and closing costs on such indebtedness; provided:

~~(a) (1)~~ The real estate loan secured in this manner is one of a type that a ~~bank, savings and loan association, or an insurance company~~ creditor, which is supervised and regulated by a department of ~~this~~ any state ~~or territory of the U.S~~ or an agency of the federal government, is authorized to make, or would be authorized to make, disregarding any requirement applicable to such an institution that the amount of the loan not exceed a certain percentage of the value of the real estate;

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- (2b) ~~The improvement on loan is to finance the acquisition, initial construction or refinancing of real estate that is a:~~
- ~~(i) Residential building designed for occupancy by not more than four families, a one-family residential condominium or unit in a planned unit development, or any other one-family residential unit as to which title may be conveyed freely; or~~
  - ~~(ii) Mixed-use building with only one non-residential use and one one-family dwelling unit; or~~
  - ~~(iii) Building or buildings designed for occupancy as specified by Subsections A(1) and A(2) of this section; and by five (5) or more families or designed to be occupied for industrial or commercial purposes.~~

~~(c32) The lien on the real estate may be subject to and subordinate to the following:~~

- ~~(a) The lien of any public bond, assessment or tax, when no installment, call or payment of or under the bond, assessment or tax is delinquent; and~~
- ~~(b) Outstanding mineral, oil, water or timber other liens, leases, rights, rights of way, easements or rights of way of support, sewer rights, building restrictions or other restrictions or easements, covenants, conditions or regulations of use, or outstanding leases upon that do not impair the use of the real property under which rents or profits are reserved to the owner thereof state for its intended purpose.~~

~~(2) Notwithstanding the foregoing, a loan referenced in Section 2(A)(1) of this Act may exceed 103% of the fair market value of the real estate in the event that the Mortgage Guaranty Insurance company has approved for loss mitigation purposes a request to refinance a loan that constitutes an existing risk in force for the company.~~

~~(3) An amortized note, bond or other instrument of indebtedness evidencing a loan secured by an ownership interest in, and a proprietary lease from, a corporation or partnership formed for the purpose of the cooperative ownership of real estate and which at the time the loan does not exceed one hundred three percent (103%) of the fair market value of the ownership interest and proprietary lease, if the loan is one of a type that meets the requirements of Section 2A(1)(a). In this Act, unless the context clearly requires otherwise, any reference to a mortgagor shall include an owner of such an ownership interest as described in this paragraph and any reference to a lien or mortgage shall include the security interest held by a lender in such an ownership interest.~~

~~B. “Bulk Mortgage Guaranty Insurance” means mortgage guaranty insurance that provides coverage under a single transaction on each mortgage loan included in a defined portfolio of loans that have already been originated.~~

~~CP. “Certificate of Insurance” means a document issued by a mortgage guaranty insurance company to the initial insured to evidence that it has insured a particular Authorized Real Estate Security under a Master Policy, identifying the and which describes the particular characteristics, terms, and conditions and representations, in addition to those contained in the Master Policy and endorsements, applicable to such coverage of that insured Authorized Real Estate Security.~~

~~D. “Commissioner” means [insert the title of the principal insurance supervisory official] of this state, or the [insert the title of the principal insurance supervisory official]’s deputies or assistants, or any employee of the [insert name of the principal insurance regulatory agency] of this state acting in the [insert the title of the principal insurance supervisory official]’s name and by the [insert the title of the principal insurance supervisory official]’s delegated authority.~~

~~E. “Contingency Reserve” means an additional premium reserve established to protect policyholders against the effect of adverse economic cycles.~~

~~F~~

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- “Domiciliary Commissioner” means the principal insurance supervisory official of the jurisdiction in which a mortgage guaranty insurance company is domiciled, or that principal insurance supervisory official’s deputies or assistants, or any employee of the regulatory agency of which that principal insurance supervisory official is the head acting in that principal insurance supervisory official’s name and by that principal insurance supervisory official’s delegated authority.
- G. “Effective Guaranty” refers to the assumed backing of existing or future holders of securities by virtue of their issuer’s conservatorship or perceived access to credit from the U.S. Treasury, as opposed to the direct full faith and credit guarantee provided by the U.S. government.
- H. “Loss” refers to losses and loss adjustment expenses, excluding costs which have already been expensed.
- I. “Master Policy” means a document issued by a mortgage guaranty insurance company to a creditor or mortgage holding entity that establishes the terms and conditions of mortgage guaranty insurance coverage provided thereunder, including any endorsements thereto.
- J. “Mortgage Guaranty Insurance” is:
- (1) Insurance against financial loss by reason of nonpayment of principal, interest or other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate, provided the improvement on the real estate is a residential building or a condominium unit or buildings designed for occupancy by not more than four families; Authorized Real Estate Security; and
- (2) Insurance against financial loss by reason of nonpayment of principal, interest or other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate, providing the improvement on the real estate is a building or buildings designed for occupancy by five (5) or more families or designed to be occupied for industrial or commercial purposes; and
- (3) Insurance against financial loss by reason of nonpayment of rent or other sums agreed to be paid under the terms of a written lease for the possession, use or occupancy of real estate, provided the improvement on the real estate is a building or buildings designed to be occupied for industrial or commercial purposes.
- K. “Mortgage Guaranty Quality Control Program” means an early detection warning system for potential underwriting compliance issues which could potentially impact solvency or operational risk within a mortgage guaranty insurance company.
- L. “NAIC” means the National Association of Insurance Commissioners.
- M. “Pool Mortgage Guaranty Insurance” means mortgage guaranty insurance that provides coverage under a single transaction or a defined series of transactions on a defined portfolio of loans for losses up to an aggregate limit.
- N. “Right of Rescission” represents a remedy available to a mortgage guaranty insurance company to void a certificate and restore parties to their original position, based on inaccurate information provided to, or information concealed from, the mortgage guaranty insurance company in the insurance application based on inaccurate, incomplete or misleading information provided to, or information omitted or concealed from, the Mortgage Guaranty Insurance company in connection with the insurance application, resulting in an insured loan that did not meet the Mortgage Guaranty Insurance company’s eligibility requirements in effect on the date of submission of the insurance application, resulting in an insured loan which does not meet acceptable risk tolerance requirements in accordance with the mortgage guaranty insurance company’s underwriting standards.
- O. “Risk in Force” mean the mortgage guaranty insurance coverage percentage applied to the unpaid principal balance.

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**Section 3. Insurer's Authority to Transact Business**

A company may not transact the business of Mortgage Guaranty Insurance until it has obtained a Certificate of authority from the Commissioner.

**Section 4. Mortgage Guaranty Insurance as Monoline**

A Mortgage Guaranty Insurance company that anywhere transacts any class of insurance other than Mortgage Guaranty Insurance is not eligible for the issuance of a Certificate of Authority to transact Mortgage Guaranty Insurance in this state nor for the renewal thereof.

**Section 5. Risk Concentration**

A Mortgage Guaranty Insurance company shall not expose itself to any Loss on any one Authorized Real Estate Security risk in an amount exceeding ten percent (10%) of its surplus to policyholders. Any risk or portion of risk which has been reinsured shall be deducted in determining the limitation of risk.

**Section 6. Capital and Surplus**

A. **Initial and Minimum Capital and Surplus Requirements.** A Mortgage Guaranty Insurance company shall not transact the business of Mortgage Guaranty Insurance unless, if a stock insurance company, it has paid-in capital of at least \$~~10~~10,000,000 and paid-in surplus of at least \$~~15~~15,000,000, or if a mutual insurance company, a minimum initial surplus of \$~~25~~25,000,000. A stock insurance company or a mutual insurance company shall at all times thereafter maintain a minimum policyholders' surplus of at least \$~~1,500~~20,000,000.

B. **Minimum Capital Requirements Applicability.** A Mortgage Guaranty Insurance company formed prior to passage of this Act may maintain the amount of capital and surplus or minimum policyholders' surplus previously required by statute or administrative order for a period not to exceed twelve months following the effective date of the adoption of this Act.

C. **Minimum Capital Requirements Adjustments.** The Domiciliary Commissioner may by order reduce the minimum amount of capital and surplus or minimum policyholders' surplus required under Section 6A under the following circumstances:

(1) For an affiliated reinsurer that is a Mortgage Guaranty Insurance company and that is or will be engaged solely in the assumption of risks from affiliated Mortgage Guaranty Insurance companies, provided that the affiliated reinsurer is in run-off and, in the Domiciliary Commissioner's opinion, the business plan and other relevant circumstances of the affiliated reinsurer justify the proposed reduction in requirements.

(2) For Mortgage Guaranty Insurance companies that are in run-off and not writing new business that is justified in a business plan, in the Domiciliary Commissioner's opinion.

**Section 4. Insurer's Authority to Transact Business**

~~No mortgage guaranty insurance company may issue policies until it has obtained from the commissioner of insurance a certificate setting forth that fact and authorizing it to issue policies.~~

**Section 57. Geographic Concentration**

A. A Mortgage Guaranty Insurance company shall not insure loans secured by a single risk in excess of ten percent (10%) of the company's aggregate capital, surplus and Contingency Reserve.

B. No Mortgage Guaranty Insurance company shall have more than twenty percent (20%) of its total insurance in force in any one Standard Metropolitan Statistical Area (SMSA), as defined by the ~~United States~~U.S Department of Commerce.

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- C. The provisions of this section shall not apply to a Mortgage Guaranty Insurance company until it has possessed a Certificate of Authority in this state for three (3) years.

### **Section 68. Advertising**

No Mortgage Guaranty Insurance company or an agent or representative of a Mortgage Guaranty Insurance company shall prepare or distribute or assist in preparing or distributing any ~~brochure, pamphlet, report or any form of~~ advertising media or communication to the effect that the real estate investments of any financial institution are “insured investments,” unless the ~~brochure, pamphlet, report or~~ advertising media or communication clearly states that the loans are insured by Mortgage Guaranty Insurance companies possessing a ~~certificate~~Certificate of Authority to transact Mortgage Guaranty Insurance in this state or are insured by an agency of the federal government, ~~as the case may be.~~

### **Section 79. Investment Limitation**

Investments in notes or other evidence of indebtedness secured by a mortgage or other liens upon residential real property shall not be allowed as assets in any determination of the financial condition of a mortgage guaranty insurer. A Mortgage Guaranty Insurance company shall not invest in notes or other evidence of indebtedness secured by a mortgage or other lien upon real property. This section shall not apply to obligations secured by real property, or contracts for the sale of real property, which obligations or contract of sale are acquired in the course of ~~the~~ good faith settlement of claims under policies of insurance issued by the Mortgage Guaranty Insurance company, or in the good faith disposition of real property so acquired. This section shall not apply to investments backed by the full faith and credit of the U.S. Government or, with the approval of the Domiciliary Commissioner, to investments with the Effective Guaranty of the U.S. Government. This section shall not apply to investments held by a Mortgage Guaranty Insurance company prior to the passage of this Act.

### **Section 8. Coverage Limitation**

~~A mortgage guaranty insurance company shall limit its coverage net of reinsurance ceded to a reinsurer in which the company has no interest to a maximum of twenty five percent (25%) of the entire indebtedness to the insured or in lieu thereof, a mortgage guaranty insurance company may elect to pay the entire indebtedness to the insured and acquire title to the authorized real estate security.~~

### **Section 10. Filing Requirements Reserve Requirements**

- A. Unearned premium Reserves, Loss Reserves, and Premium Deficiency Reserves. Financial reporting will be prepared in accordance with the Accounting Practices and Procedures Manual and Annual Financial Statement Instructions of the National Association of Insurance Commissioners.
- B. Contingency Reserve. Each Mortgage Guaranty Insurance ~~as Monoline~~ company shall establish a Contingency Reserve subject to the following provisions:
- A. ~~A mortgage guaranty insurance~~
- (1) The Mortgage Guaranty Insurance company shall make an annual contribution to the Contingency Reserve which in the aggregate shall be equal to fifty percent (50%) of the direct earned premiums reported in the annual statement or net earned premiums reported if the reinsurer maintains the contingency reserve.
  - (2) Except as provided within this Act, a Mortgage Guaranty Insurance company’s contributions to the Contingency Reserve made during each calendar year shall be maintained for a period of 120 months, to provide for reserve buildup. The portion of the Contingency Reserve established and maintained for more than 120 months shall be released and shall no longer constitute part of the Contingency Reserve.
  - (3) Withdrawals may be made from the Contingency Reserve on a first-in, first-out basis or such other basis, with the prior written approval of the Domiciliary Commissioner, based on the amount by which:
    - (a) Incurred losses and loss adjustment expenses exceed 35% of the direct earned premium in any year. Provisional withdrawals may be made from the Contingency Reserve on a quarterly basis

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in an amount not to exceed 75% of the withdrawal as adjusted for the quarterly nature of the withdrawal, with prior written approval of the Domiciliary Commissioner; or

(b) ~~With~~ Upon the approval of the Domiciliary Commissioner and 30-day prior notification to non-domiciliary commissioners, a mortgage guaranty insurer may withdraw from the Contingency Reserve any amounts which are in excess of the ~~minimum policyholder's position~~ requirements of Section 15 as required in (insert section of the Mortgage Guaranty Insurance model law requiring minimum policyholder's position) as filed with the most recently filed annual statement.

(i.) The Mortgage Guaranty Insurance company's Domiciliary Commissioner may consider loss developments and trends in reviewing a request for withdrawal. If any portion of the Contingency Reserve for which withdrawal is requested is maintained by a reinsurer or in a segregated account or trust of a reinsurer, the Domiciliary Commissioner may also consider the financial condition of the reinsurer.

C. Miscellaneous.

(1) ~~Whenever the laws of any jurisdiction in which a Mortgage Guaranty Insurance company subject to the requirement of this Act is also licensed to transact Mortgage Guaranty Insurance require a larger unearned premium reserve or Contingency Reserve in the aggregate than that set forth herein, the establishment of the larger unearned premium reserve or Contingency Reserve in the aggregate shall be deemed to be in compliance with this Act.~~

(1) Unearned premium reserves and Contingency Reserves on risks insured before the effective date of this Act may be computed and maintained as required previously.

Section 11. Reinsurance

A. **Prohibition of Captive Reinsurance.** A Mortgage Guaranty Insurance company shall not enter into captive reinsurance arrangements which involve the direct or indirect ceding of any portion of its insurance risks or obligations to a reinsurer owned or controlled by an insured; any subsidiary or affiliate of an insured; an officer, director or employee of an insured or any member of their immediate family; a corporation, partnership, trust, trade association in which an insured is a member, or other entity owned or controlled by an insured or an insured's officer, director or employee or any member of their immediate family that has a financial interest; or any designee, trustee, nominee or other agent or representative of any of the foregoing.

B. **Subterfuge in Reinsurance Prohibited Cessions.** A mortgage guaranty insurer may, by written contract, reinsure any insurance that it transacts, except that no mortgage guaranty insurer may enter into reinsurance arrangements designed to circumvent the compensating control provisions of Section 17 or the Contingency Reserve requirement of Section 10. The unearned premium reserve, and the loss reserves, and the Contingency Reserve required by Section 10 shall be established and maintained by the direct insurer or by the assuming reinsurer so that the aggregate reserves shall be equal to or greater than the reserves required by direct writer. A reinsurer that is not a Mortgage Guaranty Insurance company is not required to establish a Contingency Reserve provided the reinsurance obligations are not supported by a reserve maintained by the reinsurer will not be entitled to reinsurance credit unless the reinsurance obligations are supported by collateral complying with the requirements of [insert provisions defining acceptable collateral for non-admitted reinsurers] and [The cession shall be accounted for as a retroactive reinsurance agreement as provided in the accounting practices and procedures prescribed or permitted by the applicable accounting practices and procedures manual of the National Association of Insurance Commissioners.]

Section 12. Sound Underwriting Practices

A. **Underwriting Review and Approval Required.** All Certificates of Mortgage Guaranty Insurance, excluding policies of reinsurance, shall be written based on an assessment of evidence that prudent underwriting standards have been met by the originator of the mortgage. Delegated underwriting decisions shall be reviewed based on a reasonable method of sampling of post-closing loan documentation to ensure compliance with the Mortgage Guaranty Insurance company's underwriting standards

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**B. Quality Control Reviews.** Quality control reviews for Bulk Mortgage Guaranty Insurance and Pool Mortgage Guaranty Insurance shall be based on a reasonable method of sampling of post-closing loan documentation for delegated underwriting decisions to ensure compliance with the representations and warranties of the creditors or creditors originating the loans and with the Mortgage Guaranty Insurance company's underwriting standards.

**C. Minimum Underwriting Guidelines Standards.** Mortgage Guaranty Insurance companies shall establish formal underwriting guidelines standards which set forth the basis for concluding that prudent underwriting standards have been met.

**D. Underwriting Guideline Review and Approval.** A Mortgage Guaranty Insurance company's underwriting guidelines standards shall be:

- (1) Reviewed and approved by executive management, including but not limited to the chief executive officer and the chief financial officer; and
- (2) Reviewed with either the board of directors or a board committee designated to provide oversight of underwriting policy and ratification of material changes under a written resolution of the board of directors setting forth the scope of review for such oversight and ratification; and
- (23) Communicated across the organization to promote consistent business practices with respect to underwriting.

**E. Maintenance of Minimum Underwriting Standards and Documentation Generally.** Underwriting standards, including but not limited to review and approval procedures, minimum underwriting guidelines, and the collection and retention of underwriting documentation shall be in accordance with:

**Minimum mortgage documentation standards;**

**Loan program or type qualification requirements;**

**Minimum borrower repayment qualification requirements; and**

**Minimum property marketability qualifications;**

**Notification of Changes in Underwriting Guidelines Standards.** OA Mortgage Guaranty Insurance company shall provide notice to the Commissioner of changes to its underwriting guidelines as follows:

On or before March 1 of each year, a Mortgage Guaranty Insurance company shall file with the Domiciliary Commissioner an annual summary of material changes into its underwriting standards and an analysis of the changes guidelines implemented during the course of the immediately preceding year along with references to supporting hardcopy or website documentation.

The annual summary of material underwriting guideline standard changes should include any change associated with loan to value ratios, debt to income ratios, borrower credit standing or maximum loan amount which has resulted in a material impact on net premium written of +/- 5% from prior year to date.

**F. Nondiscrimination.** In extending or issuing Mortgage Guaranty Insurance, a Mortgage Guaranty Insurance company may not discriminate on the basis of the applicant's sex, marital status, race, color, creed, national origin, disability, or age or solely on the basis of the geographic location of the property to be insured unless the discrimination related to geographic location is for a business purpose that is not a mere pretext for unfair discrimination; or the refusal, cancellation, or limitation of the insurance is required by law or regulatory mandate.

**Drafting Note:** States and jurisdictions should consult their constitution or comparable governance documents and applicable civil rights legislation to determine if broader protections against unacceptable forms of discrimination should be included in Section 12G.

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**Section 13. Quality Assurance**

- A. **Quality Assurance Program.** A Mortgage Guaranty Insurance company shall establish a formal internal Mortgage Guaranty Quality Assurance Program, which provides an early detection warning system as it relates to potential underwriting compliance issues which could potentially impact solvency or operational risk. This Mortgage Guaranty Quality Assurance Program shall provide for the documentation, monitoring, evaluation and reporting on the integrity of the ongoing loan origination process based on indicators of potential underwriting strategy and control inadequacies or non-compliance. This shall include, but not limited to:
- (1) **Segregation of Duties.** Administration of the quality assurance program shall be delegated to designated risk management, quality assurance or internal audit personnel, who are technically trained and independent from underwriting activities that they audit-related to loan origination, pricing, underwriting and operations.
  - (2) **Senior Management Oversight.** Quality control personnel shall provide periodic quality assurance control reports to an enterprise risk management committee or other equivalent senior management level oversight body.
  - (3) **Board of Director Oversight.** Quality assurance control personnel shall provide periodic quality assurance control reports to the board of directors or a designated committee of directors established to facilitate board of director oversight.
  - (4) **Policy and Procedures Documentation.** Mortgage Guaranty Quality Assurance Control Program, excluding policies and procedures of reinsurance, shall be formally established and documented to define scope, roles and responsibilities.
  - (5) **Underwriting Risk Review.** Quality assurance control review shall include an examination of underwriting risks including categorization classification of risk written unless and until the insurer's exposure and compliance with risk tolerance levels.
  - (6) **Lender Performance Reviews.** Quality assurance control monitoring provisions shall include an assessment of lender performance expectations.
  - (7) **Underwriting Performance Reviews.** Quality assurance control monitoring provisions shall assess compliance with underwriting guidelines standard.
  - (8) **Problem Loan Trend Reviews.** Quality assurance control monitoring provisions shall assess prospective risks associated with timely loan payment including delinquency, default inventory, foreclosure and persistency trends.
  - (9) **Underwriting System Change Oversight.** Underwriting system program changes shall be monitored to ensure the integrity of underwriting and pricing programs, which impact automated underwriting system decision making.
  - (10) **Pricing and Performance Oversight.** Pricing controls shall be monitored to ensure that business segment pricing supports applicable performance goals.
  - (11) **Internal Audit Validation.** Periodic internal audits shall be insurer has conducted to validate compliance with the Mortgage Guaranty Quality Assurance Control Program.
- B. **Regulator Access and Review of Quality Assurance Program.** The Commissioner shall be provided access to an insurer's Mortgage Guaranty Quality Assurance Control Program for review at any reasonable time upon request and during any financial regulatory examination. Nothing herein shall be construed to limit a regulator's right to access any and all of the records of an insurer in an examination or as otherwise necessary to meet regulatory responsibilities.

**Section 14.****Section 11. Policy Forms and Premium Rates Filed**

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**A. Policy Forms.**

~~A. All policy forms and endorsements, and modifications (excluding Bulk Mortgage Guaranty Insurance and Pool Mortgage Guaranty Insurance) shall be filed with and be subject to the approval of the commissioner. With respect to owner-occupied, single-family dwellings, the mortgage guaranty insurance or a mixed-use building described in Section 2A(1)(b), which is owner-occupied at the time of loan origination and for at least 50% of the days within the twelve (12) consecutive months prior to borrower default, the Mortgage Guaranty Insurance policy shall provide that the borrower shall not be liable to the insurance company for any deficiency arising from a foreclosure sale.~~

B. **Premiums and Rates.** ~~In addition, e~~ Each Mortgage Guaranty Insurance company (excluding Bulk Mortgage Guaranty Insurance and Pool Mortgage Guaranty Insurance) shall file with the ~~department commissioner~~ the rate to be charged ~~and the premium~~ including all modifications of rates and premiums to be paid by the policyholder.

C. **Schedule of Premium Charges. Premium Charges.** Every Mortgage Guaranty Insurance company shall make available to insureds the premium charges for Mortgage Guaranty Insurance policies via a company website or an integration with a third-party system. The premium rate provided shall show the entire amount of premium charge for the type of Mortgage Guaranty Insurance policy to be issued by the insurance company. Every Mortgage Guaranty Insurance company shall adopt, print and make available a schedule of premium charges for Mortgage Guaranty Insurance policies. Premium charges made in conformity with the provisions of this Act shall not be deemed to be interest or other charges under any other provision of law limiting interest or other charges in connection with mortgage loans. The schedule shall show the entire amount of premium charge for each type of Mortgage Guaranty Insurance policy issued by the insurance company.

**Drafting Note:** Open rating states may delete a portion or all of this provision and insert their own rating law.

**Section 4215. Outstanding Total Liability Risk in Force and Waivers**

A. **Risk in Force.** A Mortgage Guaranty Insurance company shall not at any time have outstanding a ~~total liability~~ Risk in Force, net of reinsurance, under its aggregate Mortgage Guaranty Insurance policies exceeding twenty-five (25) times its capital, surplus and Contingency Reserve. In the event that any Mortgage Guaranty Insurance company has outstanding total ~~liability Risk in Force~~ exceeding twenty-five (25) times its capital, surplus and Contingency Reserve, it shall cease transacting new mortgage guaranty business until such time as its total ~~liability Risk in Force~~ no longer exceeds twenty-five (25) times its capital, surplus and Contingency Reserve. Total ~~outstanding liability~~ Risk in Force shall be calculated on an ~~consolidated individual entity~~ basis for all mortgage guarantee insurance companies that are part of a holding company system.

B. **Waiver.** The Commissioner may waive the requirement found in subsection (a) of this section at the written request of a mortgage guaranty insurer upon a finding that the mortgage guaranty insurer's policyholders position is reasonable in relationship to the mortgage guaranty insurer's aggregate insured Risk in Force and adequate to its financial needs. The request must be made in writing at least 90 days in advance of the date that the mortgage guaranty insurer expects to exceed the requirement of subsection (a) of this section and shall, at a minimum, address the factors specified in subsection (j) of this section.

C. **Waiver Criteria.** In determining whether a mortgage guaranty insurer's policyholders position is reasonable in relation to the mortgage guaranty insurer's aggregate insured Risk in Force and adequate to its financial needs, all of the following factors, among others, may be considered:

(1) The size of the mortgage guaranty insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.

(2) The extent to which the mortgage guaranty insurer's business is diversified across time, geography, credit quality, origination, and distribution channels.

(3) The nature and extent of the mortgage guaranty insurer's reinsurance program.

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(4) The quality, diversification, and liquidity of the mortgage guaranty insurer's assets and its investment portfolio.

(5) The historical and forecasted trend in the size of the mortgage guaranty insurer's policyholders position.

(6) The policyholders position maintained by other comparable mortgage guaranty insurers in relation to the nature of their respective insured risks.

(7) The adequacy of the mortgage guaranty insurer's reserves.

(8) The quality and liquidity of investments in affiliates. The Commissioner may treat any such investment as a nonadmitted asset for purposes of determining the adequacy of surplus as regards policyholders.

(9) The quality of the mortgage guaranty insurer's earnings and the extent to which the reported earnings of the mortgage guaranty insurer include extraordinary items.

(10) An independent actuary's opinion as to the reasonableness and adequacy of the mortgage guaranty insurer's historical and projected policyholders position.

(11) The capital contributions which have been infused or are available for future infusion into the mortgage guaranty insurer.

(12) The historical and projected trends in the components of the mortgage guaranty insurer's aggregate insured risk, including, but not limited to, the quality and type of the risks included in the aggregate insured risk.

**D. Authority to Retain Experts.** The Commissioner may retain accountants, actuaries, or other experts to assist the Commissioner in the review of the mortgage guaranty insurer's request submitted pursuant to subsection (i) of this section. The mortgage guaranty insurer shall bear the Commissioner's cost of retaining those persons.

**E. Specified Duration.** Any waiver shall be (i) for a specified period of time not to exceed two years and (ii) subject to any terms and conditions that the Commissioner shall deem best suited to restoring the mortgage guaranty insurer's minimum policyholders position required by subsection (a) of this section.

**Section 16. Conflict of Interest**

~~A. — A mortgage guaranty insurer may underwrite mortgage guaranty insurance on mortgages originated by the holding company system or affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate only if the insurance is underwritten on the same basis, for the same consideration and subject to the same insurability requirements as insurance provided to nonaffiliated lenders. Mortgage guaranty insurance underwritten on mortgages originated by the holding company system or affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate shall be limited to 50% of the insurer's direct premium written in any calendar year, or such higher percentage established in writing for the insurer in the commissioner's discretion, based on the commissioner's determination that a higher percentage is not likely to adversely affect the financial condition of the insurer. If a member of a holding company system, a~~

~~A. — A Mortgage Guaranty Insurance company licensed to transact business in this state shall not, as a condition of its Certificate of Authority, knowingly underwrite Mortgage Guaranty Insurance on mortgages originated by the holding company system or an affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly, by the holding company system or an affiliate.~~

~~B. — A Mortgage Guaranty Insurance company, the holding company system of which it is a part, or any affiliate shall not, as a condition of the Mortgage Guaranty Insurance company's Certificate of Authority, engage in activities proscribed in Sections 17 and 18.~~

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**Section 1714. Compensating Balances Prohibited**

Except for commercial checking accounts and normal deposits in support of an active bank line of credit, a Mortgage Guaranty Insurance company, holding company or any affiliate thereof is prohibited from maintaining funds on deposit with the lender for which the Mortgage Guaranty Insurance company has insured loans. Any deposit account bearing interest at rates less than what is currently being paid other depositors on similar deposits or any deposit in excess of amounts insured by an agency of the federal government shall be presumed to be an account in violation of this section. Furthermore, a Mortgage Guaranty Insurance company shall not use compensating balances, special deposit accounts or engage in any practice that unduly delays its receipt of monies due or that involves the use of its financial resources for the benefit of any owner, mortgagee of the real property or any interest therein or any person who is acting as agent, representative, attorney or employee of the owner, purchaser or mortgagee as a means of circumventing any part of this section.

**Section 18. Limitations on Rebates, Commissions, Charges and Contractual Preferences**

- A. **No Inducements.** Unless set force in the policy and subject to the [state equivalent of the Unfair Trade Practices Act (Model #880)], a Mortgage Guaranty Insurance company shall not pay or cause to be paid either directly or indirectly, to any owner, purchaser, lessor, lessee, mortgagee or prospective mortgagee of the real property that secures the Authorized Real Estate Security or that is the fee of an insured lease, or any interest therein, or to any person who is acting as an agent, representative, attorney or employee of such owner, purchaser, lessor, lessee or mortgagee, any commission, or any part of its premium charges or any other consideration as an inducement for or as compensation on any Mortgage Guaranty Insurance business.
- B. **No Compensation for Placement.** In connection with the placement of any Mortgage Guaranty Insurance, a Mortgage Guaranty Insurance company shall not cause or permit the conveyance of anything of value, including but not limited to any commission, fee, premium adjustment, remuneration or other form of compensation of any kind whatsoever to be paid to, or received by an insured lender or lessor; any subsidiary or affiliate of an insured; an officer, director or employee of an insured or any member of their immediate family; a corporation, partnership, trust, trade association in which an insured is a member, or other entity in which an insured or an officer, director or employee or any member of their immediate family has a financial interest; or any designee, trustee, nominee or other agent or representative of any of the foregoing, except for the value of the insurance itself or claim payments thereon as provided by contract or settlement.
- ~~A.C. **No Rebates.** Unless set force in the policy and subject to the [state equivalent of the Unfair Trade Practices Act (Model #880)], a Mortgage Guaranty Insurance company shall not make a rebate of any portion of the premium charge, as shown by the schedule required by Section 14C. No Mortgage Guaranty Insurance company shall not quote any rate or premium charge to a person that is different than that currently available to others for the same type of coverage. The amount by which a premium charge is less than that called for by the current schedule of premium charges is an unlawful rebate.~~
- ~~D. **No Undue Contractual Preferences.**~~
- ~~(1) Any contract, letter agreement, or other arrangement used to modify or clarify any terms, conditions, or interpretations of a Master Policy or Certificate shall be documented in writing.~~
- ~~(2) Any contractual or letter agreements used to modify or clarify general business practices and administrative, underwriting, claim submission or other information exchange processes shall not contain provisions which override or significantly undermine the intent of key provisions of the Mortgage Guaranty Insurance Model Act, including mortgage insurer discretion, rights and responsibilities related to:~~
- ~~(a) Underwriting standards~~
- ~~(b) Quality assurance~~
- ~~(c) Rescission~~
- E. **Sanctions.** The Commissioner may, after notice and hearing, suspend or revoke the Certificate of Authority of a Mortgage Guaranty Insurance company, or in his or her discretion, issue a cease and desist order to a Mortgage Guaranty Insurance company that pays a commission, rebate, or makes any unlawful conveyance of value under this section in willful violation of the provisions of this Act. In the event of the issuance of a

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## Mortgage Guaranty Insurance Model Act

cease and desist order, the Commissioner may, after notice and hearing, suspend or revoke the Certificate of Authority of a Mortgage Guaranty Insurance company that does not comply with the terms thereof.

- F. **Educational Efforts and Promotional Materials Permitted.** A Mortgage Guaranty Insurance company may engage in any educational effort with borrowers, members of the general public, and officers, directors, employees, contractors and agents of insured lenders that may reasonably be expected to reduce its risk of Loss or promote its operational efficiency and may distribute promotional materials of minor value.

**Section 19. Rescission**

The Right of Rescission shall be governed by the following:

- A. **Rescission Rights and Responsibilities.** All Mortgage Guaranty Insurance company master policies shall include a detailed description of provisions governing rescissions, re-pricing, and cancellations, which specify the insurer's and insured's rights, obligations and eligibility terms under which those actions may occur to ensure transparency.

- ~~B. **Rescission Relief Provisions.** Mortgage Guaranty Insurance company rescission relief practices shall be in accordance with the following:~~

~~A Mortgage Guaranty Insurance Master Policy may provide for mandatory rescission relief based on evidence of compliance with payment history and loan status eligibility requirements.~~

~~A Mortgage Guaranty Insurance Master Policy may offer an earlier rescission relief option based on evidence of compliance with underwriting and payment history eligibility requirements.~~

~~A Mortgage Guaranty Insurance company shall retain the Right of Rescission in instances in which a creditor or the officers, directors, employees, contractors, and agents of a creditor engage in misstatements, misrepresentations, omissions, data inaccuracies or active efforts to deceive through submission of forged or fictitious information in connection with loan origination or closing for a period of at least 10 years, based on:~~

~~Credible evidence of the existence of the above conditions; and~~

~~Credible evidence of the materiality of the above conditions to the Mortgage Guaranty Insurance company's acceptance of risk.~~

- ~~C. **Re-pricing Provisions.** A Mortgage Guaranty Insurance company shall have the option to re-price the insurance premium for coverage upon a loan, when prudent, in lieu of rescinding coverage based on the following:~~

~~Rescission relief has not been granted based on Subsection 17B;~~

~~The loan would have been eligible for coverage with alternative pricing under the underwriting standards in effect at origination; and~~

~~Misstatements, misrepresentations, omissions or inaccuracies by the creditor or the officers, directors, employees, contractors, and agents of a creditor are not considered material based on reasonable verification of appraisal value and borrower income by the Mortgage Guaranty Insurance company.~~

**Section 20. Records Retention**

- A. **Record Files.** A licensed Mortgage Guaranty Insurance company shall maintain its records in a manner which allows the Commissioner to readily ascertain the insurer's compliance with state insurance laws and rules during an examination including, but not limited to, records regarding the insurer's management, operations, policy issuance and servicing, marketing, underwriting, rating and claims practices.

~~Recordkeeping requirements shall relate to:~~

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NAIC Model Laws, Regulations, Guidelines and Other Resources—February 2023

~~(1) Policy records to clearly document the application, underwriting, issuance and servicing of each policy and Certificate and~~

~~(2) Claim records to clearly document the inception, handling and disposition~~

~~B. **Retention Period.** Policy and claim records shall be retained for the period during which the Certificate or claim is active plus five (5) years, unless otherwise specified by the Insurance Commissioner.~~

~~Recordkeeping requirements shall relate to:~~

~~(1) Policy records to clearly document the application, underwriting, and issuance and servicing of each Master Policy and Certificate of Insurance; and~~

~~(2) Claim records to clearly document the inception, handling and disposition~~

~~C. **Record Format.** Any record required to be maintained by a mortgage insurer may be created and stored in the form of paper, photograph, magnetic, mechanical or electronic medium.~~

~~D. **Record Maintenance.** Record maintenance under this Act shall comply with the following requirements:~~

~~Each mortgage guaranty insurance company shall establish a contingency reserve out of net premium remaining (gross premiums less premiums returned to policyholders net of reinsurance) after establishment of the unearned premium reserve. The mortgage guaranty insurance company shall contribute to the contingency reserve an amount equal to fifty percent (50%) of the remaining unearned premiums. Contributions to the contingency reserve made during each calendar year shall be maintained for a period of 120 months, except that withdrawals may be made by the company in any year in which the actual incurred losses exceed thirty five percent (35%) of the corresponding earned premiums, and no releases shall be made without prior approval by the commissioner of insurance of the insurance company's state of domicile.~~

~~If the coverage provided in this Act exceeds the limitations set forth herein, the commissioner of insurance shall establish a rate formula factor that will produce a contingency reserve adequate for the added risk assumed. The face amount of an insured mortgage shall be computed before any reduction by the mortgage guaranty insurance company's election to limit its coverage to a portion of the entire indebtedness. Insurer maintenance responsibilities shall provide for record storage in a location that will allow the records to be reasonably produced for examination within the time period required.~~

~~(21) Third-Party maintenance related responsibilities shall be set forth in a written agreement, a copy of which shall be maintained by the insurer and available for purposes of examination.~~

#### **Section 21. No Private Right of Action**

~~No Private Right of Action. Nothing in this Act is intended to, or does, create a private right of action based upon compliance or noncompliance with any of the Act's provisions. Authority to enforce compliance with this Act is vested exclusively in the Commissioner.~~

#### **Section 221**

##### ~~D. Reinsurance~~

~~Whenever a mortgage guaranty insurance company obtains reinsurance from an insurance company that is properly licensed to provide reinsurance or from an appropriate governmental agency, the mortgage guaranty insurer and the reinsurer shall establish and maintain the reserves required in this Act in appropriate proportions in relation to the risk retained by the original insurer and ceded to the assuming reinsurer so that the total reserves established shall not be less than the reserves required by this Act.~~

##### ~~E. Miscellaneous~~

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## Mortgage Guaranty Insurance Model Act

- ~~(1) Whenever the laws of any other jurisdiction in which a mortgage guaranty insurance company subject to the requirement of this Act is also licensed to transact mortgage guaranty insurance require a larger unearned premium reserve or contingency reserve in the aggregate than that set forth herein, the establishment of the larger unearned premium reserve or contingency reserve in the aggregate shall be deemed to be in compliance with this Act.~~
- ~~(2) Unearned premium reserves and contingency reserves shall be computed and maintained on risks insured after the effective date of this Act as required by Subsections A and C. Unearned premium reserves and contingency reserves on risks insured before the effective date of this Act may be computed and maintained as required previously.~~

**Section 17. Regulations**

The Commissioner shall have the authority to promulgate rules and regulations deemed necessary to effectively implement the requirements of this Act.

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*Chronological Summary of Actions (all references are to the Proceedings of the NAIC).*

*1976 Proc. II 15, 17, 647, 686, 747-753 (adopted).*

*1979 Proc. I 44, 47-48, 49, 719, 968-969 (corrected).*

March 14, 2023

Ms. Jackie Obusek, Chair  
Mortgage Guaranty Insurance (E) Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street  
Kansas City, MO 64106-2197  
c/o Andy Daleo,  
Senior Manager – Financial Regulatory Services

**RE: MI Industry Group Comment Letter – February 2023 Draft Model Act**

Dear Ms. Obusek:

The Private Mortgage Guaranty Insurance Industry Group (“Industry Group”) submits the following comments to the *Mortgage Guaranty Insurance Model Act* exposed on February 28, 2023 (“Model Act”). Also attached for your convenience is proposed clarifying language regarding the topics addressed below.

**Section 10(B)(1) – Contingency Reserve**

In Section 10(B)(1), the Industry Group seeks to clarify the language in one sentence regarding the interaction between the contingency reserve requirement and reinsurance by stating that the reinsurer’s establishment of the contingency reserve includes maintaining separately held collateral in a trust or segregated account to support the reinsurer’s obligation. We believe that this concept comports with the intent of the Working Group in redrafting Section 10(B)(1)<sup>1</sup>, but seek added clarity in the Model Act as it is vital to the reinsurance market for mortgage guaranty insurance given that many reinsurers do not file a statutory financial statement that shows a contingency reserve liability.

Specifically, insurance-linked notes (“ILNs”) are special purposes entities that do not file statutory financial statements, and certain quota share and excess of loss reinsurance (“QSR/XOL”) counterparties are Bermuda-based reinsurers that do not file statutory financial statements. However, in both the cases of ILNs and QSR/XOL reinsurance transactions, our counterparties generally are required to maintain assets isolated in trust or segregated accounts to support their reinsurance obligation.

Similarly, the requirement that the direct insurer record a liability for funds held under the reinsurance treaty serves the same function because “funds held” is reported as a liability on the insurer’s balance sheet just like the contingency reserve. Therefore we also respectfully request to address this reinsurance treaty practice in the Model Act.

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<sup>1</sup> An alternative approach similar to that used in the July 2000 Mortgage Guaranty Insurance Model Act also could be used here in addressing the effect of reinsurance on the contingency reserve requirement. See Industry Group Comment Letter dated November 18, 2022, at p. 7 (recommending the substitution of the term “*earned premiums net of reinsurance*” for “*direct earned premiums*”).

**Section 12(D) – Underwriting Review and Approval**

We respectfully request that the Model Act use the generic term “highest ranking” in front of “executive officer” and “financial officer” in Section 12(D) instead of “chief”. Many mortgage insurers do not have an officer with the title of chief executive officer or chief financial officer as these titles are more commonly reserved for use at the publicly traded holding company level rather than at the subsidiary level. The highest ranking executive officer of most mortgage insurers typically is the president, although this could vary by company.

**Section 14 – Policy Forms and Premium Rates Filed**

We respectfully request to retain a note similar to the Drafting Note that is part of the equivalent subsections of the July 2000 Mortgage Guaranty Insurance Model Act stating: “**Drafting Note:** *Open rating states may delete a portion or all of [this provision] and insert their own rating law.*” States that do not require companies writing other insurance lines to file rates or modifications of rates should be advised that the Model Act contemplates the flexibility to treat mortgage guaranty insurance the same as other types of insurance in that regard.

**Other Recommendations and Corrections to the Model Act**

Finally, we also include in the attachment recommendations to conform certain defined terms and phrases to the Working Group’s chosen terminology, along with a few other corrections of a minor nature to Sections 2(K), 12(E), 13(A)(2), 14(A), 14(B), and 16.

The Industry Group supports the Working Group’s efforts to update the Model Act, and we would be pleased to make representatives of each company available for a telephonic conference to discuss the comments in this letter if that would be of assistance to you.

Respectfully submitted on behalf of the Industry Group companies below,

**Arch Mortgage Insurance Company,  
Enact Mortgage Insurance Corporation,  
Essent Guaranty, Inc.,  
Mortgage Guaranty Insurance Corporation,  
National Mortgage Insurance Corporation, and  
Radian Guaranty Inc.**



March 13, 2023

Chief Deputy Commissioner Jackie Obusek, Chair  
Mortgage Guaranty Insurance (E) Working Group  
National Insurance Commissioners  
c/o Mr. Andy Daleo  
Senior Manager – Financial Regulatory Services  
Via email [adaleo@naic.org](mailto:adaleo@naic.org)

**Re: RAA Comments regarding proposed changes to the Mortgage Guaranty Insurance Model Act**

Dear Chief Deputy Commissioner Obusek:

The Reinsurance Association of America (RAA) appreciates the opportunity to submit comments to the Mortgage Guaranty Insurance (E) Working Group regarding the exposure draft of the *Mortgage Guaranty Insurance Model Act (#630)*. The Reinsurance Association of America (RAA) is a national trade association representing reinsurance companies doing business in the United States. RAA membership is diverse, including reinsurance underwriters and intermediaries licensed in the U.S. and those that conduct business on a cross-border basis. The RAA also has life reinsurance affiliates.

The RAA appreciates the Working Group's continued thoughtful engagement with updating the model act. While the RAA had issues with the previous draft, we believe these concerns have now been addressed. The RAA was concerned that Section 11(B) of the Model was potentially in conflict with the *Credit for Reinsurance Model Law (#785)*, but the deletion of the concerning language in the new draft has removed this potential conflict. The RAA now no longer believes there is any concern of a conflict and support this deletion of the potentially conflicting language.

The RAA understands the efforts to amend this model have been on going or quite some time and appreciates the NAIC's willingness to listen and address the RAA's concerns. The RAA appreciates the opportunity to share the thoughts of our members and looks forward to further discussions about them.

Sincerely,

A handwritten signature in black ink that reads 'Karalee C. Morell'.

Karalee C. Morell  
SVP and General Counsel  
Reinsurance Association of America



**Comments of the Center for Economic Justice**

**To the NAIC Mortgage Guaranty Insurance Working Group**

**Regarding Revisions the Mortgage Guaranty Insurance Model Act**

**March 14, 2023**

The Center for Economic Justice submits the following comments on the most recent exposure draft of revisions to NAIC Model 630. We strongly object to the insertion of the new Section 21 prohibiting a private right of action based on any provision of the model law and urgently request the removal of this new section.

The rationale offered by industry for this profoundly anti-consumer provision is their “belief” that the model represents a “complete statutory scheme” intended “to be enforced exclusively by the respective commissioners who have the expertise to administer the act.” As is typically the case with industry arguments to curtail consumer or business access to civil justice, industry argues that absent such a prohibition, frivolous litigation will result.

History tells a different story. With great respect for state insurance regulators – those who have had and continue to have responsibility for various aspects of private mortgage insurance oversight – the failure of private mortgage insurers to pursue sound risk management practices in the lead-up to the financial crisis occurred because of

- 1) the structural nature of the private mortgage insurance markets (reverse competition) and,
- 2) insurance regulators’ lack of understanding of the dangers posed by the mechanisms used by private mortgage insurers to compete for business.

PMI is sold by insurers to mortgage lenders who, in turn, sell PMI with certain mortgages to borrowers. Unlike a normally competitive market in which purchasers exert market pressure on sellers and can discipline sellers on price and terms, PMI insurers compete for the lenders’ business since the lenders are the gatekeepers for access to the premium-paying borrowers.

CEJ Comments to NAIC Mortgage Guaranty Insurance Working Group  
March 14, 2023  
Page 2

The NAIC has defined reverse competition as follows:

“Reverse competition” means competition among insurers that regularly takes the form of insurers vying with each other for the favor of persons who control, or may control, the placement of the insurance with insurers. Reverse competition tends to increase insurance premiums or prevent the lowering of premiums in order that greater compensation may be paid to persons for such business as a means of obtaining the placement of business. In these situations, the competitive pressure to obtain business by paying higher compensation to these persons overwhelms any downward pressures consumers may exert on the price of insurance, thus causing prices to rise or remain higher than they would otherwise.

In the case of PMI leading up to the financial crisis, the reverse competition led to abandonment of sound risk management by PMI insurers as they sought the lenders’ business with ever-greater kickbacks and considerations. PMI insurers invented various mechanisms to kick back PMI premium to lenders. One glaring example was the use by PMI insurers of lender-affiliated reinsurance (“captive reinsurance”). Far from being a risk management tool, as concluded by at least one senior insurance regulator, this was a blatant kickback mechanism and part of an overall abdication of effective risk management by both the insurers and regulators. Captive reinsurance was only one method of inducement.

There is simply no proven track record of state insurance regulators providing a comprehensive consumer protection capability regarding private mortgage insurance and certainly no track record to justify a prohibition on a private right of action. Given the variety of market conduct features now included in the model – prohibitions on rebates, undue contractual preference, inducements and captive reinsurance – it is critical that regulators have assistance in identifying market and compliance problems by consumer and business exercising of a right of action

The prohibition on a private right of action is hypocritically one-sided. PMI insurers face no prohibition against suing a lender, despite lenders being part of a comprehensive statutory scheme. Further, industry has offered no evidence of any significant amount of “frivolous” litigation. The prohibition against a private right of action is not only a solution in search of a problem, but also incredible chutzpah by an a sector of the insurance industry with a history of consumer abuses that contributed to the collapse of the mortgage and real estate market leading to the Great Recession.

CEJ urges the working group to remove new Section 21 from the revised model.

Draft: 3/15/23

National Treatment and Coordination (E) Working Group  
Virtual Meeting  
February 14, 2023

The National Treatment and Coordination (E) Working Group of the Financial Condition (E) Committee met Feb. 14, 2023. The following Working Group members participated: Debbie Doggett and Kelly Hopper, Co-Chair (MO); Cameron Piatt, Co-Chair (OH); Jacline Nguyen (CO); William Mitchell (CT); Sherry Wilson (DE); Alison Sterett (FL); Tangela Byrd (LA); Doug Hartz (OR); Karen Feather (PA); John Carter (TX); Jay Sueoka (UT); Ron Pastuch (WA); Christopher Martin (WI); and Doug Melvin (WY).

1. Adopted Proposal 2022-03

Doggett said the proposal was exposed for a 30-day comment period ending Dec. 12, 2022. There were no comments received. Doggett reminded the Working Group that the proposal adopted today is subject to change once the electronic format is developed to accommodate for electronic modifications.

Hartz made a motion, seconded by Wilson, to adopt proposal 2022-03 (Domestic Corporate Amendment Application and Instructions) (Attachment Two-A). The motion passed unanimously.

2. Adopted Proposal 2023-01

Piatt explained the modifications to proposal 2023-01 (Redomestication Form 2R) were to remove information that pertained to the primary (start-up) application now that the previous Form 2P has been split into two separate applications and is determined to not be necessary for a redomestication application. Piatt said that the edits to this form are self-explanatory and suggested adopting the proposal instead of exposing it for comment.

Sueoka made a motion, seconded by Pastuch, to adopt proposal 2023-01 (Redomestication Form 2R) (Attachment Two-B). The motion passed unanimously.

3. Discussed Other Matters

Jane Barr (NAIC) said that the electronic primary application is available for testing in production. Any company interested in participating should contact Barr, as the link has not been posted on the website. The developers will begin working on the Redomestication application. It has yet to be determined if that application will be available to pilot test. Barr anticipates that both applications will be ready for public use by July 1.

Barr also mentioned that the Uniform Certificate of Authority Application (UCAA) logo is being rebranded. A sample is provided on the redomestication form. Once the logo is approved, the application forms and website will be updated to coincide with the new application release. Barr will keep the Working Group updated on the timeline for that change. The intent is to update every UCAA form and content on the website. Karen Fallstrom (UnitedHealthcare) asked if that applied to form 11 and the addendum pages. Barr confirmed it did include form 11 and the addendum page.

Barr said the ad hoc groups will resume in March with a slight change to the domestic state applications. Ad hoc groups will meet on Thursday afternoons every two weeks to coincide with the enhancement release schedule.



The Form A and Biographical Database Ad Hoc Groups will meet on alternate Monday afternoons beginning in March. Anyone interested in participating should email Barr.

Having no further business, the National Treatment and Coordination (E) Working Group adjourned.

[SharePoint/NAIC Support Staff Hub/Meetings/E CMTE/2023-1-Spring/NTCWG/2\\_14\\_ccmin-draft.docx](#)

**National Treatment and Coordination (E) Working Group**  
Company Licensing Proposal Form

<b>DATE:</b> 7/19/22		<b>FOR NAIC USE ONLY</b>	
<b>CONTACT PERSON:</b> <u>Jane Barr</u>		Agenda Item #	2022-03
<b>TELEPHONE:</b> <u>816-783-8413</u>		Year	<b>2023</b>
<b>EMAIL ADDRESS:</b> <u>jbarr@naic.org</u>		<b>DISPOSITION</b>	
<b>ON BEHALF OF:</b> <u>Domestic Corp. Amend. Ad Hoc Group</u>		[ ] ADOPTED	_____
<b>NAME:</b> <u>Debbie Doggett and Cameron Piatt Co-Chairs</u>		[ ] REJECTED	_____
<b>TITLE:</b> <u>National Treatment &amp; Coordination (E) WG</u>		[ ] DEFERRED TO	_____
<b>AFFILIATION:</b> _____		[ ] REFERRED TO OTHER NAIC GROUP	_____
<b>ADDRESS:</b> _____		[ X ] EXPOSED	re-exposed 12-12-22,
		[ X ] OTHER (SPECIFY)	Revised 11/9/22

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

- UCAA Forms     UCAA Instructions     Enhancement to the Electronic Application Process
- Company Licensing Best Practices HB

**Forms:**

- Form 2 - Application                                           Form 3 – Lines of Business                                           Form 8D - Questionnaire
- Form 6- Certificate of Compliance     Form 7 – Certificate of Deposit                                           Form 8 - Questionnaire
- Form 8C- Corporate Amendment Questionnaire     Form 11-Biographical Affidavit                                           Form 12-Uniform Consent to Service of Process     Form 13- ProForma                                           Form 14- Change of Address/Contact Notification
- Form 15 – Affidavit of Lost C of A     Form 16 – Voluntary Dissolution     Form 17 – Statement of Withdrawal

**DESCRIPTION OF CHANGE(S)**

Modified the foreign corporate amendment application forms and instructions specifically for domestic state submissions.

**REASON OR JUSTIFICATION FOR CHANGE \*\***

Create specific electronic application forms for domestic state corporate amendment filings.

**Additional Staff Comments:**

- 10/26/22 Revised based on comments received.
- 11/9/22 Revised and re-exposed for a 30-day comment period ending 12-12-22

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\*\* This section must be completed on all forms.

Applicant Company Name: \_\_\_\_\_

NAIC No. \_\_\_\_\_  
FEIN: \_\_\_\_\_



**Corporate Amendments Application**  
**Application to Amend Domestic Certificate of Authority**

To the Insurance Commissioner/Director/Superintendent of the State of:

Drop-down menu with the state list.

The Uniform Certificate of Authority Corporate Amendments Application can be used to file more than one change. The Applicant Company should mark all changes being filed on the application form and submit all items required for those changes in one application.

(Select the type of transaction for which the Applicant Company is applying.)

- Add Lines of Business: The undersigned Applicant Company hereby certifies that the lines of insurance as indicated on the Lines of Insurance Form 3 are all lines of business that (a) the Applicant Company is currently authorized to transact, (b) are currently transacted, and (c) which the Applicant Company is applying to transact.
- Name Change
- Delete Lines of Business: The undersigned Applicant Company hereby certifies that the lines of insurance as indicated on the Lines of Insurance Form 3 are all lines of business that (a) the Applicant Company is currently authorized to transact, (b) are currently transacted, and (c) which the Applicant Company is applying to delete.
- Change in Company (Corporate) Structure: The Applicant Company is requesting to change its corporate structure from reciprocal to mutual, or mutual to stock, etc. Or the Applicant Company is changing from a Life to Health company, Health to Life or Health to Property and Casualty, etc.
- Change of Statutory Home Office Address
- Amended Articles of Incorporation
- Amended Bylaws

Effective Date of Name Change: \_\_\_\_\_

Previous Name of Applicant Company: \_\_\_\_\_

New Name of Applicant Company: \_\_\_\_\_

Did the Applicant Company experience a merger or an owner change prior to the name change?

Yes  No

If yes, please be sure a Form A application was also submitted for the merger and/or ownership change transaction.

Requested Effective Date of Change of Corporate Structure: \_\_\_\_\_

Statutory Reference for Conversion: \_\_\_\_\_

Previous Company Type: \_\_\_\_\_

New Company Type: \_\_\_\_\_

Has the Applicant Company's designee to appoint and remove agents changed as a result of this corporate amendment?

Yes  No

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Applicant Company Name: \_\_\_\_\_

NAIC No. \_\_\_\_\_  
FEIN: \_\_\_\_\_

If yes, please note the new designee (name natural persons only): \_\_\_\_\_

Effective Date of Statutory Home Office Address Change: \_\_\_\_\_

Previous Statutory Home Office Address: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

New Statutory Home Office Address: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Previous Administrative Office Address: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

New Administrative Office Address: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Previous Mailing Address: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

New Mailing Address: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Change in Contacts \_\_\_\_\_

Are these addresses the same as those shown on the Applicant Company’s Annual Statement?

Yes  No

If not, indicate why: \_\_\_\_\_

The following information is required of the individual (Applicant Company employee or paid consultant) who is authorized to represent the Applicant Company before the department.

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

If the representative is not employed by the Applicant Company, please provide a company contact person in order to facilitate requests for detailed financial information.

Name \_\_\_\_\_

Title \_\_\_\_\_

Mailing Address \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Please provide a listing of all other applications filed by the Applicant Company, or any of its affiliates, which are pending before the Department:

\_\_\_\_\_  
\_\_\_\_\_

Applicant Company Name: \_\_\_\_\_

NAIC No. \_\_\_\_\_  
FEIN: \_\_\_\_\_

**Applicant Company Officers’ Certification and Attestation**

One of the three officers (listed below) of the Applicant Company must read the following very carefully before signing:

1. I hereby certify, under penalty of perjury, that I have read the application, that I am familiar with its contents, and that all of the information, including the attachments, submitted in this application is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license discipline or other administrative action and may subject me, the Applicant Company, or both, to civil or criminal penalties.
2. I acknowledge that I am familiar with the insurance laws and regulations of the jurisdictions in which the Applicant Company is licensed or to which the Applicant Company is applying for licensure.
3. I acknowledge that I am the \_\_\_\_\_ of the Applicant Company, am authorized to execute and am executing this document on behalf of the Applicant Company.
4. I hereby certify under penalty of perjury under the laws of the applicable jurisdictions that all of the forgoing is true and correct, executed at \_\_\_\_\_.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of President

\_\_\_\_\_  
Full Legal Name of President

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Secretary

\_\_\_\_\_  
Full Legal Name of Secretary

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Treasurer

\_\_\_\_\_  
Full Legal Name of Treasurer

Revised //2023

Applicant Company Name: \_\_\_\_\_

NAIC No. \_\_\_\_\_

FEIN: \_\_\_\_\_



**QUESTIONNAIRE**

**For Adding Lines of Business to an Existing Certificate of Authority**

**Directions:** Complete **Section I** (questions 1 – 21) for adding new lines of business. Complete **Section II** (questions 22 through 25) for deleting lines of business. Each "Yes" or "No" question is to be answered by marking an "X" in the appropriate space. All questions should be answered. If the Applicant Company denotes a question as "Not Applicable" (N/A) an explanation must be provided. Other answers and additional explanations or details may be attached to the affidavit. Please complete this form and file it with the Applicant Company's application to change lines of business to its Certificate of Authority.

**Section I**

1. Has the Applicant Company merged or consolidated with any other company within the last five years?  
 Yes \_\_\_ No \_\_\_
  
2. Have any of the following taken place since the date of the Applicant Company's most recent Annual Statement?
  - A. Is the Applicant Company presently negotiating for or inviting negotiations for any transaction as described in question 1 above?  
 Yes \_\_\_ No \_\_\_
  - B. A change of management or control?  
 Yes \_\_\_ No \_\_\_
  - C. Does the Applicant Company contemplate a change in management or any transaction which would normally result in a change of management within the next 12 months?  
 Yes \_\_\_ No \_\_\_

If the answer to any question is yes, provide the details in writing and attach to the Questionnaire.
  
3.
  - A. Has the Applicant Company's certificate of authority to do business in any state been suspended or revoked within the last five years?  
 Yes \_\_\_ No \_\_\_
  - B. Has the Applicant Company's application for admission to any state been denied within the last five years?  
 Yes \_\_\_ No \_\_\_
  - C. Has the Applicant Company's application to add lines of business to its Certificate of Authority in any state been denied within the last five years?  
 Yes \_\_\_ No \_\_\_

If the answer to any of the above question is yes, provide the details in writing and attach to the Questionnaire.
  
4. Since the date of the most recent Annual Statement, has any person who is presently an officer, director, or shareholder of the Applicant Company, been convicted of, or pleaded guilty, or nolo contendere to, a felony charge for theft, larceny or mail fraud, or of violating any corporate securities statute or any insurance statute?  
 Yes \_\_\_ No \_\_\_

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If yes, provide the details in writing and attach to the Questionnaire.

5. Is the Applicant Company presently engaged in a dispute with any state or federal regulatory agency?

Yes \_\_\_ No \_\_\_

If yes, provide the details in writing and attach to the Questionnaire.

6. Is the Applicant Company a plaintiff or defendant in any legal action other than one arising out of policy claims?

Yes \_\_\_ No \_\_\_

If yes, provide a summary of each case and attach to the Questionnaire.

7. Has the Applicant Company, within 18 months last preceding the date of this affidavit, entered into any material transactions, as defined in the NAIC Model Law on Material Transactions, with any affiliate, officer, director, trustee, or shareholder which has not been approved in writing by the state of domicile? Material transactions include: loans, transfers of assets, purchases of assets, reductions of liabilities, or reinsurance transactions.

Yes \_\_\_ No \_\_\_

If yes, provide the details in writing and attach to the Questionnaire.

8. Please explain the Applicant Company's Management's experience, expertise or background regarding the requested lines of business. This explanation should be specific and include documentation which shows the amount of time management was involved in producing the requested lines and other information that demonstrates the experience level of management.

9. Provide a list of any affiliated parties that will be involved in the marketing, underwriting, servicing, administration, premium financing, claims adjustment or claims payment for the requested lines of business.

10. Provide a detailed description of the Applicant Company's sales techniques for the requested lines of business. The description should include:

- A. Information regarding recruitment and training of sales representatives.
- B. Identification as to whether the Applicant Company will be a direct writer or will use agents, brokers, or a combination thereof.
- C. Explanation of the compensation and control to be provided by the Applicant Company to its agents, brokers or sales personnel.
- D. Identification of any specific agency, third party administrator, or managing general agent, and a copy of the agreement. Including verification that such is properly licensed as needed.(would this be a follow-up request or due at submission?)

11. Provide the following for the requested lines of business:

- A. The product lines to be sold by the Applicant Company,
- B. The Applicant Company's marketing plan, including a description of the financial, corporate, or other connections productive of insurance,
- C. The Applicant Company's current and expected competition (both regionally and nationally) and

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- D. Include a detailed explanation as to how the Applicant Company will develop, purchase, control and supervise its advertising.

A general description of the classes to be transacted is not an adequate response. For example, if the Applicant Company plans to market credit life and disability products tailored for use by credit unions, simply stating that it will transact credit life and disability is inadequate.

- 12. If a parent, subsidiary, and/or affiliated insurer is already admitted for the classes of insurance requested in the pending application, differentiate the products and/or markets of the Applicant Company from those of the admitted insurer(s).

- 13. Explain in detail how (a) the Applicant Company’s policies will be underwritten, including the issuance of policies and endorsements (b) policies will be cancelled and (c) premiums and other funds will be handled, including:

- A. Identify the entity that will perform each of these functions.
- B. If personnel performing these functions will be shared with another entity, or if another entity will be performing these functions, provide an explanation of this arrangement.

- 14. Explain in detail how the Applicant Company will adjust and pay claims.

- A. Identify the entity that will perform the Applicant Company’s claims adjusting and claims payment functions.
- B. If personnel for claims adjusting or claims payment will be shared with another entity, or another entity will be performing the Applicant Company’s claims adjusting and claims payment, please explain this arrangement, including any affiliation with the Applicant Company.
- C. Provide detailed information as to how and by whom claim reserves will be set and modified.
- D. Does the Applicant Company pay any representative given discretion as to the settlement or adjustment of claims under life or disability policies, whether in direct negotiation with the claimant or in supervision of the person negotiating, a compensation which is in any way contingent upon the amount of settlement of such claims?

Yes \_\_\_ No \_\_\_

If yes, please provide a detailed explanation and attach to Questionnaire.

- 15. Is the Applicant Company a member of a group of companies that shares any of the following:

- A. Common facilities with another company or companies  
 Yes \_\_\_ No \_\_\_
- B. Services (e.g. accounting personnel for financial statement preparation)  
 Yes \_\_\_ No \_\_\_

If the answer to any of the above is yes please provide a detailed explanation and attach to Questionnaire.

- 16. Provide a company-wide, three-year pro forma balance sheet and income statement. For the lines being requested, provide (3) year premium and loss projections by line Projections should support all aspects of the proposed plan of operation, including reinsurance arrangements and any delegated function agreements. Include the assumptions used to arrive at these projections.

- 17. Provide an explanation of any reinsurance that will be entered into, or that is currently in place covering the requested lines of business. Provide details and attach to the Questionnaire.  
 For affiliated reinsurer – submit Form D for approval.

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18. Are any of the Applicant Company's policies being sold in connection with mutual funds or investments in securities?  
Yes \_\_\_ No \_\_\_ Not Applicable \_\_\_
- If yes, supply details including all sales literature which refers to the insurance and mutual fund or other investment plan connection.
19. If the Applicant Company is applying for authority to write Variable Annuities, provide the following:
- A. Copy of any third-party management or service contracts
  - B. Commission schedules
  - C. Five-year sales and expense projections
  - D. A statement from the Applicant Company's actuary describing reserving procedures including the mortality and expense risks which the Applicant Company will bear under the contract
  - E. Statement of the investment policy of the separate account
  - F. Copy of the variable annuity contract and application
  - G. A description of any investment advisory services contemplated relating to Separate Accounts
  - H. Board of Directors resolution authorizing the creation of the separate account.
20. If the Applicant Company is applying for authority to write Variable Life Insurance, provide the following:
- A. Copy(ies) of variable life policy(ies) the Applicant Company intends to issue
  - B. Name and experience of person(s) or firm(s) proposed to supply consulting, investments, administrative, custodial or distribution services to the Applicant Company
  - C. Disclose whether each investment advisor, 1) is registered under the Investment Advisers Act of 1940, or 2) is an investment manager under the Employee Retirement Income Security Act of 1974, or 3) whether the Applicant Company will annually file required information and statements concerning each investment advisor as required by its domiciliary state.
  - D. Statement of the investment policy of any separate account, and the procedures for changing such policy
  - F. A statement from the Applicant Company's actuary describing reserving procedures including the mortality and expense risks which the Applicant Company will bear under the contract.
  - G. Standards of suitability or conduct regarding sales to policyholders
  - H. Statement authorizing the creation of the separate account (i.e. Board resolution)
  - I. Statement specifying the standards of conduct with respect to the purchase or sale of investments of separate accounts (i.e. Board resolution)
21. If the Applicant Company is applying for authority to write Life Insurance, has the Applicant Company at any time within the last five years, irrespective of changes in management, taught or permitted its agents to sell insurance by using any of the following devices, or representations resembling any of the following:
- A. "Centers of influence" and "advisory board"

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- B. Yes \_\_\_ No \_\_\_
- B. Charter or founder’s policy  
Yes \_\_\_ No \_\_\_
- C. Profit sharing plan  
Yes \_\_\_ No \_\_\_
- D. Only a limited number of a certain policies will be sold in any given geographical area  
Yes \_\_\_ No \_\_\_
- E. “Profits” will accrue or be derived from mortality savings, lapses and surrenders, investment earnings, savings in administration  
Yes \_\_\_ No \_\_\_
- F. Printed list of several large American or Canadian insurers showing the dollar amounts of "savings", "profits" or "earnings" they have made in such categories  
Yes \_\_\_ No \_\_\_

If the answer to any of the above is yes, supply a complete set of all sales material including the sales manual, all Applicant Company instructional material, brochures, illustrations, diagrams, literature, “canned” sales talks, copies of the policies which are no longer in use, list of states where such methods were used and the date (by year) when they were used, the approximate amount of insurance originally written in each state on each policy form thusly sold, the amount currently in force, and the lapse ratio on each form year by year and cumulatively in gross to the present date.

**Deleting Lines of Business Section II**

22. Utilizing the information contained in Form 3, the lines of business requesting to be deleted, have those lines been removed from all foreign licensed states? Yes or No

If No, explain why.

- 23. Utilizing the information contained in Form 3, list all of the lines of business that the Applicant Company requests to be deleted from its Certificate of Authority.
- 24. Provide a detailed explanation for the Applicant Company’s request to delete these lines of business.
- 25. Indicate the number of policyholders by line of business that will be non-renewed or cancelled if the Applicant Company’s request to delete lines of business is approved.
- 26. Provide documentation that the Applicant Company has complied with all requirements for removal of lines of business from its Certificate of Authority, and withdrawal from the specified state.

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\_\_\_\_\_ Original Designation

\_\_\_\_\_ Amended Designation  
(must be submitted directly to states)

Applicant Company Name: \_\_\_\_\_

Previous Name (if applicable): \_\_\_\_\_

Statutory Home Office Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ NAIC CoCode: \_\_\_\_\_

The Applicant Company named above, organized under the laws of \_\_\_\_\_, and regulated under the laws of \_\_\_\_\_ for purposes of complying with the laws of the State(s) designate hereunder relating to the holding of a certificate of authority or the conduct of an insurance business within said State(s), pursuant to a resolution adopted by its board of directors or other governing body, hereby irrevocably appoints the officers of the State(s) and their successors identified in Exhibit A, or where applicable appoints the required agent so designated in Exhibit A hereunder as its attorney in such State(s) upon whom may be served any notice, process or pleading as required by law as reflected on Exhibit A in any action or proceeding against it in the State(s) so designated; and does hereby consent that any lawful action or proceeding against it may be commenced in any court of competent jurisdiction and proper venue within the State(s) so designated; and agrees that any lawful process against it which is served under this appointment shall be of the same legal force and validity as if served on the entity directly. This appointment shall be binding upon any successor to the above named entity that acquires the entity's assets or assumes its liabilities by merger, consolidation or otherwise; and shall be binding as long as there is a contract in force or liability of the entity outstanding in the State. The entity hereby waives all claims of error by reason of such service. The entity named above agrees to submit an amended designation form upon a change in any of the information provided on this power of attorney.

**Applicant Company Officers' Certification and Attestation**

One of the two Officers (listed below) of the Applicant Company must read the following very carefully and sign:

1. I acknowledge that I am authorized to execute and am executing this document on behalf of the Applicant Company.
2. I hereby certify under penalty of perjury under the laws of the applicable jurisdictions that all of the forgoing is true and correct, executed at \_\_\_\_\_.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of President

\_\_\_\_\_ Full Legal Name of President

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Secretary

\_\_\_\_\_ Full Legal Name of Secretary

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**Uniform Certificate of Authority (UCAA)  
Uniform Consent to Service of Process  
Exhibit A**

Acknowledge that the state selected below is the Applicant Company’s domiciliary state for which the person executing this form is appointing the designated agent for receipt of service of process:

<input type="checkbox"/> AL	Commissioner of Insurance # and Resident Agent*	<input type="checkbox"/> MO	Director of Insurance #
<input type="checkbox"/> AK	Director of Insurance #	<input type="checkbox"/> MT	Resident Agent*
<input type="checkbox"/> AZ	Director of Insurance # ^	<input type="checkbox"/> NE	Officer of Company* or Resident Agent* (circle one)
<input type="checkbox"/> AR	Resident Agent *	<input type="checkbox"/> NH	Commissioner of Insurance #
<input type="checkbox"/> AS	Commissioner of Insurance #	<input type="checkbox"/> NV	Commissioner of Insurance Commission # ^
<input type="checkbox"/> CO	Commissioner of Insurance # or Resident Agent*	<input type="checkbox"/> NJ	Commissioner of Banking and Insurance #^
<input type="checkbox"/> CT	Commissioner of Insurance #	<input type="checkbox"/> NM	Superintendent of Insurance #
<input type="checkbox"/> DE	Commissioner of Insurance #	<input type="checkbox"/> NY	Superintendent of Financial Services #
<input type="checkbox"/> DC	Commissioner of Insurance and Securities Regulation # or Local Agent* (circle one)	<input type="checkbox"/> NC	Commissioner of Insurance
<input type="checkbox"/> FL	Chief Financial Officer # ^	<input type="checkbox"/> ND	Commissioner of Insurance # ^
<input type="checkbox"/> GA	Commissioner of Insurance and Safety Fire # and Resident Agent*	<input type="checkbox"/> OH	Resident Agent*
<input type="checkbox"/> GU	Commissioner of Insurance #	<input type="checkbox"/> OR	Resident Agent*
<input type="checkbox"/> HI	Insurance Commissioner # and Resident Agent*	<input type="checkbox"/> OK	Commissioner of Insurance #
<input type="checkbox"/> ID	Director of Insurance # ^	<input type="checkbox"/> PR	Commissioner of Insurance #
<input type="checkbox"/> IL	Director of Insurance #	<input type="checkbox"/> RI	Superintendent of Insurance # ^
<input type="checkbox"/> IN	Resident Agent* ^	<input type="checkbox"/> SC	Director of Insurance #
<input type="checkbox"/> IA	Commissioner of Insurance #	<input type="checkbox"/> SD	Director of Insurance # ^
<input type="checkbox"/> KS	Commissioner of Insurance #	<input type="checkbox"/> TN	Commissioner of Insurance #
<input type="checkbox"/> KY	Secretary of State #	<input type="checkbox"/> TX	Resident Agent*
<input type="checkbox"/> LA	Secretary of State #	<input type="checkbox"/> UT	Resident Agent* ^
<input type="checkbox"/> MD	Insurance Commissioner #	<input type="checkbox"/> VT	Resident Agent*
<input type="checkbox"/> ME	Resident Agent* ^	<input type="checkbox"/> VI	Lieutenant Governor/Commissioner#
<input type="checkbox"/> MI	Resident Agent *	<input type="checkbox"/> WA	Insurance Commissioner #
<input type="checkbox"/> MN	Commissioner of Commerce ~	<input type="checkbox"/> WV	Secretary of State # @
<input type="checkbox"/> MS	Commissioner of Insurance and Resident Agent* BOTH are required.	<input type="checkbox"/> WY	Commissioner of Insurance #

- # For the forwarding of Service of Process received by a State Officer complete Exhibit B listing by state the entities (one per state) with **full name and address where service of process is to be forwarded**. Use additional pages as necessary. Colorado will forward Service of Process to the Secretary of the Applicant Company and requires a resident agent for foreign entities. Exhibit not required for New Jersey, and North Carolina. Florida accepts only an individual as the entity and requires an email address. New Jersey allows but does not require a foreign insurer to designate a specific forwarding address on Exhibit B. SC will not forward to an individual by name; however, it will forward to a position, e.g., Attention: President (or Compliance Officer, etc.). Washington requires an email address on Exhibit B.
- \* Attach a completed Exhibit B listing the Resident Agent for the Applicant Company (one per state). Include state name, Resident Agent’s **full name and street address**. Use additional pages as necessary. (DC\* requires an agent within a ten-mile radius of the District), (MT requires an agent to reside or maintain a business in MT).
- ^ Initial pleadings only.
- @ Form accepted only as part of a Uniform Certificate of Authority application.  
MA will send the required form to the Applicant Company when the approval process reaches that point.
- ~ Minnesota does not forward Service of Process. To effectively serve the Commissioner of Commerce, use the process under Minn. Stat. § 45.028. Applicant Company may complete Exhibit B to provide a Service of Process address that Commerce may keep on file.

**Exhibit A**

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**Uniform Certificate of Authority (UCAA)  
Uniform Consent to Service of Process  
Exhibit B**

Complete for each state indicated in Exhibit A:

State: \_\_\_\_\_ Name of Entity: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

---

State: \_\_\_\_\_ Name of Entity: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

---

State: \_\_\_\_\_ Name of Entity: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

---

State: \_\_\_\_\_ Name of Entity: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

---

State: \_\_\_\_\_ Name of Entity: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

**Exhibit B**

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**Resolution Authorizing Appointment of Attorney**

BE IT RESOLVED by the Board of Directors or other governing body of

\_\_\_\_\_  
(Applicant Company Name)

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, that the President or Secretary of said entity be and are hereby authorized by the Board of Directors and directed to sign and execute the Uniform Consent to Service of Process to give irrevocable consent that actions may be commenced against said entity in the proper court of \_\_\_\_\_ (Domestic State).....

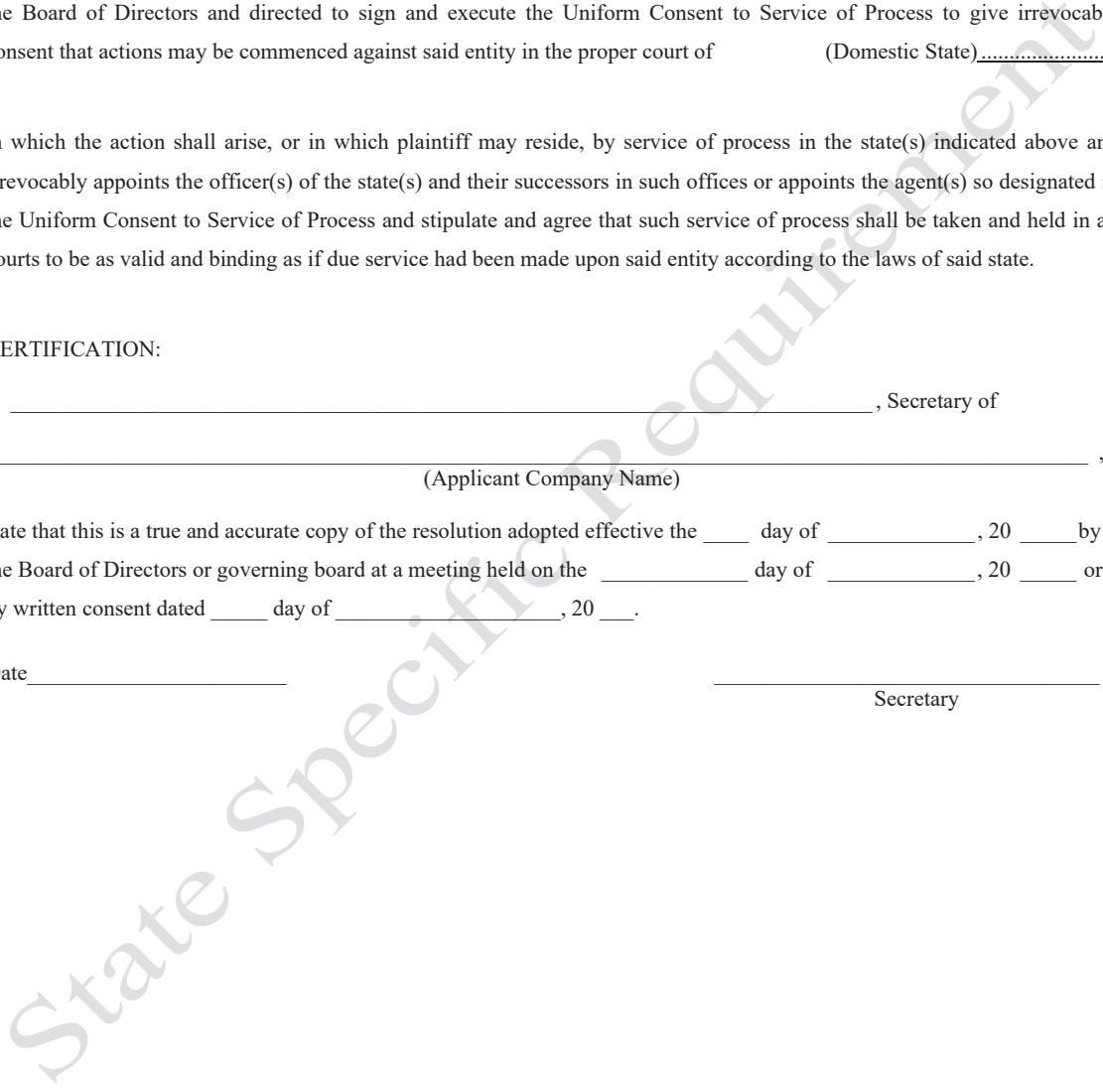
in which the action shall arise, or in which plaintiff may reside, by service of process in the state(s) indicated above and irrevocably appoints the officer(s) of the state(s) and their successors in such offices or appoints the agent(s) so designated in the Uniform Consent to Service of Process and stipulate and agree that such service of process shall be taken and held in all courts to be as valid and binding as if due service had been made upon said entity according to the laws of said state.

CERTIFICATION:

I, \_\_\_\_\_, Secretary of  
\_\_\_\_\_  
(Applicant Company Name)

state that this is a true and accurate copy of the resolution adopted effective the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ by the Board of Directors or governing board at a meeting held on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ or by written consent dated \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Date \_\_\_\_\_ Secretary \_\_\_\_\_



Applicant Company Name: \_\_\_\_\_

NAIC No. \_\_\_\_\_  
 FEIN: \_\_\_\_\_



**CHANGE OF ADMINISTRATIVE/MAILING OFFICE ADDRESS/CONTACT NOTIFICATION FORM**

**ADMINISTRATIVE/MAILING OFFICE ADDRESS/CONTACT CHANGE**

**If there has been an administrative office or mailing address and/ or contact person change, please complete the following:**

This form will notify the domiciliary regulator of administrative/ mailing office address changes or contact person changes applicable to the Applicant Company.

Catastrophe/Disaster Coordination Contact	A contact person for state departments to contact for information if there is a catastrophe or disaster.
Claim Information Contact	A contact person for the public to contact for claim information.
Consumer Complaints Contact	A contact person for state consumer complaint staff to contact for resolution of complaints filed with the state department.
Cybersecurity Contact	A contact person for the state departments to contact regarding data security and data breaches.
External Healthcare Review Contact	A contact person for state departments to initiate the external healthcare review process.
Form and/or Rate Filings Contact	A person for state departments to contact regarding issues on policy forms filings or rate filings.
Fraud Assessment Invoice Contact	A person for state departments to contact regarding issues of payment of fraud assessments.
Local Office in Domestic/Foreign State Contact	A person for the public or state departments to contact.
Managing General Agent	A person for the public or state departments to contact.
Market Conduct Contact	A person for state departments to contact regarding market conduct issues.
Market Conduct Annual Statement (MCAS) Contact	A contact person responsible for answering questions related to the MCAS.
Market Conduct Annual Statement (MCAS) Attestation #1 Contact	The primary contact person responsible for attesting to the accuracy and completeness of the MCAS.
Market Conduct Annual Statement (MCAS) Attestation #2 Contact	The secondary contact person responsible for attesting to the accuracy and completeness of the MCAS.
Policyholder Information Contact	A person for the public to contact.
Producer Licensing Contact (Appointment)	A person for state departments to contact regarding issues of producer licensing or appointments of agents.
Regulatory Compliance/Government Relations Contact	A person for state departments to contact on matters related to regulation but unrelated to public complaints filed with the state department.
Premium Tax Contact	A person for state departments to contact regarding issues of payment of premium tax.
Company Licenses/Fees Contact	A person for state departments to contact regarding issues of payment of license fees.
Deposits Contact	A person for state departments to contact regarding statutory deposits.

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U.S. Legal Counsel (for aliens)	A person for state departments to contact.
Annual Statement Contact	A contact person responsible for answering questions in the completion of the annual statement.
Company Administrative Office Address	A change to the administrative office address of the company.
Mailing Address	A change to the mailing address of the company.

**NEW CONTACT**

Contact Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Toll Free/Instate Phone #: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Previous Contact Name (if changed): \_\_\_\_\_

Entity Name of MGA (if contact or address changed): \_\_\_\_\_

MGA email: \_\_\_\_\_

**NEW ADMINISTRATIVE OFFICE ADDRESS**

Address: \_\_\_\_\_

Suite/Mail Stop: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email: \_\_\_\_\_ Toll Free/Instate Phone #: \_\_\_\_\_

Main Administrative Office Phone Number: \_\_\_\_\_

**NEW MAILING ADDRESS**

Address: \_\_\_\_\_

Suite/Mail Stop: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email: \_\_\_\_\_ Toll Free/Instate Phone #: \_\_\_\_\_

Mailing Office Phone Number: \_\_\_\_\_

\_\_\_\_\_  
Signature of Preparer

\_\_\_\_\_  
Date of Preparation

\_\_\_\_\_  
Typed or Printed Name

\_\_\_\_\_  
Title of Preparer

\_\_\_\_\_  
Phone Number of Preparer

\_\_\_\_\_  
Email Address of Preparer

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Applicant Name \_\_\_\_\_ NAIC No. \_\_\_\_\_  
 FEIN: \_\_\_\_\_



**Statement of Voluntary Dissolution  
 Summary of License Status in Non-Domicile States**

This statement is submitted to the Company’s domestic state regulator to summarize how the Company has addressed its licensure in other states. Limit the information to those states in which a Certificate of Authority has been held within the last 10 years.

Certificate of Authority has been held from the states selected:

1. Provide date of approval of surrender of Certificate of Authority for the selected state(s).  
 If surrender is not in effect, please explain. (states listed should match Sch T) (a surrender date or explanation is required)

(State)	Tracking	(Date of Surrender)	Explanation

2. Do any policyholder obligations or contingent liabilities of the dissolving company exist in the selected state?

If Yes, an explanation is required:

3. Have all premium taxes, fees and other monetary obligations owed to the selected state(s) been paid?

If no, an explanation is required:

4. Does a state regulatory deposit exist in the selected state(s)?

If Yes, provide the amount and explain its purpose.

Applicant Name \_\_\_\_\_ NAIC No. \_\_\_\_\_  
FEIN: \_\_\_\_\_



I acknowledge that I am an officer of the Company, am authorized to execute and am executing this document on behalf of the Company. I hereby certify under penalty of perjury under the laws of the applicable jurisdictions that all of the forgoing, including attachments, is true and correct as of the date of signature below.

Executed at \_\_\_\_\_  
Location

_____	_____	_____
Date	Signature of Officer	Printed Name
	_____	
	Title of Office	



## DOMESTIC STATE CORPORATE AMENDMENTS

Existing insurers use the Uniform Certificate of Authority Corporate Amendment Application for requesting amendments to its Certificate of Authority. A Uniform State is one that is committed to using the Uniform Certificate of Authority (UCAA) review process for company licensing and admissions.

The Applicant Company can use the Corporate Amendment Application to file more than one change for the domiciliary state submission. The Applicant Company should select all applicable changes and submit all items required for those changes.

The following instructions contain a detailed explanation of the various requirements designed to assist in the completion and submission of the necessary documentation to obtain regulatory approval. The state's review process will be a comprehensive and detailed operational and financial review of the Applicant Company's business.

### Corporate Amendments Application Review Process

The Corporate Amendment Application of the UCAA provides a uniform process for gaining the necessary regulatory approvals for modifications to an Applicant Company's Certificate of Authority. It is the goal of the Uniform State to process the Corporate Amendments Application within 60 calendar days of receipt.

### Proprietary Information

Both regulators and the Applicant Company should note that the Applicant Company might deem confidential any communications with insurance regulatory agencies in conjunction with the Corporate Amendment Application concerning proprietary information about the Applicant Company. States may only share information determined to be confidential with other persons as authorized by law. By law, the state will not disclose to the public any information determined to be proprietary and trade secret. The Applicant Company needs to expressly identify all information in the application and in any subsequent correspondence that the Applicant Company considers proprietary or trade secret.

The [UCAA homepage](#) contains the requirements and filing process for the Corporate Amendment Application. Contact the appropriate state regulators with any questions before filing any Uniform Application. State contact information can be found on the [Addresses and Contact Information for Submission of Application chart](#). The UCAA webpage will be reconfigured, once completed the file locations will be updated.

**Step One: Filing the Application****Processing Goal: 2 Weeks**

An Applicant Company may submit Corporate Amendment Applications anytime during the year. The state immediately reviews the application to ensure that all required information is provided as outlined in the instructions.

Generally, within two weeks from the date that the application is received, the state will update the status in the electronic application and assign the application to a lead reviewer. The lead reviewer will be identified on the summary detail of the application.

The state will contact the Applicant Company if it does not accept the application for filing due to a deficiency in the application via a Request for Information (RFI) in the electronic application. Depending upon the nature of the deficiency, the state may give the Applicant Company two weeks from the date of the RFI to correct the deficiency. Some states may notify the Applicant Company of any applications that are deficient and not accepted for filing. Electronic applications that are not accepted by the state should be withdrawn by the Applicant Company.

**Step Two: Application Review****Processing Goal: 60 Days**

A Corporate Amendment Application will undergo a rigorous financial and operational review in the application state. While the goal of each state is to complete this review in 60 days, the state cannot guarantee this time frame. Due to varying levels of resources available in each state or if the state needs additional information, the 60-day goal may not be attainable. The purpose of the Corporate Amendment Application is to streamline the application process and the states will make every effort to process a Corporate Amendment Application as quickly as possible.

At the conclusion of the substantive review the domiciliary state will grant the Applicant Company an amendment to the Certificate of Authority, allow the Applicant Company to withdraw the application, or will deny the application.

If the state deems the application incomplete, the Applicant Company will be automatically notified when the states provides a status and a detailed explanation via the RFI. The Applicant Company can amend or withdrawal their application, a detailed explanation is required for either option. If withdrawn, the Applicant Company may wish to re-file a Corporate Amendment Application at a later date. A new application and filing fee will be required for the new filing.

**How to File**

Refer to the [State-Specific Information](#). States that have provided their state specific requirements for domestic companies will be incorporated into the electronic application.

1. [Communication Between Applicant Company and Agency](#)



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2. [Questions](#)
3. [Application and Supporting Documents](#)
4. [Updates/Changes](#)
5. [Filing Fee](#)
6. [State-Specific Information](#)

## 1. **Communication Between Applicant Company and Agency**

Once a state accepts a Corporate Amendment Application for filing, the filing will be forwarded to the assigned analyst (Lead Reviewer).

Before receiving the name of the lead reviewer, an Applicant Company may contact, via the (RFI) link, before assignment all RFI's will be automatically directed to the state application coordinator or company licensing manager to obtain information regarding the status of a Corporate Amendment Application.

## 2. **Questions**

Section I through Section IX, Filing Requirements, provide detailed guidelines regarding the information required for the Corporate Amendment Application. For additional information, or clarification, the Applicant Company should review the [State Requirement charts](#) and [FAQs](#) prior to contacting the state.

## 3. **Application and Supporting Documents**

- All applicable forms are provided for the change type(s) selected.

## 4. **Updates/Changes**

The Applicant Company is responsible for informing states of any significant changes that occur or that the Applicant Company discovers during the application review period. Examples of significant changes include changes in officers and directors, material acquisition or disposal of assets, changes in reinsurance, acquisition of the insurer, regulatory actions taken against the insurer, change in current business plan or corporate structure, etc.

The Applicant Company must supply amended forms promptly if any changes occur which materially affect the accuracy of the forms originally submitted in the application. The updated attachments can be submitted via an RFI or an amended application. .

## 5. **Filing Fee**

Please see [Filing Fees - Corporate Amendments chart](#) and [Filing Fees Matrix - Corporate Amendments chart](#), located on the UCAA website, to determine the correct fee and filing instructions for the application state. Where indicated, checks will need to be mailed directly to



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the application state. Refer to the appropriate state chart for mailing instructions. Include a copy of the completed Checklist for reference to the electronic application tracking number.

## 6. State-Specific Information

Some jurisdictions may have additional requirements that the Applicant Company must meet before the state can issue an amended Certificate of Authority. Before completing a UCAA Corporate Amendment Application the Applicant Company should be familiar with its domiciliary state requirements which are located under [State-Specific Requirements](#) on the UCAA website. Some states may have their state specific requirements incorporated into the electronic application.

### Electronic Portal

The Applicant Company must first obtain a User ID and password. The individual completing the application on behalf of the Applicant Company must obtain approval from either the Corporate Secretary or General Counsel of the Applicant Company. If the Applicant Company is part of a Holding Company Structure, the User may associate multiple companies within the group to their User ID. Only one ID is allowed per individual.

A [User Guide](#) is provided as a guide for utilizing the electronic application. Tooltips are incorporated into the electronic application.

The UCAA Corporate Amendment Application has nine domiciliary change types (sections) designed to guide the Applicant Company through the licensing process.

- I. [Adding Lines of Business Filing Requirements](#)
- II. [Deleting Lines of Business Filing Requirements](#)
- III. [Name Change Filing Requirements](#)
- IV. Change of Company Structure Filing Requirements
- V. [Change of Statutory Home Office Address Filing Requirements](#)
- VI. [Amended Articles of Incorporation](#)
- VII. [Amended Bylaws](#)
- VIII. [Change of Administrative Address/Contact Notification Filing Requirement](#)
- IX. Statement of Voluntary Dissolution

### Corporate Amendments Application Section I Filing Requirements - Adding Lines of Business

This section provides a guide to understanding the focus of each change type of the Corporate Amendment Application. However, there typically are multiple purposes for documents. Therefore, it is important that applications be complete.



All required forms are provided for the application change type selected, therefore it is important to read the instructions prior to starting an electronic filing to ensure the necessary corporate amendment change type is selected and the appropriate forms are provided.

### Table of Contents/ Application Requirements

1. [Application Form and Attachments](#)
2. [Filing Fee](#)
3. [Articles of Incorporation](#)
4. [Bylaws](#)
5. [Minimum Capital and Surplus Requirements](#)
6. [Plan of Operation](#)
7. [Statutory Membership\(s\)](#)
8. [State-Specific Information](#)

#### 1. Application Form and Attachments

The application must identify all lines of insurance (Form 3) that the Applicant Company is currently authorized to transact and specify the lines of authority to add to an existing Certificate of Authority, as identified in the plan of operation (Form 8, Form 13 and Narrative). A cover letter may be included and if required, the Applicant Company's original Certificate of Authority or an Affidavit of Lost Certificate of Authority (Form 15),

#### 2. Filing Fee

The application will generate an invoice based on the change type selected and state specific requirements provided and be submitted to the application state, unless specified that the state prefers to send a separate invoice. The payee name and the instructions for submitting the filing fee are included in the [Filing Fees - Corporate Amendments](#) chart. Upload a copy of the Applicant Company's check and reference the electronic application tracking number.

#### 3. Articles of Incorporation

Indicate the location of the language within the Articles of Incorporation that allows the Applicant Company to write this line (e.g., page number, section number, etc., of the Articles of Incorporation). In addition:

- If the Articles of Incorporation have changed because of this application, file the amended Articles of Incorporation.  
If the Articles of Incorporation most recently filed in the application state have not changed because of this application, do not file the Articles of Incorporation. Simply state that the current Articles of Incorporation are already on file in the application state.



#### 4. **Bylaws**

The Applicant Company should have previously filed the most current version of their bylaws.

- If the bylaws have changed because of this application, file the amended bylaws.
- If the bylaws most recently filed in the application state have not changed because of this application, do not file the bylaws. Simply state that the current bylaws are already on file in the application state.

#### 5. **Minimum Capital and Surplus Requirements**

The application will need to show that the Applicant Company meets the state's statutory minimum capital and surplus requirements for the requested amendment to its Certificate of Authority. In some states, the minimum capital and surplus requirements are determined by the classes of insurance that the Applicant Company is requesting authority to transact. The state will determine the level of surplus required after considering the Applicant Company's product line, operating record and financial condition. Compliance with the statutorily prescribed minimum surplus requirement may not be sufficient for all Applicant Companies. The [Minimum Capital and Surplus Requirements](#) chart identifies the minimum capital and surplus requirements for each Uniform State. This chart also provides a contact person or a link to a state-specific format or RBC requirements and instructions. Submit an explanation of the Applicant Company's compliance with the capital and surplus requirements.

#### 6. **Plan of Operation**

The Plan of Operation has three components, a brief narrative, proforma financial statements/projections (Form 13) and a completed Questionnaire ([Form 8D](#)). The narrative should include significant information not captured as a part of the Questionnaire that the Applicant Company submits in support of the application. The proforma is one of three (3) components in the Plan of Operation. The forms are located under the Corporate Amendment tab. There is a proforma for Life, Property/Casualty, Health and Title companies. Provide a company-wide, three-year proforma balance sheet and income statement. The proforma workbook should be the same business type as the financial statement blank filed with the NAIC. For the lines requested, provide three-year premium and loss projections by line of business for the application state. Projections must support all aspects of the proposed Plan of Operation, including reinsurance arrangements and any delegated function agreements. Include the assumptions used to arrive at these projections.

The proforma when applied to the Corporate Amendment application is projected data. As such, the projected amounts need not balance with historical NAIC financial filings. The projected data, however, should be relevant to the Company's history of growth and losses as contemplated by the NAIC *Accounting Practices and Procedures Manual*.





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The proforma should be completed by statutory accounting and financial reporting professionals that should be available to answer any questions or concerns from reviewing regulatory staff. The proforma is completed on an annual basis, typically for a three-year time period, however, some state may require five years. The proforma balance sheet should also include the authorized control level amount to calculate the Risk-Based Capital ratio for each projected year. The proforma should start with the first full year of operation that the Applicant Company anticipates actively writing business in the state receiving the application. When preparing a five-year projection, two proforma excel workbooks can be submitted.

The proforma (Form 13) is also located in the Forms Section under each application tab on the UCAA website. Submit the narrative and completed proforma and all attachments.

#### 7. **Statutory Memberships**

In some states, the Applicant Company is required to join one or more rating, guarantee or other organizations before transacting insurance. Generally, the Applicant Company's authorized lines of insurance govern statutorily mandated memberships. The [Statutory Membership Requirements](#) chart provides the list of statutory memberships that may be required before transacting insurance. Submit documentation supporting membership application(s), in states where required.

#### 8. **State-Specific Information**

Some jurisdictions may have additional requirements that the Applicant Company must meet before the state can amend a Certificate of Authority. Before completing a UCAA Corporate Amendment Application, the Applicant Company should review the listing of requirements on the [State-Specific requirements](#) for its state of domicile. Some states may include their state specific requirements into the electronic application. Statutory Deposit may be increased due to a change in the lines of business, the state will notify the Applicant Company if deposit adjustments are required.

If your domiciliary state requires that the certificate of authority be returned, mail that directly to the state and provide a copy in the jurisdiction requirement section of the electronic application or upload an affidavit of lost certificate of authority.

Some jurisdictions may require a copy of the Form D, post licensure for affiliated parties involved in the marketing, underwriting, servicing, administration, premium financing, claims adjustment or claims payment.

Some jurisdictions may require a copy of the variable annuity prospectus expected to be filed with the SEC.



## Corporate Amendments Application Section II Filing Requirements Deleting Lines of Business

This section provides a guide to understanding the focus of each change type of the Corporate Amendment Application. However, there typically are multiple purposes for documents. Therefore, it is important that applications be complete.

All required forms are provided for the application change type selected, therefore it is important to read the instructions prior to starting an electronic filing to ensure the necessary corporate amendment change type is selected and the appropriate forms are provided.

### Table of Contents/ Application Requirements

1. [Application Form and Attachments](#)
2. [Filing Fee](#)
3. [Articles of Incorporation](#)
4. [Bylaws](#)
5. [Minimum Capital and Surplus Requirements](#)
6. [Plan of Operation](#)
7. [Statutory Membership\(s\)](#)
8. [State-Specific Information](#)

#### 1. Application Form and Attachments

The application must identify all lines of insurance that the Applicant Company is currently authorized to transact and specify the lines of authority to delete from an existing Certificate of Authority, as identified in the plan of operation. [The Applicant Company should also provide the lines of authority for its foreign states to ensure that the requested lines to be deleted are not currently being written in a foreign state. A cover letter may be included and if required, the Applicant Company's original Certificate of Authority or an Affidavit of Lost Certificate of Authority \(Form 15\).](#)

#### 2. Filing Fee

The application will generate an invoice based on the change type selected and state specific requirements submitted to the application state, unless specified that the state prefers to send a separate invoice. The payee name and the instructions for submitting the filing fee are included in the [Filing Fees - Corporate Amendments](#) chart. Upload a copy of the Applicant Company's check and reference the electronic application tracking number.

#### 3. Articles of Incorporation



Indicate the location of the language within the Articles of Incorporation that allows the Applicant Company to write this line (e.g., page number, section number, etc., of the Articles of Incorporation). In addition:

- If the Articles of Incorporation have changed because of this application, file the amended Articles of Incorporation.

If the Articles of Incorporation most recently filed in the application state have not changed because of this application, do not file the Articles of Incorporation. Simply state that the current Articles of Incorporation are already on file in the application state.

#### 4. **Bylaws**

The Applicant Company should have previously filed the most current version of their bylaws.

- If the bylaws have changed because of this application, file the amended bylaws.
- If the bylaws most recently filed in the application state have not changed because of this application, do not file the bylaws. Simply state that the current bylaws are already on file in the application state.

#### 5. **Minimum Capital and Surplus Requirements**

The application will need to show that the Applicant Company meets the state's statutory minimum capital and surplus requirements for the requested amendment to its Certificate of Authority. In some states, the minimum capital and surplus requirements are determined by the classes of insurance that the Applicant Company is requesting authority to transact. The state will determine the level of surplus required after considering the Applicant Company's product line, operating record and financial condition. Compliance with the statutorily prescribed minimum surplus requirement may not be sufficient for all Applicant Companies. The [Minimum Capital and Surplus Requirements](#) chart identifies the minimum capital and surplus requirements for each Uniform State. This chart also provides a contact person or a link to a state-specific format or RBC requirements and instructions. Submit an explanation of the Applicant Company's compliance with the capital and surplus requirements.



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## 6. Plan of Operation

The Plan of Operation has three components, a brief narrative, proforma financial statements/projections (Form 13) and a completed Questionnaire ([Form 8D](#)).

Complete [Form 8D](#) documenting the following:

- a. Utilizing the information contained in [Form 3](#), list all of the lines of business that the Applicant Company is requesting to delete from its Certificate of Authority.
- b. Provide a detailed explanation for the Applicant Company's request to delete these lines of business.
- c. For the state, indicate the number of policyholders by line of business that will be non-renewed or cancelled if the state approves the Applicant Company's request to delete lines of business.

The UCAA website contains a [Deleting Lines of Business Requirements](#) chart of individual state requirements. Provide documentation that complies with all requirements for removal of lines of business from the Certificate of Authority. The Applicant Company should notify the foreign state(s) if a line of business has been requested to be deleted from their domiciliary state's certificate of authority. **The domiciliary state will not approve the removal of any lines of business that are currently being written in a foreign state.**

The [Narrative](#) should include significant information not captured as a part of the Questionnaire that the Applicant Company submits in support of the application. The proforma is one of three (3) components in the Plan of Operation. The forms are located under the Corporate Amendment tab. There is a proforma for Life, Property/Casualty, Health and Title companies. Provide a company-wide, three-year proforma balance sheet and income statement. The proforma workbook should be the same business type as the financial statement blank filed with the NAIC. For the lines requested, provide three-year premium and loss projections by line of business for the application state. Projections must support all aspects of the proposed Plan of Operation, including reinsurance arrangements and any delegated function agreements. Include the assumptions used to arrive at these projections.

The proforma when applied to the Corporate Amendment application is projected data. As such, the projected amounts need not balance with historical NAIC financial filings. The projected data, however, should be relevant to the Company's history of growth and losses as contemplated by the NAIC *Accounting Practices and Procedures Manual*.

The proforma should be completed by statutory accounting and financial reporting professionals that should be available to answer any questions or concerns from reviewing regulatory staff. The proforma is completed on an annual basis, typically for a three-year time period, however, some state may require five years. The proforma balance sheet should also include the authorized control level amount to calculate the Risk-Based Capital ratio for each projected year. The proforma should start with the first full year of operation that the Applicant Company anticipates



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actively writing business in the state receiving the application. When preparing a five-year projection, two proforma excel workbooks can be submitted.

The proforma (Form 13) is also located in the Forms Section under each application tab on the UCAA website. Submit the narrative and completed proforma and all attachments.

#### 7. **Statutory Memberships**

In some states, the Applicant Company is required to join one or more rating, guarantee or other organizations before transacting insurance. Generally, the Applicant Company's authorized lines of insurance govern statutorily mandated memberships. The [Statutory Membership Requirements](#) chart provides the list of statutory memberships that may be required before transacting insurance. Submit documentation supporting membership application(s), in states where required.

#### 8. **State-Specific Information**

Some jurisdictions may have additional requirements that the Applicant Company must meet before the state can amend a Certificate of Authority. Before completing a UCAA Corporate Amendment Application, the Applicant Company should review the listing of requirements on the [State-Specific requirements](#) for its state of domicile. Some states may include their state specific requirements into the electronic application.

[If required, the certificate of authority should be returned and a copy provided in the Jurisdiction Requirements, or attach an Affidavit of Lost Certificate of Authority \(Form 15\).](#)

### **Corporate Amendments Application Section III Filing Requirements (Name Change)**

All required forms pertaining to a name change are automatically provided when this change type is selected.

#### **Table of Contents/ Application Requirements**

1. [Application Form and Attachments](#)
2. [Filing Fee](#)
3. [Articles of Incorporation](#)
4. [Bylaws](#)
5. [Service of Process](#)
6. [State-Specific Information](#)
7. [Name Approval](#)

#### **1. Application Form and Attachments**



A cover letter may be included and if required, the Applicant Company's original Certificate of Authority or an Affidavit of Lost Certificate of Authority (Form 15),

## 2. Filing Fee

The application will generate an invoice based on the change type selected and state specific requirements provided and submit to the domiciliary state, unless the state prefers to send a separate invoice. . The payee name and the instructions for submitting the filing fee are included in the [Filing Fees - Corporate Amendments](#) chart. Attach a copy of the Applicant Company's check if the state does not accept electronic filing fees. Reference the electronic application tracking number with the payment.

## 3. Articles of Incorporation

Indicate the location of the language within the Articles of Incorporation that reflects the new name (e.g., page number, section number, etc., of the Articles of Incorporation). In addition:

- If the Articles of Incorporation have changed because of this application, file the amended Articles of Incorporation.
- If the Articles of Incorporation most recently filed in the application state have not changed because of this application, do not file the Articles of Incorporation. Simply state that the current Articles of Incorporation are already on file in the application state.

## 4. Bylaws

The Applicant Company should have previously filed the most current version of their bylaws.

- If the bylaws have changed because of this application, file the amended bylaws.
- If the bylaws most recently filed in the application state have not changed because of this application, do not file the bylaws. Simply state that the current bylaws are already on file in the application state.

## 5. Service of Process

An electronically executed UCAA Service of Process ([Form 12](#)) may be required for this change type or see [state-specific requirements](#).

## 6. State-Specific Information

Some jurisdictions may have additional requirements that the Applicant Company must meet before the state can amend a Certificate of Authority. Before completing a UCAA Corporate Amendment Application, the Applicant Company should review a listing of requirements for its



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domiciliary state.. [State-specific requirements](#) are located on the UCAA website. Some states may incorporate those state specific requirements into the electronic application.

## 8. Name Approval

Each state has different guidelines and procedures for name approval. The [Name Approval Requirements](#) chart is intended to serve as a guide for the various name approval requirements of each Uniform State. The Applicant Company should check with each state separately to ensure compliance with all applicable name approval requirements. Where applicable, submit evidence of the name approval request.

Automatic notification will be provided to the NAIC once the domiciliary state approves the name change. Verify that the NAIC has completed the name change prior to preparation of any foreign state(s) electronic application. Email confirmation to: [jheinz@naic.org](mailto:jheinz@naic.org).

### Corporate Amendments Application Section IV Filing Requirements (Change of Company Structure)

#### Table of Contents/ Filing Requirements

1. [Application Form and Attachments](#)
2. [Filing Fee](#)
3. [Articles of Incorporation](#)
4. [Bylaws](#)
5. [State-Specific Information](#)

#### 1. Application Form and Attachments

A cover letter may be included with the Applicant Company's original Certificate of Authority or an Affidavit of Lost Certificate of Authority ([Form 15](#)), if required. All required forms and attachment buttons will be provided in the electronic application for the change type selected.

#### 2. Filing Fee

The application will need to include a filing fee for the application state. The payee name and the instructions for submitting the filing fee are included in the [Filing Fees - Corporate Amendments](#) chart. Checks will need to be mailed directly to the application state, if your domiciliary state does not accept electronic fees. Reference the electronic application tracking number with your payment.



### 3. Articles of Incorporation

Indicate the location of the language within the Articles of Incorporation that reflects the change to the corporate structure of the Applicant Company. (e.g., page number, section number, etc., of the Articles of Incorporation). In addition:

- If the Articles of Incorporation have changed because of this application, file the amended Articles of Incorporation.
- If the Articles of Incorporation most recently filed in the application state have not changed because of this application, do not file the Articles of Incorporation. Simply state that the current Articles of Incorporation are already on file in the application state.

### 4. Bylaws

The Applicant Company should have previously filed the most current version of their bylaws.

- If the bylaws have changed because of this application, file the amended bylaws.
- If the bylaws most recently filed in the application state have not changed because of this application, do not file the bylaws. Simply state that the current bylaws are already on file in the application state.

### 5 Jurisdiction Requirements

Some jurisdictions may have [State-Specific Requirements](#) that the Applicant Company must meet before the state can amend a Certificate of Authority. Before completing a UCAA Corporate Amendment Application, the Applicant Company should review a listing of requirements for their domiciliary state. Completed the optional Form 14, if contact address information has changed because of this application.

## Corporate Amendments Application Section V Filing Requirements (Change of Statutory Home Office Address)

### Table of Contents/ Filing Requirements

1. [Application Form and Attachments](#)
2. [Filing Fee](#)
3. [Articles of Incorporation](#)
4. [Bylaws](#)
5. [Service of Process](#)
6. [State-Specific Information](#)





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**1. Application Form and Attachments**

A cover letter may be included with the Applicant Company's original Certificate of Authority or an Affidavit of Lost Certificate of Authority ([Form 15](#)), if required. All required forms and attachment buttons are provided in the electronic application for the change type selected.

**2. Filing Fee**

The application will need to include a filing fee for the application state. The payee name and the instructions for submitting the filing fee are included in the [Filing Fees - Corporate Amendments](#) chart. Checks will need to be mailed directly to the application state, if your domiciliary state does not accept electronic fees. Reference the electronic application tracking number with your payment.

**3. Articles of Incorporation**

Indicate the location of the language within the Articles of Incorporation that reflects the change in corporate structure of the Applicant Company (e.g., page number, section number, etc., of the Articles of Incorporation). In addition:

- If the Articles of Incorporation have changed because of this application, file the amended Articles of Incorporation.
- If the Articles of Incorporation most recently filed in the application state have not changed because of this application, do not file the Articles of Incorporation. Simply state that the current Articles of Incorporation are already on file in the application state.

**4. Bylaws**

The Applicant Company should have previously filed the most current version of their bylaws.

- If the bylaws have changed because of this application, file the amended bylaws.
- If the bylaws most recently filed in the application state have not changed because of this application, do not file the bylaws. Simply state that the current bylaws are already on file in the application state.

**5. Service of Process**

An executed UCAA Service of Process form ([Form 12](#)) may be required or [State-Specific Requirements](#). [Jurisdiction-Specific Requirements](#).

**6. [Jurisdiction](#)-Specific Information**



Some jurisdictions may have [State-Specific Requirements](#) that the Applicant Company must meet before the state can amend a Certificate of Authority. Before completing a UCAA Corporate Amendment Application, the Applicant Company should review a listing of requirements for their domiciliary state. Completed the optional Form 14, if contact address information has changed because of this application.

## **Corporate Amendments Application Section VI Filing Requirements (Amended Articles of Incorporation)**

### **Table of Contents / Filing Requirements**

1. [Application Form and Attachments](#)
2. [Filing Fee](#)
3. [Articles of Incorporation](#)
4. [Bylaws](#)
5. [State-Specific Information](#)

#### **1. Application Form and Attachments**

A cover letter may be included with the Applicant Company's original Certificate of Authority or an Affidavit of Lost Certificate of Authority ([Form 15](#)), if required. All required forms and attachment buttons are provided in the electronic application for the change type selected.

#### **2. Filing Fee**

The application will need to include a filing fee for the state to which the Applicant Company is submitting. The payee name and the instructions for submitting the filing fee are included in the: [Filing Fees - Corporate Amendments](#) chart on the UCAA website. Submit a copy of the Applicant Company's check, reference the electronic application tracking number with your payment.

#### **3. Articles of Incorporation**

Indicate the location of the language within the Articles of Incorporation that reflects the change (e.g., page number, section number, etc., of the Articles of Incorporation).

#### **4. Bylaws**

The Applicant Company should have previously filed the most current version of their bylaws.

- If the bylaws have changed as a result of this application, file the amended bylaws.



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- If the most recently filed (in the state in which application is being made) bylaws have not changed as a result of this application, do not file the bylaws. Simply state that the current bylaws are already on file in the state to which this application relates.

## 5. State-Specific Information

Some jurisdictions may have additional requirements that must be met before a Certificate of Authority can be amended. Before completing a UCAA Corporate Amendment Application, the Applicant Company should review a listing of requirements for the state(s) in which application is being made.

### Corporate Amendments Application Section VII Filing Requirements (Amended Bylaws)

#### Table of Contents /Filing Requirements

1. [Application Form and Attachments](#)
2. [Filing Fee](#)
3. [Bylaws](#)
4. [State of Domicile Approval](#)
5. [State-Specific Information](#)

#### 1. Application Form and Attachments

A cover letter may be included with the Applicant Company's original Certificate of Authority or an Affidavit of Lost Certificate of Authority ([Form 15](#)), if required. All required forms and attachment buttons are provided in the electronic application for the change type selected.

#### 2. Filing Fee

The application will need to include a filing fee for the state to which the Applicant Company is submitting. The payee name and the instructions for submitting the filing fee are included in the [Filing Fees - Corporate Amendments](#) chart on the UCAA website. For electronic filings, checks will need to be mailed directly to the application state, reference the electronic application tracking number with your payment.

#### 3. Bylaws

Indicate the location of the language within the bylaws that reflects the change (e.g., page number, section number, etc., of the bylaws).

#### 5. State-Specific Information



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Some jurisdictions may have additional requirements that must be met before a Certificate of Authority can be amended. Before completing a UCAA Corporate Amendment Application, the Applicant Company should review a list of requirements for the state in which application is being made.

**The following applications are considered stand-alone applications.**

**Corporate Amendments Application Section VIII  
Filing Requirements (Change of Mailing/Administrative Office Address/Contact Notification)**

**Instructions**

The Applicant Company should complete the Corporate Amendment Application Section VII as a courtesy filing in conjunction with other changes or to notify regulatory officials of an administrative office or mailing address changes or contact person changes applicable to the Applicant Company. For electronic filings, this change is submitted separately (stand-alone) or in conjunction with any other change type.

**Table of Contents / Filing Requirements**

1. [Application Form and Attachments](#)
2. [State-Specific Information](#)

**1. Application Form and Attachments - Item 1 of Application**

The Change of Administrative Office Address/Contact Notification is used to update contact information or administrative office address information and does not require an approval. Submit a completed Change of Mailing/Administrative Office Address/Contact Notification ([Form 14](#)).

**2. State-Specific Information - Item 2 of Application**

The Applicant Company should review the [State-specific requirements](#) for the application state.

**Corporate Amendments Application Section IX  
Filing Requirements (Uniform Consent to Service of Process)**

This section provides a guide to understanding the focus of a stand-alone Uniform Consent to Service of Process Application. It is important that the application be complete.

Please [contact the states individually](#) if there are questions about a specific document that is not noted under the state specific instructions on the UCAA website.



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The electronic stand-alone application is located under the [Electronic Application](#) link on the UCAA web site and requires a user ID and password to access.

Please read the following Instructions before proceeding in completing Corporate Amendment Application Section IX.

### **Instructions**

The Applicant Company can complete the Uniform Consent to Service of Process Application as a stand-alone filing or in conjunction with any other Corporate Amendment Application via the electronic application where a service of process form is required to notify regulatory officials of service of process changes to the Applicant Company.

### **Table of Contents /Filing Requirements**

1. [Application Form and Attachments](#)
2. [Filing Fee](#)
3. [State-Specific Information](#)

#### **1. Uniform Consent to Service of Process Form**

The Uniform Consent to Service of Process is located on the UCAA website. Submit a completed Uniform Consent to Service of Process ([Form 12](#)) via the electronic stand-alone application process.

#### **2. Filing Fee**

The application will need to include a filing fee if required by the application state. Check the Corporate Amendment Filing Fee chart /Filing Fee Matrix on the UCAA website or contact the application state for filing requirements. If retaliatory, verify fee information via the State [Retaliatory Information](#) link. Submit a copy of the Applicant Company's check. For electronic filings, the fees should reference the electronic filing's tracking number.

#### **3. State-Specific Information**

Some jurisdictions may have additional requirements that the Applicant Company must meet before the state can accept the amended Consent to Service of Process form. Before completing a UCAA Uniform Consent to Service of Process Application, the Applicant Company should review the listing of [State-Specific Requirements](#) for the application state.



A PRODUCT OF THE **NAIC**

**Corporate Amendments Application Section X  
Filing Requirements (Statement of Voluntary Dissolution)**

This section provides a guide to understanding the purpose of completing the statement of voluntary dissolution. This courtesy filing does not require approval but should be provided when the Applicant Company is exiting the marketplace. This form is also available for [Risk Retention Group registrations](#).

This form should be completed by those reporting entities that are ending their existence in all states. The Applicant Company should complete Form 16a or 16b and submit to the domicile state when requesting dissolution or cancellation of the Certificate of Authority and may also be requested by non-domiciliary states when requesting cancellation of the foreign Certificate of Authority (Form 17 Statement of Withdraw). The purpose of the form is to provide information about the status of all foreign Certificates of Authority and any obligations that are still present in those states.

**Table of Contents /Filing Requirements/Columns**

- [1. List state\(s\) where certificate of authority has been held.](#)
- [2. Approval date for the surrender of the Certificate of Authority.](#)
- [3. Policyholder obligations or contingent liabilities.](#)
- [4. Status of premium taxes, fees and other monetary obligations to the foreign state.](#)
- [5. State deposits, amount and purpose.](#)

**1. Certificate of Authority has been held from the states listed below**

List each state from which the entity has held a certificate of authority during the last 10 years. Include states where a certificate of authority had been issued and surrendered within the 10-year period. For Risk Retention Groups-list each state from which the entity has registered during the last 10 years. Include states where a registration had been issued and surrendered within the 10-year period.

**2. Approval date of surrender of Certificate of Authority by state**

Report the date that the state department of insurance approved the surrender or cancellation of the Certificate of Authority in that state. For Risk Retention Groups – report the date of registration cancellation by state.

**3. Policyholder obligations or contingent liabilities**

Report any kind of obligation that exists on the date of the signature on this form which is related to the policies or contracts issued by the entity or RRG. Include claim obligations, loss adjustment expenses, involuntary reinsurance pool obligations and any other unpaid charges that arise from policies or contracts written in that state or that are expected to arise from the policy or contract activities of the entity or RRG in that state. Estimate the amount if the actual amount is not known.

**4. Premium taxes, fees and other monetary obligations owed to the foreign state**



Report any other obligations that exist on the date of the signature on this form. Include taxes, fees, assessments, creditor obligations and any other unpaid charges that arise from that state or that are expected to arise from the operations of the entity or RRG in that state. Estimate the amount if the actual amount is not known.

#### **5. State Deposit**

Report the amount of any statutory or regulatory deposit that exists in the state on the date of the signature on this form. Explain the reason for the deposit, if known.

**National Treatment and Coordination (E) Working Group**  
Company Licensing Proposal Form

<p align="center"><b>DATE:</b></p> <p><b>CONTACT PERSON:</b> <u>Jane Barr</u></p> <p><b>TELEPHONE:</b> <u>816-783-8413</u></p> <p><b>EMAIL ADDRESS:</b> <u>jbarr@naic.org</u></p> <p><b>ON BEHALF OF:</b></p> <p><b>NAME:</b> <u>Debbie Doggett and Cameron Piatt Co-Chairs</u></p> <p><b>TITLE:</b> <u>National Treatment &amp; Coordination (E) WG</u></p> <p><b>AFFILIATION:</b> _____</p> <p><b>ADDRESS:</b> _____</p>	<p align="center"><b><u>FOR NAIC USE ONLY</u></b></p> <p>Agenda Item # <b>2023-01</b></p> <p>Year <b>2023</b></p> <p align="center"><b><u>DISPOSITION</u></b></p> <p>[ ] ADOPTED _____</p> <p>[ ] REJECTED _____</p> <p>[ ] DEFERRED TO _____</p> <p>[ ] REFERRED TO OTHER NAIC GROUP _____</p> <p>[ X ] EXPOSED <b>March 17, 2023</b> _____</p> <p>[ ] OTHER (SPECIFY) _____</p>
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**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

- [ X ] UCAA Forms [ ] UCAA Instructions [ X ] Enhancement to the Electronic Application Process  
 [ ] Company Licensing Best Practices HB

Forms:

- [ X ] Form 2 - Application [ ] Form 3 – Lines of Business [ ] Form 8D - Questionnaire  
 [ ] Form 6- Certificate of Compliance [ ] Form 7 – Certificate of Deposit [ ] Form 8 - Questionnaire  
 [ ] Form 8C- Corporate Amendment Questionnaire [ ] Form 11-Biographical Affidavit [ ] Form 12-Uniform Consent to Service of Process [ ] Form 13- ProForma [ ] Form 14- Change of Address/Contact Notification  
 [ ] Form 15 – Affidavit of Lost C of A [ ] Form 16 – Voluntary Dissolution [ ] Form 17 – Statement of Withdrawal

**DESCRIPTION OF CHANGE(S)**

To remove requirements from the Redomestication form that pertained to a primary (start-up) and not to an existing company moving to a new domestic state.

**REASON OR JUSTIFICATION FOR CHANGE \*\***

**To remove requirements that do not pertain to an existing company’s application to redomesticate to another state.**

**Additional Staff Comments:**

\*\* This section must be completed on all forms.



Applicant Company Name: \_\_\_\_\_ NAIC Cocode: \_\_\_\_\_  
 FEIN: \_\_\_\_\_

**Uniform Certificate of Authority Application (UCAA)  
 Redomestication Application**

To the Insurance Commissioner/Director/Superintendent of the State of:  
 (Select the appropriate state in which the Applicant Company is applying.)

Drop-down menu with the state list.

The undersigned Applicant Company hereby certifies that the classes of insurance as indicated on the Lines of Insurance, Form 3, are the lines of business which the Applicant Company is (a) currently authorized for transaction, (b) currently transacted and (c) which the Applicant Company is applying to transact.

Applicant Company Name:			
NAIC Cocode:		Group Code: (If Applicable)	

Home Office Address:	
----------------------	--

Administrative Office Address:	
--------------------------------	--

Mailing Address:	
------------------	--

Are these addresses the same as those shown on the Applicant Company’s Annual Statement?

Yes  No

If not, indicate why:

Attachment Button

Phone:	
<del>Fax:</del>	
<del>Date Incorporated:</del>	
<del>Form of Organization:</del>	
<del>Date Organized:</del>	

<del>Country of Domicile:</del>	
(If Applicable)	

	Original	Last Amendment
<del>Date of Charter</del>		
<del>Date of Bylaws</del>		
<del>Date of Subscriber's Agreement</del>		
<del>Date of Last Market Conduct Examination:</del>		
<del>Date of Last Financial Examination:</del>		

<del>Par Value of Issued Stock:</del>	\$	
<del>Surplus as regards policyholders:</del>	\$	
<del>Certificate of Deposit (Prior State)</del>		

<del>Ultimate Owner/Holding Company:</del>	
--------------------------------------------	--

Applicant Company Name: \_\_\_\_\_ NAIC Cocode: \_\_\_\_\_  
FEIN: \_\_\_\_\_

Billing Address:			
E-Mail Address:	Phone:	<del>Fax:</del>	

Premium Tax Statement Address:			
E-Mail Address:	Phone:	<del>Fax:</del>	

Producer Licensing Address:			
E-Mail Address:	Phone:	<del>Fax:</del>	

Rate/Form Filing Address:			
E-Mail Address:	Phone:	<del>Fax:</del>	

Consumer Affairs Address:			
E-Mail Address:	Phone:	<del>Fax:</del>	

Has the Applicant Company ever been refused admission to this or any other state prior to the date of this application?

Yes  No

If yes, give full explanation in an attached letter.



The Applicant Company hereby designates (name natural persons only) \_\_\_\_\_, to appoint persons and entities to act as and to be licensed as agents in the State of \_\_\_\_\_, and to terminate the said appointments.

NOTE: This does not apply to those states that do not require appointments

The following information is required of the individual who is authorized to represent the Applicant Company before the department.

Name:			
Title:			
Mailing Address:			
E-Mail Address:	Phone:	<del>Fax:</del>	

If the representative is not employed by the Applicant Company, please provide a company contact person in order to facilitate requests for detailed financial information.

Name:			
Title:			
Mailing Address:			
E-Mail Address:	Phone:	<del>Fax:</del>	

Applicant Company Name: \_\_\_\_\_ NAIC Cocode: \_\_\_\_\_  
FEIN: \_\_\_\_\_

**Applicant Company Incorporators’ Certification and Attestation**

One of the officers (listed below) of the Applicant Company must read the following very carefully:

1. I hereby certify, under penalty of perjury, that I have read the application, that I am familiar with its contents, and that all of the information, including the attachments, submitted in this application is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license discipline or other administrative action and may subject me or the Applicant Company, or both, to civil or criminal penalties.
2. I acknowledge that I am familiar with the insurance laws and regulations of said state, except the Constitution of such state, in which the Applicant Company is licensed or to which the Applicant Company is applying for licensure.
3. I acknowledge that I am the \_\_\_\_\_ of the Applicant Company, am authorized to execute and am executing this document on behalf of the Applicant Company.
4. I hereby certify under penalty of perjury under the laws of the applicable jurisdictions that all of the forgoing is true and correct, executed this \_\_\_\_\_ at \_\_\_\_\_.

_____	_____
Date	Electronic Signature of President
	_____
	Full Legal Name of President
_____	_____
Date	Electronic Signature of Secretary
	_____
	Full Legal Name of Secretary
_____	_____
Date	Electronic Signature of Treasurer
	_____
	Full Legal Name of Treasurer
	_____
	Electronic Name of Applicant Company

_____	_____
Date	Electronic Signature of Witness
	_____
	Full Legal Name of Witness

Applicant Company Name: ###ApplicantCompanyNameHeader###  
 FEIN: ###fein###  
 Tracking Number: ###trackingNumber###



**REDOMESTICATION APPLICATION**

To the Insurance Commissioner/Director/Superintendent of ###jurisdiction###,

The undersigned Applicant Company hereby certifies that the classes of insurance as indicated on the Lines of Insurance, Form 3P, are the lines of business which the Applicant Company is applying to transact.

**CONTACTS**

**Authorized Individual**

**Full Legal Name:** ###authorizedIndvName###  
**Title:** ###authorizedIndvTitle###  
**Address:** ###authIndvaddress###  
**Email:** ###authIndvEmail###  
**Phone:** ###authIndvPhone###

**Is the authorized representative an employee of the applicant company:** ###isAuthorizedRepEmployee###

**Financial Information**

**Full Legal Name:** ###financialContactName###  
**Address:** ###financialContactAddress###  
**Email:** ###financialContactEmail###  
**Phone:** ###financialContactPhone###

**Designee**

**Full Legal Name:** ###designeeName###

**APPLICATION**

Applicant Company Name: ###ApplicantCompanyNameHeader###  
FEIN: ###fein###  
Tracking Number: ###trackingNumber###



**Applicant Company**

**Name:** ###companyName###  
**Domiciliary State:** ###Domiciliarystate###  
**Group Code:** ###naicCompanyCode###

**Statutory Office Address:** ###StatutoryAddress###  
**Email:** ###StatutoryEmail###  
**Phone:** ###StatutoryPhone###

**Are these addresses the same as those shown on the Applicant Company’s Annual Statement? Yes or No**  
**If not, explain why:**

**Holding Company:** ###holdingCompanyName###  
**Holding Company Attachments:** ###holdingCompanyAttachments###  
**Cover Letter:** ###coverLetterAttachList###

---

**Additional Address Information**

**Administrative Office**  
**Address:** ###adminAddress###  
**Email:** ###adminEmail###  
**Phone:** ###adminPhone###

**Mailing Office**  
**Address:** ###mailingAddress###  
**Email:** ###mailingEmail###  
**Phone:** ###mailingPhone###

**Billing Office**  
**Address:** ###billingAddress###  
**Email:** ###billingEmail###  
**Phone:** ###billingPhone###

**Premium Tax Office**  
**Address:** ###premiumTaxAddress###

Applicant Company Name: ###ApplicantCompanyNameHeader###  
FEIN: ###fein###  
Tracking Number: ###trackingNumber###



**Email:** ###premiumTaxEmail###  
**Phone:** ###premiumTaxPhone###

**Producer Licensing Office**

**Address:** ###producerLicensingAddress###  
**Email:** ###producerLicensingEmail###  
**Phone:** ###producerLicensingPhone###

**Rate/Form Office**

**Address:** ###rateFormAddress###  
**Email:** ###rateFormEmail###  
**Phone:** ###rateFormPhone###

**Consumer Affairs Office**

**Address:** ###consumerAffairsAddress###  
**Email:** ###consumerAffairsEmail###  
**Phone:** ###consumerAffairsPhone###

Draft: 3/28/23

Risk-Focused Surveillance (E) Working Group  
Louisville, Kentucky  
March 23, 2023

The Risk-Focused Surveillance (E) Working Group of the Financial Condition (E) Committee met March 23, 2023. The following Working Group members participated: Amy Malm, Chair (WI); Lindsay Crawford, Vice Chair (NE); Blase Abreo and Sheila Travis (AL); Susan Bernard and Michelle Lo (CA); Michael Shanahan (CT); Virginia Christy (FL); Daniel Mathis (IA); Cindy Andersen (IL); Roy Eft (IN); Stewart Guerin (LA); Dmitriy Valekha (MD); Vanessa Sullivan (ME); Judy Weaver (MI); Debbie Doggett (MO); Monique Smith (NC); Pat Gosselin (NH); David Wolf (NJ); Mark McLeod (NY); Dwight Radel (OH); Eli Snowbarger (OK); Doug Hartz (OR); Diana Sherman and Matt Milford (PA); Ted Hurley and John Tudino (RI); Johanna Nickelson (SD); Amy Garcia (TX); Jake Garn (UT); Greg Chew, David Smith, and Doug Stolte (VA); Dan Petterson (VT); and Steve Drutz (WA).

1. Discussed and Exposed Updated Guidance for Reviewing Transactions/Services with Affiliates

Malm stated that the first agenda item is to discuss an updated draft of proposed edits to NAIC handbooks to provide additional guidance for state insurance regulators in reviewing and monitoring transactions and service agreements between insurers and their affiliates. Revisions to the NAIC's *Financial Analysis Handbook* and its *Financial Condition Examiners Handbook* were prepared for review by the Affiliated Services Drafting Group. This issue was originally brought to the Working Group through a referral from the Chief Financial Regulator Forum in 2021 due to the growing prevalence of market-based expense allocations in affiliated service agreements. Because the issue is important to both financial analysis and financial examinations, the topic was referred to the Working Group so that guidance for both functions could be developed together.

Malm stated that initially, a small volunteer group of state insurance regulators with experience in reviewing affiliated services developed guidance for the Working Group's consideration, which was then exposed for public comment in the fall of 2021. As a result of the exposure period, comment letters were received that raised various issues the Working Group determined were important to address. As such, the Working Group formed a joint drafting group of state insurance regulators and interested parties to work on updating the proposed guidance for the issues identified.

The Affiliated Services Drafting Group consists of state insurance regulators from Connecticut, Idaho, Maine, North Carolina, Pennsylvania, Texas, Virginia, and Wisconsin. In addition, the Drafting Group includes industry representatives from the America Council of Life Insurers (ACLI), America's Health Insurance Plans (AHIP), the American Property Casualty Insurance Association (APCIA), the Blue Cross Blue Shield Association (BCBSA), Equitable, The Travelers Companies (Travelers), and the UnitedHealth Group (UHG).

Bruce Jenson (NAIC) provided an overview of the updated guidance, which is intended to provide additional considerations for regulators in reviewing service agreements between insurers and their affiliates, particularly those that incorporate market-based reimbursement for services performed. Such considerations include expanded guidance for reviewing the fairness and reasonableness of reimbursement rates on an ongoing basis during financial examinations as warranted, based on communications with the financial analysis department. Jenson stated that the proposed revisions also incorporate additional guidance from the 2021 revisions to the *Insurance Holding Company System Regulatory Act (#440)* that are focused on ensuring the continuity of services provided by an affiliate when an insurer is placed into receivership.

Malm stated that while the proposed revisions will assist both financial analysts and examiners in evaluating the fairness and reasonableness of services with affiliates on both an initial and ongoing basis, there is one area in which the drafting group found it difficult to develop guidance. This has to do with situations where the services an affiliate provides are not directly comparable to services offered in the open market, making it challenging to assess the fairness and reasonableness of the proposed reimbursement rate. Often, the rate proposed for these services is structured as “cost-plus” reimbursement, whereby the affiliate charges the insurer for the cost to provide the service plus a profit margin to account for the risk the affiliate is assuming in providing the service.

Malm stated that the drafting group recognizes that “cost-plus” reimbursement rates are already being used in some insurance service agreements but was reluctant to develop and expose guidance in this area before receiving input from a larger number of states and industry participants. Malm proposed that the Working Group requests comments on whether to include guidance on reviewing “cost-plus” agreements and how to address that topic. For example, some questions to ask during the exposure period include:

1. Should guidance on reviewing “cost-plus” reimbursement rates be added to the handbooks?
2. In which situations or for what types of services might “cost-plus” reimbursement be appropriate?
3. What rationale should the insurer provide to justify the profit margin included within the cost-plus rate, particularly if there is no comparable market data?
4. What tools or benchmarks could regulators use in evaluating the fairness and reasonableness of the profit margin included in the cost-plus rate?

Malm asked for comments from Working Group members on whether to request input on “cost-plus” guidance during the exposure period. Shanahan stated his support for requesting input on this topic as it represents a complex issue that is becoming more prevalent in service agreements. Andersen agreed that regulators could benefit from additional guidance in this area. Hartz stated that additional guidance for “cost-plus” agreements could be beneficial but that regulators also need to carefully review the details of cost allocations to ensure they are appropriate.

Tom Finnell (representing AHIP) stated that a joint group of interested parties agree with the request for input on the development of “cost-plus” guidance but would have concern if no guidance is placed within NAIC handbooks on this topic. Finnell stated that “cost-plus” agreements exist and have been approved in several state insurance departments, even if they are not approved in all states. Therefore, NAIC members and the industry would benefit from some consistent guidance in this area. Finnell also stated that some international service agreements are required to be prepared under a “cost-plus” approach to ensure that profits are accounted for correctly to facilitate tax reporting.

Finnell also stated that the revisions the Working Group exposed in the fall of 2021 raised concerns about financial examiners reopening agreements that state insurance departments had already approved. While the updated draft still includes considerations and suggested procedures for financial examinations, the regulators and interested parties were able to come to some agreement regarding how and when to review the fairness and reasonableness of reimbursement rates during an examination. Of key importance is the communication and coordination between the financial examiner and the financial analyst who conducted the initial review and approval.

Radel made a motion, seconded by Crawford, to expose the proposed guidance for a 45-day public comment period ending May 5. The motion passed unanimously.



## 2. Discussed Plans for Financial Analyst/Examiner Salary Survey

Malm stated that recommended salary ranges for financial analysts and examiners were first added to the NAIC's handbooks in 2020 based on the efforts and research of this Working Group. At that time, the Working Group committed to reviewing and updating the ranges as needed, with a minimum review period of every other year. As the ranges were last reviewed and updated in 2021 through a simplified review process, the Working Group is expected to conduct a more detailed review in 2023.

An all-state salary survey was conducted in 2019 to pave the way for the initial salary ranges to be adopted in 2020. As a result of that survey, data was collected from 43 different states for commonly held analysis and exam positions. This data was then compared against external market data for comparable industry positions, as well as salary rates for federal and state banking regulators.

Malm proposed a similar process for 2023, whereby a salary survey would be sent to all state insurance departments. Participation in the survey would be voluntary and state-specific responses would be kept confidential and only published at an aggregated level. The survey would request information on actual salaries paid (aggregated at the average salary per position), along with the number of individuals employed at that level and recent turnover statistics. In addition to the quantitative data, the survey could ask some qualitative questions regarding staffing levels, retention, and recruitment to assist regulators in evaluating how states are performing in these areas. Malm stated that the Working Group's leadership plans to finalize the survey questions in the coming weeks before releasing the survey in late spring or early summer for state insurance departments to complete.

Milford asked whether the survey could collect data on salaries paid to contract regulators, as state insurance departments often compete against contract firms for staffing services. Jenson responded that the NAIC maintains a listing of contract firms to which a salary survey could be distributed but noted that external firms might view their salary data, even when aggregated, as proprietary and confidential. Hartz indicated that although the data might be viewed as proprietary, the contractors generally work on behalf of state insurance departments and might be willing to provide the information upon request. Hartz also stated that information on examination billing rates could also be beneficial.

Malm indicated that the Working Group's leadership would work with NAIC staff to incorporate contract regulators into the salary survey as deemed appropriate.

## 3. Discussed Plans for 2023 Peer Review Sessions

Crawford stated that the NAIC Peer Review Program provides the opportunity for a group of experienced financial analysts and examiners to participate in reviewing recently completed analysis and examination files to identify best practices and opportunities for improvement within individual files and on an aggregate level.

Crawford reported that a financial analysis session was held in February, with 10 different states participating just ahead of the annual statement filing deadline to help prepare them for annual analysis work. The session received excellent participation and feedback from all participants.

Crawford stated that the Working Group has scheduled and filled a financial exam session for May, which will involve both contract examiners and the department employees overseeing their work for each of the files being reviewed. This should be an excellent opportunity to identify best practices and opportunities for improvement in overseeing contract examination work.

Crawford stated that an Own Risk and Solvency Assessment (ORSA)-themed financial analysis session is being scheduled for this summer and that the focus of the review will be on the analyst's assessment and use of an insurer's ORSA Summary Report to inform their ongoing financial analysis activities. The session is planned for six different states to participate. Additional information will be provided to chief financial regulators following the Spring National Meeting.

Crawford stated that the Working Group plans to offer one more traditional financial analysis peer review session this fall, with additional details to be announced in the coming months. As the risk-focused financial analysis process is still relatively new, the Working Group continues to see more demand for financial analysis sessions and will continue to schedule sessions, when possible, to meet demand.

#### 4. Discussed Other Matters

Malm reminded Working Group members that a referral was received from the Macroprudential (E) Working Group in 2022 on various issues in affiliated service agreements. The first issue relates to the development of guidance around the regulatory review of investment management agreements between an insurer and an investment manager affiliate. The second issue relates to capital maintenance agreements between an insurer and a parent company or affiliate. Malm stated that the Working Group plans to move forward in finalizing its general affiliated services guidance before getting into the more specific issues raised in the referral. As such, it plans to work on guidance related to investment management agreements and other topics raised in the referral later this year.

Having no further business, the Risk-Focused Surveillance (E) Working Group adjourned.

SharePoint/NAICSupportStaffHub/Member Meetings/E CMTE/2023-1-Spring/RFSWG/Surveillance WG 3-23-23 Minutes.docx



TO: Elizabeth Kelleher Dwyer, Chair, Financial Conditions (E) Committee  
 Marlene Caride, Chair, Financial Stability (E) Task Force  
 Bob Kasinow, Chair, Macroprudential (E) Working Group  
 Thomas Botsko, Chair, Capital Adequacy (E) Task Force  
 Phillip Barlow, Chair, Risk-Based Capital Investment Risk and Evaluation (E) Working Group  
 Cassie Brown, Chair, Life Actuarial (A) Task Force  
 Judy Weaver, Chair, Financial Analysis (E) Working Group  
 Dale Bruggeman, Chair, Statutory Accounting Principles (E) Working Group  
 Fred Andersen, Chair, Valuation Analysis (E) Working Group

FROM: Carrie Mears, Chair, Valuation of Securities (E) Task Force

CC: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)  
 Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau  
 Dan Daveline, Director, NAIC Financial Regulatory Services  
 Todd Sells, Director, NAIC Financial Regulatory Policy & Data  
 Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)  
 Julie Gann, Assistant Director, NAIC Solvency Policy  
 Bruce Jenson, Assistant Director, NAIC Solvency Monitoring  
 Pat Allison, Managing Life Actuary, NAIC Financial Regulatory Affairs  
 Jane Koenigsman, Sr. Manager II, NAIC L/H Financial Analysis  
 Andy Daleo, Sr. Manager I, NAIC P/C Domestic and International Analysis  
 Dave Fleming, Sr. Life RBC Analyst, NAIC Financial Regulatory Affairs  
 Jennifer Frasier, Life Examination Actuary, NAIC Financial Regulatory Affairs  
 Scott O'Neal, Life Actuary, NAIC Financial Regulatory Affairs  
 Eva Yeung, Sr. P/C RBC Analyst/Technical Lead, NAIC Financial Regulatory Affairs

RE: Referral on Additional Market and Analytical Information for Bond Investments

DATE: February 13, 2023

**Summary** – The Investment Analysis Office (IAO) staff recommended in its Feb. 25, 2022, memorandum to the Valuation of Securities (E) Task Force (VOSTF) (attached hereto, Blanks Market Data Disclosure v2.pdf) that it would like additional market-data fields added to the annual statement instructions for bond investments. This was, in part, based upon the NAIC's adoption in 2010 of the recommendations of

Washington, DC 444 North Capitol Street NW, Suite 700, Washington, DC 20001-1509 p | 202 471 3990 f | 816 460 7493

Kansas City 1100 Walnut Street NW, Suite 1500, Kansas City, MO 64106-2197 p | 816 842 3600 f | 816 783 8175

New York One New York Plaza, Suite 4210, New York, NY 20004 p | 212 398 9000 f | 212 382 4207

www.naic.org

the Rating Agency (E) Working Group (RAWG), which was formed following the Great Financial Crisis of 2007-2008 to study the NAIC's reliance on rating agencies, and the IAO staff's recent findings in its Nov. 2021 memo regarding disparities between rating agencies. RAWG recommended that: 1) regulators explore how reliance on rating agencies can be reduced when evaluating new, structured, or alternative asset classes, particularly by introducing additional or alternative ways to measure risk; and 2) consider alternatives for regulators' assessment of insurers' investment risk, including expanding the role of the NAIC Securities Valuation Office ("SVO"); and 3) VOSTF should continue to develop independent analytical processes to assess investment risks. These mechanisms can be tailored to address unique regulatory concerns and should be developed for use either as supplements or alternatives to ratings, depending on the specific regulatory process under consideration.

The NAIC's need for alternative measures of investment risk has only increased since RAWG made its recommendations, as privately issued and rated complex structured finance transactions have become commonplace without adequate ways of identifying them. The SVO recommended the following market data fields to be added to the annual statement instructions: Market Yield, Market Price, Purchase Yield, Weighted Average Life, Spread to Average Life UST, Option Adjusted Spread, Effective Duration, Convexity and VISION Issue ID. Please refer to the attached memo for more detail on each data field.

In comments received from industry there were question as to how the SVO, VOSTF and/or other regulators who would receive the analytic data included in the proposal would utilize that information and why it is of value to them. The SVO was also asked to consider industry's recommendation that the NAIC be responsible for calculating this analytical information by utilizing commercially available data sources and investment models instead of having each individual insurance company incur the costs to implement system changes. The SVO shared their thoughts on the alternatives in the Jul. 14, 2022, memorandum to the VOSTF (attached, Blanks\_Market\_Data\_Options\_v3.pdf).

Capabilities like this within the SVO would permit it to calculate for regulators all the analytic values previously mentioned for any Schedule D investment along with additional measures such as key rate duration (a measure of interest rate sensitivity to maturity points along the yield curve), sensitivity to interest rate volatility, principal and interest cash flow projections for any security or portfolio for any given interest rate projection, loss estimates for any security for any given scenario and many others measures.

**Referral** – VOSTF refers this matter to the above referenced Committees, Task Forces and Working Groups for consideration and requests a response from you by May 15<sup>th</sup> outlining:

1. Indicate if your group is supportive of creating this capability within the SVO.
2. List the investment analytical measures and projections that would be most helpful to support the work performed by your respective group.
3. Describe how your group would utilize the data and why it would be of value.
4. Are there other investment data or projection capabilities that would be useful to your group that could be provided by commercially available data sources or investment models? And if so, please list them.
5. Any other thoughts you may have on this initiative.

Please contact Charles Therriault or Marc Perlman with any questions.



TO: Carrie Mears, Chair, Valuation of Securities (E) Task Force  
Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)  
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Additional Market Data Fields for Bond Investments

DATE: February 25, 2022

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The SVO proposes adding additional market-data fields for bond investments to the annual statement instructions based on 2010 adopted recommendations of the Rating Agency (E) Working Group (RAWG) and the IAO staff's findings regarding the discrepancies between ratings, presented in its Nov. 2021 memo.

The RAWG was formed after the Financial Crisis of 2008 and was charged with gathering and assessing information on:

1. *The problems inherent in reliance on ratings, including impact on the filing exempt ("FE") process and Risk-Based Capital ("RBC");*
2. *The reasons for recent rating shortcomings, including but not limited to structured security and municipal ratings;*
3. *The current and potential future impact of ratings on state insurance financial solvency regulation; and*
4. *The effect of the use of NRSRO ratings on public confidence and public perception of regulatory oversight of the quality of insurance.*

The RAWG made the following summary recommendations in their Apr. 28, 2010, report that was adopted by the Financial Condition (E) Committee (emphasis added):

1. **Regulators explore how reliance on ARO (Approved Ratings Organization) ratings can be reduced when evaluating new, structured, or alternative asset classes, particularly by introducing additional or alternative ways to measure risk;**
2. **Consider alternatives for regulators' assessment of insurers' investment risk, including expanding the role of the NAIC Securities Valuation Office ("SVO"); and**

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3. *When considering continuing the use of ratings in insurance regulation, the **steps taken by the NRSROs in correcting the causes that led to recent rating shortfalls**, including the NRSROs' efforts in implementing the recommended structural reforms, should be taken into account.*

As the IAO staff demonstrated with the analysis in its Nov. 29, 2021, memo regarding ratings discrepancies, not all credit rating provider (CRP) ratings reflect a reasonable assessment of a security's risk, indicating that rating shortfalls persist today. The NAIC has not made additional progress in reducing reliance on CRPs and the IAO proposed several steps in its memo to accomplish that objective. As noted by the RAWG and reflected in the IAO's memo, there persists a situation where "... ratings are neither consistent nor uniform for individual securities, nor across different types and classes of securities..." However, the role of the SVO has not been expanded to include "... evaluating credit and other risks of securities."<sup>1</sup>

One step towards introducing alternative ways to measure a security's risk would be to require insurers to report various analytical measures about each security including metrics such as its current market yield, interest rate sensitivity, spread relative to risk-free securities such as United States Treasuries and average remaining life. The more a security's market yield and spread differ from similarly rated securities, the more likely it is that the implied market-perceived risk of that security differs from the risk indicated by the credit rating assigned to it. The yield difference or spread in basis points can potentially help identify securities whose risk assessment warrants further review by the SVO, examiners or other regulatory groups, for example, a AAA rated security with a yield of 5%. Other fields that measure a security's price sensitivity to interest rate movements may also help to identify market-perceived risk inconsistent with the assigned credit rating. These additional market data fields would align with the RAWG's referral to the Task Force and SVO Initiatives (EX) Working Group, as noted in their following detailed recommendations (emphasis added):

1. *Referral to the NAIC Valuation of Securities (E) Task Force: VOS should continue to **develop independent analytical processes to assess investment risks**. These mechanisms can be tailored to address unique regulatory concerns and should be developed for **use either as supplements or alternatives to ratings**, depending on the specific regulatory process under consideration.*
2. *Referral to the NAIC Valuation of Securities (E) Task Force: ARO ratings have a role in regulation; however, since **ratings cannot be used to measure all the risks that a single investment or a mix of investments may represent in an insurer's portfolio**, NAIC policy on the use of ARO ratings should be **highly selective and incorporate both supplemental and alternative risk assessment benchmarks**.*
3. *Referral to the NAIC's SVO Initiatives (EX) Working Group: NAIC should evaluate whether to **expand the use of SVO and increase regulator reliance on the SVO for evaluating credit and other risks of securities**.*

**Recommendation:** The SVO recommends the following market data fields and related descriptions be added to all the annual statement instructions, through a referral to the Blanks (E) Working Group, for all bonds reported on Schedule D, Part 1 (those within scope of SSAP No. 26R – Bonds and SSAP No. 43R – Loan-Backed and Structured Securities). To allow sufficient time for insurers to update their systems, the SVO further recommends that the changes be implemented as electronic only fields effective beginning with the reporting year ending December 31, 2023.

- Market Yield – The Market Yield is the internal rate of return discount rate that makes the net present value (NPV) of all expected cash flows equal to zero in a discounted cash flow analysis. Therefore, Fair

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<sup>1</sup> Evaluating the Risks Associated with NAIC Reliance on NRSRO Credit Ratings – Final Report of the RAWG to the Financial Conditions (E) Committee, April 28, 2010

Value, which is already reported, is the present value (PV) of all expected cash flows discounted at the Market Yield.

- Market Price – The Market Price per unit of Par Value, which is already reported, is reflected in the Fair Value as of the financial statement date. The Market Price, which excludes accrued interest, when multiplied by Par Value and divided by 100 will be equal to the Fair Value.
- Purchase Yield – The Purchase Yield is the internal rate of return discount rate that makes the net present value (NPV) of all expected cash flows equal to zero in a discounted cash flow analysis as of the Acquired Date. Therefore, Actual Cost is the present value (PV) of all expected cash flows discounted at the Purchase Yield as of the Acquired Date.
- Weighted Average Life – The Weighted Average Life is the average length of time that each dollar of unpaid principal remains outstanding. The time weightings used in weighted average life calculations are based on payments to the principal. The calculation is "weighted" because it considers when the payments to the principal are made—if, for example, nearly all of the principal payments are made in five years, WAL will be close to five years. Weighted average life does not consider payments to interest on the loan. This value is recalculated at each statement date for the remaining principal payments.
- Spread to Average Life UST - The spread is the difference between the interpolated U.S. Treasury bond yield that matches the reported debt security's Weighted Average Life. Spreads between interpolated U.S. Treasuries and other bond issuances are measured in basis points, with a 1% difference in yield equal to a spread of 100 basis points.
- Option Adjusted Spread - The option-adjusted spread (OAS) is the measurement of the spread of a fixed-income security rate and the risk-free rate of return (typically U.S. Treasury yield), which is then adjusted to take into account an embedded option and expressed in basis points. The spread is added to the fixed-income security price to make the risk-free bond price the same as the bond. The option-adjusted spread considers historical data such as the variability of interest rates and prepayment rates. These calculations are complex since they attempt to model future changes in interest rates, prepayment behavior of mortgage borrowers, and the probability of early redemption.
- Effective Duration - This is a duration calculation for bonds that have embedded options. This measure of duration takes into account the fact that expected cash flows will fluctuate as interest rates change and is, therefore, a measure of risk given the security's Fair Value. As a formula, Effective Duration =  $(P(1) - P(2)) / (2 \times P(0) \times Y)$ , where  $P(0)$  = the bond's Market Price per \$100 worth of par value,  $P(1)$  = the price of the bond if the yield were to decrease by Y percent,  $P(2)$  = the price of the bond if the yield were to increase by Y percent, and Y = the estimated change in yield used to calculate  $P(1)$  and  $P(2)$ .
- Convexity - This is a measure of the curvature, or the degree of the curve, in the relationship between bond prices and bond yields. Convexity demonstrates how the duration of a bond changes as the interest rate changes.
- VISION ISSUE ID: The NAIC VISION system security ID reported in AVS+.

<https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2022/2022-04 - Spring National Meeting/04 - Blanks Referral Analytical Risk Measures/2021-053.01 Blanks Market Data Disclosure v2.docx>



TO: Carrie Mears, Chair, Valuation of Securities (E) Task Force  
Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)  
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Possible Options for Additional Market Data Fields for Bond Investments

DATE: July 14, 2022

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**Summary** - The SVO proposed adding additional market-data fields for bond investments to the annual statement instructions in its memo dated Feb. 25, 2022, titled “Additional Market Data Fields for Bond Investments” that was discussed at the 2022 Spring National Meeting. The recommendation was based, in part, on 2010 adopted recommendations of the Rating Agency (E) Working Group (RAWG) and the NAIC Investment Analysis Office’s (IAO) staff’s findings regarding the discrepancies between ratings, presented in its Nov. 29, 2021 memo, “Rating Issues and Proposed Changes to the Filing Exemption Process.” In this memo the SVO further outlines the regulatory benefits and proposes two possible approaches.

The benefits of collecting additional market-data for each insurer bond investment are several:

- Assist in SVO identification of securities with credit rating provider (CRP) ratings which may be inconsistent with a security’s actual overall risk.
- Greater transparency for regulators into the risks and characteristics of insurer investments.
- Incorporation of insurer investment portfolio analysis into the examination process.
- Availability of more Level 1 and 2 Inputs which will be included in the AVS+ pricing data for all securities compared to the mostly Level 3 Inputs for only some securities today.
- Allow state insurance regulators to assess the capabilities of an insurer’s investment management or risk management processes by reviewing the quality and accuracy the market data fields.
- Provide NAIC staff with the capability to run cash flow simulations on insurer investments.

Regarding the first bullet, the SVO would use this market-data information to help identify securities with credit rating provider (CRP) ratings that may be inconsistent with the security’s actual overall risk. The SVO and SSG have raised concerns over the years about a number of asset classes (e.g. residential

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mortgage backed securities (RMBS), commercial mortgage backed securities (CMBS), public and private fund investments, principal protected securities (PPS) including CLO Combo Notes, regulatory transactions, residual interests, and now collateralized loan obligations (CLO), and structure equity and funds) and specific securities in other asset classes where a rating agency rating often does not adequately reflect the investment risk for NAIC purposes. The SVO needs this analytical information so that it can identify and take potential action on investment risk assessment inaccuracies. Without this data and potentially other information in the future, coupled with some level of discretion over NAIC Designations derived from ratings, the SVO and regulators will remain in the dark about these risks. Additionally, the incentive for significant risk-based capital arbitrage utilizing CRP ratings will likely continue to increase and rating agencies will effectively remain a de-facto “super regulator” in that any investment they assign a rating to is automatically accepted by the NAIC without any regulatory discussion, analysis, oversight or consideration as to how the rating agency’s decisions align to the NAIC’s statutory framework.

Inconsistent and potentially inaccurate assessments of investment risk is a critical issue not only for the Valuation of Securities (E) Task Force but for other state insurance regulatory groups that are interested in identifying and analyzing investment risks, whether it be at the individual security, asset class, legal entity or industry level. The following are just a few groups that have active work streams involving investment risk: Life Actuarial (A) Task Force, Capital Adequacy (E) Task Force and its Working Groups, Statutory Accounting Principles (E) Working Group, Financial Stability (E) Task Force, Macroprudential (E) Working Group and Financial Analysis (E) Working Group. The proposed market data fields will benefit each of these groups in their work assessing insurer investments and portfolio risks.

The requested market data fields other than purchase yield, which should be available from any investment accounting system, are all at the security issue level (i.e. CUSIP). Any insurer system that can receive security issue level data such as a market prices, credit ratings, bond factors, cashflows, or NAIC Designations should be able to accommodate these proposed security issue-level data fields. The SVO acknowledges this change will require time for insurer system providers to accommodate these new data fields into their data structures and Schedule D reporting applications. However, these data fields are very common in the management of a bond portfolio, and it would be a significant enterprise risk deficiency if an insurer’s investment managers did not have them.

Some alternate measures of risk (e.g. Sharpe Ratio and Sortino Ratio) were mentioned during the Task Force discussion. These metrics, however, would require insurers to calculate the total return and the standard deviation of those returns for each security they own in order to produce and report these metrics which would be significantly more costly and more appropriate for assessing relative value and less applicable for assessing investment risk.

**Alternatives** – The SVO was asked to consider industry’s recommendation that the NAIC produce these fields. Below are our thoughts on each alternative.

- **NAIC Produced Analytics** – The SVO can take on the responsibility for producing the analytical data elements requested in this proposal. To do so it would require enhancements to the SVO’s existing systems (VISION, AVS+ and STS), and vendor pricing data, investments in new systems to provide the modeling, more staff for the incremental and on-going support of these systems and processes, new data feeds to support the modeling software, and new data bases and reporting capabilities to provide the information to regulators. Enhancements would also

need to include the ability for insurers to provide electronically to the SVO the full security structure of any security that the modeling software does not know about. We strongly believe that the benefits to be gained by state regulators, the SVO and other NAIC groups with interests in investment risk of bringing this modelling capability in-house greatly outweigh, in the long run, the initial costs and effort to make these capabilities operational.

- **Pros:**

- Market analytical information would be independently and consistently produced.
- The SVO's pricing data would need to include more Level 1 and 2 Inputs for all securities versus primarily Level 3 Inputs for only some securities today.
- Regulators would eventually be able to ask NAIC staff to model the risks or cash flows of any bond security or insurer bond portfolio, including, stress testing those securities and portfolios.
- Regulators would have significantly greater transparency into the risks and characteristics of insurer investments.
- Analytical analysis of insurer investment portfolios could be incorporated into the examination process.
- The overall cost to insurers through any increased fee would likely be much less than each insurer building out its own capability to provide the data.

- **Cons:**

- The NAIC would need to make significant enhancements to VISION, AVS+, and STS, and develop new reporting data bases.
- The NAIC will need to license a security analytic modelling system and provide it with the data it requires, some of which may require new data licenses. This includes full access to vendor applications like Bloomberg or Aladdin.
- The NAIC will incur additional fees for higher level of security pricing data. The NAIC will also need additional staff to develop and support the technology enhancements and to support the on-going modeling of securities and portfolios.
- It may take longer for the NAIC to build this capability.
- Insurers would still need to report some of this information on their Schedule D filings from data published through AVS+.
- Insurers would need to provide the SVO with full security structure modeling and supporting data (e.g. collateral, payments, actions) for any security the analytic modelling system does not have within its data base.

- **Insurer Produced Analytics** – Insurer investment managers should already have the market data fields requested in this proposal. Insurers would need to get this information into their systems that produce their Schedule D filings. This option would require more up-front work on the part of the insurers and less by the NAIC. The uses of the data, however, whether by regulators, the SVO or other interested

NAIC groups, could be significantly more limited than in the first option, because of the inconsistency in data between insurers.

- **Pros:**
  - Insurers already have this information as part of their investment management or risk management processes.
  - State insurance regulators could assess the capabilities of an insurer’s investment management or risk management processes by reviewing the quality and accuracy the market data fields.
  - The timeframe to implement would likely be shorter than the SVO having to build out this capability.
- **Cons:**
  - Insurer security pricing is very inconsistent today which will lead to a high degree of variability in these analytical values.
  - The modeling software and assumptions used by insurers to produce these analytical value can vary significantly which will also lead to a high degree of variability in the values.
  - Insurers and their system providers will need to develop new interfaces to ingest this data and produce it in their Schedule D filing. That time frame could vary significantly by vendor and insurer.
  - State insurance regulators would not be able to request the modeling of any investment security or portfolio.
  - Insurers would directly bear the expense of these changes which will likely be greater than it would be if the NAIC produced this information.

**Next Steps** – The SVO continues to strongly believe that these market data fields are an important first step in finding alternative ways to measure insurers investment risk and reducing the NAIC reliance rating agency ratings. As noted by the RAWG and reflected in the IAO’s memo, there persists a situation where “... ratings are neither consistent nor uniform for individual securities, nor across different types and classes of securities...” yet the role of the SVO has not been expanded to include using these alternatives in “... evaluating credit and other risks of securities.” The objective of this request is to begin addressing these investment risk issues but this may not be the only information needed.

Both alternatives will involve a commitment of resources either by the NAIC or industry. The major question before the Task Force is whether it has a preferred source for these market data fields: the NAIC’s SVO or insurer reporting? The SVO believes that the first option would provide the most standardization in data and utility to regulators, the SVO and other interested NAIC groups and would be worth the slightly longer time and cost needed to develop the capabilities.

If, as the SVO recommends, the Task Force prefers the NAIC’s SVO as the source of this analysis, then the next step would be a referral to the Financial Condition (E) Committee to request their sponsorship for this initiative and, if provided, begin a fiscal request. If Financial Condition (E) Committee declines to sponsor the initiative or if insurer reporting is the preferred source, we would recommend reverting to insurer reporting and directing the SVO staff to prepare the Blanks referral.



TO: Carrie Mears, Chair, Valuation of Securities (E) Task Force  
Members of the Valuation of Securities (E) Task Force

FROM: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau  
Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)  
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)

RE: Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office  
(the “P&P Manual”) to Include Collateralized Loan Obligations (CLO) as a Financially Model  
Security in Part Four

DATE: September 16, 2022 (**Updated: December 20, 2022**)

**Summary** – A collateralized loan obligation (CLO) is type of structured security backed by a pool of debt, typically corporate loans with low credit ratings. An insurer that purchases every tranche of a CLO holds the exact same investment risk as if it had directly purchased the entire pool of loans backing the CLO. The aggregate risk-based capital (RBC) factor for owning all of the CLO tranches should be the same as that required for owning all of the underlying loan collateral. If it is less, it means there is risk-based capital (RBC) arbitrage. As noted in the Investment Analysis Office’s (IAO) memo of May 25, 2022, “Risk Assessment of Structured Securities – CLOs”, it is currently possible to materially (and artificially) reduce C1 capital requirements just by securitizing a pool of assets.

**Recommendation** – The Investment Analysis Office recommends the Task Force assign the Structured Securities Group (SSG) the responsibility of financially modeling CLO investments. SSG can model CLO investments and evaluate all tranche level losses across all debt and equity tranches under a series of calibrated and weighted collateral stress scenarios to assign NAIC Designations that create equivalency between securitization and direct holdings, thereby eliminating RBC arbitrage.

The Task Force sent a referral to the Capital Adequacy (E) Task Force (CATF) and its Risk-Based Capital Investment Risk and Evaluation (E) Working Group (RBCIREWG) requesting those groups consider adding two new RBC factors. These recommended new RBC factors would account for the tail risk in any structured finance tranche. Staff also recommends adding NAIC Designation Categories (e.g. 6.A, 6.B and 6.C) with possible interim RBC factors of 30%, 75% and 100%, respectively, until those groups can further study structured securities. Staff request approval to draft a Blanks proposal for the new NAIC Designation Categories.

**Proposed Amendment** - The proposed text changes to P&P Manual are shown below with additions in red underline, deletions in ~~red strikethrough~~ as it would appear in the 2022 P&P Manual format. Changes made on December 20, 2022 are highlighted in **yellow**.

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To: Superintendent Elizabeth Kelleher Dwyer (RI), Chair, Financial Condition (E) Committee

From: Jackie Obusek (NC), Chair, Mortgage Guaranty Insurance (E) Working Group

Date: March 1, 2023

Re: Request for Extension – Mortgage Guaranty Insurance Model Act (#630)

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The Mortgage Guaranty Insurance (E) Working Group is in the process of fulfilling its charge to update the *Mortgage Guaranty Insurance Model Act* (Model #630). The Working Group anticipated completion of its Charge by the 2023 Spring National Meeting. As Chair, I would like to update that request to the Financial Condition (E) Committee in accordance with NAIC procedures.

The Working Group exposed for public comment the Draft Mortgage Guaranty Insurance Model Act (#630) during its October 6, 2022 interim meeting. The exposure ended on November 7 and several comments were received and discussed during the 2022 Fall National Meeting. During January and February 2023, the drafting group discussed and addressed each comment. As a result, several revisions were made to draft Model #630. The drafting group exposed the Model for a secondary public comment period just prior to the 2023 Spring National Meeting. It is anticipated that following discussion of additional comments received as a result of the exposure, the Working Group will be in a better position to vote to adopt draft Model #630 following review and discussion on any additional comments.

At this time, we believe we can complete this work by the 2023 Fall National Meeting. The request for additional time is to allow the necessary time to address comments and ensure that a comprehensive regulatory framework is in place to effectively regulate these complex insurance entities. We are aware that we have been unable to complete our work within the one-year time period expected under the NAIC model law process and request an extension until the 2023 Fall National Meeting in order to finalize a product that can be adopted by the domestic states of the mortgage insurers, as well as any other state also wishing to adopt the same.

## Updates to 2023 Charges

10. The **Restructuring Mechanisms (E) Working Group** will:

- A. Evaluate and prepare a white paper that:
  - 1. 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.
  - 2. Summarizes the existing state restructuring statutes.
  - 3. 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.
  - 4. Considers the impact that a restructuring might have on guaranty associations and policyholders that had guaranty fund protection prior to the restructuring.
  - 5. 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 in 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 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.
- ~~C.E.~~ Review the various restructuring mechanisms, and develop, if deemed needed, accounting and reporting requirements for referring to the Statutory Accounting Principles (E) Working Group.

~~11. The **Restructuring Mechanisms (E) Subgroup** of the Restructuring Mechanisms (E) Working Group will:~~

- ~~A. Develop best practices to be used in 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 to the Financial Regulation Standards and Accreditation (F) Committee for its consideration.~~
- ~~B. Consider the need to make changes to the RBC formula to better assess the minimum surplus requirements for companies in runoff.~~
- ~~C. Review the various restructuring mechanisms, and develop, if deemed needed, accounting and reporting requirements for referring to the Statutory Accounting Principles (E) Working Group.~~

## ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

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Draft: 4/4/23

Accounting Practices and Procedures (E) Task Force  
Louisville, Kentucky  
March 23, 2023

The Accounting Practices and Procedures (E) Task Force met in Louisville, KY, March 23, 2023. The following Task Force members participated: Cassie Brown, Chair, represented by Jamie Walker (TX); Mike Causey, Vice Chair, represented by Jackie Obusek (NC); Lori K. Wing-Heier represented by David Phifer (AK); Mark Fowler represented by Sheila Travis and Todrick Burks (AL); Alan McClain represented by Chris Erwin (AR); Ricardo Lara represented by Kim Hudson; Andrew N. Mais represented by William Arfanis and Michael Shanahan (CT); Karima M. Woods represented by N. Kevin Brown (DC); Trinidad Navarro represented by Rylynn Brown (DE); Michael Yaworsky represented by Jason Reynolds (FL); Doug Ommen represented by Kevin Clark (IA); Dean L. Cameron represented by Eric Fletcher and Jessie Adamson (ID); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Jeff Gaither (KY); Gary D. Anderson represented by John Turchi (MA); Timothy N. Schott represented by Vanessa Sullivan (ME); Anita G. Fox represented by Judy Weaver and Steve Mayhew (MI); Grace Arnold represented by Kathleen Orth (MN); Chlora Lindley-Myers represented by Debbie Doggett (MO); Troy Downing represented by Kari Leonard (MT); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Andrea Johnson (NE); Marlene Caride represented by John Sirovetz (NJ); Chris Nicolopoulos represented by Pat Gosselin and Doug Bartlett (NH); Adrienne A. Harris represented by Bob Kasinow (NY); Judith L. French represented by Dale Bruggeman (OH); Glen Mulready represented by Eli Snowbarger (OK); Michael Humphreys represented by Diana Sherman and Matt Milford (PA); Elizabeth Kelleher Dwyer represented by John Tudino and Ted Hurley (RI); Michael Wise represented by Thomas Baldwin (SC); Larry D. Deiter represented by Johanna Nickelson (SD); Carter Lawrence represented by Trey Hancock (TN); Jon Pike represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA); Kevin Gaffney represented by Dan Petterson (VT); Mike Kreidler represented by Steve Drutz (WA); and Nathan Houdek represented by Amy Malm (WI).

1. Adopted its 2022 Fall National Meeting Minutes

Walker directed the members to the Task Force's 2022 Fall National meeting minutes. Obusek made a motion, seconded by Doggett, to adopt the Task Force's Dec. 14, 2022, minutes (see *NAIC Proceedings – Fall 2022, Accounting Practices and Procedures (E) Task Force*). The motion passed unanimously.

2. Adopted the Report of the Statutory Accounting Principles (E) Working Group

Bruggeman provided the report of the Statutory Accounting Principles (E) Working Group, which met March 22. During this meeting, the Working Group adopted its 2022 Fall National Meeting minutes.

Bruggeman stated that during its March 22 meeting, the Working Group also adopted *Issue Paper No. 167—Derivatives and Hedging*, which historically documents new Statutory Accounting Principles (SAP) concept revisions to the documentation and assessment of hedge effectiveness, measurement method guidance for excluded components, and modified incorporation of the U.S. generally accepted accounting principles (GAAP) portfolio layer method and the partial-term hedging method in *Statement of Statutory Accounting Principles (SSAP) No. 86—Derivatives*. (Ref #2017-33)

Bruggeman stated that the Working Group adopted the following clarifications to statutory accounting guidance:

- A. *SSAP No. 25—Affiliates and Other Related Parties*: Revisions clarify that any invested asset held by a reporting entity that is issued by an affiliated entity, or which includes the obligations of an affiliated entity, is an affiliated investment. (Ref #2022-15)

- B. *SSAP No. 34—Investment Income Due and Accrued*: Revisions add and data-capture additional disclosures. Directed NAIC staff to submit a corresponding blanks proposal to the Blanks (E) Working Group for year-end 2023. (Ref #2022-17)
- C. *SSAP No. 100R—Fair Value*: Revisions adopt, with modification, *Accounting Standards Update (ASU) 2022-03, Fair Value Measurement of Equity Securities Subject to Contractual Sales Restrictions*, with modification to reject the contractual sales restrictions disclosures. (Ref #2022-16)
- D. *SSAP No. 105R—Working Capital Finance Investments*: Rejects guidance from *ASU 2017-12, Derivatives and Hedging* and *ASU 2022-04, Disclosure of Supplier Finance Program Obligations*, as the disclosures are for borrowers, not insurance entity investors. (Ref #2022-18)

Bruggeman stated that the Working Group exposed the following SAP clarifications to statutory accounting guidance for a public comment period ending June 9, except for agenda items 2023-03 and 2023-11EP, which have a public comment period ending May 5:

- A. *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets* and *Issue Paper No. 16X—Updates to the Definition of a Liability*: Exposure includes revisions that defer to topic-specific SSAP guidance that varies from the liability definition. (Ref #2022-01)
- B. *SSAP No. 20—Nonadmitted Assets* and *SSAP No. 21R—Other Admitted Assets*: Exposed revisions clarify that pledged collateral must qualify as an admitted invested asset for a collateral loan to be admitted. The revisions require audits and the use of net equity value for valuation assessments when the pledged collateral is in the form of partnerships, limited liability companies, or joint ventures. (Ref #2022-11)
- C. *SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items*: Exposed revisions to SSAP No. 24 to clarify rejection of *ASU 2021-10, Government Assistance*, and the incorporation of disclosures regarding government assistance. (Ref #2023-06)
- D. *SSAP No. 43R—Loan-Backed and Structured Securities*: Exposed revisions to incorporate changes to add collateralized loan obligations (CLOs) to the financial modeling guidance and to clarify that CLOs are not captured as legacy securities. (Ref #2023-02)
- E. *SSAP No. 104R—Share-Based Payments* and *SSAP No. 95—Nonmonetary Transactions*: Exposed revisions to adopt with modification *ASU 2019-08, Compensation—Stock Compensation (Topic 718) and Revenue from Contracts with Customers (Topic 606): Codification Improvements—Share-Based Consideration Payable to a Customer*. The revisions add guidance to include share-based consideration payable to customers. (Ref #2023-07)
- F. *Interpretation (INT) 03-02: Modification to an Existing Intercompany Pooling Arrangement*: Exposed the intent to nullify INT 03-02, as it is inconsistent with SSAP No. 25. (Ref #2022-12)
- G. *INT 20-01: ASU 2020-04 and 2021-01 – Reference Rate Reform*: Exposed revisions to revise the expiration date of INT 20-01 to Dec. 31, 2024. (Ref #2023-05)
- H. *Schedule D Reporting*: Exposed revisions to *SSAP No. 26R—Bonds*, *SSAP No. 21R*, *SSAP No. 43R*, and other impacted SSAPs to refine guidance for the principles-based bond project. Directed NAIC staff to continue interim discussions with interested parties. (Ref #2019-21)

- I. Review Annual Statement Instructions for Accounting Guidance: Exposed a proposed new project to review the annual and quarterly statement instructions to ensure that accounting guidance is reflected within the SSAPs. (Ref #2023-01)
- J. C-2 Mortality Risk Note: Exposed revisions to *SSAP No. 51R—Life Contracts*, *SSAP No. 59—Credit Life and Accident and Health Insurance Contracts*, and *SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance* providing new disclosures, which provide net amount at risk detail needed to support updates to the life risk-based capital (RBC) C-2 mortality risk charges. This item was exposed with a shortened comment deadline of May 5. (Ref #2023-03)
- K. *Accounting Practices and Procedures Manual (AP&P Manual)* Editorial Updates: Exposed editorial revisions. This item was exposed with a shortened public comment period ending May 5. (Ref #2023-11EP)
- L. Appendix D—Nonapplicable GAAP Pronouncements: The following U.S. GAAP standards were exposed with revisions to reject, as they are not applicable to statutory accounting:
  - i. *ASU 2019-07—Codification Updates to SEC Sections: Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10532, Disclosure Update and Simplification, and Nos. 33-10231 and 33-10442, Investment Company Reporting Modernization, and Miscellaneous Updates* (Ref #2023-08)
  - ii. *ASU 2020-09, Amendments to SEC Paragraphs Pursuant to SEC Release No. 33-10762—Debt (Topic 470)* (Ref #2023-09)
  - iii. *ASU 2022-05, Transition for Sold Contracts*, as not applicable for statutory accounting. (Ref #2023-10)

Bruggeman stated that the Working Group directed NAIC staff on the following items:

- A. Tax Credits: Directed NAIC staff to proceed with drafting revised accounting guidance and a related issue paper for both *SSAP No. 93—Low-Income Housing Tax Credit Property Investments* and *SSAP No. 94R—Transferable and Non-Transferable State Tax Credits*. Revisions will consider final Financial Accounting Standards Board (FASB) guidance on tax equity investments and interested party feedback. (Ref #2022-14)
- B. *SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve*: Directed NAIC staff regarding the consideration of negative interest maintenance reserve (IMR) with an intent to work on both a 2023 solution and a long-term solution as follows:
  - i. Recommend a referral to the Life Actuarial (A) Task Force on further consideration of the asset adequacy implications of negative IMR. Items to include: 1) developing a template for reporting within asset adequacy testing (AAT); 2) considering the actual amount of negative IMR that is admitted to be used in the AAT; 3) better consideration of cash flows within AAT (and documentation), as well as any liquidity stress test (LST) considerations; 4) ensuring that excessive withdrawal considerations are consistent with actual data (sales of bonds because of excess withdrawals should not use the IMR process); and 5) ensuring that any guardrails for assumptions in the AAT are reasonable and consistent with other aspects.
  - ii. Recommend a referral to the Capital Adequacy (E) Task Force for the consideration of eliminating any admitted net negative IMR from total adjusted capital (TAC) and the consideration of sensitivity testing with and without negative IMR.

- iii. Develop guidance for future Working Group consideration that would allow the admission of negative IMR up to 5% of surplus using the type of limitation calculation similar to that used for goodwill admittance. The guidance should also provide for a downward adjustment if the RBC ratio is less than 300.
  - iv. Review and provide updates on any annual statement instructions for excess withdraws, related bond gains/losses, and non-effective hedge gains/losses to clarify that those related gains/losses are through asset valuation reserve (AVR), not IMR.
  - v. Develop accounting and reporting guidance to require the use of a special surplus (account or line) for net negative IMR.
  - vi. Develop governance-related documentation to ensure sales of bonds are reinvested in other bonds.
  - vii. Develop a footnote disclosure for quarterly and annual reporting. (Ref #2022-19)
- C. Corporate Alternative Minimum Tax (CAMT): Directed NAIC staff to continue work with industry and the Working Group on developing guidance for the reporting of the CAMT for interim Working Group discussion. (Ref #2023-04)

Bruggeman stated that the Working Group received updates on the following items:

- A. Received a referral from the Valuation of Securities (E) Task Force to inquire about the NAIC Securities Valuation Office (SVO) obtaining the ability to calculate analytical information.
- B. Announced that copyrighted PDF copies of the AP&P Manual will be made available through Account Manager upon purchase of the 2023 AP&P Bookshelf subscription.
- C. Received a request from the American Academy of Actuaries (Academy) for clarification on observed diversity across issuers regarding long-term care (LTC) AAT under *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51)* and *SSAP No. 54R—Individual and Group Accident and Health Contracts and Appendix A-010, Minimum Reserve Standards for Individual and Group Accident and Health Insurance Contracts*.
- D. Received an update on international activity as discussed by the International Association of Insurance Supervisors (IAIS) Accounting and Auditing Working Group (AAWG). This discussion noted that public consultations of *Insurance Core Principle (ICP) 14: Valuation* and *ICP 17: Capital Adequacy* are expected in July 2023.
- E. Received an update on U.S. GAAP exposures, noting that pending items will be addressed during the normal maintenance process.

Bruggeman made a motion, seconded by Kasinow, to adopt the report of the Statutory Accounting Principles (E) Working Group (Attachment One). The motion passed unanimously.

### 3. Adopted the Report of the Blanks (E) Working Group

Gosselin provided the report of the Blanks (E) Working Group, which met March 7. During this meeting, the Working Group adopted its Nov. 17, 2022, minutes (see *NAIC Proceedings – Fall 2022, Accounting Practices and Procedures (E) Task Force, Attachment Two*).

Gosselin stated that during its March 7, 2023, meeting, the Working Group also adopted its editorial listing and the following proposals:

- A. 2022-14BWG Modified – Modify Exhibit 1, Part 1 and 2, and Exhibit 8, Part 1 and 2, in the life and accident and health/fraternal blank, to include the line of business detail reported on the Analysis of Operations by Lines of Business pages.
- B. 2022-15BWG – In the life, accident and health/fraternal, and property/casualty (P/C) blanks, revise the language of the Schedule H, Part 5 to remove the 5% of premiums filing exemption.
- C. 2022-16BWG – Remove Supplemental Health Care Exhibit Part 3 and Supplemental Health Care Exhibit's Expense Allocation Report.
- D. 2022-18BWG – For the life and accident and health/fraternal blank, instructional corrections on the handling of exchange traded funds (ETFs) and/or SVO identified funds within the IMR and the AVR.
- E. 2022-20BWG – Modify the instructions and blanks for various health exhibits to change the order of the Vision and Dental lines of business to be consistent with all other statement types.

Gosselin stated that the Working Group re-exposed proposal 2022-17BWG – Add new disclosure paragraph for Note 8 – Derivative Instruments and illustration to new disclosure to be data captured. Add electronic-only columns related to derivatives with excluded components to Schedule DB, Part A and Part B for both Section 1 and Section 2. Add new code column instructions for Schedule DB, Part A and B (SAPWG 2021-20). Re-exposed for a public comment period ending April 28.

Gosselin stated that the Working Group exposed nine new proposals for a public comment period ending April 28 for eight of the proposals and June 30 for proposal 2023-06BWG addressing Schedule D, Part 1, reporting.

Gosselin made a motion, seconded by Travis, to adopt the report of the Blanks (E) Working Group (Attachment Two). The motion passed unanimously.

Having no further business, the Accounting Practices and Procedures (E) Task Force adjourned.

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Draft: 4/11/23

Statutory Accounting Principles (E) Working Group  
Louisville, Kentucky  
March 22, 2023

The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force met in Louisville, KY, March 22, 2023. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Vice Chair (IA); Sheila Travis (AL); Kim Hudson (CA); William Arfanis (CT); Rylenn Brown (DE); Cindy Andersen (IL); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); Diana Sherman and Matt Milford (PA); Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI). Also participating were: Blase Abreo and Todrick Burks (AL); Michael Shanahan (CT); Bill Carmello (NY); Tom Botsko (OH); Doug Hartz (OR); and Rachel Hemphill (TX).

1. Adopted its 2022 Fall National Meeting Minutes

The Working Group met March 16, Feb. 22, Jan. 20, and Jan. 17 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings. No actions were taken during these meetings, as the discussion previewed the Spring National Meeting agendas and discussed other items with NAIC staff pursuant to the NAIC Policy Statement on Open Meetings.

Malm made a motion, seconded by Sherman, to adopt the Working Group's Dec. 13, 2022, minutes (*see NAIC Proceedings – Fall 2022, Accounting Practices and Procedures (E) Task Force, Attachment One*). The motion passed unanimously.

2. Adopted Non-Contested Positions

The Working Group held a public hearing to review comments (Attachment One-A) on previously exposed items.

Walker made a motion, seconded by Weaver, to adopt the revisions detailed below as non-contested statutory accounting revisions. The motion passed unanimously.

a. Agenda Item 2017-33

Bruggeman directed the Working Group to agenda item 2017-33: ASU 2022-01, *Issue Paper No. 167—Derivatives and Hedging* (Attachment One-B). Julie Gann (NAIC) stated that this agenda item is for an issue paper that provides historical documentation of the revisions adopted to *Statement of Statutory Accounting Principles (SSAP) No. 86—Derivatives* from the review of *Accounting Standards Update (ASU) 2017-22, Derivatives and Hedging* and *ASU 2022-01, Fair Value Hedging – Portfolio Layer Method*. Interested parties had no comments on the exposure.

b. Agenda Item 2022-15

Bruggeman directed the Working Group to agenda item 2022-15: *Affiliate Reporting Clarification* (Attachment One-C). Jake Stultz (NAIC) stated that during the 2022 Fall National Meeting, the Working Group exposed statutory accounting principle (SAP) clarifications to *SSAP No. 25—Affiliates and Other Related Parties* to clarify that any invested asset held by a reporting entity, which is issued by an affiliated entity, or which includes the obligations of an affiliated entity is an affiliated investment. Interested parties had no comments on the exposure.

c. Agenda Item 2022-16

Bruggeman directed the Working Group to agenda item 2022-16: *ASU 2022-03, Fair Value Measurement of Restricted Securities* (Attachment One-D). Stultz stated that revisions to *SSAP No. 100R—Fair Value* were exposed for adoption with modifications to ASU 2022-03 to be consistent with existing statutory accounting guidance, but the revisions do not incorporate the new ASU disclosures on sales restrictions. He noted that the items restricted as to sale would be captured as restricted assets per *SSAP No. 1—Accounting Policies, Risks & Uncertainties and Other Disclosures*. He noted that ASU 2022-03 provides updated guidance for two specific scenarios: 1) the restriction is based on the entity holding the equity security; and 2) the restriction is a characteristic of equity security. Interested parties had no comments on the exposure.

d. Agenda Item 2022-18

Bruggeman directed the Working Group to agenda item 2022-18: *ASU 2022-04, Disclosure of Supplier Finance Program Obligations* (Attachment One-E). Robin Marcotte (NAIC) stated that this agenda item is a clarification to *SSAP No. 105R—Working Capital Finance Investments* to reject ASU 2022-04 for statutory accounting, as these disclosures are for borrowers in these programs and, as such, are not relevant for insurance reporting entities that may invest in these programs. Interested parties had no comments on the exposure.

3. Reviewed Comments on Exposed Itemsa. Agenda Item 2019-21

Bruggeman directed the Working Group to agenda item 2019-21: Principles-Based Bond Definition. Gann stated that in November 2022 and at the 2022 Fall National Meeting, the Working Group exposed revisions to *SSAP No. 26R—Bonds*, *SSAP No. 43R—Loan-Backed and Structured Securities*, and other SSAPs, as necessary, to update statutory accounting guidance for the principles-based bond project. These revisions also included edits to *SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments* to restrict asset-backed securities (ABS) from being captured in scope and *SSAP No. 21R—Other Admitted Assets* to include new guidance for the debt securities that do not qualify within the bond definition. In addition to the revisions, an updated issue paper detailing the discussions and revisions, as well as proposed reporting changes, were also exposed.

Gann stated that interested parties provided detailed comment letters included in the meeting materials. She stated that NAIC staff reviewed the comments and made several changes to the proposed guidance. She stated that one change pertains to nominal interest rate adjustments in the prior guidance. Under the prior exposure, if the principal or interest can fluctuate based on non-bond related variables, it would preclude the security from being a bond. Gann stated that NAIC staff included guidance to have a very limited exception for nominal interest related adjustments, mostly pertaining to sustainability type bonds, but not limited in scope to that specific instance. Also included was guidance in *SSAP No. 21R* for residual tranche securities. Gann stated that interested parties highlighted that the guidance for residual tranche securities was still in *SSAP No. 26R* and *SSAP No. 43R*, but residual tranche securities do not technically qualify as bonds. Gann stated that *SSAP No. 21R* also reflects additional revisions to the guidance proposed for non-bond debt securities. She stated that there are questions for interested parties regarding the method that is being used to amortize residual tranche securities, as well as for the assessments of other-than-temporary impairment (OTTI) and how that has occurred historically. She stated that NAIC staff recommend that the Working Group expose the revised SSAPs. She stated that *SSAP No. 21R* has been broken out so that it is its own stand-alone document, so the documents for exposure include *SSAP No. 26R*, *SSAP No. 43R*, *SSAP No. 21R*, and the other SSAP revisions. In addition to the SSAP guidance revisions, NAIC staff also proposed Schedule BA reporting line changes very similar to what was done in the past for the broader bond changes. Gann stated that NAIC staff recommended exposing the proposed reporting changes as a conceptual

change at the Working Group, and after considering comments, a blanks proposal could then be submitted to the Blanks (E) Working Group.

Michael Reis (Northwestern Mutual), representing interested parties, expressed his appreciation of the dialogue with NAIC staff and state insurance regulators, as well as support for the nominal interest rate adjustment that Gann discussed. He stated that interested parties continue to look forward to working with the NAIC staff and state insurance regulators on this project.

Gann stated that there were two additional items to highlight: 1) the issue paper detailing discussions and decisions for the principles-based bond project will be updated after this meeting for subsequent exposure; and 2) the Blanks (E) Working Group exposed the broad bond reporting changes (2023-06BWG) with a public comment period ending June 30.

Clark made a motion, seconded by Walker, to expose the above agenda items. The motion passed unanimously. After the Spring National Meeting, the chair agreed to extend the exposure deadline for the Schedule BA reporting changes to June 30 to mirror the exposure deadline for the blanks reporting changes. The SSAP exposures were not extended and have a public comment period ending June 9.

b. Agenda Item 2022-01

Bruggeman directed the Working Group to agenda item 2022-01: Conceptual Framework – Updates. Marcotte stated that during the 2022 Fall National Meeting, the Working Group re-exposed revisions to *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets* and *Issue Paper No. 16X—Updates to the Definition of a Liability*. The revisions incorporate the definition of a liability from Financial Accounting Standards Boards (FASB) *Concepts Statement No. 8, Conceptual Framework for Financial Reporting—Chapter 7, Presentation and Concepts Statement No. 8, Conceptual Framework for Financial Reporting—Chapter 4, Elements of Financial Statements*, which updates the definition of an asset and definition of a liability.

Marcotte stated that NAIC staff recommend exposure of additional clarifications, deferring to SSAP guidance, which provides topic-specific variations from the definition of a liability and SSAP No. 5R, and the related issue paper, as illustrated in the proposed revisions in the meeting materials. These clarifications are recommended because of the authoritative treatment that statutory accounting provides to the definition of an asset and liability in *SSAP No. 4—Assets and Nonadmitted Assets* and SSAP No. 5R. Marcotte stated that for U.S. generally accepted accounting principles (GAAP), the FASB conceptual framework definitions are not authoritative, but they are concepts to consider when developing and applying guidance. Particularly for liabilities, this is needed because of the existing variations in SSAPs, such as asset valuation reserve (AVR) and interest maintenance reserve (IMR) and the provision for reinsurance and other post-retirement benefits. Marcotte stated that the proposed footnote defers to other topic-specific guidance in other SSAPs when appropriate. She stated that due to prior interested parties' comments, NAIC staff have also prepared a new agenda item 2023-01: Review Annual Statement Instructions for Accounting Guidance—which proposes a project to ensure that accounting guidance from the annual statement instructions are incorporated in the SSAPs, as needed.

Walker made a motion, seconded by Malm, to expose the additional clarifications deferring to SSAP guidance. The motion passed unanimously.

c. Agenda Item 2022-11

Bruggeman directed the Working Group to agenda item 2022-11: Collateral for Loans. Marcotte stated that during the 2022 Fall National Meeting, the Working Group re-exposed revisions to SSAP No. 21R to clarify that assets



pledged as collateral for admitted collateral loans must qualify as admitted invested assets. She stated that interested parties proposed a footnote on audit requirements allowing a third-party-determined fair value to be used in the place of an audited valuation.

NAIC staff recommended revisions to SSAP No. 21R, illustrated in the agenda item, proposing the clarification of guidance, along with the addition of a new footnote. This footnote, originating from state insurance regulators, noted that it was imperative to uphold and maintain audit requirements of joint ventures, limited liability companies (LLCs), or investments that would qualify as a subsidiary controlled entity if they were pledged as collateral for a loan. State insurance regulators had concerns that allowing these investments to qualify as acceptable collateral without an audit would lower the collateral requirement standard and allow for potential arbitrage within risk-based capital (RBC) and the admissibility of assets.

Marcotte stated that NAIC staff's recommendation is to continue to require audits for joint ventures, limited LLCs, and partnerships, as well as investments that would qualify as subsidiary, controlled, and affiliated (SCA) entities if these items are pledged as collateral to support the admittance of a collateral loan. Furthermore, the recommendation proposes to revise the standard to note that a fair value comparison is required unless the collateral is an *SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies* or *SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities* investment, in which case the comparison to the loan is to the audited net equity value of the pledged collateral. Marcotte stated that this is closer to what the day two value would be in the event that the loan defaulted and the collateral was assumed by the insurance reporting entity. In addition, NAIC staff are recommending that the words “admitted” and “investment” be inserted into paragraph 4.b. of *SSAP No. 20—Nonadmitted Assets* for consistency. Marcotte recommended exposing the proposed edits to SSAP No. 21R and SSAP No. 20.

Bruggeman stated that the concept that nonadmitted assets cannot find their way into an admitted asset balance sheet came up several years ago. He stated there are some fair value considerations, but with SSAP No. 48 and SSAP No. 97 entities that almost always require an audit, and if that audit is the support to admit the loan receivable, the Working Group must ensure that if there are nonadmitted assets being pledged as collateral, they are not being moved up to the regulated entity balance sheet in a different way.

Andrew Morse (Global Atlantic Financial Group), representing interested parties, stated his appreciation of the collaborative and clear process on this topic. He stated that interested parties made a comment at the 2022 Fall National Meeting on this topic and have read the proposed exposure, and they believe it is significantly clearer in terms of what is needed. He added that interested parties' ability to comment and engage in dialogue with state insurance regulators is appreciated.

Clark made a motion, seconded by Weaver, to expose the revisions to SSAP No. 21R proposing the addition of a new footnote and minor consistency edits to SSAP No. 20. The motion passed unanimously.

d. Agenda Item 2022-12

Bruggeman directed the Working Group to agenda item 2022-12: Review of INT 03-02: Modifications to an Existing Intercompany Pooling Arrangement. Marcotte stated that during the 2022 Fall National Meeting, the Working Group re-exposed the intent to nullify *Interpretation (INT) 03-02: Modification to an Existing Intercompany Pooling Arrangement*. With this re-exposure, the Working Group requested industry provide comments on specific instances in which the interpretation was being applied and specific staff-identified items were noted in the agenda.

Marcotte stated that interested parties provided comments that were included in the meeting materials. She stated that NAIC staff continue to recommend nullification of INT 03-02, as it is inconsistent with SSAP No. 25 guidance regarding economic and non-economic transactions between related parties. She stated that after speaking with interested parties, NAIC staff do not believe there is a compelling need to be different when valuing these types of intercompany transactions. She stated that the recommendation is exposure with an effective nullification date of Dec. 31, 2023. She stated that interested parties requested another exposure to allow for further discussion.

Bruggeman stated that there may be a need to review the guidance in *SSAP No. 62R—Property and Casualty Reinsurance* transactions, particularly with pooling and netting arrangements as part of this exposure and discussion to ensure SSAP No. 62R is not in conflict, and requested comments from state insurance regulators and industry on this dynamic during the exposure period.

Keith Bell (Travelers), representing interested parties, commented that while INT 03-02 is in conflict with SSAP No. 25, there is consistency and comparability of accounting because of the interpretation. He stated that there is concern that the nullification of INT 03-02 is going to cause a high risk of inconsistency of interpretation by companies, state insurance regulators, and auditors on the issue of economic versus non-economic transactions. He also stated that the nullification will end up with different reinsurance accounting depending on whether interest rates are going up or going down and for bonds with an unrealized gain versus unrealized loss position. He stated that there is also going to be inconsistency within an intercompany pooling arrangement depending on whether investments are in an unrealized gain or loss position. For example, the same company group could trigger both gains and losses, meaning some companies would end up with prospective reinsurance because of the change, and other companies within the same group would end up with retroactive reinsurance. Bell noted that there is going to be some inconsistency within a group based on the ownership chain of companies. If there is a single insurer at the top of the ownership chain, there will be a different set of rules on the economic distinction, versus having multiple companies at the top of the ownership chain. Bell stated that interested parties will look at the re-exposure, and they may present language that could narrow this down even further to be included in SSAP No. 62R as permanent guidance rather than be part of an INT.

Bruggeman requested that interested parties include specific wording or economic versus non-economic situations, as well as the unrealized gain/loss scenario he discussed for bonds. He stated that specificity or examples that could be provided, rather than a theoretical discussion, would help the Working Group understand how to incorporate necessary guidance within SSAP No. 62R. Bell stated that the response will include these details.

Malm made a motion, seconded by Walker, to re-expose INT 03-02 with an effective nullification date of Dec. 31, 2023. The motion passed unanimously.

e. Agenda Item 2022-14

Bruggeman directed the Working Group to agenda item 2022-14: New Market Tax Credits. Gann stated that this agenda item addresses new market tax credits, but more broadly, overall tax credit accounting. She stated that at the 2022 Fall National Meeting, the Working Group exposed both the agenda item and a discussion document that walked through proposed SSAP changes, and it requested feedback from state insurance regulators and interested parties. The Working Group received a very detailed comment letter from interested parties that addressed all the discussion document questions. Interested parties also provided two general key theme comments. One comment asked for a reconsideration of the existing guidance to have both the amortization of the investments and the use of the tax credits go through the same income statement line, consistent with U.S. GAAP. Gann stated that statutory accounting intentionally took a different approach when the guidance was

originally adopted. NAIC staff will research this to understand why the divergence from U.S. GAAP was undertaken and determine if there is a reason to change to be consistent with U.S. GAAP. The second comment pertained to the classification of tax credit investments that are in the form of debt on Schedule D and not Schedule BA. Gann stated that NAIC staff have received comments from state insurance regulators that they are more appropriate to be on Schedule BA and should not be reported as bonds. She stated that NAIC staff are requesting feedback from state insurance regulators if that is an incorrect assessment. She stated that NAIC staff are recommending that the Working Group direct NAIC staff to continue moving forward with drafting SSAP guidance, noting that the FASB has a pending issuance regarding the proportional amortization method. NAIC staff will also review comments received from interested parties, as well as the new U.S. GAAP ASU once it has been issued, and move forward with proposing SSAP revisions for exposure at a later date. She stated that NAIC staff also recommend direction to work with interested parties directly during the interim.

Bruggeman stated that there are currently only line items for low-income housing tax credits in Schedule BA of the financial statements and RBC calculations. He stated that there may come a time that if there are differentiations, the Working Group will inform interested state insurance regulators and interested parties of those and will pass that information along to the Capital Adequacy (E) Task Force.

Gann stated that it is anticipated that this project will continue to sponsor blanks and RBC reporting changes since current reporting is specific to low-income housing tax credits, and the project is expanding to encompass more types of tax credits.

Bruggeman stated that the Working Group does not need to make a motion for this agenda item, and NAIC staff have been directed based on these recommendations.

f. Agenda Item 2022-17

Bruggeman directed the Working Group to agenda item 2022-17: Interest Income Disclosure Update. Stultz stated that this agenda item came from the larger principles-based bond project. He stated that during one of the earlier exposures, interested parties suggested revisions to further enhance reporting for interest income. He stated that there are two distinct items that came from the original interested parties' comments addressed in this agenda item. First, interested parties suggest data-capturing the gross nonadmitted and admitted amounts of interest income due and accrued. Second, interested parties suggested that a data element for paid-in-kind (PIK) interest mirror the definition included in the bond proposal project and reflect the cumulative amount of PIK interest included in the current principal balance. Stultz stated that from the original exposure of this agenda item, interested parties provided some revisions that are shown in the agenda. Interested parties also asked to have an effective date that is consistent with the bond project. He stated that because this disclosure is unrelated to that project overall, NAIC staff recommend that this be adopted for 2023 year-end reporting. He stated that NAIC staff's recommendation is to adopt the agenda item with the interested parties' suggested revisions but keep the 2023 year-end date. He stated that there is a corresponding Blanks (E) Working Group proposal that will be exposed, and NAIC staff will work closely with the interested parties to ensure that the language in the proposal is consistent with their suggested revisions.

Tip Tipton (Thrivent), representing interested parties, stated that they are appreciative of the changes made. He stated that these are just aggregate total amounts of deferred interest and PIK interest. He noted that beginning in 2025 with the bond project, the expectation is these will be identified separately for each investment, but for now, at least for 2023 and 2024, this will be just a total aggregate amount. He stated that is interested parties' understanding, and they support this effort. He stated interested parties look forward to the opportunity to comment on the Blanks (E) Working Group proposal.

Clark made a motion, seconded by Walker, to adopt the agenda item with the interested parties' suggested revisions but keep the 2023 year-end effective date (Attachment One-F). The motion passed unanimously.

g. Agenda Item 2022-19

Bruggeman directed the Working Group to agenda item 2022-19: Negative IMR. Gann stated during the 2022 Fall National Meeting, the Working Group exposed the agenda item as a new SAP concept. She stated that it detailed the current guidance and the history of negative IMR, but there were no actual recommendations included. She stated that the Working Group also had regulator-only discussions in January and February to hear company presentations regarding negative IMR. She stated that the Working Group also received a comment letter from the American Council of Life Insurers (ACLI) during the exposure period, which was included in the meeting materials. She stated that NAIC staff are requesting the Working Group to provide feedback and direction.

Brown stated that it is important to help state insurance regulators understand the impact of negative IMR and to have special reporting so it can be easily identified. She expressed support for a referral to the Capital Adequacy (E) Task Force in regard to RBC. She suggested an admittance limitation of 1% of capital and surplus. She stated that there are a variety of things for the Working Group to consider and discuss.

Hudson stated that the Working Group has a number of items that should be directed to NAIC staff. First, he suggested a referral to the Life Actuarial (A) Task Force on the asset adequacy implications of negative IMR, and he directed NAIC staff to help with the template for reporting asset adequacy. Secondly, he reiterated Brown's comments for a referral to the Capital Adequacy (E) Task Force to consider the elimination of any net negative IMR from total adjusted capital (TAC) and consideration of sensitivity testing with and without negative IMR. Thirdly, he said he supports separate surplus reporting for the admitted negative IMR. Fourth, he recommended a cap on admitted negative IMR as a percentage of surplus, such as what exists for goodwill, and consideration of a downward adjustment when RBC reaches below 300%. Fifth, he suggested the consideration of an update to the instructions for excess withdrawal and related capital gains and loss to ensure that it is clear on the division between AVR and IMR. Sixth, he said there should be additional footnote disclosure.

Walker agreed with Hudson and emphasized that the Working Group is trying to find a solution quickly on this topic. She stated that the prior discussion of negative IMR was a multi-year long discussion that got nowhere. So, the Working Group may have to do an interim solution until feedback is received in response to the referrals to the task forces and other groups involved in this issue get a permanent solution. She stated that the Working Group should try to address the current issue while also establishing a robust and well-thought-out overall policy related to negative IMR.

Malm agreed with Walker, and she stated that the Working Group should not close the issue until a solution is reached to prevent this dynamic from reoccurring after another 10 years. She stated that the issues should be well documented, with full understanding of the pros and cons, and a conclusion reached.

Clark stated support for the comments that Walker and Malm made and the direction that Hudson laid out. He stated that he would add one element, which is one of the things that interested parties recommended in their comment letter, to include an opt-in approach that would come with documentation around asset-liability matching (ALM) policies. He stated that having an approach where there might be differences between companies may not be desirable, but he noted that there are elements of the opt-in idea that could be applied across the board. He stated that he is not sure that the current guidance specifies that sales of assets for other than reinvestment purposes cannot be deferred; therefore, that could be the presumption for why negative IMR should be admitted. He stated that explicitly spelling out what is permitted for IMR might be needed, as well as potentially

some form of attestation from the company that any deferred losses were in fact for reinvestment purposes and not for non-reinvestment purposes.

Bruggeman stated the need to ensure the discussion and conclusions, with the final accounting guidance fully documented. He stated that this is one topic where there are instructions in the NAIC *Annual Statement Instructions* and generic instructions in *SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve*. He stated the Working Group needs to ensure that those are consistent with the hierarchy, so statutory accounting comes first. He stated that blanks instructions cannot change the accounting guidance. He stated that the Working Group needs to ensure that the language between the instructions, SSAP No. 7, and SSAP No. 86 are lined up as best as possible when discussing types of assets, such as bonds and interest rate-related impacts, especially with derivatives that have yet to be discussed. He stated that the whole idea with bonds is they are being carried at amortized cost. With amortized cost measurement, there is no recording of an unrealized gain or loss fluctuation during the life of the asset, and that is why IMR was established. He stated that where there are already assets, whether they are bonds or derivatives that are recorded at fair value, those items should probably not end up in IMR. He stated that there are instructional elements that are not laid out exactly right that should be addressed as part of this project.

Reis stated that the ACLI would like to thank the NAIC for picking up this issue with urgency. He stated that the ACLI would like to acknowledge that there was a prior Working Group discussion, a regulator-to-regulator session with the Life Actuarial (A) Task Force, a discussion at the Financial Condition (E) Committee, a discussion here today, and many state insurance regulator discussions with individual ACLI companies, and all of those efforts are very much appreciated. He stated that he wants to start with maybe the main thrust of the ACLI letter and try to address a few key points. He stated that the ACLI brought forth the opt-in approach in its letter because it believed it was something that would best address state insurance regulator concerns. He stated that it would be intended to be a very structured process that had many potential appropriate safeguards, such as proving reinvestments, ALM objectives being met, a recommendation of asset adequacy testing (AAT) tightening attestation, potentially tethering to RBC, and significant transparency. He stated that throughout state insurance regulator and individual member company discussions, the ACLI has been hearing a lot of different thoughts. Some participants really like the opt-in approach; some, perhaps Delaware, may want segregating surplus through a special surplus account, and they appreciate the detailed consideration that has been going into this. He stated that he believes the ACLI would support, maybe along the lines of what Clark suggested, either of those approaches or some combination of these approaches, certainly with the requisite safeguards mentioned. He stated that one common theme that the ACLI has heard from state insurance regulators is that they do not want to disincentivize prudent behavior transactions. At the same time, the ACLI has heard that state insurance regulators do not want to incentivize imprudent behavior or transactions. He stated that the ACLI certainly shares those objectives and welcomes any specific concerns that state insurance regulators have so they can help to address those. He stated that higher interest rates are generally positive for life insurance companies, and for all the reasons that IMR was developed, ACLI companies believe that it is important that financial strength be accurately reflected. Current interest rates, or even higher rates, will only exacerbate the negative IMR issue as companies look to make decisions throughout 2023 and beyond and likely many years down the road. Therefore, ACLI companies are hopeful that they can work with state insurance regulators and NAIC staff toward a year-end resolution if possible, and they are here to support that effort in any way they can. He stated that the ACLI is thankful for all the consideration, and it is certainly willing to discuss or take questions as well.

Bruggeman asked if there were any questions for Reis, and he stated that the options hint at incorporating governance within accounting, but there are, as Clark described, ways to do that. Bruggeman stated that he agrees with Clark that an opt-in is probably not the best way to get consistency; therefore, if something like that is supported by the Working Group, it would have to be across the board. He stated that asset adequacy testing is done through the Life Actuarial (A) Task Force, and with the actuarial assumptions, there are certain things that

perhaps do not have as many guardrails. There are a lot of cash flow assessments to consider, and there is a bigger picture for the whole industry and the Financial Stability (E) Task Force on liquidity stress testing (LST). He stated that he does not know if that is part of AAT testing, and that it is kind of indirect. However, because these are deferred losses, if there is a liquidity stress within one company, which may not be in the whole industry, those create different kinds of issues, going to the heart of reinvestment.

Bruggeman stated that there is already a requirement for excess withdrawals, and if there are excess withdrawals and a company is forced to sell bonds, the loss that happens in that situation does not currently go through IMR. If the Working Group needs to tighten up that language, it may help ensure that reinvestment occurs. Bruggeman stated that in situations where losses go to IMR and reinvestment does not occur, then the Working Group and state insurance regulators need to understand to verify that it was because of the excess withdrawal. He stated that the state insurance regulators want to prevent any gamesmanship going on with that scenario.

Bruggeman stated that he is trying to ensure that the Working Group is addressing all components of this topic, and at the end of the discussion, the intent is to give directions to NAIC staff to move forward. He stated that he heard a percentage of surplus admittance limitation from Brown at 1%. He stated that NAIC staff have done an overall analysis by company, which was shared with state insurance regulators, on the percentage of net negative IMR that is currently nonadmitted compared to capital and surplus. He also noted that state insurance regulators received a five-year history of net negative IMR by reporting entity. He stated that there are individual circumstances where companies go from positive to negative, but there are several reporting entities that have been in a net negative IMR position for all five years. He stated there could be a lot of reasons why those companies have been in a net negative position, but recognizing this dynamic goes back to the key components of the original ACLI letter and what guardrails should exist before permitting an admitted asset for net negative IMR.

Reis stated that the ACLI letter does not oppose looking at the excess withdrawal guidance. He identified that certain liabilities with market value adjustments are believed to be excluded from the excess withdrawal guidance, and there are questions on why those were excluded. Regarding the data that details ongoing years of negative IMR by some reporting entities, he stated that the economy has been in a 30-year period of declining interest rates; therefore, the five-year historical data may not be the most useful assessment. He stated the results for net negative IMR could go back for an extended period.

Reis stated that an admittance limit of 1% of surplus is a small number compared to what companies are anticipating. He stated that the ACLI's position is that an arbitrary safeguard of 1% is too low. He also stated concern with the view that IMR creates an intangible asset of prior realized losses that cannot be used to pay claims. He stated it is very important to understand the presence of the intangible asset with the current reporting of bonds at amortized cost, and he provided an example, noting that it is an oversimplification of the theory behind IMR. He stated that if a reporting entity has a bond that was bought for \$100 on the balance sheet and because of rising interest rates, the fair value of the bond is \$80, a reporting entity effectively has \$80 of claims paying ability or liquidity, on the balance sheet has an intangible asset on the balance sheet of \$20. This is because the bond is reporting at amortized cost (100), so there is an intangible asset reported with the bond, which is the difference between the fair value and the amortized cost. Reis stated that if a reporting entity was to sell the bond at fair value, predicated on reinvestment, the reporting entity would acquire a new bond for \$80. As such, the reporting entity still has the same \$80 liquid asset, and with the allocation to IMR for the \$20 loss from the sale—\$100 to \$80—the reporting entity still has the same \$20 in intangible assets they had when the bond was reported at \$100. As such, in terms of financial position and a reporting entity's claims paying ability from liquidity, a reporting entity would be in the same position pre- and post-bond sale with reinvestment. Reis stated that he has been asked why reporting entities do these transactions, and he noted that there are many reasons. He stated that a reporting entity could be doing it to shorten or lengthen portfolios to either affect disintermediation risk or

ensure that guarantees do not get hit in the long term. He stated that the duration of the sold bond and reinvested bond could be different, but that change does not affect claims paying ability or liquidity, and it could put reporting entities in a better spot in the long term. He stated that it has also been inquired as to whether the reporting entities reinvest with different credit-rated bonds, and he advised that entities do not necessarily think linearly, and if they are going to sell a AAA bond, then they are going to reinvest in another AAA bond. He noted that if the credit rating were different, higher or lower, that would be picked up in RBC. In conclusion, he stated that he wanted to be sure to make the point that liquidity and claims paying ability is not affected, as that is an important point.

Bruggeman requested discussion on how to direct NAIC staff to prepare guidance for exposure, and he opened the floor to begin with the admittance limit as a percentage of surplus. He stated that Brown has proposed a 1% limit, and goodwill is limited to 10% of surplus, noting that could be perceived as a large range between limits. Brown stated that it is a compromise to allow the admittance of even a small amount, but the 1% proposal is open to negotiation. She stated some think it should be 10%, but she believes it should be 1%, so perhaps somewhere in the middle would be a good place to start.

Bruggeman stated that he had heard potential support closer to the 15% used for the deferred tax asset (DTA), but he noted that there is a secondary guardrail there with the three-year limit, so that is why he believes maybe closer to the goodwill 10% limit may be more appropriate.

Brown stated that some states use 5% of capital and surplus in determining materiality, and if the amount is considered material, it is a big deal. However, she said she is certainly willing to hear what everyone else has to say.

Bruggeman suggested starting at 5% of capital and surplus as an admittance limit with an elimination of admittance if RBC goes below 300%. He asked if anyone objects to the 5% limit as the initial direction to staff. Reis asked if it makes sense to focus on the broader conceptual direction that seemingly makes sense and is without controversy and leave open a specific percentage in the exposure as something to debate further. Bruggeman stated his preference to have a percentage limit in the exposure. He stated that he is not aware of the support for the 10% goodwill limit, and he requested NAIC staff research that historical discussion. He stated support for 10%, but he is sensitive to Brown's comments that materiality assessments are at 5%, noting that there could be a secondary guardrail where asset adequacy testing is the primary guardrail.

Clark stated that he is not opposed to an admittance limit for exposure, as the point of the exposure is to get comments before having additional discussion, and getting industry feedback will be important. He stated that the desire for an admittance limit makes logical sense from a conservatism perspective. But given the size of insurers' balance sheets in comparison to surplus and the size of their fixed income portfolios, even a 10% allowance is going to be very small in comparison to what interest rates have done to some reporting entity's fixed income portfolios. He stated that is an issue the Working Group should explore, but he believes it is going to be kind of a difficult one to meaningfully address the IMR impact of the significant rise in interest rates and what that has done to asset values with a 5% limit.

Malm stated that the analysis needs to be done before a percentage is set. She stated that industry should do an analysis as well because they know their investment portfolios and their surplus, and it would be beneficial for them to provide the Working Group with what they are projecting. Bruggeman stated that individual company analysis is key to understanding the potential impact if sales are planned for investments held at amortized cost.

Hartz stated that getting input from industry and considering the type of transaction that is giving rise to the negative IMR might be more important than a target rate or target percentage of surplus.

Walker stated that if the Working Group takes too much time for analysis, they will not arrive at a solution by year-end. As such, there is a give and take from a short-term solution versus a long-term solution. If there is a desire to have the long-term solution conversation, then it will likely take more time than what is available to have a solution this year. She stated that although it is only the first quarter, the Working Group already has a limited amount of time for a year-end solution. Bruggeman agreed with these comments.

Hudson stated support for a numerical cap even if it ends up not being the perfect solution. The Working Group needs to get something in place, and the initial limit can always be changed. He stated the Working Group should start off with the cap, if it is 5% of surplus, to start the discussion process. Weaver agreed to put in a percentage limitation, also acknowledging that it is under negotiation. Walker and Weaver both stated support for a 5% admittance limit to capital and surplus. Hartz also noted that 5% is between the 1% and 10% options being considered, so it is a good place to begin as an initial direction to NAIC staff.

Brown stated that once other safeguards are in place, the Working Group could consider raising the admittance limit. Bruggeman and Walker agreed with these comments.

Reis stated that the admittance limit is important and supports the idea that it will be subject to additional discussion.

Bruggeman then discussed providing direction to NAIC staff to provide referrals to both the Life Actuarial (A) Task Force and the Capital Adequacy (E) Task Force. For the referral to the Life Actuarial (A) Task Force, he requested further consideration of asset adequacy implications of negative IMR. He directed NAIC staff to assist in developing a template for AAT disclosures, noting that he is aware of the current initiative for an *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53) documentation enhancement. He stated that it is important to consider the actual amount of admitted negative IMR that is being used within the asset adequacy testing, because the higher the negative IMR, the more potential there is for an AAT liability. He requested the referral also address the considerations of cash flows within AAT with liquidity stress testing considerations to ensure that excessive withdrawal considerations are consistent with the actual data. He stated that it is important for the assumptions of cash flows and liquidity stress testing to be consistent, and he referred to the existing guidance for tax planning strategies, where it is noted that tax planning strategies cannot be inconsistent with other company assertions. He stated that the referral should request guardrails within AAT that are reasonable and consistent with other aspects.

Bruggeman stated that for the referral to the Capital Adequacy (E) Task Force, he requested consideration to remove any admitted net negative IMR from total adjusted capital (TAC) with inclusion of any other sensitivity testing that may be needed for IMR. He stated that RBC is supposed to be a weakness indicator and is a state insurance regulator tool, not a strength indicator for other uses. He stated that he knows it gets used for other things, but the state insurance regulator use and tool is the first priority. Brown and Walker agreed with this recommended referral.

In response to an inquiry from Reis asking whether the referral will remove admitted negative IMR from TAC for the RBC calculation, or just for sensitivity testing, Bruggeman confirmed that the referral is to remove admitted negative IMR from TAC in determining the RBC percentage. Bruggeman noted that the discussion on this aspect will occur at the Capital Adequacy (E) Task Force. He stated that this change may not be viable for year-end, so that is why other points and guardrails need to be considered.

Bruggeman directed NAIC staff to proceed with guidance to allocate the admitted negative IMR to special surplus. He stated that this allocation will make it easier to identify in the quarterly financials, as the IMR schedule is only completed for the annual reporting.



Bruggeman requested that NAIC staff review the annual statement instructions for excess withdrawals and for bonds and derivatives reported at fair value to ensure those gains and losses are not going through IMR. He also noted a need to review the AVR guidance, which is intended for credit losses, to ensure that the division between IMR and AVR is clear. He requested NAIC staff to also consider additional disclosure reporting that would help state insurance regulators identify or summarize aggregate activity, especially with quarterly reporting.

Bruggeman reiterated that the Working Group is trying to provide guidance quickly as an interim step, but it needs to have a long-term solution so that this is not a pending issue in another 10 years. Although it is unlikely to be fully done by year-end, he would like to work towards June 30 for the interim solution, as that allows the other affected groups to receive the interim guidance in a timely manner before it is applicable for year-end.

In response to an inquiry from Brown on a potential blanks referral, Bruggeman stated that the Working Group would consider a disclosure first as part of the interim discussion and then sponsor a blanks proposal.

In response to Weaver's comments on the lengthy list of action items, items to consider, and the time that may be needed, Bruggeman stated he already had several of these identified, and he has given NAIC staff a preview, contingent on the discussion of the Working Group from this meeting. He stated that NAIC staff will move forward on this quickly as directed by the Working Group. He stated that the approach is trying to identify a good solution for industry but also ensure appropriate financial reporting and regulatory tools. Bruggeman stated that it would have been easier if a resolution to this topic had been established 20 years ago, but there were other urgent issues. He stated when interest rates increase more than 4% in a year, some weird circumstances happen.

Carmello asked for clarity on the referral to the Life Actuarial (A) Task Force, specifically on the topic of reasonable guardrails. He stated that there are no guardrails now on AAT other than in New York. He asked whether the Working Group will ask for guardrails to be established on a national basis. Bruggeman responded that the request to the Task Force is to look at the guardrails in place in New York, as well as other options, to see if there are any that can be incorporated. Carmello stated that Minnesota made a proposal for AG 53 guardrails last year, and it was voted down. As such, he does not believe the Working Group should be relying on AAT.

Hemphill stated that the question of whether there is a need for AAT guardrails dovetails with other work the Life Actuarial (A) Task Force and the Valuation Analysis (E) Working Group is going to be doing with AG 53. She stated that it might be a heavy change to make, but they may indeed find that there are guardrails needed, and if those changes are made, then that would provide actuaries more comfort with applying AAT to a greater extent. She stated that without guardrails, she would also be uncomfortable in relying on AAT, and it makes sense for the Life Actuarial (A) Task Force to review what could be established.

Walker stated that her message to industry is that there are going to be three groups that will be working on this negative IMR issue. While the Statutory Accounting Principles (E) Working Group is going to consider an interim solution, the longer-term resolution may be contingent on what the other groups decide. Walker stated that the solutions of those other groups may allow the state insurance regulators of the Working Group to decide whether to allow a higher admitted asset on the balance sheet. As such, it is going to be a balancing act, and there may be tough discussions on a long-term solution if there are no guardrails on AAT or changes to TAC, or other RBC calculation revisions. Without those revisions, the long-term solution may have a far less admitted amount than what industry might prefer.

Smith stated that the Working Group keeps talking about a long-term solution, but he believes it is important to highlight that this will be a new long-term solution. He stated the long-term solution that has been in place for 31 years is that negative IMR is nonadmitted. He stated that the recent discussion has implied that the Working

Group did not address this issue, and that is incorrect. He reiterated that since 1992, negative IMR has been required to be nonadmitted, and that long-term process should speak for itself.

Hartz stated that the long-term solution may be to leave the existing guidance as it is, as nonadmittance is more conservative. He stated not allowing negative IMR and leaving it nonadmitted is consistent with statutory accounting, but even in that circumstance, there may be special circumstances that state insurance regulators may need to consider.

Smith stated that he does not disagree with the discussion or the proposed actions, but he wants to be clear that the admittance of negative IMR will be a change to the long-time existing guidance. He noted that the existing guidance was an intentional decision.

Bruggeman expressed appreciation for the detailed discussion, and he requested that NAIC staff have the minutes explicitly detailed for historical purposes. He stated that the Working Group does not generally take a vote to direct NAIC staff, but for this topic, he would like to have a vote.

Malm made a motion, seconded by Walker, to direct NAIC staff to work on both a 2023 solution and a long-term solution as follows:

- i. Recommend a referral to the Life Actuarial (A) Task Force on further consideration of the asset adequacy implications of negative IMR. Items to include: 1) developing a template for reporting within AAT; 2) considering the actual amount of negative IMR that is admitted to be used in the AAT; 3) better consideration of cash flows within AAT and documentation, as well as any LST considerations; 4) ensuring that excessive withdrawal considerations are consistent with actual data—sales of bonds because of excess withdrawals should not use the IMR process; and 5) ensuring that any guardrails for assumptions in the AAT are reasonable and consistent with other aspects.
- ii. Recommend a referral to the Capital Adequacy (E) Task Force for the consideration of eliminating any admitted net negative IMR from TAC and the consideration of sensitivity testing with and without negative IMR.
- iii. Develop guidance for future Working Group consideration that would allow for the admission of negative IMR up to 5% of surplus using the type of limitation calculation similar to that used for goodwill admittance. The guidance should also provide for a downward adjustment if the RBC ratio is less than 300%.
- iv. Review and provide updates on any annual statement instructions for excess withdrawals, related bond gains/losses, and non-effective hedge gains/losses to clarify that those related gains/losses are through AVR, not IMR.
- v. Develop accounting and reporting guidance to require the use of a special surplus—account or line—for net negative IMR.
- vi. Develop governance-related documentation to ensure sales of bonds are reinvested in other bonds.
- vii. Develop a footnote disclosure for quarterly and annual reporting.

The motion passed unanimously.

#### 4. Considered Maintenance Agenda – Active Listing

Walker made a motion, seconded by Weaver, to expose the following agenda items for a public comment period ending June 9, except for agenda item 2023-03: New C-2 Mortality Risk Note and agenda item 2023-11-EP: AP&P Manual Editorial Updates, which will be exposed for a public comment period ending May 5. The motion passed unanimously.

##### a. Agenda Item 2023-01

Bruggeman directed the Working Group to agenda item 2023-01: Review Annual Statement Instructions for Accounting Guidance. Gann stated that this agenda item has been developed to establish a project to review the annual and quarterly statement instructions to ensure that primary accounting guidance is reflected within the SSAPs. Although the duplication or reference of accounting guidance may occur for ease in applying the reporting guidance, the focus of this project is to ensure that the annual or quarterly statement instructions are not the primary source of statutory accounting guidance. For the purposes of this agenda item, accounting guidance is intended to refer to measurement, valuation, admittance/nonadmittance, as well as when assets and liabilities should be recognized or derecognized within the statutory financial statements.

This agenda item and project is proposed to address limited situations in which the annual statement instructions have been identified to reflect more detailed accounting guidance than the SSAPs. Under the statutory hierarchy, the SSAPs are Level 1 and the authoritative source for accounting provisions. If guidance does not exist in the SSAPs, then other sources of guidance can be considered based on the statutory hierarchy, but it is not intended that guidance purposely be captured in the annual statement instructions (which are level 3,) in lieu of the inclusion of guidance in the SSAPs.

Although it is anticipated that only limited situations will be identified, this agenda item proposes a broad project to review the instructions and identify where accounting guidance may need to be captured in the SSAPs.

##### b. Agenda Item 2023-02

Bruggeman directed the Working Group to agenda item 2023-02: SSAP No. 43R – CLO Financial Modeling. Gann stated that this agenda item proposes revisions to SSAP No. 43R to incorporate edits to reflect changes adopted by the Valuation of Securities (E) Task Force on Feb. 21 to include collateralized loan obligations (CLOs) in the Securities Valuation Office (SVO) financial modeling process.

This agenda item has been drafted to ensure the financial modeling guidance summarized in SSAP No. 43R reflects the practices, as directed by the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual). The *Accounting Practices and Procedures Manual* (AP&P Manual) is higher in the statutory hierarchy than the P&P Manual, but the primary source of authoritative guidance for financial modeling is the P&P Manual. Only a general description of the modeling process is included in SSAP No. 43R. The methodology to model CLOs is still being developed, but guidance that permits the SVO to model CLOs has been adopted and should be followed once CLOs begin to be financially modeled.

##### c. Agenda Item 2023-03

Bruggeman directed the Working Group to agenda item 2023-03: New C-2 Mortality Risk Note. Marcotte stated that the Life Risk-Based Capital (E) Working Group is working on a project to modify its C-2 mortality risk charges. The Life Risk-Based Capital (E) Working Group, in cooperation with the C-2 Mortality Work Group of the American Academy of Actuaries (Academy), developed structural updates to the life RBC treatment of group permanent life

and miscellaneous other instruction updates. The proposal assigns the same factors to group permanent life as individual permanent life for policies with and without pricing flexibility.

A new financial statement note will provide the development of net amounts at risk in the categories needed for the Life C-2 mortality risk charges. These categories are designed to create a direct link to a financial statement source and accompanying life RBC C-2 mortality risk updates.

As the notes to the financial statements are maintained by the Statutory Accounting Principles (E) Working Group, this agenda item is to add the requirement for the new proposed note into the *Accounting Practices and Procedures Manual*. An annual statement blanks proposal is being simultaneously exposed at the Life Risk-Based Capital (E) Working Group, which has requested year-end 2023 as the effective date for the note.

d. Agenda Item 2023-04

Bruggeman directed the Working Group to agenda item 2023-04: Corporate Alternative Minimum Tax Guidance. Marcotte stated that the Inflation Reduction Act (IRA) was enacted on Aug. 16, 2022, and it included a new corporate alternative minimum tax (CAMT), which goes into effect for the 2023 tax year. In December 2022, the Working Group adopted temporary guidance to address the CAMT in *INT 22-02: Third Quarter 2022 through First Quarter 2023 Reporting of the Inflation Reduction Act - Corporate Alternative Minimum Tax*.

This agenda item is to begin the project of providing guidance regarding the CAMT for periods after the first quarter of 2023. Interested parties have submitted initial informal recommendations to assist with preparing the guidance. The CAMT is more complex than the prior alternative minimum tax, and it is assessed at the consolidated return level using book income. She noted that the Working Group will need to have interim small group discussions and may also need to consider extending INT 22-02.

e. Agenda Item 2023-05

Bruggeman directed the Working Group to agenda item 2023-05: ASU 2022-06, Reference Rate Reform (Topic 848), Deferral of the Sunset Date of Topic 848. Stultz stated that the FASB issued ASU 2022-06 to extend the sunset date of the reference rate reform guidance that was included in *ASU 2020-04, Reference Rate Reform (Topic 848) Facilitation of the Effects of Reference Rate Reform on Financial Reporting* and *ASU 2021-01, Reference Rate Reform (Topic 848), Scope*.

Stultz stated that reference rate reform refers to the transition away from referencing the London Interbank Offered Rate (LIBOR), and other interbank offered rates (IBORs), and moving toward alternative reference rates that are more observable or transaction based. In July 2017, the governing body responsible for regulating LIBOR announced it would no longer require banks to continue rate submissions after 2021, thus likely sunsetting both the use and publication of LIBOR. An important item to note is that while LIBOR is the primary IBOR, other similar rates are potentially affected by reference rate reform. For simplicity, LIBOR will be the sole IBOR referenced throughout this agenda item.

With a significant number of financial contracts referencing LIBOR, its discontinuance will require organizations to reevaluate and modify any contract that does not contain a substitute reference rate. A large volume of contracts and other arrangements, such as debt agreements, lease agreements, and derivative instruments, will likely need to be modified to replace all references of IBORs that are expected to be discontinued. While operational, logistical, and legal challenges exist due to the sheer volume of contracts that will require modification, accounting challenges were presented as contract modifications and typically require an evaluation to determine whether the modifications result in the establishment of a new contract or the continuation of an existing contract. As is

often the case, a change to the critical terms, including reference rate modifications, typically requires the remeasurement of the contract, or in the case of a hedging relationship, a redesignation of the transaction.

To address ASU 2020-04, the Working Group issued *INT 20-01: ASU 2020-04 – Reference Rate Reform*, and this interpretation was then revised to incorporate guidance from ASU 2021-01. This agenda item recommends revisions to INT 20-01 to include the updated sunset date of Dec. 31, 2024.

f. Agenda Item 2023-06

Bruggeman directed the Working Group to agenda item 2023-06: Additional Updates on *ASU 2021-10, Government Assistance*. Marcotte stated that on Aug. 10, 2022, the Working Group adopted revisions to *SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items* in agenda item 2022-04: *ASU 2021-10, Government Assistance*. The revisions incorporate certain disclosures, adopted with modification from ASU 2021-10, to supplement existing disclosures regarding unusual or infrequent items.

This agenda item is to provide additional clarifications to *SSAP No. 24*, regarding follow-up questions that NAIC staff received regarding the adoption of the disclosures about government assistance in ASU 2021-10. The primary questions were regarding whether the adoption with modification of the ASU disclosures intended to allow insurers to use the grant and contribution model. If the intent was not to allow for the use of the grant and contribution model, then the question becomes in what situation these disclosures would be required. Because NAIC staff understanding is that the grant and contribution model was not intended to be permitted for statutory accounting, additional modifications to clarify this point have been proposed that reject ASU 2021-10 but still incorporate when the government assistance disclosures from ASU 2021-10 were adopted.

g. Agenda Item 2023-07

Bruggeman directed the Working Group to agenda item 2023-07: *ASU 2019-08, Codification Improvements to Topic 718 and Topic 606*. Stultz stated that in November 2019, the FASB issued *ASU 2019-08 Compensation, Stock Compensation (Topic 718) and Revenue from Contracts with Customers (Topic 606): Codification Improvements—Share-Based Consideration Payable to a Customer*, which includes amendments to Topics 718 and 606. The changes to Topic 718 include share-based payment transactions for acquiring goods and services from non-employees, and in doing so, superseded guidance in Subtopic 505-50, *Equity—Equity-Based Payments to Non-Employees*. The changes to Topic 606 expand the scope of the codification to include share-based payment awards granted to a customer in conjunction with selling goods or services.

The amendments in ASU 2019-08 require an entity measure and classify share-based payment awards granted to a customer by applying the guidance in Topic 718. The amount recorded as a reduction of the transaction price is required to be measured on the basis of the grant-date fair value of the share-based payment award in accordance with Topic 718. The grant date is the date at which a grantor (supplier) and a grantee (customer) reach a mutual understanding of the key terms and conditions of a share-based payment award. The classification and subsequent measurement of the award are subject to the guidance in Topic 718 unless the share-based payment award is subsequently modified, and the grantee is no longer a customer.

For statutory accounting assessments, prior U.S. GAAP guidance related to share-based payments has been predominantly adopted with modification in *SSAP No. 104R—Share-Based Payments*. Statutory accounting modifications to the U.S. GAAP guidance have mostly pertained to statutory terms and concepts.

h. Agenda Item 2023-08

Bruggeman directed the Working Group to agenda item 2023-08: ASU 2019-07, Codification Updates to SEC Sections. Stultz stated that the FASB issued *ASU 2019-07, Codification Updates to SEC Sections: Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10532, Disclosure Update and Simplification, and Nos. 33-10231 and 33-10442, Investment Company Reporting Modernization, and Miscellaneous Updates*, which amends and supersedes certain U.S. Securities and Exchange Commission (SEC) sections in Topic 942, 944, and 946 to align codification guidance with SEC Releases No. 33-10532, 33-10231, and 33-10442. These SEC Releases amend a wide range of disclosure requirements, which were determined to be redundant, duplicative, overlapping, outdated, or superseded by other relevant literature. Additionally, the SEC Releases include several miscellaneous updates and corrections intended to clarify SEC guidance. SEC guidance from ASUs have generally been rejected as not applicable for statutory accounting in Appendix D, but all ASUs are reviewed for statutory accounting purposes to determine if the guidance should be considered for statutory accounting.

i. Agenda Item 2023-09

Bruggeman directed the Working Group to agenda item 2023-09: ASU 2020-09, Amendments to SEC Paragraphs. Stultz stated that the FASB issued *ASU 2020-09, Amendments to SEC Paragraphs Pursuant to SEC Release No. 33-10762—Debt (Topic 470)*, which amends and supersedes certain SEC sections in Topic 470 to align codification guidance with SEC Release No. 33-10762, which amends the SEC financial disclosure requirements for guarantors and issuers of guaranteed securities registered or being registered, and issuers' affiliates whose securities collateralize securities registered or being registered in Regulation S-X to improve those requirements for both investors and registrants. The changes are intended to provide investors with material information, given the specific facts and circumstances, make the disclosures easier to understand, and reduce the costs and burdens to registrants. SEC guidance from ASUs have generally been rejected as not applicable for statutory accounting in Appendix D, but all ASUs are reviewed for statutory accounting purposes to determine if the guidance should be considered for statutory accounting.

j. Agenda Item 2023-10

Bruggeman directed the Working Group to agenda item 2023-10: ASU 2022-05, Transition for Sold Contracts. Stultz stated that this agenda item has been drafted to consider *ASU 2022-05, Transition for Sold Contracts* for statutory accounting. He noted that the FASB issued the ASU in December 2022 to amend specific sections of *ASU 2018-12, Targeted Improvements for Long-Durations Contracts*. The amendments made by the ASU are intended to reduce the implementation costs and complexity associated with the adoption of long-duration contracts (LDTI) for contracts that have been derecognized in accordance with the ASU before the LDTI effective date. The revisions captured in the ASU are summarized as follows: The amendments in the ASU amend the LDTI transition guidance to allow an insurance entity to make an accounting policy election on a transaction-by-transaction basis. An insurance entity may elect to exclude contracts that meet certain criteria from applying the amendments in the LDTI.

k. Agenda Item 2023-11EP

Bruggeman directed the Working Group to agenda item 2023-11EP: AP&P Manual Editorial Updates. Gann stated that this agenda item details editorial updates for the *Accounting Practices and Procedures Manual*. These revisions are captured in three broad categories:

- SSAP No. 86: Change a disclosure category from “intrinsic value” to “volatility value.”

- Various – Streamline references to the P&P Manual.
- Various – Changes to consistently reference percent (with % sign and not “percent”) throughout SSAPs.

## 5. Discussed Other Matters

### a. Received and Discussed Valuation of Securities (E) Task Force Referral

Gann stated that the Working Group was one of several groups that received a referral from the Valuation of Securities (E) Task Force (Attachment One-G) to inquire about the NAIC SVO obtaining the ability to calculate analytical information by utilizing commercially available data sources and investment models instead of requesting individual insurance companies to incur the costs to implement system changes. The referral identifies that if the SVO had the capabilities, it could calculate for state insurance regulators various measures, including key rate duration, sensitivity to interest rate volatility, principal and interest cash flow projections for any security or portfolio for any given interest rate projection, loss estimates, and many other measurements. The referral asks each group to respond to the following questions by May 15:

1. Indicate if your group is supportive of creating this capability within the SVO.
2. List the investment analytical measures and projections that would be most helpful to support the work performed by your respective group.
3. Describe how your group would utilize the data and why it would be of value.
4. Are there other investment data or projection capabilities that would be useful to your group that could be provided by commercially available data sources or investment models? And if so, please list them.
5. Any other thoughts you may have on this initiative.

Bruggeman requested that the Working Group provide comments to NAIC staff by April 15 so a referral response could be submitted to the Valuation of Securities (E) Task Force.

### b. 2023 NAIC Accounting Practices and Procedures Manual

Gann stated that on Jan. 9, interested parties provided comments to the NAIC Chief Executive Officer and the Chief Operating Officer/Chief Legal Officer on the Bookshelf product limitations and the need for industry to have a searchable and printable portable document format (PDF) of the AP&P Manual (Attachment One-H).

On Feb. 6, a response letter was provided (Attachment One-I) informing that for the 2023 AP&P Manual, the NAIC is proud to announce that a copyrighted PDF will be made available, at no additional charge, to those who purchase a subscription to the AP&P Manual. Similar to the current subscription process, access will be restricted to the individual level; however, the PDF will be searchable and printable like any other PDF document. This process is specific to the 2023 AP&P Manual only, and for the 2024 AP&P Manual, the NAIC is dedicated to finding an amicable, long-term solution that will result in ease of access for industry users.

The process to obtain the PDF is anticipated to be automatic upon purchase of the 2023 AP&P Bookshelf subscription through Account Manager. Acquiring it through Account Manager is key to obtaining the PDF download, and manual processing will not be available.

### c. American Academy of Actuaries Request

Marcotte stated that on Feb. 23, the Financial Reporting and Solvency Committee of the Health Practice Council

of the American Academy of Actuaries, submitted a request to the Long-Term Care Actuarial (B) Working Group and the Statutory Accounting Principles (E) Working Group that requests clarifications regarding some observed diversity in practice across issuers of long-term care insurance (LCTI) regarding how the new guidance in *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long Term Care Insurance Reserves* (AG 51), and specifically Section 4C, on determining when additional reserves may be necessary, interacts with existing guidance on accident and health (A&H) insurance reserve adequacy, as found in paragraph 24 of *SSAP No. 54R—Individual and Group Accident and Health Contracts* and paragraph 26 of *Appendix A-010—Minimum Reserve Standards for Individual and Group Accident and Health Insurance Contracts* (Attachment One-J). NAIC staff will work with the American Academy of Actuaries representatives and NAIC support staff of the Long-Term Care Actuarial (B) Working Group and the Valuation Analysis (E) Working Group to develop an agenda item for future Statutory Accounting Principles (E) Working Group discussion.

d. Update on International Activity – IAIS AAWG

Gann stated that she participates on behalf of the NAIC in the International Association of Insurance Supervisors (IAIS) Accounting and Auditing Working Group (AAWG). The AAWG focuses on developing, or providing input on, IAIS high-level principles-based supervisory and supporting material related to the accounting, auditing, valuation, reporting, and public disclosures of insurers. The AAWG monitors international developments and prepares comments letters and other papers in relation to the above focus, as deemed appropriate.

Recent discussions of the AAWG have focused on updates to Insurance Core Principle (ICP) 14: Valuation. Gann advised that public consultation of the draft revised ICP 14, as well as ICP 17: Capital Adequacy, is expected to occur in July 2023.

Other discussions of the AAWG have focused on the implementation of International Financial Reporting Standard (IFRS) 17: Insurance Contracts by other jurisdictions, and future discussions are expected to review the International Auditing and Assurance Standards Board (IAASB) proposed strategy and work plan for 2024–2027, as well as the proposed International Standard on Auditing (ISA) 500: Audit Evidence. NAIC staff are monitoring these discussions and requesting comments from state insurance regulators or industry if there are positions or concerns that should be communicated to the AAWG. NAIC staff anticipate including regular updates as any other matter within national meeting agendas.

e. Review of U.S. GAAP Exposures

Stultz identified two items with disclosure deadlines from January to February that will be reviewed by the Working Group in the normal maintenance process (Attachment One-K).

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.

[https://naiconline.sharepoint.com/teams/frsstatutoryaccounting/national meetings/a. national meeting materials/2023/3-22-23 - spring/summary and minutes/sapwg minutes 03.22.23.docx](https://naiconline.sharepoint.com/teams/frsstatutoryaccounting/national%20meetings/a.%20national%20meeting%20materials/2023/3-22-23-%20spring/summary%20and%20minutes/sapwg%20minutes%2003.22.23.docx)



**Statutory Accounting Principles (E) Working Group  
Spring National Meeting  
Comment Letters Received**

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February 10, 2023

Mr. Dale Bruggeman, Chairman  
Statutory Accounting Principles Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

RE: Items Exposed for Comment by the Statutory Accounting Principles Working Group with Comments due February 10th

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the exposure drafts released for comment by the NAIC Statutory Accounting Principles (E) Working Group (the Working Group) on December 13, 2022, with comments due February 10th.

We offer the following comments:

### **Principles-Based Bond Definition**

The Working Group exposed changes that include proposed revisions to reflect the bond definition in SSAP No. 26R—Bonds and SSAP No. 43R—Asset Backed Securities. Exposure also includes corresponding revisions to other SSAPs, which includes guidance restricting asset-backed securities (ABS) from SSAP No. 2R and guidance for debt instruments that do not qualify as bonds in SSAP No. 21R.

Interested parties have submitted a separate comment letter on these proposed changes.

### **Ref #2019-21: Proposed Bond Definition**

The Working Group also exposed reporting changes for bonds under the principles-based bond project. In addition to a new schedule and granular reporting lines, the exposure includes proposed revisions to other schedules and instructions that reference bond reporting. The exposure also includes a revised issue paper to detail discussions and decisions on the bond

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project.

Interested parties have not provided any comments on these exposures during this comment period as we have provided comments previously on similarly exposed items. Also, based on conversations with NAIC staff, interested parties believe that our comments can be optimized once the official Blanks items are exposed from the Blanks Working Group in March.

### **Issue Paper: SSAP 86, Derivatives and Hedging**

The Working Group proposed a new issue paper to detail revisions previously adopted with the review of ASU 2017-12, Derivatives and Hedging and ASU 2022-01 Fair Value Hedging – Portfolio Layer Method.

Interested parties have no comments on this item.

### **Ref #2022-01: Conceptual Framework – Updates**

The Working Group re-exposed revisions to the definition of a liability and issue paper to incorporate the concepts from Financial Accounting Standards Boards (FASB) Concepts Statement No. 8.

Interested parties are currently reviewing the additional materials provided by NAIC staff and will comment at a later date.

### **Ref #2022-11: Collateral for Loans**

The Working Group re-exposed revisions to SSAP No. 21R to clarify that invested assets pledged as collateral for admitted collateral loans must qualify as admitted invested assets.

The impact of the new exposed language can be interpreted to affect requirements for collateral loans which are backed by investments in joint ventures, partnerships, and LLCs. As commented during the 2022 NAIC National Fall Meeting, we believe that audits of joint ventures, partnerships, and LLCs, while required under SSAP No. 97 and SSAP No. 48 for those assets held directly, are not necessarily suited for the task of assessing sufficiency of collateral, because an audit does not validate fair value of the investment, which is a core standard of collateral guidance, and audits may be unreasonably costly for this narrow purpose.

Interested parties noted that regulators indicated concern over arrangements in which the collateral asset or the collateral loan itself may be related to or affiliated with the reporting entity. We believe that this concern is more directly addressed in recent industry exposures and adoptions over related party reporting; a collateral loan involving a related party is required to be labeled as such in annual statement filings. A collateral loan which is backed by a related joint venture, partnership, or LLC, is expected to be disclosed as such under existing SSAP No. 25 guidance. It is our view that in cases where an audit is not performed, allowing an unrelated third party to perform a fair value assessment would address objectivity concerns for this narrow

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purpose, noting that primary guidance over related party transactions is addressed elsewhere outside of SSAP No. 21R.

Interested parties propose that the following footnote be included in SSAP No. 21R which would effectively permit companies with these investments to obtain a third-party valuation assessment in place of an audit, where the third-party assessment would satisfy both the admitted asset requirement as well as the fair value sufficiency requirement applicable to collateral assets.

Footnote:

Because an audit, which is required for certain investments in joint ventures, partnerships, and LLCs to be admitted assets, does not necessarily provide assurance over the fair value of such an investment which is collateral for a loan, companies are permitted to obtain a fair value assessment provided by an unrelated third party in place of an audit, in order for a collateral asset which is a joint venture, partnership, or LLC to qualify as an admitted asset under this standard.

**Ref #2022-12: Review of INT 03-02: *Modification to an Existing Intercompany Pooling Arrangement***

The Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and re-exposed the intent to nullify INT 03-02. This re-exposure requested industry to provide comments on specific instances in which the interpretation was being applied. In addition, the following key points were noted for consideration during the exposure in response to some of the comments received.

Staff provided the following comments regarding some of the key points from industry. Interested parties' response to each comment is provided in italics below following each comment:

1. In the current interest rate environment, the fair value of many bonds is below book value. For example, a bond with an amortized cost of \$100 with a fair value of \$85. The way INT 03-02 is written a bond with a fair value of 85 could be used to settle an intercompany reinsurance pooling obligation of \$100. If the reporting entity paid with cash, they would be required to pay \$100. The actual cash value of obligations when they are extinguished is a relevant measure of the transaction.

*If a bond was transferred at market value in order to settle the \$100 pooling obligation as proposed by NAIC staff in the example above, a bond with a fair value of \$100 would have to be used to settle the obligation. In the event that the bond was in an unrealized loss position at the time of the transfer, a realized loss would be recognized on the transferring entity's books and the combined pool's books. To avoid this situation, a legal entity could use cash to settle the obligation, but the use of such cash may not be the most efficient use of the transferring entity's resources.*

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*If the bond was transferred at FV as proposed by NAIC staff but the bond was in an unrealized gain position, a more significant issue would arise. Realized gains would be recorded in the financial statements of the transferring entity, thus resulting in an initial gain in surplus at the legal entity level of reporting as part of the intercompany pooling modification **and requiring the intercompany pooling reinsurance to be accounted for as retroactive reinsurance.***

*There are extreme anomalies with transferring bonds at market value, as illustrated above.*

- Using book value for measurement of payments between affiliates can result in either unrecognized [gains or losses] of in effect dividend or losses. SSAP No. 25 requires such transfers of assets between affiliates to use fair value. If a subsidiary can pay the parent with assets that have a lower fair value than book value (ex, owes \$100 but pays with a bond of 85), this has a similar effect as an unrecognized capital contribution to the subsidiary. SSAP No. 72 requires a capital contribution to be valued using fair value.

*The hypothetical capital contribution noted by NAIC staff is mitigated by the fact that, in actual practice, the transferring company would likely have two options if it did not transfer the bond:*

- The company could sell the bond, recognize a realized loss, and reinvest in a higher interest-bearing bond which would offset the realized loss over time.*
- The company could hold the bond until maturity, at which point it is redeemed at the \$100 par value.*

*We also note that modifications to intercompany pooling arrangements are subject to prior regulatory review and approval, and if the example noted by NAIC staff were part of a planned intercompany pooling transaction, the regulator could address it before granting approval to the intercompany pooling modification.*

- Staff agrees that at the ultimate parent level such transfer of assets (in accordance with SSAP No. 25 guidance) may be noneconomic in that the parent continues to hold an interest in the same assets. Therefore, at the parent level, such transfers of assets may result in the deferral of gains. Staff believes that losses would not be deferred at the ultimate parent level.

*The issue noted by interested parties is not that the bond transaction may be economic at the subsidiary level but non-economic at the parent level. Rather, the interested parties letter notes that the transfer of reserves in an intercompany pooling modification is a non-economic transfer, and INT-03-02 treats the transfer of bonds consistently (i.e., non-economic) with the transfer of the liabilities.*

- Staff notes that while it may be more expedient to pay intercompany reinsurance pooling transactions with assets, the valuation used should be similar to if the obligation was extinguished with cash. Therefore, an entity can still choose to pay with assets, they just need to be valued consistently with SSAP No. 25 guidance.

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*This comment seems to imply that staff disagrees with the views of the Statutory Accounting Principles Working Group, which deliberated this issue in 2003 and decided that the appropriate guidance is SSAP No. 62 and not SSAP No. 25.*

5. SSAP No. 62R, paragraph 36d provides an exception to retroactive reinsurance accounting guidance which allows for prospective accounting treatment for intercompany reinsurance among 100% owned affiliated provided there is no gain to the ceding entity. If there is a gain to the ceding entity, there is guidance in SSAP No. 62R, paragraph 37 which requires a more punitive method of accounting than either prospective or retroactive reinsurance accounting. Therefore, NAIC staff comment is that the statutory accounting objective is to provide different treatment for retroactive reinsurance contracts if there is a gain to the ceding entity. This is another reason that the guidance in INT 03-02 is problematic. The object is to correctly measure the effects of the contract, which drives the accounting. The objective is not to obscure whether there is a gain to the ceding entity, which can happen in the event that the assets used in payment are not measured correctly.

*INT 03-02 avoids the gain in surplus issue by requiring that the transfer of bonds be at book value. This avoids inconsistent accounting of intercompany pooling modifications between prospective reinsurance accounting and retrospective reinsurance accounting. INT 03-02 provides consistent accounting for all such modification transactions.*

*Interested parties believe that INT 03-02 was not meant to address whether assets used as payments in an intercompany pooling modification are measured correctly, but rather the INT was meant to address which accounting is appropriate given the facts and circumstances of the transaction. We still believe that INT 03-02 provides a reasonable approach with respect to accounting for intercompany pooling modifications and provides consistency in reporting across companies.*

6. Interested parties noted that modifications to intercompany pooling arrangements are typically effective retroactive to the beginning of the year. Staff notes that the payment value when the transaction is settled should be equivalent to the cash value of what is owed on the date of extinguishment of the liability.

*This view raises the question of whether the “fair value” of the reserves need to be considered. That would be unprecedented and not consistent with any statutory accounting guidance.*

7. Many of the interested parties’ comments regarding GAAP use of book value are more relevant to consolidated basis accounting which is not consistent with the legal entity basis of statutory accounting.

*Interested parties respectfully disagree. The interested parties comment letter references the example of accounting for mergers, which is not the same as consolidation accounting.*

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8. Interested parties' comments noted that there is a difference in treatment for intercompany pooling participants who are not 100% owned by a common parent. NAIC staff notes that retroactive pooling agreement changes with participants that are not 100% under common control do not meet the exception to retroactive accounting provided in SSAP No. 62R, paragraph 36d. NAIC staff notes that SSAP No. 62R, paragraph 37 provides guidance for retroactive reinsurance agreements among affiliates where there is a gain to the ceding entity.

*This comment appears to conflate the issue of being under the control of a common parent versus under 100% common control of a group. The interested parties comment letter was distinguishing between intercompany pool entities which have a common parent versus intercompany pool entities which do not have a common parent. All of the intercompany pool entities are under 100% common control, but not necessarily under the same common parent.*

*As an example, there may be downstream insurance subsidiaries of two top-tier insurance entities. The downstream insurance subsidiaries do not have common parents but are under 100% common control of the group.*

We believe that nullification of the existing INT will likely result in inconsistent interpretation of the guidance by both companies and regulators and will result in inconsistent accounting treatment.

#### **Ref #2022-14: New Market Tax Credits**

The Working Group moved this agenda item to the active listing, categorized as a new SAP concept, and exposed a discussion document to expand current statutory accounting guidance for low-income housing tax credits to capture all tax equity investments that provide general federal business tax credit and state premium tax credits if they meet specified criteria.

Interested parties agree with having uniformity in accounting and reporting for equity investments for which the return is earned primarily through tax credits. Interested parties agree that the proportional amortization method is an appropriate method to use for any type of investment (debt or equity) where the return is primarily earned through tax credits. We are providing responses to the questions exposed in the Discussion Paper in this document. There are two key take aways from our responses summarized as follows:

1. Interested parties ask the Working Group to consider allowing for the reporting of both the amortization of the investments and the use of the tax credits themselves in the same income statement line similar to what is required under U.S. GAAP.
2. Interested parties have concerns regarding tax credit investments that are issued in debt form and requiring those investments to be reported on Schedule BA instead of Schedule D. Interested parties believe that tax credit investments issued in debt form are better suited for Schedule D reporting.

We have provided responses to the questions in the Discussion Paper below for your

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consideration.

- 1) Paragraph 1 – The scope intends to include programs that provide general business federal tax credits, which are income tax credits, and programs that meet the criteria that provide for state premium tax credits. This would be an extension from the FASB exposure that only permits income tax credits but is in line with comments received by the FASB that insurers receive credits for state premium tax. Comments are requested on the proposed inclusion for programs that meet the criteria in paragraph 3 that generate state premium tax credits.

*Interested Parties Response:* Interested parties agree that all investments, no matter what legal form, for which the return is earned primarily through tax credits should follow the proportional amortization method.

The proposal seems to only scope in equity investments in tax credit structures and a very limited set of debt tax credit investments. Interested parties note that there are also other types of debt investments for which the return is primarily earned through tax credits with many structures including cash payments as well. We have listed examples of such debt structures in the Appendix. We have the following comments specifically related to these debt investments for which the return is earned primarily through tax credits if the intent is to scope those investments as well into the proposal:

- a. Currently, debt investments in CAPCOs which provide state tax credits follow the SSAP No. 26 guidance and reporting, including INT 06-02 *Accounting and Reporting for Investments in a Certified Capital Company (CAPCO)*. It is unclear from the exposure whether these investments will continue to be reported on Schedule D and/or whether new investments under this program should follow the new revised guidance. See the Appendix for more information on these investments.
- b. For companies that currently invest in bonds for which the return is primarily earned through tax credits, moving these investments to Schedule BA causes concerns since there are limitations on the amount of assets that can be reported on Schedule BA. These investments are sound and of high credit quality because the tax credits are highly probable and any contractual cash payments are typically escrowed in cash. Interested parties would also note that these programs are aimed at promoting the development and growth of distressed communities and moving them to Schedule BA may deter insurers from investing in these structures since the level of risk perceived from Schedule BA assets would not be commensurate with the return on these investments (more like debt returns versus more risky Schedule BA returns). Interested parties ask the Working Group to consider allowing for debt tax credit investments to be reported on Schedule D. Although tax credits in the legal form of debt may not result in a direct payment of cash from the borrower to the investor, there is a reduction in cash payments by the investor for income tax expenses, premium tax expenses, or state income taxes, depending on the nature of the tax credit investment. Interested parties note that cash is fungible so whether in the form of direct payments of cash from the borrower to the insurer for principal and interest or reduced insurer payments of taxes, the investment results in increased cash



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available to the insurer. The debt form of tax credit investments has contractual fixed payments of principal and interest in the form of reduced cash payments as noted. From this perspective, these instruments may meet the proposed principle-based bond definition.

- c. Companies currently report tax credit debt investments on Schedule D with an NAIC designation, which usually comes from the SVO. If the intent is for these investments to move to Schedule BA, it is imperative that these investments are allowed to be reported with an NAIC designation (see high credit quality referenced in prior paragraph). We would like to stress the fact that the risk profile of tax credit investments is not commensurate with equity-type risk as these investments tend to be of high credit quality with a very good history of performance. It is very important to take into consideration any potential RBC impacts when making any accounting or reporting changes.
  - d. Interested parties also note that if the proposal intends to scope in all tax credit investments in debt form, which we would be supportive of, this needs to be clarified in the exposure as the exposure may be interpreted to only include equity investments. For example, the criteria currently included in the exposure to apply the proportional amortization method is very specific to investments made in equity form. If the proposal is scoping in debt investments as well, the criteria need to be updated so that it is tailored to debt investments as well.
- 2) Paragraph 3 – The criteria mirror the concepts included in the proposed FASB guidance. Under U.S. GAAP, the use of the portfolio allocation method is an election, but under SAP, the guidance would be required if the criteria are met. (This would be consistent with the existing guidance in SSAP No. 93 for LIHTC.) Based on the FASB comment letters reviewed, the criteria are expected to be met for most state premium-based tax equity investments. Should other criteria be considered or are there concerns with requiring application if the criteria are met?

*Interested Parties Response:* Interested parties agree that the same criteria currently required under U.S. GAAP should apply to SAP for application of the proportional amortization method. Interested parties do not have an issue with the proportional amortization method being a requirement, as opposed to an option, if the criteria are met. We have two observations regarding the criteria:

- a. Criteria “d” requires that “substantially all of the projected benefits are from tax credits and other tax benefits, determined on a discounted basis using a discount rate that is consistent with the cash flow assumptions utilized by the reporting entity for the purpose of making a decision to invest in the project.” Interested parties would like to confirm that this criterion along with the rest of the criteria are assessed at the time of purchase of the investment and not at every reporting period. This is consistent with the Bond project proposals for the principles-based bond definition also. For certain tax credit investments such as renewable energy tax credit investments, this criterion is usually met at origination. However, if the project does

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not produce the actual amount of production tax credits expected at origination, the investee may be contractually required to make cash distributions from operations in excess of what was originally anticipated to compensate investors for the reduction in expected tax credits. In this case, substantially all of the projected benefits may end up not being from tax credits and other tax benefits. This is why it is important for the criteria to be assessed at origination.

- b. As explained under question #1 if the intent is to also scope in debt investments, the criteria need to be modified so that both types of investments are addressed. We have included some examples of tax credit investments issued in debt form in the Appendix.
- 3) Paragraphs 5-8 – The information details IRS provisions to qualify for the tax credit and overall information on the use of tax credits investments. Under the IRS rules, the federal business tax credits are not transferable, as only the entity that has a true equity interest can take the tax credit. Furthermore, the designs are most often established to have provisions to liquidate the equity investment (through a put/call) at the end of the timeframe. Comments are requested on whether other designs are prevalent as well as inclusion of this guidance in the SSAP and/or the Issue Paper.

*Interested Parties Response:* We agree with the discussion topics in paragraphs 5-8 regarding federal and premium tax credit programs with a few exceptions. As explained in the Appendix, there are other forms of debt investments for which the return is primarily earned through tax credits that do not seem to be addressed in the Discussion paper. Interested parties would also like to clarify that debt tax credit investments are usually transferrable, but for debt tax credit investments that require the purchase of an equity interest, they would have to be transferred along with the equity investment. Therefore, although the debt piece may not be transferable on its own for those types of deals, it is transferable along with the equity.

In addition, the Discussion paper states “a guarantee of return disqualifies the investor as obtaining a tax credit for federal income tax purposes. A limited exception to this structure can exist for NMTC using a financial institution syndicating a NMTC in which the financial institution guarantees the credit or returns.” Interested parties note that guarantees exist in structures other than New Market Tax Credit (NMTC) structures. For example, there are at least 2 financial institution syndicators actively offering LIHTC transactions with an 80% tax credit guarantee for which tax opinions have been obtained to ensure this still qualifies the investor as a “true partner.” There are also various guarantees offered in the Renewable Energy Tax Credit space where guarantees may be issued by financial institutions to provide for a dollar-for-dollar guarantee for the first 25% of tax credits recaptured or disallowed. Any guarantees issued by financial institutions on the tax credits are done in a way that still ensures the eligibility of the credits. Our reason for bringing this up is that the Discussion Paper seems to limit the existence of such guarantees to NMTC deals and we want to clarify that guarantees exist in other tax credit transactions. At the same time, for the debt deals where these guarantees exist, the risk profile is even stronger since the insurer will get a return of all or a portion of its initial investment if the tax credits do not emerge and as a

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result, we believe whether a guarantee exists or not, should be irrelevant to the use of the proportional method and the proposed reporting.

- 4) Paragraphs 10-14 – This information mirrors guidance from the proposed ASU with SAP clarifications. Comments are requested on whether SAP modifications should be considered.

*Interested Parties Response:* Interested parties request that SAPWG consider applying the same geography requirements under U.S. GAAP to SAP. Currently under SAP for Low Income Housing Tax Credit Investments, the amortization of the investment is reported in net investment income (NII) and the tax credits are reported in the tax expense line for federal tax structures and in state premium tax or state income tax for state tax structures. Under U.S. GAAP, both the amortization and the tax credits are reported together in the income tax line. We believe that reporting both the amortization and the tax credits in tax expense for federal programs and in the state premium tax or state income tax lines for state programs more faithfully represents the intent of the credits, which is to reduce the expenses and thus is a much better presentation of these investments. When the amortization is reported in net investment income, these investments are reported as if they had a negative return since the amortization is divorced from the tax credits, which is not a true representation of the return on these investments. If the tax credits allow state income tax or premium tax credits to be taken by an insurer, the expense line of the income statement will result in much more volatility when the amortization of the credits is not matched with the tax credits themselves in the same income statement line item. Not matching could have an indirect impact on insurers “rate setting” process on P&C business.

Interested parties would be happy to work with the Working Group to determine the best way to present tax credit investments on the investment schedules with amortization being reported in the same income statement line item as the tax credits themselves. One item that would have to be addressed for federal tax programs is whether a deferred tax asset (DTA) would still be recorded for any tax credit carryforwards. Under U.S. GAAP, DTAs are not recorded for LIHTC investments accounted for under the proportional amortization method since both the amortization and the tax credits are reported in income tax expense.

- 5) Paragraphs 15-16 - This guidance details the application of the proportional amortization method for statutory accounting. It is more detailed, but generally consistent with SSAP No. 93. The existing SAP guidance was driven from EITF 94-1 and refers to recognition at the time a tax credit can be included in a tax return. However, that guidance is contradictory with the recognition of tax credit carryforwards under both current SAP and U.S. GAAP. The proposed guidance in paragraph 11 reflects the new GAAP guidance for recognition in the year in which the credit arises, and the guidance in paragraph 16 identifies how carryforwards would be considered a DTA.

*Interested Parties Response:* Interested parties agree that DTAs would be set up for any tax credits that can be carried over. As stated above, we understand that under U.S. GAAP, there are no DTAs set up for tax credit carryovers since the amortization and the tax credits are reported in the same line.

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- 6) Paragraphs 17-20 – These paragraphs provide explicit SAP provisions for admittance. If the program does not generate tax credits or if the reporting entity cannot use the tax credits, the guidance requires nonadmittance. Consideration was given as to whether admittance should be permitted based on the ability to liquidate the investment, but that is not proposed. As detailed in the scope criteria, substantially all of the projected benefits from the investment should be from tax credits or other tax benefits. From information gathered for the federal tax credit programs, liquidation may be restricted for set periods of time or be contingent on finding a buyer for the equity interest. Although a put/call provision may be in place to revert the equity interest at the end of the life for the investment, such amounts are nominal to the original investment amount. With the guidance, if the tax credits will not be received or cannot be utilized, then the investment shall be nonadmitted. If an entity cannot obtain or utilize tax credits from the investment, and can liquidate the investment, then a reporting entity should consider liquidating the investment to have cash for reinvestment / admittance purposes. Until then, the investment is proposed to be nonadmitted.

*Interested Parties Response:* Interested parties believe that it is too punitive to require non-admission of the whole investment if an entity does not have taxable income in a given year. As stated above, insurers may be able to utilize the tax credits through carryback to the prior year. If not, insurers would usually set up a DTA for any tax credit carryforwards if there is an expectation that the credits will be utilized in future years. Therefore, interested parties believe that if there is no valuation allowance on the tax credit DTA and the DTA is admitted under the three-year turnaround criteria, then the investment should be fully admitted. This would not preclude impairment analysis on the investment itself.

The Discussion Paper also includes discussion about requiring a tax opinion for admissibility purposes. Interested parties would like to confirm that the tax opinion is required upon acquisition of the investment by the insurer and not at every reporting date.

It is also important to clearly distinguish between non-admission and impairment. Question #6 makes reference to the program not generating tax credits or the reporting entity not obtaining the tax credits. Under these circumstances, it seems that the guidance would point to impairment and not non-admission.

- 7) Paragraphs 21-24 – This guidance is generally consistent with SSAP No. 93, except the recognition of a liability for a future contribution follows the loss contingency guidance in SSAP No. 5R. This is consistent with the ‘probable’ threshold reflected under U.S. GAAP.

*Interested Parties Response:* Interested parties agree that the guidance in SSAP No. 5R regarding contingencies needs to be evaluated to determine if a commitment related to future contributions gives rise to a liability.

- 8) Paragraphs 25- Paragraph 25 is consistent with SSAP No. 93, except it incorporates fair value as the compared value. Current SSAP No. 93 uses the present value calculation, so it is retained as a proxy of fair value. U.S. GAAP uses fair value, and the existing disclosure in SSAP No. 93 also references fair value.

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*Interested Parties Response:* Interested parties do not have an objection with incorporating fair value in the assessment of impairment. Since these investments do not trade frequently, most companies are probably already doing a present value calculation to determine fair value so this should not change what reporting entities are currently doing.

- 9) Paragraph 26 - This guidance incorporates concepts on whether the structure will continue to produce qualifying tax credits. The guidance specific to LIHTC from SSAP No. 93 is not retained. The guidance has divided the guidance for nonadmittance to reflect situations that impact a reporting entity's use of tax credits and OTTI to reflect issues with the actual investment in generating qualified tax credits. Comments are requested on this approach and the principle concepts for OTTI.

*Interested Parties Response:* As stated under question #6, non-admitting the entire investment appears too punitive for companies that expect to utilize the credits in a later year. Interested parties agree that impairment would occur when the credits will not emerge at all. Question #6 needs to be clarified to explain these concepts since the way it is currently written, it seems to scope in the impairment criteria into the non-admission review.

- 10) Paragraph 27 – Disclosures in 27a-b are from U.S. GAAP.

*Interested Parties Response:* Interested parties do not have an objection with disclosing information about the nature of investments for which tax credits are earned. 27(b) seems repetitive with the other information that is being required under paragraph 28 regarding the amount of tax credits and other tax benefits during the years presented. If different information is being requested under 27b, it would be helpful for industry to get more clarity on what specifically is being requested under that item.

- 11) Paragraph 28 - Disclosures in paragraph 28 a-c come from U.S. GAAP. The disclosures in paragraphs 28d-e are based on concepts previously included SSAP No. 93. Comments are requested on whether those disclosures (or other disclosures from SSAP No. 93) should be included. (For 28d, the prior SSAP No. 93 disclosure was for a number of remaining years of unexpired tax credits and the required holding period, but since that is an individual investment disclosure, it has been modified to reflect an aggregate investment disclosure.)

*Interested Parties Response* The proposed disclosures in paragraph 28 a-c are similar to what is already required under SSAP No. 93 so they should not be a concern. 28e will require additional work to be done since the requirement is to disclose the aggregate amount of tax credits to be earned each year on all tax credit investments for the next fifteen years, which is not currently disclosed. Such detail is not required for other investments. As a result, we would encourage SAPWG to evaluate whether it is needed.

- 12) Paragraph 30 – This disclosure is in SSAP No. 93 and comments are requested on whether it should be retained.

*Interested Parties Response:* This disclosure requires detailed balance sheet and income statement information for tax credit investments if, in the aggregate, tax credit investments exceed 10% of the total admitted assets of the reporting entity. It is probably rare for insurers

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to hold tax credit investments that represent such a significant amount of total admitted assets. In addition, detailed balance sheet and income statement information for the underlying investees does not seem to provide very relevant information about these investments since the return on these investments is primarily through tax credits and not related to the earnings of the underlying investees. Interested parties believe that this disclosure requirement should be removed.

### **Other Interested Party Comments**

Although the Discussion paper is focused on SSAP No. 93 and equity investments for which the return is primarily through tax credits, we provide the following observations regarding SSAP No. 94 as we understand that the Working Group may add another project to its agenda regarding this standard:

1. We believe that one of the key differences between SSAP No. 93 and SSAP No. 94 is that SSAP No. 93 relates to tax credit structures where the insurer is an actual investor (i.e. equity owner) whereas SSAP No. 94 addresses certificated state tax credits that are purchased outright without the insurer owning an equity or debt security. More clarity on the difference between both standards is welcomed especially since we understand that under the Inflation Reduction Act, there will be certificated federal tax credits available for purchase as well.
2. We note that the accounting under SSAP No. 94 requires for the certificates purchased to be reported as “other-than-invested” assets. Therefore, these certificates are not currently reported on Schedule BA. They are reported in the “Aggregate Write-Ins for Other Than Invested Assets” balance sheet line. We would like to make sure that the Working Group is aware of this difference in reporting.
3. The accounting for the certificates laid out in SSAP No. 94 requires that the carrying value of the tax credits be reduced as the credits are redeemed through a reduction of an insurer’s tax payable. Therefore, the way of amortizing the asset is similar to the proportional amortization method, except that under SSAP No. 94, the amortization and the tax credits are only reflected in the balance sheet. Any gains on these deals, which are usually related to the fact that they are purchased at a discount, are required to be reported in other income per SSAP No. 94, not NII. Interested parties look forward to further discussing the income statement presentation of these gains if changes are made to SSAP No. 93 regarding income statement presentation to ensure consistency in reporting.

**Some of the feedback received from interested parties is that in practice, the offset to the tax liability account usually occurs in the year when the credit is available for use regardless of when the tax return is filed. Clarification may be needed on this point in the standard.**

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**Ref #2022-15: SSAP No. 25 – Affiliate Reporting Clarification**

The Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to SSAP No. 25 to clarify that any invested asset held by a reporting entity which is issued by an affiliated entity, or which includes the obligations of an affiliated entity is an affiliated investment.

Interested parties have no comments on this item.

**Ref #2022-16: *ASU 2022-03, Fair Value Measurement of Equity Securities Subject to Contractual Sale Restrictions***

The Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to SSAP No. 100R to adopt *ASU 2022-03, Fair Value Measurement of Equity Securities Subject to Contractual Sale Restrictions* with modification to be consistent with statutory language in the respective statutory accounting statements, as illustrated above. Note that this agenda item does not recommend incorporating the new proposed GAAP disclosures on sales restrictions, but identifies those items restricted as to sale would be captured as restricted assets per SSAP No. 1 and subject to admittance considerations under SSAP No. 4.

Interested parties have no comments on this item.

**Ref #2022-17: Interest Income Disclosure Update**

The Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to SSAP No. 34, to add additional disclosures, and to data-capture the disclosures.

Interested parties propose that the exposed changes which are an outgrowth of the Bond project should share the same effective date. This will also allow companies to make the system changes needed to provide this information.

Interested parties also suggest the following editorial revisions to the disclosures contained in SSAP No. 34 for clarification and to be consistent with the proposed Blanks changes:

7. The following disclosures shall be made for investment income due and accrued in the financial statements. (SSAP No. 37 captures disclosures for mortgage loans on nonaccrual status pursuant to paragraph 6.)
  - a. The bases by category of investment income for excluding (nonadmitting) any investment income due and accrued;
  - b. Disclose total amount excluded;

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- c. Disclose the gross, nonadmitted and admitted amounts for interest income due and accrued.
- d. Disclose aggregate deferred interest ~~and cumulative amounts of paid-in-kind (PIK) interest included in the current principal balance.~~
- e. Disclose cumulative amounts of paid-in-kind (PIK) interest included in the current principal balance.

**Ref #2022-18: ASU 2022-04, Disclosure of Supplier Finance Program Obligations**

The Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to SSAP No. 105R to reject ASU 2022-04 for statutory accounting as the disclosures are not relevant for insurance entity preparers.

Interested parties have no comment on this item.

**Ref #2022-19: Negative IMR**

The Working Group moved this agenda item to the active listing, categorized as a New SAP Concept and exposed the agenda item with a request for comments by industry on potential guardrails and details on unique considerations. The Working Group directed NAIC staff to coordinate with the Life Actuarial (A) Task Force and request regulator-only sessions with industry to receive specific company information.

ACLI will submit a separate comment letter on February 17, 2023.

\* \* \*

Thank you for considering interested parties' comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell

Rose Albrizio

cc: NAIC staff  
Interested parties



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## **Appendix A – Examples of Debt Tax Credit Structures**

These are some of the debt tax credit structures of which industry is aware:

- i. Bonds Issued by CAPCOs - Although the peak of these investments was in 2003, there has been a resurgence in functionally equivalent forms of this structure starting in 2010. Connecticut, Mississippi, Pennsylvania, Utah and Ohio have recently issued these bonds and legislative vehicles for these bonds are growing increasingly popular to address rural economic development. The bond is usually issued at a premium ranging from 50-90%. A material portion of the return in these structures is earned through cash payments (generally ranging from 40-60%). CAPCO and CAPCO-like deals are different from other state tax credit deals for a few reasons: (1) these entities have more time to invest the capital they receive than other state or federal deals; (2) they may have a smaller acquisition premium; (3) there is no equity investment required. Tax credit bonds issued by CAPCOs are usually only transferrable to affiliates of the reporting entity.
- ii. Other State Tax Credits issued in Bond Form – Any state can issue debt investments where the investor earns tax credits outside of the CAPCO structures. Some of these are referred to as New Market Tax Credits (NMTC), which are different from the federal NMTC program. These programs multiplied as states saw the positive impact of the federal program on low-income communities. Unlike federal credits, these credits may be specially allocated by a partnership. In these deals, an issuer creates a special purpose vehicle (SPV), which purchases equity investments in entities that make investments in distressed communities. The SPV then issues securities to investors composed of tax credit debt and a small equity component (typically 1%) to be admitted as a partner and receive an allocation of credits. The tax credit debt has a higher acquisition premium than CAPCO and CAPCO-like structures (typically 90%). Although most of the return is earned through state tax credits, these investments earn about 10% of their return in cash. The tax credits earned by the SPV are passed on to the investors based on the SPV's partnership agreement. This structure may be used in other contexts where credits can be specially allocated (e.g. state historic tax credits, low-income housing tax credits and other economic development tax credit programs). In order to transfer the bond investment, a sale of the equity interest must take place simultaneously to the same investor.
- iii. State or Municipal Tax Credit Bond Strips – These include bonds issued by state or municipalities for certain projects such as school construction (i.e. Build America bonds). The bonds are stripped into a principal amount and the tax credit amount. Investors in the tax credit strips only earn a return through the tax credits provided by the municipality or state. These strips are transferable. There are no cash payments on the tax credit strips as the return is solely earned through tax credits.
- iv. Federal NMTC programs – These are already addressed in the exposure. To summarize, an investor must purchase a pro rata share of the equity and the debt in these structures. Federal tax credits are earned as long as the investor is an equity investor as well. In order to transfer the bond investment, a sale of the equity interest must take place simultaneously to the same investor. The return on these investments is earned solely through tax credits. The investor

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receives cash for the principal on the bond, which is usually less than 10% of the original investment since these investments are issued at a significant premium.

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February 10, 2023

Mr. Dale Bruggeman, Chairman  
Statutory Accounting Principles Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

**RE: Interested Parties Comments on the SSAP No. 26R, SSAP No. 43R, and Other SSAP exposures related to the Principle-Based Bond Definition Project**

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the above-mentioned documents that were exposed for comment by the Statutory Accounting Principles Working Group (Working Group) on November 16, 2022.

Interested parties also appreciate the collaborative effort on this project, the receptivity to our comments in our previous letter(s), and the disciplined thought that has gone into this project. We continue to believe this effort is headed in the right direction and look forward to continued collaboration on what undoubtedly is a complex and wide-ranging project.

In that spirit, interested parties would like to provide the following comments.

**Paragraph 6d of SSAP No. 26**

Paragraph 6d is arguably one of the more complex concepts within the principle-based bond definition. This paragraph attempts to define non-debt variables that are or could be embedded within a financial instrument, that call into question the overall instrument's debt or bond like characteristics, while not also capturing embedded derivatives commonly found within debt instruments that do not call into question their overall debt or bond like characteristics. Interested parties believe this paragraph generally captures regulator concerns, while appropriately recognizing instances where such embedded derivatives are or should not be of concern. The following focuses on two instances where interested parties believe regulators did not intend to capture (and should not want to capture) embedded derivatives within financial instruments that

could be considered non-debt variables, and thus where the overall financial debt instruments would not be considered bonds for reporting on schedule D.

#### Credit Rating-Related Interest Rate Adjustments

Paragraph 6d, includes an exclusion that prevents certain embedded derivatives from “tainting” the host financial instrument and thereby preventing it from being reported as a bond where the embedded derivative does not call into question its bond-like characteristics. This exclusion includes “credit-rating related interest rate adjustments” where a bond coupon rate could be adjusted upward if the entity issuing the debt is down-graded by a rating agency. Such adjustments align the interests of debtholders and issuing entities by incentivizing the issuing entity to keep its financial house in order and compensating the debtholder if it does not.

Interested parties agree with this exclusion but suggest it be modified from “credit-rating related” to “credit-quality related” to encompass the broader range of such adjustments that align interests of debtholders and issuing entities (e.g., debt to EBITDA ratio, interest coverage ratio, debt service coverage ratio, etc.). Such bonds are very prevalent in insurer portfolios.

#### Sustainability-Linked Bonds (SLBs) With De Minimis Interest Rate Adjustments

Interested parties believe paragraph 6d also would inappropriately capture certain bonds with an interest coupon rate linked to sustainability goals. For example, the debt may have coupon interest equal to either a fixed or floating rate (e.g., SOFR) that is adjusted based on one or more sustainability goals or variables (e.g., the company’s CO2 emissions or workplace injury record). That is, the company’s performance against the metrics, in this example, could cause the interest rate to either decrease or increase 5 basis points for a total range off the potential base interest rate of 10 basis points. Both the CO2 emissions and workplace injury record are metrics of the borrower’s operation of physical assets owned by the company.

Interested parties understand that the NAIC wants to focus on solvency when developing standards, and not necessarily make special accommodation for social causes at solvency’s expense. Though insurers are increasingly focused on environmental, social, and governance attributes of investments they make, risk/reward remains an overriding consideration. In the case of SLBs, the contingent coupon adjustments generally do not factor into the insurer’s risk/reward calculations as they are uniformly de minimis. Interested parties do not believe SLBs, which are somewhat prevalent, warrant non-schedule D reporting and potentially punitive risk-based capital treatment.

Interested parties therefore suggest either a special exclusion for these type of debt instruments such as “SLB-linked bonds with de minimis interest rate adjustments” or “SLB-linked bonds with interest rate adjustments with the potential to adjust the total return from interest by no more than 10%”. Quite possibly, it may be more appropriate for such a “de minimis” exclusion to be applied to other non-debt variables more broadly so there is not an abrupt cliff effect for non-schedule D reporting due to the potentially punitive risk-based capital treatment, for de minimis non-debt variables in general.

Interested parties look forward to working with regulators and NAIC staff on this issue to appropriately thread the needle between preventing concerns of regulators while also not capturing de minimis types of adjustments that are potentially both prevalent and not the primary concern of regulators.

### **Paragraph 22 of SSAP No. 21 and Other Debt Securities That do not Qualify as Bonds**

SSAP No. 21 has proposed changes for Debt Securities That Do Not Qualify as Bonds and is meant to capture any security which does not qualify as either an issuer credit obligation (ICO) or asset back security (ABS) and addresses the accounting and reporting for such securities. Such securities in scope would be limited to:

- a. Debt securities for which the investment does not reflect a creditor relationship in substance,
- b. Debt securities that do not qualify for bond reporting due to a lack of substantive credit enhancement, or
- c. Debt securities that do not qualify for bond reporting due solely to a lack of meaningful cash flows.

These categories reflect instances where a debt instrument does not meet the principle-based bond definition as laid out in SSAP No. 26R. However, there may be further instances where a security does not meet the definition of a bond such as with paragraphs 5 and 7 of SSAP No. 26R (e.g., not meeting the definition of a security or not meeting the primary source of repayment requirements, respectively, etc.). Further, condition a. above is a potentially broad category inclusive of non-qualifying equity backed securities all the way toward financial instruments with embedded derivatives that are potentially de minimis. Interested parties would like to think this through with Staff if further refinement is necessary especially if the intent of these categories is to feed risk-based capital factors where additional refinement may be necessary.

Securities solely not meeting condition c. shall use the same accounting and measurement basis described in SSAP 43R – Asset-Backed Securities, including using a carrying value method determined by NAIC designation. Reporting entities that are reporting an amortized cost measurement shall obtain an NAIC designation in accordance with the parameters of the Purposes and Procedures Manual of the NAIC Investment Analysis Office and report the designation on Schedule BA. It is unclear if the NAIC designation required for accounting purposes would also be used for risk-based capital. Interested parties would like to think this through with Staff to understand the intent. For example, if the NAIC designation is not used for risk-based capital purposes, is it appropriate to require an NAIC designation for purely accounting purposes?

All other debt securities that do not meet conditions a. and b. shall be reported at acquisition cost, including brokerage and other related fees on Schedule BA. These securities are permitted as admitted assets, with subsequent measurement at the lower of amortized cost or fair value. Changes in measurement to reflect the lower value or to reflect changes in fair value shall be recorded as unrealized gains or losses.

Paragraph 22 includes the following:

*Debt securities in scope for which the source of repayment is derived through rights to underlying collateral, qualify as admitted assets only to the extent they are secured by admitted invested assets. Any amounts in excess of the fair value of the underlying admitted invested assets shall be nonadmitted.*

Interested parties believe we understand the rationale for why this was drafted. That is, if an ABS security does not meet either the substantive credit enhancement or meaningful cash flows criteria, the security in question is potentially very similar to a collateral loan. Nonetheless, this is a meaningful penalty (i.e., from bond treatment to non-admission) and interested parties would like a little more time to think through and discuss with Staff. This paragraph ultimately only came into our focus late in our review and we would like the opportunity to further think through the appropriateness of the abrupt cliff effect. For example, it is even conceivable, that a securitization would have the residual tranche be reported as an admitted asset while a more senior tranche would be a non-admitted asset.

Paragraph 10 (b) of SSAP No. 26R

Interested Parties noted that there is an inconsistency with the treatment of residual tranches between SSAP No. 43R and SSAP No. 26. SSAP No. 26 refers the reader to SSAP No. 21 to determine the accounting for residual tranches whereas SSAP No. 43R states that residuals are to be reported on Schedule BA as other invested assets at the lower of cost or market (SSAP No. 43R, paragraph 11.c). Since the revised SSAP No. 21 guidance only addresses debt securities (and does not address residual tranches) and we understand that the Working Group does not view residual tranches as debt instruments, we have the following proposed wording changes to SSAP No. 26 to address this inconsistency:

The first loss position may be issued as part of a securitization in the form of a debt or equity interest, or it may be retained by the sponsor and not issued as part of the securitization. If the first loss position (or a more senior position(s), if the first loss position(s) lacks contractual payments along with a substantive credit enhancement) is issued as part of the securitization, and does not have contractual principal and interest payments along with substantive credit enhancement and is held by a reporting entity, the investment(s) does not qualify for reporting as a bond and should be reported on Schedule BA: Other Long-Term Invested Assets at the lower of amortized cost or fair value consistent with the accounting treatment for residuals. ~~as a non-bond security pursuant to SSAP No. 21R—Other Admitted Assets.~~

**Paragraphs 43 – 46 of SSAP No. 26R**

Paragraphs 43 - 46 of SSAP No 26R are related to effective date and transition. Interested parties believe the transition guidance is appropriate under the circumstances but propose some minor editorial adjustments which we believe provide more granular meaning to what we believe was

the intent. These proposed adjustments related to the second and third sentences of paragraph 44 as follows:

*The bond definition requires assessments at the time of Acquisition (as of the origination date), and it is recognized that reporting entities may not have the means to complete historical assessments for securities held at the time of transition. For these instances, if information is not readily available for reporting entities to assess a security as of the date at ~~acquisition~~ origination, reporting entities may utilize current or acquisition information in concluding that a security qualifies for reporting as a bond as either an issuer obligation or asset-backed security.*

Interested parties believe the transition guidance should also indicate that the disclosures should reflect that the revised bond categories from the annual statement prospectively beginning with the first year of adoption and not result in a restatement of the prior year's reporting.

### **Further Clarification on RSATs**

Replication Synthetic Assets (RSATs) are nuanced types of transactions, which must be approved by the Securities Valuation Office (SVO). Interested parties propose the following edits to ensure that RSATs, which have been historically allowed, continue to meet the replication accounting requirements regardless of changes to the definition of a Schedule D Bond. Besides the edits proposed below, as a result of the accounting convention for certain bonds being other than amortized cost, interested parties would like to work with Staff on the specific paragraphs of SSAP No. 86 that currently address the accounting for replication transactions as changes may be needed to coincide with the effective date of the principles-based bond definition.

Provide a Footnote after the first sentence of the structured note definition in paragraph 6di of SSAP No. 26R to clarify that one needs to also look to SSAP No. 86:

*A replication (synthetic asset) transaction addressed in SSAP No. 86-Derivatives may reproduce the investment characteristics of an otherwise permissible investment that would not meet the principles-based bond definition (e.g., is distinct from a “structured note” as defined here); the admissibility, classification and measurement of a replication (synthetic asset) transaction are not preemptively determined by the principles-based bond definition, and should be evaluated in accordance with the guidance on replication (synthetic asset) transactions within SSAP No. 86- Derivatives.*

Propose further clarification in SSAP No. 86 by adding the following to the end of Footnote 5 within the exposure:

*A replication (synthetic asset) transaction addressed within this standard may reproduce the investment characteristics of an otherwise permissible investment that would not meet the principles-based bond definition (e.g., is distinct from a “structured note” as defined here); the admissibility, classification and measurement of a replication (synthetic asset) transaction are not preemptively determined by the principles-based bond definition, and*

*should be evaluated in accordance with the guidance on replication (synthetic asset) transactions within this standard.*

## **SSAP No. 43R – Example 2**

Interested parties appreciate the proposed changes to Example 2 within SSAP No. 26R as they provide an example where recourse to assets can be outside of a securitization. This is a good clarification and makes the examples in aggregate more broadly instructive. Interested parties have two suggested changes, which we believe are editorial in nature that provide a nuanced technical clarification and a more formal conclusion within the example rationale.

**Example 2:** *A reporting entity invested in a debt instrument issued by a SPV. Payments under the instrument are secured by a note, a legal assignment from the borrower of a lease for real property and an assignment of the lease payments from an operating entity tenant. Additional security is provided by a mortgage on the leased property (the “underlying collateral”). The leased property is owned by the borrower under the note -- the SPV does not have any ownership interest in the underlying collateral, though it has legal recourse to it through the mortgage. The tenant makes contractually-fixed payments over the life of the lease to the borrower, who has assigned both the lease and the lease payments to the SPV as security for the debt. While the debt is outstanding, the lease, the lease payments, and the mortgage all serve as security for the debtholders. Should a default occur, the debtholders can foreclose on and liquidate the real property as well as submit an unsecured lease claim in the lessee’s bankruptcy for ~~any~~ all or a portion of the defaulted lease payments. The loan-to-value (as a percentage of property value) at origination is 100%.*

**Example 2 Rationale:** *The reporting entity determined that the debtholder was in a fundamentally different position than if the real estate was owned directly. The lease is a cash generating non-financial asset which is expected to generate a meaningful level of cash flows for the repayment of the bonds which covers all interest payments and 50% of the principal payments. The level of reliance on the collateral value for sale or refinancing is just over the cutoff for using the practical expedient (<50%), so a full analysis is required. In reaching its determination, the reporting entity considered the predictable nature of the cash flows, which are contractually fixed for the life of the debt instrument, as well as the ability of the underlying collateral value to provide for the balloon payment through sale or refinancing in light of its characteristics. While the real property may have some market value volatility and periods of lower liquidity at points in time, the cash flows produced by the lease were concluded to reduce the loan balance to a level (50% loan-to-value) that would be able to be recovered by sale or refinancing at the maturity of the loan.*

\*\*\*\*\*

Interested parties continue to support the development of high-quality bond standards and believe they are headed in the right direction. Staff has tackled this project with appropriate rigor and their



collaboration with us has been greatly appreciated. We stand ready to continue to assist as this project gets nearer the finish line.

Sincerely,

D. Keith Bell

Rose Albrizio

cc: Interested parties  
NAIC staff

**Mike Monahan**

Senior Director, Accounting Policy  
202-624-2324 t  
[mikemonahan@acli.com](mailto:mikemonahan@acli.com)

February 17, 2023

Mr. Dale Bruggeman, Chairman  
Statutory Accounting Principles Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

Dear Mr. Bruggeman:

**Re: Exposure Ref #2022-19: SSAP No. 7 - IMR**

The American Council of Life Insurers (ACLI) appreciates the opportunity to provide comments on the above referenced exposure as well as the thoughtful and timely attention this important topic is receiving from SAPWG and LATF.

The ACLI stands ready to continue working with the NAIC to create sufficient, yet practical, safeguards to ensure that the most appropriate treatment of Interest Maintenance Reserve (IMR) can be applied, and a company's surplus and financial strength are properly reflected, while not disincentivizing prudent investment and risk management in the best interest of all.

A rising interest rate environment from historically low rates is generally favorable to the financial health of the life insurance industry. However, ACLI is concerned that without a change to the current treatment of negative IMR, the environment will give the inappropriate perception of decreased financial strength through lower surplus and risk-based capital ratios. This problem will only be exacerbated if interest rates remain at or near their current levels or increase further; therefore, it is imperative that we work together toward developing an industry-wide solution for implementation by year-end 2023.

Upon the sale of and subsequent reinvestment in a fixed income instrument, the reflection in surplus of either a gain or loss is not reflective of the true economics, as there is no change to solvency, liquidity, or claims paying ability because the difference between the reported amortized cost value and fair value is equal to the IMR. This letter addresses our assessment of the suitability of the five potential guardrails proposed at the SAPWG fall national meeting and raises two additional proposals for consideration.

## Background

While this letter will focus on potential additional safeguards, as suggested at the SAPWG fall national meeting, this is a complex topic and we want to summarize, review, and expand on relevant background information largely included in our previous letter dated October 31, 2022.

The NAIC's statutory accounting framework is largely an "amortized cost framework" in that fixed income investments are generally reported at amortized cost and long-term insurance liabilities are generally reported with locked and conservative assumptions.

We strongly support the NAIC framework, as it facilitates the issuance of long-term insurance products in the US market by not overly focusing on current market fluctuations. This is unlike many market valuation regimes where over-reliance or misapplication of current market conditions often distorts the financial solvency of insurance companies and can lead and has led to the decrease or elimination of such long-term product issuances in those regimes.

However, an amortized cost framework could also potentially distort the financial solvency of insurance companies through the misrepresentation of surplus. The IMR was developed as a safeguard to ensure surplus is properly reflected within the NAIC's framework.

Specifically, in a declining interest rate environment, an insurance company could sell its fixed income investment portfolio, recognize gains, increase surplus and show increased financial strength. This increase in surplus would largely be illusory as the increased surplus would be offset by a lower yielding investment portfolio.

IMR requires deferrals of those gains from surplus, and the gains are amortized through income over the remaining life of the bonds sold to:

- Ensure accurate representation of a company's reported surplus by eliminating the potential for overstatement of surplus, and
- Keep the relationship of anticipated investment yield consistent with that needed to support the liabilities.

But without IMR, a rising interest rate environment could result in similarly misleading surplus (in this case an illusory lack of surplus) because a company would be investing in higher yielding bonds.

When IMR was developed, it was anticipated that the IMR would work consistently for both net realized gains and losses; however, the allowance of a net negative IMR was not initially adopted upon implementation in 1992. It was expected that the issue would be addressed in subsequent years and remained on the SAPWG agenda at least until 2005 but was never addressed in any substantive way. This was largely because of a lack of urgency due to the decades-long declining interest rate environment where IMR was largely positive for life insurance companies.

This issue had been referred to SAPWG from the AVR/IMR working group which believed the basic rationale for the IMR would conclude that neither a maximum nor minimum is appropriate. It was fully

expected that the IMR, whether negative or positive, would be included in asset adequacy testing and addressed by the actuarial opinion.

We are very appreciative that SAPWG and LATF are looking to substantively revisit the negative IMR issue as anticipated during its original development. The current interest rate environment has changed circumstances in a meaningful way. While rising interest rates from historically low levels are beneficial to insurance companies, the recent rapid rise of interest rates has increased the urgency to address the negative IMR issue to avoid the misrepresentation of capital positions of insurance companies.

The current interest rate environment or a further rise in interest rates would only exacerbate the urgency as losses from bond sales could result in a significantly inappropriate portrayal of surplus that would be inconsistent with the rationale for which IMR was initially developed. In this case, insurers would show a significant illusory lack of surplus because they would be investing in higher yielding bonds.

IMR is an important construct that effectively adjusts liabilities so that the balance sheet liabilities net of IMR remain on the same basis as the reported balance sheet assets, limiting artificial volatility within surplus. As discussed above, negative IMR, from an asset-liability perspective, represents either high future income from reinvestments or future reserve releases that will be available to pay claims from an asset liability perspective.

Although the status quo use of permitted practices may grant relief for specific companies, it may lead to an unlevel playing field. Consequently, the ACLI wants to emphasize the importance of developing a uniform national standard for consistently ensuring the appropriate theoretical and practical treatment of IMR (e.g., symmetrical treatment of both gains and losses).

The ACLI would like to work with the NAIC to fulfill the original intent of IMR that ensures surplus and financial strength are properly reflected and do not disincentivize prudent investment and risk management. At the same time, we want to work with regulators to ensure IMR cannot somehow be circumvented in a rising interest rate environment, whether intentionally or inadvertently, to misrepresent financial strength.

### **Common Interest to not Disincentivize Prudent Behavior**

We want to reiterate the importance of not disincentivizing prudent portfolio and asset liability management.

In addition to prudent portfolio management and managing credit/investment risk exposure, insurance companies manage duration. These prudent risk management processes all require on-going transactions that impact the IMR, such as whether it is sales and reinvestment in fixed income investments, which we discussed in our previous letter dated October 31, 2022, or use of derivatives to achieve the same appropriate end. We would note that bond sales may trigger derivative terminations that offset in IMR; however, derivatives settlements can impact IMR without an offset impact from a bond sale.

Hedging strategies are used to address product risks like contract guarantees, disintermediation, and reinvestment risks as part of prudent risk management practices utilized by life insurance companies.

These hedging strategies may involve interest rate swaps, caps, floors, swaptions, interest rate futures, among others, that also may generate IMR gains and losses.

For example, negative IMR can be generated by hedging strategies utilized for pension risk transfers. Once the contract is executed, insurers will enter hedging contracts to ensure interest rate certainty while awaiting cash and assets in-kind and/or the right investment opportunities to meet the long-term goals for the accounts. As the hedges are unwound to meet pricing and investment targets, immediate losses and negative IMR may be generated as interest rates rise, but the losses are ultimately offset over time with higher fixed instrument yields.

Further, many life insurance and annuity products have significant long term reinvestment risk, where premiums are received for many decades before benefit payments may be made. Companies may use interest rate futures, swaps, or bond forwards, to reduce reinvestment risk by locking in interest rates at which the future premiums will be invested. When interest rates rise, these hedging transactions may settle, roll-over, or be terminated, leading to expected IMR losses but are ultimately offset by future higher reinvestment yields. Without these hedging transactions, returns might not be equivalent to policyowner obligations, exposing the company to significant interest rate risk.

Similarly, life insurance companies may utilize stochastic asset liability modeling to establish asset duration targets that may include setting different asset duration targets by product if appropriate, through an asset segmentation plan. This considers scenarios where interest rates increase rapidly (where there is potential for disintermediation risk) and very low interest rates (considering product guarantees). Such analysis is refreshed on a regular basis to update the duration target based both on the liability in force characteristics and the economic environment. Portfolio asset duration is managed to the target on an ongoing basis and requires asset sales /purchases or use of derivatives that affect IMR. These are but several distinct examples of the types of prudent risk management practices utilized by life insurance companies.

A rising interest rate environment is generally favorable to the financial health of the life insurance industry. Without a change to the treatment of negative IMR, a rising interest rate environment will give the inappropriate perception of decreased financial strength through lower surplus and risk-based capital ratios, which is both counterintuitive and not reflective of the economics. It may create undesirable incentives for companies to deviate from prudent investment/risk management to avoid creating negative IMR.

It essentially creates two equally objectionable alternatives for insurers and their policyowners.

- Applying the current statutory guidance will improperly reflect financial strength through understating surplus,
- Insurers could take steps to manage their current capital position by limiting trading of fixed income investments and/or usage of derivatives, which would diminish significant economic value or worse, create a mismatch between assets and liabilities and prevent the ability to fulfil long-term contract obligations. Insurers may avoid hedging or trading to ensure future reinvestment risks are mitigated, by being incentivized to overly focus on managing misrepresented short-term

financial position by effectively keeping asset duration shorter than their liabilities and taking on interest rate risk.

We do not believe this is in the best interest of insurance companies or their policyowners and believe it is a common interest we share with regulators. Consequently, developing a national standard for allowing negative IMR with appropriate safeguards should be a common goal for all.

### **Existing Safeguards**

As noted above, IMR itself is a safeguard for the NAIC's amortized cost framework that accomplishes two main objectives:

- Addresses the risk of misrepresentation of surplus, and
- Keeps the relationship of anticipated investment yield consistent with that needed to support the liabilities.

### Excess Withdrawal Safeguard

An Excess Withdrawal safeguard is already embedded in the IMR framework for the situations in which asset sales are “forced”, either due to reputational or disintermediation events, and the liability that the assets supported no longer exists. At such a point, deferring gains and losses to IMR ceases.

While we believe this safeguard was primarily developed to address troubled companies or potential disintermediation in a rising interest rate environment, we understand regulators may want to re-assess the safeguard's robustness. The ACLI supports such a re-assessment and looks forward to working with the NAIC.

### Asset Adequacy Testing (AAT)

AAT is an additional safeguard that helps protect against further unintended consequences when IMR goes negative. Reflecting all admitted negative IMR in AAT would replace assets that generate investment income in AAT, where the starting point is statutory assets are equal to statutory liabilities. Unless the remaining assets can earn a sufficient yield due to reinvestment, there will be negative impacts to the results, which could lead to additional asset adequacy reserves and hence a reduction in statutory surplus. AAT provides a framework to ensure that there are sufficient margins to support claims alongside a negative IMR asset that eventually amortizes to zero, hence ensuring adequate reserves and proper representation of surplus. A simplified example of how AAT works with negative IMR in different reinvestment scenarios is included in Appendix I of this letter.

While we believe that AAT provides a robust safeguard that prevents a misuse of allowable negative IMR, we understand the NAIC wants to contemplate additional safeguards, as AAT may not be applied uniformly across states and practitioners and is only shared with regulators annually.

### **Additional Potential Safeguards**

At the SAPWG fall national meeting the following five potential safeguards were discussed:

- 1) Ensure there is reinvestment in fixed income securities (see below),
- 2) Enhancement to asset adequacy testing (see below),
- 3) Shorten the amortization period for negative IMR (see Appendix II),
- 4) Limit negative IMR as a percentage of surplus, assets, etc. (see Appendix II), or
- 5) Restrict surplus via the special surplus funds (see Appendix II).

ACLI proposes two additional possibilities:

- 1) Limit based on the risk-based capital framework (see below), or
- 2) Create an “Opt-in Framework” with structured governance (see below).

The remainder of this letter outlines a broad framework of the aforementioned additional safeguards that we believe are responsive to regulators’ specific concerns. Redundant or more arbitrary potential safeguards are further discussed in Appendix II attached to this letter.

#### Ensure there is reinvestment in fixed income securities

IMR theory assumes sales of fixed income investments are reinvested in new fixed income investments. When doing so, the reinvestment is done in the current interest rate environment, and the difference in earnings arising from the reinvestment is roughly equal in magnitude, but opposite in direction, to the gain or loss realized on the old investment.

In a rising interest rate environment, a sale essentially transforms the loss to negative IMR. There is essentially no difference in balance sheet economics pre- and post-trade, related to liquidity or claims paying ability, as the difference between the reported amortized cost value, and fair value, upon sale, is equal to the negative IMR.

While AAT would arguably address any deficit in reinvestment as illustrated in our example in Appendix I, ACLI is open to supporting additional demonstrations of reinvestment in fixed income investment. This could be done, for example, by generally requiring the sum of the proceeds from the sale and maturity of bonds (line 12.1) and mortgage loans (line 12.3) are less than the sum of the cost of bonds acquired bonds (line 13.1) and mortgage loans (line 13.3) from the cash flow statement ultimately submitted to regulators in the annual statement.

Such a requirement would provide the following benefits:

- 1) It is objective, easily verifiable, and ultimately rolls up into the audited financial statements,
- 2) It eliminates the issue surrounding the “fungibility of cash” – that is “proving” reinvestment of each sale, which would be difficult and potentially inappropriate, if on a macro basis there was a major shift to equities for example, and
- 3) It demonstrates on a macro basis significant reinvestment is occurring.

We note that even if there were a significant shift to equities, in theory, this should be captured by AAT with equity investments being appropriately stressed, but it would also significantly reduce risk-based capital ratios which would provide significant dis-incentivization for this to occur.

Lastly, such a metric could be coupled with the “Opt-in Approach” proposed below, that would provide additional structure by requiring documentation and controls on prudent strategies for investment management, asset liability management or hedging deemed appropriate and against which future transactions could subsequently be verified as appropriate by the company’s domiciliary regulator.

### Enhancement to Asset Adequacy Testing

We propose that negative IMR should only be allowed if it is included in AAT. This would replace assets that generate investment income in AAT when starting with statutory assets equal to statutory liabilities. Unless the remaining assets can earn a higher yield through reinvestment at higher rates, there will be negative impacts to the results, which could lead to additional asset adequacy reserves and a reduction in statutory surplus.

Fixed income investments that sit in surplus or non-product portfolios could be sold generating IMR. Therefore, we recommend the allowance of negative IMR only if it is included in AAT. This would further prevent any potential balance sheet manipulation, whether intentional or unintentional, through shifting assets with losses to non-insurance portfolios and admitting losses on assets that are not offset by matched liabilities.

This concept could also be coupled with the “Opt-in Approach” proposed below.

### Limit based on the risk-based capital framework

One potential safeguard that was not mentioned by SAPWG at the fall national meeting is to allow negative IMR only if a company’s risk-based capital threshold showed that they were financially strong. This would have the following benefits:

- 1) Address regulator concerns on allowing negative IMR if a company was or was nearing being financially troubled,
- 2) Would not be arbitrary and would be based on an objective and verifiable threshold that would be available to regulators, potentially quarterly, and provide early warning to any concerns they may have in this regard, and
- 3) Would essentially achieve the same ends as shortening the amortization period, restricting capital, or creating an arbitrary limit.

We are willing to work with the NAIC to think through an appropriate threshold as well as what would occur if that threshold was subsequently crossed so there would not be inappropriate cliff effects.

This concept could also be coupled with the “Opt-in Approach” proposed below.



### Create an “Opt-in Framework” with Structured Governance

An “Opt-in Framework”, similar to the framework included within SSAP No. 108 – Derivative Hedging Variable Annuity Guarantees (SSAP No. 108), could be developed.

SSAP No. 108 recognizes the prudence of hedging guarantees embedded within variable annuity contracts while also recognizing the non-economic volatility created (and therefore inappropriate under/overstatement of surplus). It also recognized that this volatility was created because derivatives used in a dynamic hedging approach were required to be reported at fair market value, as they would not meet the strict hedge accounting requirements, while the liabilities did not require marking to market of the hedged guarantees.

To not disincentivize this prudent dynamic hedging, SSAP No. 108 requires additional structure and governance to avoid misrepresentation. The allowance of negative IMR has similar parallels.

Key provisions of SSAP No. 108 that could be considered for a framework for negative IMR allowability include:

- Explicit approval of a company’s domiciliary regulator prior to implementation,
- A clearly defined portfolio and asset liability management strategy (with documentation; analogous to SSAP No. 108 but tailored more appropriately for portfolio and asset liability management strategies),
- Actuarial certification of the asset liability management strategy, and
- Certification by a financial officer of the company (CFO, treasurer, CIO, or designated person with authority over the actual portfolio and asset liability management strategies).

This framework provides sufficient tools that allow for timely and appropriate regulatory review; additional tools could be specifically tailored for IMR.

In the context of a negative IMR, the approach could be tailored to incorporate documentation and controls of prudent strategies for investment management, asset liability management, and hedging strategies deemed appropriate and against which future transactions could subsequently be verified as necessary by the company’s domiciliary regulator.

Achieving the “opt-in” in the context of negative IMR could require satisfying these documentation requirements, in addition to incorporating and complying with a combination of one or more of the other potential safeguards mentioned above. This package of requirements and safeguards would constitute a national standard for allowing negative IMR that can be consistently applied across all companies.

\*\*\*\*\*

In the current interest rate environment, and with additional interest rate increases potentially on the horizon, the disallowance of negative IMR has become a serious and pressing issue for industry as we seek to execute prudent portfolio and risk management strategies that align with our economic realities. The ACLI looks forward to working with the NAIC to expedite a reasonable, permanent solution that fulfills the original intent of IMR and work on the appropriate additional safeguards that may be needed

for year-end 2023 implementation. Lastly, ACLI recalls a specific question raised by regulators at the NAIC's fall national meeting. We would like to understand this question and/or concern more fully and discuss with regulators or NAIC staff.

If you have any questions regarding this letter, please do not hesitate to contact us.

Sincerely,

A handwritten signature in black ink that reads "Mike Monahan". The signature is written in a cursive style with a large initial "M".

Mike Monahan  
Senior Director, Accounting Policy

A handwritten signature in black ink that reads "Paul A. Graham". The signature is written in a cursive style with a large initial "P" and a stylized "G".

Paul Graham  
Senior Vice President, Policy and Legal

**Appendix I****Simplified Example – How AAT Works With Negative IMR in Different Reinvestment Scenarios**

This example illustrates the effectiveness of the AAT safeguard in ensuring company solvency even with an admitted negative IMR. In particular, the Appendix also illustrates how AAT bolsters the reinvestment guardrail.

## Assumptions:

- A 10-year zero-coupon bond with a par value of \$1,000 and interest rate of 3%.
- A 10-year endowment liability with a rate of 3% maturing for \$1,344.
- The corresponding formulaic reserves at “time zero” would be \$1,000 assuming a valuation rate of 3%.
- The assets and liabilities are cashflow matched and no AAT deficiencies are assumed. Investment income of \$344 earned over ten years is sufficient to cover the increase in liability in the same period.

<b>Balance Sheet</b>	<b>12/31/22</b>	<b>12/31/32</b>
<b>Assets</b>		
Bonds	1,000	1,344
<b>Total Assets</b>	<b>1,000</b>	<b>1,344</b>
<b>Liabilities</b>		
Policy Reserves	1,000	1,344
IMR Liability	0	0
<b>Total Liabilities</b>	<b>1,000</b>	<b>1,344</b>

Income Statement	12/31/22 – 12/31/32
<b>Income</b>	
Net Investment Income before IMR	344
IMR Amortization	0
<b>Benefits and Expenses</b>	
Benefits	0
Addition to Reserves	344
<b>Net Income (Loss)</b>	<b>0</b>

Rate Increase Scenario (with reinvestment opportunity)

If interest rates immediately rise to 4%, the insurer could sell the bond and reinvest (assume no policy surrenders):

- Formulaic reserves remain unchanged at \$1,000 due to the valuation rate being locked in at 3% and no surrenders.
- The original bonds would be sold at a capital loss of \$92 and would be reinvested in a higher yielding asset (earning 4%).
- The capital loss of \$92 would be transferred into a negative IMR and amortized over ten years (remaining life).

In this scenario, even though the newly purchased bonds are recorded at \$908, appearing lower than before the sale, the higher investment income of \$436 is sufficient to cover the increase in liability and IMR amortization over ten years. No asset adequacy reserves would need to be established as part of the asset adequacy analysis<sup>1</sup>.

Balance Sheet	12/31/22 Before Asset Sale	12/31/22 After Asset Sale	12/31/32
<b>Assets</b>			
Bonds	1,000	908	1,344
<b>Total Assets</b>	1,000	908	1,344
<b>Liabilities</b>			
Policy Reserves	1,000	1,000	1,344
IMR Liability	0	(92)	0
<b>Total Liabilities</b>	1,000	908	1,344

<sup>1</sup> Asset adequacy testing requires that assets included in testing be no greater than the reserves and liabilities being tested. Even if there were other assets in addition to the \$908 bonds, a robust AAT safeguard would require that admitted negative IMR be reflected in AAT, effectively constraining the income generating assets that can be used in AAT to support liabilities when testing for deficiencies. AAT pressures to set up asset adequacy reserves will increase unless reinvestment into higher yielding assets occurs.

Income Statement	12/31/22 – 12/31/32
<b>Income</b>	
Net Investment Income before IMR	436
IMR Amortization	(92)
<b>Benefits and Expenses</b>	
Benefits	0
Addition to Reserves	344
<b>Net Income (loss)</b>	<b>0</b>

Rate Increases, and Surrenders Scenario (No reinvestment opportunity)

Assume rates immediately rise to 4% and 50% of liabilities are immediately surrendered<sup>2</sup>:

- 50% of the liability surrenders, with a surrender value of \$500.
- Bonds are sold to fund withdrawals. Due to the rate increase, the book value of bonds sold (\$551) is higher than their market value of (\$500), resulting in a capital loss of \$51.
- As withdrawal activity is not deemed to be excessive, the capital loss of \$51 is transferred into negative IMR which is amortized over ten years.
- The remaining \$449 of bonds would continue to earn their original interest rate of 3%.

In this scenario, the total assets included in asset adequacy analysis are \$449 of original bonds (yielding 3%) and negative IMR at \$51. However, these would be insufficient to cover the total remaining liability requirement of \$672 after 10 years. Therefore, an AAT reserve of \$51 would be established to cover this inadequacy, resulting in a P&L impact and ultimately a reduction to statutory surplus. Inclusion of the negative IMR in AAT accurately portrays the company's surplus and results in additional reserves of \$51. The additional assets (assumed to also earn 3% like the original bonds) backing the AAT reserves combined with the \$449 of original bonds are now sufficient to cover the remaining liability requirement of \$672 after 10 years.

Balance Sheet	12/31/22 Before Asset Sale and Surrender	12/31/22 After Asset Sale and Surrender, but before AAT	12/31/22 After Asset Sale, Surrender, and AAT	12/31/32
<b>Assets</b>				
Bonds	1,000	449	449	672
Extra Assets for AAT	0	0	51 <sup>3</sup>	0
<b>Total Assets</b>	1,000	449	500	672
<b>Liabilities</b>				
Policy Reserves	1,000	500	500	672
AAT Reserves	0	0	51	0
IMR Liability	0	(51)	(51)	0
<b>Total Liabilities</b>	1,000	449	500	672

<sup>2</sup> Assumes that a 50% surrender does not constitute Excess Withdrawal Activity as defined in the Life, Accident & Health/Fraternal Annual Statement Instructions. If it did constitute Excess Withdrawal Activity, deferring losses to IMR would cease and result in an instant hit to statutory surplus.

<sup>3</sup> Extra assets of \$51 would be a reduction to surplus in the year of testing when the additional AAT reserves are recorded.

<b>Income Statement</b>	<b>12/31/22 – 12/31/32</b>
<b>Income</b>	
Net Investment Income before IMR	172
IMR Amortization	(51)
<b>Benefits and Expenses</b>	
Benefits	0
Addition to Reserves	121
Addition to AAT Reserves on 12/31/22	51
<b>Net Income (loss)</b>	<b>(51)</b>



**Appendix II****Other Potential Safeguards****Shorten Amortization Period**

As negative IMR is included in AAT, shortening the amortization period arguably would not be needed but also contradicts the theory of IMR. We believe that shortening the amortization period asymmetrically would obviate one of the objectives of IMR – to keep the relationship of anticipated investment yield consistent with that needed to support the liabilities. Further it would introduce a host of practical challenges.

Examples of practical challenges from shortening the amortization period include:

- Shorten the amortization period only when net negative balances occur?
- If so, in what discrete period?
- For the year?
- What happens when the balance switches from negative to positive (or vice versa) during the year and amortization had already been shortened at the start of the year?

We also wanted to address a further potential concern that has been raised and is best illustrated in the following example:

- There is a \$1 billion IMR gain with a 20-year amortization period
- Subsequently it is offset to zero by a \$1 billion loss with a 1-year amortization period.
- Does this accelerate the gain recognition which was really the impetus behind IMR in the first place?

This would not be the case as gains and losses are amortized separately regardless of whether the gross balances offset one another. While it is true that on day 1, there would be an offset to zero, both the gains and losses are amortized separately, and in this case, in year two approximately \$950 million (assuming straight line amortization for simplicity) would be the total credit IMR balance representing the gains that still need to be amortized.

As shortening the amortization period:

- contradicts the theory and objectives of IMR,
- is arbitrary,
- would create practical challenges to implement,
- would penalize strong companies the same as weakly capitalized companies, and
- would be unduly punitive to companies with strong and weak AAT practices alike.

We do not believe this solution to be appropriate, or in line with prudent best practices.

Limit as a percentage of surplus, etc.

Limiting negative IMR to a percentage of surplus would again be an arbitrary limit that contradicts the theory of IMR and would penalize strong and weak companies alike, similar to shortening the amortization period, and we believe it does not best serve an appropriate safeguard.

While we are not against further safeguards, we believe any additional safeguards should address a very specific concern of regulators and/or a concern that is not already adequately addressed by existing safeguards or are more tailored to specific concerns such as with the “Opt-in Approach” recommended.

Restrict Surplus via the special surplus fund

The effect of AAT requiring additional reserves is equivalent to restricting surplus available for dividends to stockholders or participating policyowners. Thus, restricting surplus (the special surplus fund) for an amount equal to allowable negative IMR would be redundant when AAT requires additional reserves. Further, because dividends are governed by varying state laws, restricting surplus would provide inconsistent treatment, which is a suboptimal solution. The same ends could be achieved elsewhere such as with a limit based on the risk-based capital framework in combination with the “Opt-in Approach” recommended.

## Statutory Issue Paper No. 167

### Derivatives and Hedging

#### STATUS

Finalized March 22, 2023

#### Original SSAP and Current Authoritative Guidance: SSAP No. 86

#### Type of Issue:

Common Area

#### SUMMARY OF ISSUE

1. Statutory accounting guidance for derivatives is in *SSAP No. 86—Derivatives*. Although SSAP No. 86 indicates “adoption of the framework” of specific U.S. GAAP guidance, the accounting and reporting guidance for derivatives, particularly with regards to the four U.S. GAAP derivative cornerstones, is distinctly different between SSAP No. 86 and FAS 133/ASC 815. For example, under U.S. GAAP, assessment effectiveness under U.S. GAAP is largely an income statement management tool (to offset variations consistently through net income or other comprehensive income – OCI), but as SAP uses an amortized cost measurement method for a number of hedged items, the criteria for hedge effectiveness and the measurement approach for derivatives must be adjusted accordingly.

2. In August 2017, the FASB issued *ASU 2017-12, Derivatives and Hedging (Topic 815): Targeted Improvements to Accounting for Hedging Activities* to improve the financial reporting of hedging relationships to better portray the economic results of an entity’s risk management activities in its financial statements. In addition, the amendments incorporated certain targeted improvements to simplify the application of the hedge accounting guidance in current U.S. GAAP. ASU 2017-12 included a new concept for a ‘last of layer’ approach to make portfolio fair value hedge accounting more accessible for specific assets. With the issuance of the last-of-layer guidance, a number of questions were received. After considering those questions, *ASU 2022-01 Fair Value Hedging – Portfolio Layer Method* was issued. This ASU expanded the original guidance and provided additional specifications and guidance.

3. The Statutory Accounting Principles (E) Working Group has considered several revisions to SSAP No. 86 in response to the review of ASU 2017-12 and ASU 2022-01. This issue paper has been drafted to detail the revisions incorporated into statutory accounting. These revisions, except for those initially adopted in 2018, are considered new SAP concepts.

#### DISCUSSION

##### *Topic 1: Hedge Documentation and Initial Assessment Efficiencies (Agenda Item 2018-30)*

4. The overall intent of ASU 2017-12 was to reduce cost and complexity of applying hedge accounting by simplifying the way assessments of hedge effectiveness may be performed. It was noted that the efficiencies gained from the revisions in the ASU for U.S. GAAP filers would be lost if corresponding provisions were not considered for statutory accounting. Pursuant to a July 9, 2018, interested parties’ comment letter, three elements were requested to be considered by the Statutory Accounting Principles (E) Working Group in a nonsubstantive (SAP clarification) proposal. Interested parties noted that these elements will reduce the costs associated with hedge accounting, while neither changing the underlying accounting, nor creating any additional regulatory risks or concerns:

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- a. Allow companies to perform subsequent assessments of hedge effectiveness qualitatively if certain conditions are met.
- b. Allow companies more time to perform the quantitative hedge effectiveness assessment.
- c. Clarify that companies may apply the “critical terms match” method for a group of forecaster transactions if the transactions occur and the derivatives mature within the same 31-day period or fiscal month, and the other requirements for applying the critical match method are satisfied.

5. On August 4, 2018, the Working Group exposed revisions to incorporate hedge documentation and assessment efficiencies from ASU 2017-12. This item was exposed with a shortened comment period to allow for potential revisions and re-exposure if needed, to permit adoption and application prior to year-end 2018. On November 15, 2018, the Working Group adopted the exposed revisions as final. The revisions were adopted with an effective date of January 1, 2019, with early adoption permitted for year-end 2018. U.S. GAAP filers could only early adopt if they had also early adopted ASU 2017-12.

6. Additionally, in ASU 2017-12, in response to comments requesting a more flexible approach to hedging interest rate risk, the FASB decided to amend the guidance for hedging interest rate risk of financial instruments for both fair value and cash flow hedges. With the revisions, the FASB decided to redefine the term interest rate risk and eliminate the benchmark interest rate concept for variable-rate financial instruments. With the changes, the FASB incorporated the SIFMA rate in the list of eligible rates for fixed income instruments and noted that the FASB will add to the list of eligible benchmark rates as necessary. The revisions adopted to SSAP No. 86 are detailed in Exhibit A.

7. With the inclusion of revisions, certain elements from the U.S. GAAP guidance were not duplicated within statutory accounting. The elements were considered part of the prior adoption of the “FAS 133 / technical guidance” originally reflected in SSAP No. 86:

- a. Exceptions from the initial prospective quantitative assessment were not captured in the statutory guidance as they were not necessarily new under ASU 2017-12. The following overview details when an initial prospective quantitative assessment would not be required:
  - i. In a cash flow or fair value hedge, the entity applies the short-cut method.
  - ii. In a cash flow or fair value hedge, the entity determines that the critical terms of the hedging instrument and the hedged item match.
  - iii. In a cash flow hedge, the hedging instrument is an option and it meets specific criteria detailed in the U.S. GAAP guidance
  - iv. In a cash flow hedge, a private company that is not a financial institution applies the simplified hedge accounting approach.
  - v. In a cash flow hedge, the entity assesses hedge effectiveness under the change in variable cash flows method permitted under U.S. GAAP, with all noted conditions being met.
  - vi. In a cash flow hedge, the entity assesses hedge effectiveness under the hypothetical derivative method permitted under U.S. GAAP and all the critical terms of the hypothetical derivative and the hedging instrument are the same.

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- vii. In a net investment hedge, the entity assesses hedge effectiveness using a method based on changes in spot exchange rates, and the conditions noted under U.S. GAAP are met.
  - viii. In a net investment hedge, the entity assesses hedge effectiveness using a method based on changes in forward exchange rates and the noted condition under U.S. GAAP are met.
- b. The short-cut method and critical terms match method are current method permitted under U.S. GAAP retained under ASU 2017-12. Under these methods, an entity may qualitatively assume, in very limited circumstances, that

8. Ultimately, the revisions incorporated in 2018, effective January 1, 2019, with early application permitted, from ASU 2017-12 were limited to specific provisions, and related transition guidance, pertaining to the documentation and assessment of hedge effectiveness: 1) provisions allowing more time to perform the initial qualitative hedge effectiveness assessment; 2) provisions allowing subsequent assessments of hedge effectiveness to be performed qualitatively if certain conditions are met; and 3) revisions regarding use of the critical terms and short-cut method for assessing hedge effectiveness. With the adoption of the limited provisions, it was identified that the remaining provisions of ASU 2017-12 would be subsequently assessed for statutory accounting and shall not be considered adopted for statutory accounting until that assessment is completed, with a conclusion to adopt the U.S. GAAP guidance.

9. The revisions adopted in November 2018 included revisions to both SSAP No. 86 as well as Exhibit B – Assessment of Hedging Effectiveness. The subsequent revisions adopted in 2022 eliminated Exhibit B as well as incorporated new guidance through the SSAP. Ultimately, the final adopted guidance, as reflected in the AP&P Manual, is the authoritative guidance.

***Topic 2: Hedge Effectiveness and Measurement Methods for Excluded Components (Ref #2021-20)***

10. In December 2011, consideration began on revisions to facilitate effective hedge assessments consistently between statutory accounting and U.S. GAAP. The Working Group exposed a concept agenda item to solicit comments and directed NAIC staff to work with regulators and industry in developing revisions for consistent hedge effectiveness assessments and with the treatment of excluded components.

11. After working with industry, on April 4, 2022, the Working Group exposed two documents for public comment. The first document proposed revisions in the form of a new exhibit A to SSAP No. 86, which would replace both Exhibit A and Exhibit B. This new exhibit A would adopt with modification U.S. Guidance in determining hedge effectiveness. The second document proposed revised guidance to SSAP No. 86 to update the permitted excluded components to mirror U.S. GAAP but establish statutory-specific measurement methods for the excluded components.

12. The new Exhibit A intends to reflect the position that the assessment of hedge effectiveness for derivatives should be consistent between U.S. GAAP and SAP. In other words, transactions identified to be highly effective hedges under U.S. would be identified as highly effective hedged under statutory accounting. If a hedging instrument results with offsetting changes (or other permitted aspects) to a hedged item pursuant to the guidelines under U.S. GAAP to qualify as a highly effective hedge, the same assessment as a highly effective hedge should occur under SAP.

13. The Exhibit A would adopt, with modification U.S. GAAP guidance pertaining to the criteria for initial and subsequent hedge effectiveness detailed in the FASB Accounting Standards Codification (ASC) paragraphs 815-20-25-72 through 815-20-35-20, as modified through the issuance of ASU 2017-12.

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Although the U.S. GAAP guidance for the assessment and determination of hedge effectiveness is proposed to be adopted, statutory modifications are captured to specify that the accounting and reporting of hedging instruments, including excluded components of the instruments, shall follow statutory specific guidance detailed in SSAP No. 86. The intent of this guidance is to clarify that the determination of whether a hedging instrument qualifies as an effective hedge shall converge with U.S. GAAP, but that the measurement method shall continue to follow statutory specific provisions. The adopt from U.S. GAAP only extends to revisions incorporated through ASU 2017-12, as such, any subsequent U.S. GAAP edits would require statutory accounting consideration before they were considered adopted.

14. In addition to new Exhibit A to SSAP No. 86, the Working Group also exposed proposed revisions to SSAP No. 86, paragraphs 23, 40-41 and Exhibit C, to expand the list of permitted excluded components in assessing derivative effectiveness to match U.S. GAAP and to establish statutory specific measurement requirements for each type of excluded component.

15. The prior SSAP No. 86 guidance reflected the list of permitted excluded components originally adopted from U.S. GAAP. Since the original inclusion in SSAP No. 86, and within ASU 2017-12, U.S. GAAP had expanded the list, and it was noted that the statutory accounting treatment of excluded components related to foreign currency transactions were hindering the ability to engage in those transactions. It was also identified that current measurement guidance within the SSAP was conflicting between the guidance and specific hedge procedures detailed in Exhibit C. Through the discussions with industry, it was identified that different measurement or recognition provisions should be considered to properly reflect the type of excluded component with the financial statements, with specific guidance included in SSAP No. 86 accordingly:

- a. If the excluded component pertains to the difference between a foreign currency spot price and the forward or future price (e.g., a forward spot rate), then this premium/discount shall be amortized into income over the life of the contract or hedged program. (This guidance addresses the excluded component in Exhibit A, paragraph 8.d.)
- b. If the excluded component pertains to a foreign currency swap cross-currency basis spread, the impact of fair value changes shall be reflected as a component of the foreign currency swap's periodic interest accrual. (This guidance addresses the excluded component in Exhibit A, paragraph 8.e.)
- c. For all other excluded components, the excluded component shall be measured and reported at fair value, with changes in fair value recognized as unrealized gains or losses. (This guidance shall be applied to excluded components detailed in Exhibit A, paragraphs 8.a. through 8.c.)

16. On August 10, 2022, after the exposure timeframe, in which interested party comments were received supporting the proposed revisions, the Working Group adopted the exposed revisions. This adoption resulted with both the new Exhibit A that adopts with modification U.S. GAAP guidance in determining hedge effectiveness and the revisions to SSAP No. 86 to incorporate measurement method guidance for excluded components. These revisions were adopted with a January 1, 2023, effective date, with early adoption permitted. With the action to adopt, the Working Group directed a blanks proposal to incorporate Schedule DB reporting fields and templates to capture the new disclosures for excluded components. These disclosure and investment schedule changes will be in effect for year-end 2023. Companies that early adopt the revisions are directly to complete the required disclosures in a narrative format for year-end 2022.

**Topic 3: Portfolio Layer Method and Partial Term Hedging (Ref #2022-09)**

17. In August 2022, considerations began to expand statutory accounting guidance to incorporate the portfolio layer method detailed in *ASU 2022-01, Fair Value Hedging – Portfolio Layer Method*. The guidance in ASU 2022-01 reflects an expansion of the last-of-layer method detailed in ASU 2017-12.

18. Under the last-of-layer approach captured in ASU 2017-12, for a closed portfolio of prepayable financial assets or one or more beneficial interests secured by a portfolio of prepayable financial instruments, entities were allowed to hedge a stated amount of the asset or assets in the closed portfolio that is anticipated to be outstanding for the designated hedged period. If the requirements for the last-of-layer method were met, prepayment risk is not incorporated into the measurement of the hedged item. With the application of this guidance, a number of questions were received. After considering those questions, FASB issued *ASU 2022-01, Fair Value Hedging – Portfolio Layer Method*, which expanded the guidance and provided additional specifications for application. Ultimately, for a closed portfolio of financial assets or one of more beneficial interests secured by a portfolio of financial instruments, an entity may designate as the hedged item or items a hedged layer or layers if the following criteria is met:

- a. As part of the initial hedge documentation, an analysis is completed and documented to support the entity's expectation that the hedged item or items (that is, the hedged layer or layers in aggregate) is anticipated to be outstanding for the designated hedge period. That analysis shall incorporate the entity's current expectations of prepayments, defaults, and other factors affecting the timing and amount of cash flows associated with the closed portfolio.
- b. For purposes of its analysis, the entity assumes that as prepayments, defaults, and other factors affecting the timing and amount of cash flows occur, they first will be applied to the portion of the closed portfolio that is not hedged.
- c. The entity applies the partial-term hedging guidance to the assets or beneficial interests used to support the entity's expectation. An asset that matures on a hedged layer's assumed maturity date meets this requirement.

19. Similar to concepts supporting the adoption of prior U.S. GAAP revisions, there is a general assessment that determination of effective hedges shall be consistent between statutory accounting and U.S. GAAP. As such, new SAP concepts revisions to reflect the portfolio layer method in establishing effective hedge dynamics was proposed to be consistent with U.S. GAAP. With the U.S. GAAP guidance limiting the application of this guidance to hedges of recognized financial assets, a consistent scope threshold was established for statutory accounting.

20. The review of the portfolio layer method identified that U.S. GAAP prevents basis adjustments directly to assets hedged in a portfolio and it was considered on whether statutory revisions would be necessary to address similar basis adjustment revisions under statutory accounting. However, after further assessments, it was identified that the fair value measurement method under U.S. GAAP, which results in ongoing basis adjustments from changes in fair value over the derivative term, would not be a prominent issue under statutory accounting, which predominantly uses an amortized cost approach for effective hedges. With the use of amortized cost, basis adjustments do not occur until hedge termination or at designation of the hedge, therefore this was identified as not a key statutory accounting impact.

21. In addition to considering guidance for the portfolio layer method, representatives from interested parties proposed to also capture concepts for partial term hedges from ASU 2017-12. (As detailed in the

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FASB criteria above in paragraph 18 for portfolio layer method hedges, application of a the partial-term hedging guidance is used to support the entity's expectation.) Prior review of partial term hedge concepts noted concern as how interim adjustments to hedged items, particularly for hedged liabilities, would be reflected in the financial statements. With the statutory accounting guidance to reflect derivative gains or losses as basis adjustments on the hedge item, if a hedge to a recognized liability resulted in a reduction to the presentation of the liability, this could misrepresent the financial statements as the liability itself had not been reduced. In considering these concerns and recognizing that a broader project would likely be needed to address these basis adjustments, representatives from industry recommended incorporated the U.S. GAAP guidance for partial term hedges, with a statutory modification to limit the application to hedges of recognized assets.

22. Although the proposal to limit partial term hedges to recognized assets is a modification from the overarching concept to mirror hedge effectiveness assessments between U.S. GAAP and SAP, it was identified as an approach that would be consistent with the U.S. GAAP scope application for the portfolio layer method and would reflect how industry currently uses partial term hedge transactions. As such, although the modification created a U.S. GAAP and SAP difference, the modification satisfies the current need for statutory guidance and prevents significant concerns on how the guidance could impact the presentation of liabilities. With this discussion, it was identified that subsequent consideration of the limitation to recognized assets could occur, with potential expansion to hedges of recognized liabilities as part of a broader discussion on how derivative gains and losses are recognized as basis adjustments.

23. The proposed revisions exposed to incorporate the portfolio layer method and the partial-term hedging method are summarized as follows:

- a. Revisions to SSAP No. 86, predominantly in paragraph 26.d., 26.f., and 26.g., to detail the ability to hedge recognized assets under the portfolio layer method and partial-term hedge. Also, revisions to paragraph 62 for a new disclosure for portfolio layer derivatives that no longer qualify for hedge accounting and the circumstances that led to the breach, as well as guidance in paragraphs 65.c. and 74.f. to detail relevant U.S. GAAP literature and the effective date.
- b. Revisions to SSAP No. 86 – Exhibit, Exhibit A – Assessment of Hedge Effectiveness, to add a new section on the assessment of portfolio layer method for hedge effectiveness. (Note – This exhibit was the new exhibit adopted in agenda item 2021-20 which replaced the prior Exhibit A and Exhibit B within SSAP No. 86.)
- c. Revisions to SSAP No. 86 – Exhibit C, paragraph 2.d., for which a portfolio layer method is discontinued to detail how the basis adjustment shall be allocated to the remaining individual assets in the closed portfolio. (Note – With the adoption of agenda item 2021-20, this Exhibit was renamed as Exhibit B.)

24. The proposed revisions reflect adoption of U.S. GAAP for the criteria for the portfolio layer method detailed in ASU 2022-01, criteria to only consider how changes in the benchmark interest rate affect the decision to settle the hedged item before its scheduled maturity date in ASC 815-20-25-6B, adding option in calculating the change in the hedged item's fair value attributed to changes in the benchmark interest rate based on the benchmark rate components of the contractual cash flows detailed in FASB ASC 815-25-35-13, and the partial-term hedging method detailed in FASB ASC 815-25-35-13B. The adoption of the partial term hedging method reflects statutory modifications that limits its use only when the hedged item is a recognized asset. This is different than U.S. GAAP, which permits the partial term method for hedged liabilities. The statutory limitation is established to prevent interim basis adjustments to hedged liabilities



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that could present a reduction of reported liabilities on the financial statements when the actual liability has not been reduced. Reconsideration of this statutory limitation may occur after a broader project to consider how derivative basis adjustments to hedged liabilities shall be reflected in the financial statements.

25. On December 13, 2022, the Working Group adopted the exposed revisions. This adoption resulted with the revisions identified in paragraph 23 above. These revisions were adopted with a January 1, 2023 effective date, with early adoption permitted. The revisions shall be applied prospectively to qualifying new hedges.

~~25:~~26. An updated version of this Issue Paper was exposed on December 12, 2022, and adopted on March 22, 2023. The purpose of this Issue Paper is to document the historical actions resulting in new SAP concepts within SSAP No. 86—Derivatives. As issue papers are not represented in the statutory hierarchy, the adoption of this Issue Paper does not change the effective date of the previously adopted authoritative literature.

**Exhibit 1 – Revisions adopted to SSAP No. 86 on November 15, 2018 (Agenda Item 2018-30)**

38. At inception of the hedge, documentation must include:

- a. A formal documentation of the hedging relationship and the entity's risk management objective and strategy for undertaking the hedge, including identification of the hedging instrument, the hedged item, the nature of the risk being hedged, and how the hedging instrument's effectiveness in offsetting the exposure to changes in the hedged item's fair value or variability in cash flows attributable to the hedged risk will be assessed, including whether an entity will perform subsequent effectiveness assessments on a qualitative basis (per paragraph 42) and how it intends to carry out that qualitative assessment. There must be a reasonable basis for how the entity plans to assess the hedging instrument's effectiveness;
- b. An entity's defined risk management strategy for a particular hedging relationship may exclude certain components of a specific hedging derivative's change in fair value, such as time value, from the assessment of hedge effectiveness, as discussed in paragraph 37 and Exhibit B;
- c. Signature of approval, for each instrument, by person(s) authorized, either by the entity's board of directors or a committee authorized by the board, to approve such transactions; and
- d. A description of the reporting entity's methodology used to verify that opening transactions do not exceed limitations promulgated by the state of domicile.

39. At inception, if an entity is required to perform an initial prospective assessment of hedge effectiveness on a quantitative basis (using information applicable as of the date of hedge inception<sup>FN</sup>), the assessment is considered to be performed concurrently at hedge inception if it completed by the earliest of the following: (815-20-25-3)

- a. The first quarterly hedge effectiveness assessment date.
- b. The date that financial statements that include the hedged transaction are available to be issued.

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- c. The date that the hedging instrument and hedged item no longer qualify for hedge accounting.
- d. The date of expiration, sale, termination or exercise of the hedging instrument.
- e. The date of dedesignation of the hedging relationship.
- f. For a cash flow hedge of a forecasted transaction, the date that the forecasted transaction occurs.

New Footnote – Entities are required to perform an initial prospective assessment unless qualifying for an exception in accordance with ASU 2017-12, paragraph 815-20-25-3.

40. For all derivatives terminated, expired, or exercised during the year:
- a. Signature of approval, for each instrument, by person(s) authorized, either by the entity's board of directors or a committee authorized by the board, to approve such transactions;
  - b. A description, for each instrument, of the nature of the transaction, including:
    - i. The date of the transaction;
    - ii. A complete and accurate description of the specific derivative, including description of the underlying securities, currencies, rates, indices, commodities, derivatives, or other financial market instruments;
    - iii. Number of contracts or notional amount;
    - iv. Date of maturity, expiry or settlement;
    - v. Strike price, rate or index (termination price for futures contracts);
    - vi. Counterparty, or exchange on which the transaction was traded; and
    - vii. Consideration paid or received, if any, on termination.
  - c. Description of the reporting entity's methodology to verify that derivatives were effective hedges; and
  - d. Identification of any derivatives that ceased to be effective as hedges.
41. For derivatives open at quarter-end:
- a. A description of the methodology used to verify the continued effectiveness of hedges, and whether the entity is using qualitative assessments pursuant to paragraph 42<sup>FN</sup>;
  - b. An identification of any derivatives that have ceased to be effective as hedges;
  - c. A description of the reporting entity's methodology to determine fair values of derivatives;
  - d. Copy of Master Agreements, if any, where indicated on Schedule DB Part D.

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New Footnote: For purposes of this requirement, this statement adopts the guidance for effectiveness assessment after initial designation reflected in ASU 2017-12, including the concepts and restrictions for use of the short-cut method and the critical terms match method.

42. An entity may subsequently qualitatively assess hedge effectiveness, on a hedge-by-hedge basis, if both the conditions in paragraphs 42.a. and 42.b. were initially met. When an entity performs subsequent qualitative assessments of hedge effectiveness, it shall verify and document whenever financial statements or earnings are reported and at least every three months that the facts and circumstances related to the hedging relationship have not changed such that it can assert qualitatively that the hedging relationship was and continues to be highly effective. An entity may perform a quantitative assessment in any reporting period to validate whether qualitative assessments remain appropriate. When facts and circumstances change such that an entity no longer can assert qualitatively that the hedging relationship continue to be highly effective, then the entity shall begin performing quantitative assessments. (815-20-35-2A, 2C and 2D abbreviated)

- a. An entity performs an initial quantitative test of hedge effectiveness on a prospective basis (that is, it is not assuming that the hedging relationship is perfectly effective at hedge inception) and the results of that quantitative test demonstrate highly effective offset.
- b. At hedge inception, an entity can reasonably support an expectation of high effectiveness on a qualitative basis in subsequent periods.

## RELEVANT LITERATURE

~~6059~~. This statement adopts the framework established by FAS 133, FASB Statement No. 137, Accounting for Derivative Instruments and Hedging Activities—Deferral of the Effective Date of FASB Statement No. 133, An amendment of FASB Statement No. 133 (FAS 137) and FASB Statement No. 138, Accounting for Certain Derivative Instruments and Certain Hedging Activities, An amendment of FASB Statement No. 133 (FAS 138), for fair value and cash flow hedges, including its technical guidance to the extent such guidance is consistent with the statutory accounting approach to derivatives utilized in this statement. This statement adopts the provisions of FAS 133 and 138 related to foreign currency hedges. With the exception of guidance specific to foreign currency hedges and amendments specific to refining the hedging of interest rate risk (under FAS 138, the risk of changes in the benchmark interest rate would be a hedged risk), this statement rejects FAS No. 137 and 138 as well as the various related Emerging Issues Task Force interpretations. This statement adopts paragraphs 4 and 25 of FASB Statement No. 149: Amendment of Statement 133 on Derivative Instruments and Hedging Activities (FAS 149) regarding the definition of an underlying and guidance for assessing hedge effectiveness. All other paragraphs in FAS 149 are rejected as not applicable for statutory accounting. This statement adopts FSP FAS 133-1 and FIN 45-5: Disclosures about Credit Derivatives and Certain Guarantees, An Amendment of FASB Statement No. 133 and FASB Interpretation No.45 and Clarification of the Effective Date of FASB Statement No. 161 (FSP FAS 133-1 and FIN 45-4) and requires disclosures by sellers of credit derivatives. This statement rejects FSP FIN 39-1, Amendments of FASB Interpretation No. 39, and ASU 2014-03, Derivatives and Hedging – Accounting for Certain Receive-Variable, Pay-Fixed Interest Rate Swaps – Simplified Hedge Accounting Approach.

61 This statement adopts certain revisions to ASC 815-20 included in ASU 2017-12. This adoption is limited to specific provisions, and related transition guidance, pertaining to the documentation and assessment of hedge effectiveness and only includes: 1) provisions allowing more time to perform the initial quantitative hedge effectiveness assessment; 2) provisions allowing subsequent assessments of hedge effectiveness to be performed qualitatively if certain conditions are met; and 3) revisions regarding use of

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[the critical terms and short-cut methods for assessing hedge effectiveness. The remaining provisions of ASU 2017-12 will be subsequently assessed for statutory accounting and shall not be considered adopted for statutory accounting until that assessment is complete.](#)

~~6260~~. This statement adopts with modification revisions to ASC 815 as reflected within ASU 2016-05, Effect of Derivative Contract Novations on Existing Hedge Accounting Relationships. This guidance is modified to require prospective application, as such it is only applicable to future counterparty changes in derivative instruments, and this guidance cannot be used to adjust derivative transactions previously terminated. This statement adopts revisions to ASC 815-20-25-15 as reflected within ASU 2010-08, Technical Corrections to Various Topics. This statement adopts revisions to ASC 815-10-50-4K as reflected within ASU 2010-11, Derivatives and Hedging (Topic 815), Scope Exception Related to Embedded Credit Derivatives, but rejects all other GAAP revisions from ASU 2010-11 and ASU 2014-16, Derivatives and Hedging, Determining Whether the Host Contract in a Hybrid Financial Instrument Issued in the Form of a Share is More Akin to Debt or to Equity and ASU 2016-06, Derivatives and Hedging, Contingent Put and Call Options in Debt Instruments. These GAAP revisions are rejected as embedded derivatives are not separated from the host contract and recognized as derivatives under SSAP No. 86. Revisions are also incorporated to SSAP No. 86 to require disclosures on embedded credit derivatives that expose the holder of a financial instrument to the possibility of being required to make future payments. This disclosure is a modification to the GAAP disclosures specific to statutory accounting as embedded credit derivatives are not separately recognized under statutory accounting. It should be noted that the conclusions reached in this statement are not intended to usurp the rules and regulations put forth by states in their respective investment laws. The contents of this statement are intended to provide accounting guidance on the use of derivatives as allowed by an insurer's state of domicile. It is not intended to imply that insurers may use derivatives or cash instruments that the insurer's state of domicile does not allow under the state's insurance regulatory requirements, e.g., in replication transactions.

~~6364~~. This statement adopts revisions to ASC 815-20 as reflected within ASU 2013-10, Derivatives and Hedging, Inclusion of the Fed Funds Effective Swap Rate (or Overnight Index Swap Rate) as a benchmark interest rate for Hedge Accounting Purposes. These revisions define a benchmark interest rate, clarify what can be used in the U.S. for a benchmark interest rate, and eliminate the prior restriction on using different benchmark rates for similar hedges.

### **Effective Date and Transition**

~~6765~~. This statement is effective for derivative transaction entered into or modified on or after January 1, 2003. A modification is any revision or change in contractual terms of the derivative. SSAP No. 31 applies to derivative transaction prior to January 1, 2003. Alternatively, an insurer may choose to apply this statement to all derivatives to which the insurer is a party as of January 1, 2003. In either case, the insurer is to disclose the transition approach that is being used. Revisions adopted to paragraph 59 to reject FSP FIN 39-1 is effective January 1, 2013, for companies that have previously reported a position in the balance sheet that was net of counterparty agreements. (Companies that have previously reported derivative instruments and/or related collateral gross shall not be impacted by these revisions.) Revisions adopted in paragraph 15 clarify the reporting for amounts received/paid to adjust variation margin until the derivative contract has ended and are effective January 1, 2018, on a prospective basis, for reporting entities that have previously considered these amounts to reflect settlement or realized gains/losses. (Companies that have previously reported variation margin changes in line with the revisions shall not be impacted by these revisions.) [Revisions to incorporate limited provisions from ASU 2017-12 pertaining to the documentation of hedge effectiveness \(detailed in paragraph 61\) are effective January 1, 2019, with early adoption permitted for year-end 2018. However, if the reporting entity is a U.S. GAAP filer, the reporting entity may only elect early adoption if the entity has also elected early adoption of ASU 2017-12 for year-end 2018.](#)

**SSAP NO. 86 - EXHIBIT B – ASSESSMENT OF HEDGING EFFECTIVENESS**

The following is based on paragraphs 62-70 of FAS 133 to offer additional guidance on assessing hedging effectiveness. The intent of such is to remain consistent with ~~FAS 133~~[U.S. GAAP](#) with respect to assessing hedge effectiveness, [including guidance in ASU 2017-12 that outlines when an entity may perform subsequent assessments of hedge effectiveness qualitatively](#).

1. This statement requires that an entity define at the time it designates a hedging relationship the method it will use to assess the hedge's effectiveness in achieving offsetting changes in fair value or offsetting cash flows attributable to the risk being hedged. It also requires that an entity use that defined method consistently throughout the hedge period to assess at inception of the hedge and on an ongoing basis whether it expects the hedging relationship to be highly effective in achieving offset. If the entity identifies an improved method and wants to apply that method prospectively, it must discontinue the existing hedging relationship and designate the relationship anew using the improved method. Although this statement suggests a method for assessing whether a hedge is expected to be highly effective or measuring hedge ineffectiveness, the appropriateness of a given method of assessing hedge effectiveness can depend on the nature of the risk being hedged and the type of hedging instrument used. Ordinarily, however, an entity should assess effectiveness for similar hedges in a similar manner; use of different methods for similar hedges should be justified.

2. In defining how hedge effectiveness will be assessed, an entity must specify whether it will include in that assessment all of the gain or loss on a hedging instrument. As discussed in paragraph 33, this statement permits (but does not require) an entity to exclude all or a part of the hedging instrument's time value from the assessment of hedge effectiveness, as follows:

- a. If the effectiveness of a hedge with an option contract is assessed based on changes in the option's intrinsic value, the change in the time value of the contract would be excluded from the assessment of hedge effectiveness.
- b. If the effectiveness of a hedge with an option contract is assessed based on changes in the option's minimum value, that is, its intrinsic value plus the effect of discounting, the change in the volatility value of the contract would be excluded from the assessment of hedge effectiveness.
- c. If the effectiveness of a hedge with a forward or futures contract is assessed based on changes in fair value attributable to changes in spot prices, the change in the fair value of the contract related to the changes in the difference between the spot price and the forward or futures price would be excluded from the assessment of hedge effectiveness.

In each circumstance above, changes in the excluded component would be included in unrealized gains or losses. As noted in paragraph 1 of this Exhibit, the effectiveness of similar hedges generally should be assessed similarly; that includes whether a component of the gain or loss on a derivative is excluded in assessing effectiveness. No other components of a gain or loss on the designated hedging instrument may be excluded from the assessment of hedge effectiveness.

3. In assessing the effectiveness of a cash flow hedge, an entity generally will need to consider the time value of money if significant in the circumstances. Considering the effect of the time value of money is especially important if the hedging instrument involves periodic cash settlements. An example of a situation in which an entity likely would reflect the time value of money is a tailing strategy with futures contracts. When using a tailing strategy, an entity adjusts the size or contract amount of futures contracts

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used in a hedge so that earnings (or expense) from reinvestment (or funding) of daily settlement gains (or losses) on the futures do not distort the results of the hedge. To assess offset of expected cash flows when a tailing strategy has been used, an entity could reflect the time value of money, perhaps by comparing the present value of the hedged forecasted cash flow with the results of the hedging instrument.

4. ~~Whether a hedging relationship qualifies as highly effective sometimes will be easy to assess.~~ If the critical terms of the hedging instrument and of the ~~entire~~ hedged ~~item~~ asset or liability (as opposed to ~~selected cash flows~~) or hedged forecasted transaction are the same, the entity could conclude that changes in fair value or cash flows attributable to the risk being hedged are expected to completely offset at inception and on an ongoing basis. For example, an entity may assume that a hedge of a forecasted purchase of a commodity with a forward contract will be ~~highly~~ perfectly effective if:

- a. The forward contract is for purchase of the same quantity of the same commodity at the same time and location as the hedged forecasted purchase.
- b. The fair value of the forward contract at inception is zero.
- c. Either the change in the discount or premium on the forward contract is excluded from the assessment of effectiveness and included directly in unrealized gains and losses pursuant to paragraph 22.B. or the change in expected cash flows on the forecasted transaction is based on the forward price for the commodity.

5. In a cash flow hedge of a group of forecasted transactions, an entity may assume that the timing in which the hedged transactions are expected to occur and the maturity date of the hedging instrument match in accordance with paragraph if those forecasted transactions occur and the derivative matures within the same 31-day period or fiscal month. (815-20-25-84A)

~~56.~~ However, assessing hedge effectiveness can be more complex. For example, hedge effectiveness would be reduced by the following circumstances, among others:

- a. A difference between the basis of the hedging instrument and the hedged item or hedged transaction (such as a Deutsche mark-based hedging instrument and Dutch guilder-based hedged item), to the extent that those bases do not move in tandem
- b. Differences in critical terms of the hedging instrument and hedged item or hedged transaction, such as differences in notional amounts, maturities, quantity, location, or delivery dates.

Hedge effectiveness also would be reduced if part of the change in the fair value of a derivative is attributable to a change in the counterparty's creditworthiness.

~~67.~~ A hedge that meets the effectiveness test specified in paragraphs 19.b. and 20.b. (that is, both at inception and on an ongoing basis, the entity expects the hedge to be highly effective at achieving offsetting changes in fair values or cash flows) also must meet the other hedge accounting criteria to qualify for hedge accounting. If the hedge initially qualifies for hedge accounting, the entity would continue to assess whether the hedge meets the effectiveness test. If the hedge fails the effectiveness test at any time (that is, if the entity does not expect the hedge to be highly effective at achieving offsetting changes in fair values or cash flows), the hedge ceases to qualify for hedge accounting. The discussions of measuring hedge effectiveness in the examples in the remainder of this Exhibit assume that the hedge satisfied all of the criteria for hedge accounting at inception.



**Exhibit 2 – Revisions adopted to SSAP No. 86 on August 10, 2021 (Agenda Item 2021-20)****Derivatives Used in Hedging Transactions**

22. Derivative instruments used in hedging transactions that meet the criteria of a highly effective hedge shall be considered an effective hedge and are permitted to be valued and reported in a manner that is consistent with the hedged asset or liability (referred to as hedge accounting). For instance, assume an entity has a financial instrument on which it is currently receiving income at a variable rate but wishes to receive income at a fixed rate and thus enters into a swap agreement to exchange the cash flows. If the transaction qualifies as an effective hedge and a financial instrument on a statutory basis is valued and reported at amortized cost, then the swap would also be valued and reported at amortized cost. Derivative instruments used in hedging transactions that do not meet or no longer meet the criteria of an effective hedge, or that meet the required criteria but the entity has chosen not to apply hedge accounting, shall be accounted for at fair value and the changes in the fair value shall be recorded as unrealized gains or unrealized losses (referred to as fair value accounting)<sup>1</sup>.

23. Entities shall not bifurcate the effectiveness of derivatives. A derivative instrument is either classified as an effective hedge or an ineffective hedge. Entities must account for the derivative using fair value accounting if it is deemed to be ineffective or becomes ineffective. [Derivative instruments classified as effective with excluded components in determining hedge effectiveness pursuant to Exhibit A, paragraph 8, shall account for the derivative and excluded components pursuant to the guidance in paragraph 40.](#) Entities may redesignate a derivative in a hedging relationship even though the derivative was used in a previous hedging relationship that proved to be ineffective. A change in the counterparty to a derivative instrument that has been designated as the hedging instrument in an existing hedging relationship would not, in and of itself, be considered a termination of the derivative instrument. An entity shall prospectively discontinue hedge accounting for an existing hedge if any one of the following occurs:

- a. Any criterion in paragraphs 26-38 is no longer met;
- b. The derivative expires or is sold, terminated, or exercised (the effect is recorded as realized gains or losses or, for effective hedges of firm commitments or forecasted transactions, in a manner that is consistent with the hedged transaction – see paragraph 24);
- c. The entity removes the designation of the hedge; or
- d. The derivative is deemed to be impaired in accordance with paragraph 18. A permanent decline in a counterparty's credit quality/rating is one example of impairment required by paragraph 18, for derivatives used in hedging transactions.

**Hedge Effectiveness**

39. The measurement of hedge effectiveness for a particular hedging relationship shall be consistent with the entity's risk management strategy and the method of assessing hedge effectiveness that was documented at the inception of the hedging relationship, as discussed in paragraph 41.

40. The gain or loss on a derivative designated as a hedge and assessed to be effective is reported consistently with the hedged item. [\(Therefore, if the hedged item is reported at amortized cost, and the hedging instrument is consistent with that measurement method, fluctuations in fair value would not be](#)

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<sup>1</sup> Pursuant to paragraph 19, the gross reported value of a derivative and the determination of unrealized gains or losses shall exclude the impact of financing premiums. Premiums payable or receivable from the acquisition or writing of a derivative shall not be reflected in the gross reporting of derivatives or in determining the fair value change in a derivative.

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recognized as unrealized gains or losses for either the hedging item or hedging instrument.) If an entity's defined risk management strategy for a particular hedging relationship excludes a specific component of the gain or loss, or related cash flows, on the hedging derivative from the assessment of hedge effectiveness (as discussed in Exhibit BA, paragraph 8), specific accounting treatment shall be followed for the that excluded component: ~~of the gain or loss shall be recognized as an unrealized gain or loss. For example, if the effectiveness of a hedge with an option contract is assessed based on changes in the option's intrinsic value, the changes in the option's time value would be recognized in unrealized gains or losses. Time value is equal to the fair value of the option less its intrinsic value.~~

- a. If the excluded component pertains to the difference between a foreign currency spot price and the forward or future price (e.g., a forward spot rate), then this premium/discount shall be amortized into income over the life of the contract or hedged program. (This guidance addresses the excluded component in Exhibit A, paragraph 8.d.)
- b. If the excluded component pertains to a foreign currency swap cross-currency basis spread, the impact of fair value changes shall be reflected as a component of the foreign currency swap's periodic interest accrual. (This guidance addresses the excluded component in Exhibit A, paragraph 8.e.)
- c. For all other excluded components, the excluded component shall be measured and reported at fair value, with changes in fair value recognized as unrealized gains or losses. (This guidance shall be applied to excluded components detailed in Exhibit A, paragraphs 8.a.-8.c.)

41. Hedging instruments with excluded components shall be identified in the financial statement investment schedule (Schedule DB) and shall be disclosed pursuant to paragraph 41.g.

*Proposed New Disclosure Paragraph (This is proposed as a new paragraph 41.g. with reordering of subsequent paragraphs.)*

- g. For hedging instruments with excluded components for determining hedge effectiveness:
  - i. In the investment schedule, identify hedging instruments with excluded components, and report the current fair value of the excluded component, the fair value of the excluded component that is reflected in the reported BACV for the hedging instrument (this item would not be applicable for foreign-currency forwards and currency swaps where the forward points or cross-currency basis, respectively, are the excluded component), and the change in fair value reported as an unrealized gains/loss. (Note – These items will be proposed in electronic columns to Schedule DB.)
  - ii. In the notes to the financial statements, provide information on the aggregate excluded components by category: Time Value, Intrinsic Value, Forward Points and Cross Currency Basis Spread. The aggregate amounts reported should include the following (as applicable): current fair value, recognized unrealized gain/loss, the fair value reflected in BACV, and for the excluded forward points (e.g., forward spot rates), the aggregate amount owed at maturity, along with current year and remaining amortization. (Note – These items will be captured in a blanks proposal/template.)



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**Relevant Literature**

64. This statement adopts the framework established by FAS 133, *FASB Statement No. 137, Accounting for Derivative Instruments and Hedging Activities—Deferral of the Effective Date of FASB Statement No. 133, An amendment of FASB Statement No. 133* (FAS 137) and *FASB Statement No. 138, Accounting for Certain Derivative Instruments and Certain Hedging Activities, An amendment of FASB Statement No. 133* (FAS 138), for fair value and cash flow hedges, including its technical guidance to the extent such guidance is consistent with the statutory accounting approach to derivatives utilized in this statement. This statement adopts the provisions of FAS 133 and 138 related to foreign currency hedges. With the exception of guidance specific to foreign currency hedges and amendments specific to refining the hedging of interest rate risk (under FAS 138, the risk of changes in the benchmark interest rate would be a hedged risk), this statement rejects FAS No. 137 and 138 as well as the various related Emerging Issues Task Force interpretations. This statement adopts paragraphs 4 and 25 of *FASB Statement No. 149: Amendment of Statement 133 on Derivative Instruments and Hedging Activities* (FAS 149) regarding the definition of an underlying and guidance for assessing hedge effectiveness. [\(The adoption from FAS 149 on the assessment of hedge effectiveness is impacted by the adoption with modification of guidance from ASU 2017-12 as detailed in paragraph 65.b., with the guidance from ASU 2017-12 superseding the prior adoption to the extent applicable.\)](#) All other paragraphs in FAS 149 are rejected as not applicable for statutory accounting. This statement adopts FSP FAS 133-1 and FIN 45-5: *Disclosures about Credit Derivatives and Certain Guarantees, An Amendment of FASB Statement No. 133 and FASB Interpretation No. 45 and Clarification of the Effective Date of FASB Statement No. 161* (FSP FAS 133-1 and FIN 45-4) and requires disclosures by sellers of credit derivatives. This statement rejects *FSP FIN 39-1, Amendments of FASB Interpretation No. 39*, and *ASU 2014-03, Derivatives and Hedging – Accounting for Certain Receive-Variable, Pay-Fixed Interest Rate Swaps – Simplified Hedge Accounting Approach*.

65. This statement adopts [with modification](#), certain revisions to ASC 815-20 included in ASU 2017-12. [Remaining provisions of ASU 2017-12 will be subsequently assessed for statutory accounting and shall not be considered adopted for statutory accounting until that assessment is complete.](#)

- a. [Revisions effective January 1, 2019, with early adoption permitted, ~~This adoption is~~are](#) limited to specific provisions, and related transition guidance, pertaining to the documentation and assessment of hedge effectiveness and only includes: 1) provisions allowing more time to perform the initial quantitative hedge effectiveness assessment; 2) provisions allowing subsequent assessments of hedge effectiveness to be performed qualitatively if certain conditions are met; and 3) revisions regarding use of the critical terms and short-cut methods for assessing hedge effectiveness.
- b. [Revisions effective January 1, 2023, with early adoption permitted, are limited to the criteria for initial and subsequent hedge effectiveness detailed in the FASB Accounting Standards Codification \(ASC\) paragraphs 815-20-25-72 through 815-20-35-20, as modified through the issuance of ASU 2017-12. This adoption reflects statutory modifications to specify that the accounting and reporting of hedging instruments, including excluded components of the instruments, shall follow statutory specific guidance detailed in the statement. The intent of this guidance is to clarify that the determination of whether a hedging instrument qualifies as an effective hedge shall converge with U.S. GAAP, but that the measurement method shall continue to follow statutory specific provisions. The adoption of the referenced ASC paragraphs only extends to revisions incorporated through ASU 2017-12; therefore, any subsequent U.S. GAAP edits would require statutory accounting consideration before considered adopted.](#)

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~~The remaining provisions of ASU 2017-12 will be subsequently assessed for statutory accounting and shall not be considered adopted for statutory accounting until that assessment is complete.~~

### Effective Date and Transition

~~74.73~~ This statement is effective for derivative transaction entered into or modified on or after January 1, 2003. A modification is any revision or change in contractual terms of the derivative. SSAP No. 31 applies to derivative transaction prior to January 1, 2003. Alternatively, an insurer may choose to apply this statement to all derivatives to which the insurer is a party as of January 1, 2003. In either case, the insurer is to disclose the transition approach that is being used.

- a. Revisions adopted to paragraph 64 to reject FSP FIN 39-1 is effective January 1, 2013, for companies that have previously reported a position in the balance sheet that was net of counterparty agreements. (Companies that have previously reported derivative instruments and/or related collateral gross shall not be impacted by these revisions.)
- b. Revisions adopted in paragraph 16 clarify the reporting for amounts received/paid to adjust variation margin until the derivative contract has ended and are effective January 1, 2018, on a prospective basis, for reporting entities that have previously considered these amounts to reflect settlement or realized gains/losses. (Companies that have previously reported variation margin changes in line with the revisions shall not be impacted by these revisions.)
- c. Revisions to incorporate limited provisions from ASU 2017-12 pertaining to the documentation of hedge effectiveness (detailed in paragraph 65) are effective January 1, 2019, with early adoption permitted for year-end 2018. However, if the reporting entity is a U.S. GAAP filer, the reporting entity may only elect early adoption if the entity has also elected early adoption of ASU 2017-12 for year-end 2018.
- d. Revisions adopted April 2019 to explicitly include structured notes in scope of this statement are effective December 31, 2019. Revisions adopted July 2020 to define “derivative premium,” require gross reporting of derivatives without the impact of financing premiums and require separate recognition of premiums payable and premiums receivable, are effective January 1, 2021.
- e. Revisions adopted August 2022 that adopt with modification the criteria for initial and subsequent hedge effectiveness detailed in the FASB ASC paragraphs 815-20-25-72 through 815-20-35-20, as modified through the issuance of ASU 2017-12 and that incorporate statutory accounting revisions for the accounting and reporting of excluded components are effective January 1, 2023, with early adoption permitted. These revisions shall be applied prospectively for all new and existing hedges. Entities shall detail the adoption of this guidance as a change in accounting principle pursuant to SSAP No. 3—Accounting Changes and Corrections of Errors

*With the adoption of the new Exhibit A as detailed in the subsequent section, Exhibit C will be renamed Exhibit B. Due to the details of Exhibit A (including the FASB ASC paragraphs not duplicated in the SSAP), the following Exhibit B section is included before the new Exhibit A in this issue paper for ease of readability.*

**EXHIBIT ~~C~~B – SPECIFIC HEDGE ACCOUNTING PROCEDURES FOR DERIVATIVES**

Specific hedge accounting procedures for derivative instruments are outlined below.

1. Call and Put Options, Warrants, Caps, and Floors:
  - a. Accounting at Date of Acquisition (purchase) or Issuance (written): The premium paid or received for purchasing or writing a call option, put option, warrant, cap or floor shall either be (i) recorded as an asset (purchase) or liability (written) on the Derivative line on the Assets (or) Liabilities pages or (ii) combined with the hedged item(s) individually or in the aggregate;
  - b. Statement Value:
    - i. Open derivatives hedging items recorded at amortized cost:
      - (a) Options, warrants, caps, and floors purchased or written shall be valued at amortized cost in a manner consistent with the hedged item. (Components of a hedging instrument excluded from the determination of hedge effectiveness shall be recognized at fair value, with changes in fair value recognized as unrealized gains/losses throughout the duration of the hedging instrument. These components are not captured within the guidance for effective hedges detailed within this section.);
      - (b) The amortization period and methods used shall result in a constant effective yield over the life of the hedged item or program. (For floating rate hedged items, the estimated effective yield shall be based on the current rate so the changes in yields attributable to changes in interest rates will be recognized in the period of change). Specific treatment includes:
        - (1) Holdings in derivatives purchased or written within a year of maturity or expiry need not be amortized;
        - (2) For hedges of forecasted transactions or firm commitments, the derivative may be recorded at cost until the hedged transaction occurs or it is determined that the hedge was not effective (see (d) in this section 1.b.i.);
        - (3) For other derivatives, the amortization period is usually from date of acquisition (issuance) of the derivative to maturity of the hedged item or program.
      - (c) For hedges where the cost of the derivative is combined with the hedged item, the statement value is zero. The fair value of the derivative and hedged item shall be determined and reported separately, either individually or in the aggregate;
      - (d) For hedges of forecasted transactions or firm commitments, the derivative shall be recorded at cost until (1) the hedged transaction occurs or (2) it is determined that the hedge was not effective (when the derivative is valued in accordance with (e) in this section);

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- (e) If during the life of the derivative it or a designated portion of the derivative is no longer effective as a hedge, valuation at amortized cost ceases and the derivative or the designated portion of the derivative shall be valued at its current fair value with gains and losses recognized in unrealized gains or unrealized losses to the extent it ceased to be an effective hedge.
- d. Gain/Loss on Termination of an option, warrant, cap or floor accounted for under hedge accounting (includes closing, exercise, maturity, and expiry):
- i. Exercise of an Option: The remaining book value of the derivative shall become an adjustment to the cost or proceeds of the hedged item(s) received or disposed of individually or in aggregate;
  - ii. Sale, maturity, expiry, or other closing transaction of a derivative which is an effective hedge—Any gain or loss on the transaction, except for excluded components, will adjust the basis (or proceeds) of the hedged item(s) individually or in aggregate. Alternatively, if the item being hedged is subject to IMR, the gain or loss on the terminated hedging derivative may be realized and shall be subject to IMR upon termination. For hedging instruments with excluded components in determining hedge effectiveness, the unrealized gain/loss from the change in fair value of the excluded component shall be realized upon the closing transaction. This gain/loss shall not be used to adjust the basis or proceeds of the hedged item.
  - iii. Gain/loss on termination of derivatives will be recognized currently in net income (realized gain/loss) to the extent they ceased to be effective hedges.
  - iv. Upon the redesignation of a derivative from a currently effective hedging relationship:
    - (a) with an item(s) carried at amortized cost to another effective hedging relationship with an item(s) carried at amortized cost, the derivative shall continue to be recorded at amortized cost and no gain or loss on the derivative shall be recognized.
    - (b) with an item(s) carried at amortized cost or fair value to an effective relationship with an item(s) carried at fair value, the accounting for the derivative shall be consistent with (ii) above.
    - (c) with an item(s) carried at fair value to an effective relationship with an item(s) carried at amortized cost, the accounting for the derivative shall be consistent with (ii) above.
2. Swaps, Collars, and Forwards (see also discussion in Introduction above):
- a. Accounting at Date of Opening Position:
    - i. Any premium paid or received at date of opening shall either be (a) recorded on the Derivative line on the Assets (or) Liabilities pages or (b) combined with the hedged item(s), individually or in the aggregate;

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## b. Statement Value:

## i. Open derivatives hedging items recorded at amortized cost:

- (a) Swaps, collars, and forwards shall be valued at amortized cost in a manner consistent with hedged item. (Components of a hedging instrument excluded from the determination of hedge effectiveness not addressed in 2.b.iii. shall be recognized at fair value, with changes in fair value of the excluded component recognized as unrealized gains/losses throughout the duration of the hedging instrument. These components are not captured within the guidance for effective hedges detailed within this section.);
- (b) The amortization period and methods used shall result in a constant effective yield over the life of the hedged item or program. (For floating rate hedged items the estimated effective yield shall be based on the current rate so the changes in yields attributable to changes in interest rates will be recognized in the period of change.) Specific treatment includes:
  - (1) Holdings in derivatives purchased or written within a year of maturity or expiry need not be amortized;
  - (2) For hedges of forecasted transactions or firm commitments, the derivative shall be recorded at cost until (a) the hedged transaction occurs or (b) it is determined that the hedge was not effective (see (5) in this section 2.b.i.);
  - (3) For other derivatives the amortization period is usually from date of acquisition (issuance) of the derivative to maturity of the hedged item or program;
  - (4) For hedges where the cost of the derivative is combined with the hedged item, the statement value is zero. The fair value of the derivative and hedged item shall be determined and reported separately, either individually or in the aggregate;
  - (5) If during the life of the derivative it or a designated portion of the derivative is no longer effective as a hedge, valuation at amortized cost ceases and the derivative or a designated portion of the derivative shall be valued at its current fair value with gains and losses recorded in unrealized gains or unrealized losses to the extent that it ceased to be an effective hedge. Upon redesignation into an effective hedging relationship, the derivative's mark to fair value through unrealized gain or loss shall be reversed.

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- ii. Open derivatives hedging items recorded at fair value (where gains and losses on the hedged item are recognized as adjustments to unassigned funds (surplus):
  - (a) Swaps, collars, or forwards shall be valued at current fair value with changes in fair value recognized currently consistent with the hedged item; this will result in unrealized gain/loss treatment with adjustment to unassigned funds (surplus);
  - (b) For hedges where the derivative is combined with the hedged item, the fair value of the derivative and hedge item shall be determined and reported separately, either individually or in the aggregate. The cost (book value) basis used to figure gain/loss on the derivative is zero.
- iii. Open foreign currency swap and forward contracts hedging foreign currency exposure on items denominated in a foreign currency and translated into U.S. dollars where fair value accounting is not being used:
  - (a) ~~The foreign exchange premium (discount) on the currency contract shall be amortized into income over the life of the contract or hedge program.~~ The foreign exchange premium (discount) is defined as the foreign currency (notional) amount to be received (paid) times the net of the forward rate minus the spot rate at the time the contract was opened. For forward contracts, an excluded component representing a foreign exchange premium (discount) (forward points) on the currency contract shall be amortized into income over the life of the contract or hedge program. Amortization is not required if the contract was entered into within a year of maturity. For foreign currency swaps, an excluded component representing a cross-currency basis spread, is recognized into income through the foreign currency swap's periodic interest accruals.  
  
~~Amortization is not required if the contract was entered into within a year of maturity;~~
    - (b) A foreign currency translation adjustment shall be reflected as an unrealized gain/loss (unassigned funds (surplus) adjustment) using the same procedures as done to translate the hedged item;
    - (c) The unrealized gain/loss for the period equals the foreign currency (notional) amount to be received (paid) times the net of the current spot rate minus the prior period end spot rate;
    - (d) The statement value of the derivative equals the amortized cost plus:
      - 1. For forward contracts, the amortized (premium) discount plus the cumulative unrealized gain/(loss) on the contract.
      - 2. For foreign currency swaps, ~~T~~the cumulative unrealized gain/(loss) on the contract. The cross-currency basis spread is recorded through the Investment Income Due and Accrued or Other Liabilities, as a component of the foreign currency swap's periodic interest accrual.

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The cumulative unrealized gain/loss equals the foreign currency (notional) amount to be received (paid) times the net of the current spot rate minus the spot rate at the time the contract was opened;

- (e) Recognition of unrealized gains/losses and amortization of foreign exchange premium/discount on derivatives hedging forecasted transactions or firm commitments shall be deferred until the hedged transaction occurs. These deferred gains/losses will adjust the basis or proceeds of the hedged transaction when it occurs;
- (f) For hedges where the cost of the foreign currency contract is combined with the hedged item, the statement value on Schedule DB is zero. The fair value of the derivative and hedged item shall be determined and reported separately, either individually or in the aggregate;

- (g) ~~If during the life of the currency contract it or a designated portion of the currency contract is not effective as a hedge, The derivative shall be recorded at fair value and valuation at amortized cost shall cease. To the extent it ceased to be an effective hedge,~~ a cumulative unrealized gain/loss (surplus adjustment) ~~will~~ shall be recognized equal to the difference between the carrying value of the derivative on the balance sheet and the fair value of the derivative if either of the following occur:

1. During the life of the currency contract it or a designated portion of the currency contract is not effective as a hedge.
2. The entity decides to terminate the derivative in advance of scheduled maturity.

~~notional amount or designated notional amount times the difference between the forward rate available for the remaining maturity of the contract (i.e., the forward rate as of the balance sheet date) and the forward rate at the time it ceased to be an effective hedge.~~

- iv. Open derivatives hedging items recorded at fair value, where gains and losses on the hedged item are recognized currently in earnings: swaps, collars and forwards shall be valued at current fair value with changes in fair value recognized currently in earnings together with the gains and losses on the hedged item.
  - (a) If during the life of the derivative it or a designated portion of the derivative is no longer effective as a hedge, recognition of changes in fair value through earnings ceases. The derivative shall continue to be valued at its current fair value, but thereafter gains or losses shall be recognized in unrealized gains or unrealized losses to the extent it ceased to be an effective hedge.

c. Cash Flows and Income:

- i. Where the cost of the derivative is not combined with the hedged item:



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- (a) Amortization of premium paid or received on derivatives is an adjustment to net investment income or another appropriate caption within operating income consistent with the reporting of the hedged item;
  - (b) Periodic cash flows and accruals of income/expense are to be reported in a manner consistent with the hedged item, usually as net investment income or another appropriate caption within operating income.
- ii. Where the cost of the derivative is combined with the hedged item, the cash flows and income of the derivative on Schedule DB is zero. All related amortization and cash flow accounting shall be reported with the hedged item instead of with the derivative.
- d. Gain/Loss on Termination of a swap, collar or forward accounted for under hedge accounting (includes closing, exercise, maturity, and expiry):
    - i. Exercise—The remaining book value of the derivative shall become an adjustment to the cost or proceeds of the hedged item(s) received or disposed of individually or in aggregate;
    - ii. Sale, maturity, expiry, or other closing transaction of a derivative which is an effective hedge—Any gain or loss on the transaction, except for excluded components, will adjust the basis (or proceeds) of the hedged item(s) individually or in aggregate. Alternatively, if the item being hedged is subject to IMR, the gain or loss on the terminated hedging derivative may be realized and shall be subject to IMR upon termination.<sup>5</sup>
    - iii. Gain/loss on termination of derivatives will be recognized currently in net income (realized gain/loss) to the extent they ceased to be effective hedges.
    - iv. Upon the redesignation of a derivative from a currently effective hedging relationship-
      - (a) with an item(s) carried at amortized cost to another effective hedging relationship with an item(s) carried at amortized cost, the derivative shall continue to be recorded at amortized cost and no gain or loss on the derivative shall be recognized.
      - (b) with an item(s) carried at amortized cost or fair value to an effective relationship with an item(s) carried at fair value, the accounting for the derivative shall be consistent with (ii) above.
      - (c) with an item(s) carried at fair value to an effective relationship with an item(s) carried at amortized cost, the accounting for the derivative shall be consistent with (ii) above.

*The following new Exhibit A replaces both Exhibit A and Exhibit B within the existing SSAP No. 86. This is new guidance within SSAP No. 86, and the tracked changes shown in the section below reflect the modifications from U.S. GAAP. References to the FASB ASC are included in this issue paper for historical reference and will not be duplicated within the SSAP.*



**EXHIBIT A – DISCUSSION OF HEDGE EFFECTIVENESS**

The guidance within this exhibit reflects the adoption, with modification, of *FASB Accounting Standards Codification (ASC) 815-20-25-72 through 815-20-35-20*, as revised through the issuance of *ASU 2017-12: Derivatives and Hedging: Targeted Improvements to Accounting for Hedging Activities* (ASU 2017-12) (issued on August 28, 2017). This adoption captures the U.S. GAAP guidance for the assessment and determination of hedge effectiveness, with modification to require the accounting and reporting of hedging instruments, including excluded components of hedging instruments to follow specific statutory accounting guidance in SSAP No. 86. The intent of this guidance is to clarify that the determination of whether a hedging instrument and derivative transaction qualifies as an effective hedge shall converge with U.S. GAAP, but that the measurement and reporting of effective hedge transactions shall follow statutory specific provisions. The adoption only extends to revisions incorporated to the FASB ASC through ASU 2017-12, therefore any subsequent U.S. GAAP edits to the ASC would require statutory accounting adoption before application. The guidance within this Exhibit reflects excerpts from the U.S. GAAP ASC, but do not reflect the full U.S. GAAP guidance referenced in the adopted language. The exclusion of cited guidance is to manage the extent of detail included within SSAP No. 86. Excerpts not duplicated within from the cited U.S. GAAP guidance are considered adopted unless subject to the specific accounting and reporting statutory exclusion. This Exhibit intends to supplement the guidance in SSAP No. 86 on hedge effectiveness. In any event in which this Exhibit could be interpreted as conflicting with the SSAP No. 86 guidance, the guidance in the body of SSAP No. 86 shall be followed.

*Hedge Effectiveness Criteria Applicable to Both Fair Value Hedges and Cash Flow Hedges*

1. This guidance addresses hedge effectiveness criteria applicable to both fair value hedges and cash flow hedges. (815-20-25-74)
2. To qualify for hedge accounting, the hedging relationship, both at inception of the hedge and on an ongoing basis, shall be expected to be highly effective in achieving either of the following: (815-20-25-75)
  - a. Offsetting changes in fair value attributable to the hedged risk during the period that the hedge is designated (if a fair value hedge)
  - b. Offsetting cash flows attributable to the hedged risk during the term of the hedge (if a cash flow hedge), unless the hedging instrument is used to modify the contractually specified interest receipts or payments associated with a recognized financial asset liability from one variable rate to another variable rate. ~~except as indicated in paragraph 815-20-25-50~~
3. If the hedging instrument (such as an at-the-money option contract) provides only one-sided offset of the hedged risk, either of the following conditions shall be met: (815-20-25-76)
  - a. The increases (or decreases) in the fair value of the hedging instrument are expected to be highly effective in offsetting the decreases (or increases) in the fair value of the hedged item (if a fair value hedge).
  - b. The cash inflows (outflows) from the hedging instrument are expected to be highly effective in offsetting the corresponding change in the cash outflows or inflows of the hedged transaction (if a cash flow hedge).

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4. There would be a mismatch between the change in fair value or cash flows of the hedging instrument and the change in fair value or cash flows of the hedged item or hedged transaction in any of the following circumstances, among others: (815-20-25-77)

- a. A difference between the basis of the hedging instrument and the hedged item or hedged transaction, to the extent that those bases do not move in tandem
- b. Differences in critical terms of the hedging instrument and hedged item or hedged transaction, such as differences in any of the following:
  - i. Notional amounts
  - ii. Maturities
  - iii. Quantity
  - iv. Location (not applicable for hedging relationships in which the variability in cash flows attributable to changes in a contractually specified component is designated as the hedged risk)
  - v. Delivery Dates

5. An entity shall consider hedge effectiveness in two different ways—in prospective considerations and in retrospective evaluations: (815-20-25-79)

- a. Prospective considerations. The entity's expectation that the relationship will be highly effective over future periods in achieving offsetting changes in fair value or cash flows, which is forward looking, must be assessed on a quantitative basis at hedge inception unless one of the exceptions [detailed in ASU 2017-12](#), paragraph 815-20-25-3(b)(2)(iv)(01)<sup>2</sup> is met. Prospective assessments shall be subsequently performed whenever financial statements or earnings are reported and at least every three months. The entity shall elect at hedge inception ~~in accordance with paragraph 815-20-25-3(b)(2)(iv)(03)~~ whether to perform subsequent [retrospective and prospective hedge effectiveness](#) assessments on a quantitative or qualitative basis. ~~See paragraphs 815-20-35-2A through 35-2F for additional guidance on qualitative assessments of hedge effectiveness.~~ A quantitative assessment can be based on regression or other statistical analysis of past changes in fair values or cash flows as well as on other relevant information. The quantitative prospective assessment of hedge effectiveness shall consider all reasonably possible changes in fair value (if a fair value hedge) or in fair value or cash flows (if a cash flow hedge) of the derivative instrument and the hedged items for the period used to assess whether the requirement for expectation of highly effective offset is satisfied. The quantitative prospective assessment may not be limited only to the likely or expected changes in fair value (if a fair value hedge) or in fair value or cash flows (if a cash flow hedge) of the derivative instrument or the hedged items. Generally, the process of formulating an expectation regarding the effectiveness of a proposed hedging relationship involves a probability-weighted analysis of the possible changes in fair value (if a fair value hedge) or in fair value or cash flows (if a cash flow hedge) of the derivative instrument and the hedged items for the hedge period. Therefore, a probable future change in fair value will

<sup>2</sup> Reference to this ASU 2017-12 guidance is consistent with the guidance in SSAP No. 86, paragraph 42, footnote 5.

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be more heavily weighted than a reasonably possible future change. ~~That calculation technique is consistent with the definition of the term expected cash flow in FASB Concepts Statement No. 7, Using Cash Flow Information and Present Value in Accounting Measurements.~~

- b. Retrospective evaluations. An assessment of effectiveness may be performed on a quantitative or qualitative basis on the basis of the entity's election at hedge inception ~~in accordance with paragraph 815-20-25-3(b)(2)(iv)(03).~~ That assessment shall be performed whenever financial statements or earnings are reported, and at least every three months. ~~See paragraphs 815-20-35-2 through 35-4 for further guidance.~~ At inception of the hedge, an entity electing a dollar-offset approach to perform retrospective evaluations on a quantitative basis may choose either a period-by-period approach or a cumulative approach in designating how effectiveness of a fair value hedge or of a cash flow hedge will be assessed retrospectively under that approach, depending on the nature of the hedge initially documented in accordance with paragraph 815-20-25-3. ~~For example, an entity may decide that the cumulative approach is generally preferred, yet may wish to use the period-by-period approach in certain circumstances. See paragraphs 815-20-35-5 through 35-6 for further guidance.~~

*(ASC paragraph 815-20-25-79A not included in Exhibit A.)*

6. All assessments of effectiveness shall be consistent with the originally documented risk management strategy for that particular hedging relationship. An entity shall use the quantitative effectiveness assessment method defined at hedge inception consistently for the periods that the entity either elects or is required to assess hedge effectiveness on a quantitative basis. *(815-20-25-80)*

7. This Subtopic guidance does not specify a single method for assessing whether a hedge is expected to be highly effective. The method of assessing effectiveness shall be reasonable. The appropriateness of a given method of assessing hedge effectiveness depends on the nature of the risk being hedged and the type of hedging instrument used. Ordinarily, an entity shall assess effectiveness for similar hedges in a similar manner, including whether a component of the gain or loss on a derivative instrument is excluded in assessing effectiveness for similar hedges. Use of different methods for similar hedges shall be justified. The mechanics of isolating the change in time value of an option discussed beginning in paragraph 13 815-20-25-98 also shall be applied consistently. *(815-20-25-81)*

8. In defining how hedge effectiveness will be assessed, an entity shall specify whether it will include in that assessment all of the gain or loss on a hedging instrument. An entity may exclude all or a part of the hedging instrument's time value from the assessment of hedge effectiveness, as follows: *(815-20-25-82)*

- a. If the effectiveness of a hedge with an option is assessed based on changes in the option's intrinsic value, the change in the time value of the option would be excluded from the assessment of hedge effectiveness.
- b. If the effectiveness of a hedge with an option is assessed based on changes in the option's minimum value, that is, its intrinsic value plus the effect of discounting, the change in the volatility value of the contract shall be excluded from the assessment of hedge effectiveness.

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- c. An entity may exclude any of the following components of the change in an option's time value from the assessment of hedge effectiveness:
  - i. The portion of the change in time value attributable to the passage of time (theta)
  - ii. The portion of the change in time value attributable to changes due to volatility (vega)
  - iii. The portion of the change in time value attributable to changes due to interest rates (rho).
- d. If the effectiveness of a hedge with a forward contract or futures contract is assessed based on changes in fair value attributable to changes in spot prices, the change in the fair value of the contract related to the changes in the difference between the spot price and the forward or futures price shall be excluded from the assessment of hedge effectiveness.
- e. An entity may exclude the portion of the change in fair value of a currency swap attributable to a cross-currency basis spread.

9. No other components of a gain or loss on the designated hedging instrument shall be excluded from the assessment of hedge effectiveness nor shall an entity exclude any aspect of a change in an option's value from the assessment of hedge effectiveness that is not one of the permissible components of the change in an option's time value. For example, an entity shall not exclude from the assessment of hedge effectiveness the portion of the change in time value attributable to changes in other market variables (that is, other than rho and vega). (815-20-25-83)

*Note – The following ASC Paragraphs 815-20-25-83A and 83B are not adopted within SSAP No. 86 as they address measurement and recognition. Measurement and recognition guidance shall follow the provisions detailed in SSAP No. 86.*

For fair value and cash flow hedges, the initial value of the component excluded from the assessment of effectiveness shall be recognized in earnings using a systematic and rational method over the life of the hedging instrument. Any difference between the change in fair value of the excluded component and amounts recognized in earnings under that systematic and rational method shall be recognized in other comprehensive income. Example 31 beginning in paragraph 815-20-55-235 illustrates this approach for a cash flow hedge in which the hedging instrument is an option and the entire time value is excluded from the assessment of effectiveness. (815-20-25-83A)

For fair value and cash flow hedges, an entity alternatively may elect to record changes in the fair value of the excluded component currently in earnings. This election shall be applied consistently to similar hedges in accordance with paragraph 815-20-25-81 and shall be disclosed in accordance with paragraph 815-10-50-4EEEE. (815-20-25-83B)

10. If the critical terms of the hedging instrument and of the hedged item or hedged forecasted transaction are the same, the entity could conclude that changes in fair value or cash flows attributable to the risk being hedged are expected to completely offset at inception and on an ongoing basis. For example, an entity may assume that a hedge of a forecasted purchase of a commodity with a forward contract will be perfectly effective if all of the following criteria are met:

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- a. The forward contract is for purchase of the same quantity of the same commodity at the same time and location as the hedged forecasted purchase. Location differences do not need to be considered if an entity designates the variability in cash flows attributable to changes in a contractually specified component as the hedged risk and the requirements in paragraphs 815-20-25-22A through 25-22B of the FASB Codification are met. (815-20-25-84)
- b. The fair value of the forward contract at inception is zero.
- c. Either of the following criteria is met:
  - i. The change in the discount or premium on the forward contract is excluded from the assessment of effectiveness pursuant to paragraphs 7-9~~815-20-25-81 through 25-83~~.
  - ii. The change in expected cash flows on the forecasted transaction is based on the forward price for the commodity.

11. In a cash flow hedge of a group of forecasted transactions in accordance with paragraph 28.a. of the SSAP guidance~~815-20-25-15(a)(2)~~, an entity may assume that the timing in which the hedged transactions are expected to occur and the maturity date of the hedging instrument match in accordance with paragraph 10.a. ~~815-20-25-84(a)~~ if those forecasted transactions occur and the derivative matures within the same 31-day period or fiscal month. (815-20-25-84A)

12. If all of the criteria in paragraphs 10-11 ~~815-20-25-84 through 25-84A~~ are met, an entity shall still perform and document an assessment of hedge effectiveness at the inception of the hedging relationship and, ~~as discussed beginning in paragraph 815-20-35-9~~, on an ongoing basis throughout the hedge period. No quantitative effectiveness assessment is required at hedge inception if the criteria in paragraphs 10-11 ~~815-20-25-84 through 25-84A~~ are met ~~(see paragraph 815-20-25-3(b)(2)(iv)(01))~~. (815-20-25-85)

*(ASC paragraphs 815-20-25-86 to 815-20-25-97 not included in Exhibit A.)*

#### *Computing Changes in an Option's Time Value*

13. In computing the changes in an option's time value that would be excluded from the assessment of hedge effectiveness, an entity shall use a technique that appropriately isolates those aspects of the change in time value. Generally, to allocate the total change in an option's time value to its different aspects—the passage of time and the market variables—the change in time value attributable to the first aspect to be isolated is determined by holding all other aspects constant as of the beginning of the period. Each remaining aspect of the change in time value is then determined in turn in a specified order based on the ending values of the previously isolated aspects. (815-20-25-98)

14. Based on that general methodology, if only one aspect of the change in time value is excluded from the assessment of hedge effectiveness (for example, theta), that aspect shall be the first aspect for which the change in time value is computed and would be determined by holding all other parameters constant for the period used for assessing hedge effectiveness. However, if more than one aspect of the change in time value is excluded from the assessment of hedge effectiveness (for example, theta and vega), an entity shall determine the amount of that change in time value by isolating each of those two aspects in turn in a prespecified order (one first, the other second). The second aspect to be isolated would be based

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on the ending value of the first isolated aspect and the beginning values of the remaining aspects. The portion of the change in time value that is included in the assessment of effectiveness shall be determined by deducting from the total change in time value the portion of the change in time value attributable to excluded components. (815-20-25-99)

*(ASC paragraphs 815-20-25-100 and 815-20-25-101 not included in Exhibit A.)*

*Assuming Perfect Hedge Effectiveness in a Hedge with an Interest Rate Swap*

15. The conditions for the shortcut method do not determine which hedging relationships qualify for hedge accounting; rather, those conditions determine which hedging relationships qualify for a shortcut version of hedge accounting that assumes perfect hedge effectiveness. If all of the applicable conditions in the list in paragraph ~~17 815-20-25-104~~ are met, an entity may assume perfect effectiveness in a hedging relationship of interest rate risk involving a recognized interest-bearing asset or liability (or a firm commitment arising on the trade [pricing] date to purchase or issue an interest-bearing asset or liability) and an interest rate swap (or a compound hedging instrument composed of an interest rate swap and a mirror-image call or put option as discussed in paragraph ~~17.e. 815-20-25-104[e]~~) provided that, in the case of a firm commitment, the trade date of the asset or liability differs from its settlement date due to generally established conventions in the marketplace in which the transaction is executed. The shortcut method's application shall be limited to hedging relationships that meet each and every applicable condition. That is, all the conditions applicable to fair value hedges shall be met to apply the shortcut method to a fair value hedge, and all the conditions applicable to cash flow hedges shall be met to apply the shortcut method to a cash flow hedge. A hedging relationship cannot qualify for application of the shortcut method based on an assumption of perfect effectiveness justified by applying other criteria. The verb *match* is used in the specified conditions in the list to mean *exactly the same* or *correspond exactly*. (815-20-25-102)

16. Implicit in the conditions for the shortcut method is the requirement that a basis exist for concluding on an ongoing basis that the hedging relationship is expected to be highly effective in achieving offsetting changes in fair values or cash flows. In applying the shortcut method, an entity shall consider the likelihood of the counterparty's compliance with the contractual terms of the hedging derivative that require the counterparty to make payments to the entity. (815-20-25-103)

17. All of the following conditions apply to both fair value hedges and cash flow hedges: (815-20-25-104)

- a. The notional amount of the interest rate swap matches the principal amount of the interest-bearing asset or liability being hedged.
- b. If the hedging instrument is solely an interest rate swap, the fair value of that interest rate swap at the inception of the hedging relationship must be zero, with one exception. The fair value of the swap may be other than zero at the inception of the hedging relationship only if the swap was entered into at the relationship's inception, the transaction price of the swap was zero in the entity's principal market (or most advantageous market), and the difference between transaction price and fair value is attributable solely to differing prices within the bid-ask spread between the entry transaction and a hypothetical exit transaction. The guidance in the preceding sentence is applicable only to transactions considered *at market* (that is, transaction price is zero exclusive of commissions and other transaction costs, ~~as discussed in paragraph 820-10-35-9B~~). If the hedging instrument is solely an interest rate swap that at the inception of the hedging relationship has a positive or negative



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fair value, but does not meet the one exception specified in this paragraph, the shortcut method shall not be used even if all the other conditions are met.

- c. If the hedging instrument is a compound derivative composed of an interest rate swap and mirror-image call or put option as discussed in (e), the premium for the mirror-image call or put option shall be paid or received in the same manner as the premium on the call or put option embedded in the hedged item based on the following:
- i. If the implicit premium for the call or put option embedded in the hedged item is being paid principally over the life of the hedged item (through an adjustment of the interest rate), the fair value of the hedging instrument at the inception of the hedging relationship shall be zero (except as discussed previously in (b) regarding differing prices due to the existence of a bid-ask spread).
  - ii. If the implicit premium for the call or put option embedded in the hedged item was principally paid at inception-acquisition (through an original issue discount or premium), the fair value of the hedging instrument at the inception of the hedging relationship shall be equal to the fair value of the mirror-image call or put option.
- d. The formula for computing net settlements under the interest rate swap is the same for each net settlement. That is, both of the following conditions are met:
- i. The fixed rate is the same throughout the term.
  - ii. The variable rate is based on the same index and includes the same constant adjustment or no adjustment. The existence of a stub period and stub rate is not a violation of the criterion in (d) that would preclude application of the shortcut method if the stub rate is the variable rate that corresponds to the length of the stub period.
- e. The interest-bearing asset or liability is not prepayable, that is, able to be settled by either party before its scheduled maturity, or the assumed maturity date if the hedged item is measured as a partial-term hedge of interest rate risk in which the assumed maturity of the hedged items occur on the date in which the last hedged cash flow is due and payable, in accordance with paragraph 815-25-35-13B, with the following qualifications:
- i. This criterion does not apply to an interest-bearing asset or liability that is prepayable solely due to an embedded call option (put option) if the hedging instrument is a compound derivative composed of an interest rate swap and a mirror-image call option (put option).
  - ii. The call option embedded in the interest rate swap is considered a mirror image of the call option embedded in the hedged item if all of the following conditions are met:
    - (a) The terms of the two call options match exactly, including all of the following:
      - (1) Maturities

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- (2) Strike price (that is, the actual amount for which the debt instrument could be called) and there is no termination payment equal to the deferred debt issuance costs that remain unamortized on the date the debt is called
  - (3) Related notional amounts
  - (4) Timing and frequency of payments
  - (5) Dates on which the instruments may be called.
- (b) The entity is the writer of one call option and the holder (purchaser) of the other call option.
- f. Any other terms in the interest-bearing financial instruments or interest rate swaps meet both of the following conditions:
- i. The terms are typical of those instruments.
  - ii. The terms do not invalidate the assumption of perfect effectiveness.
18. All of the following incremental conditions apply to fair value hedges only: *(815-20-25-105)*
- a. The expiration date of the interest rate swap matches the maturity date of the interest-bearing asset or liability or the assumed maturity date if the hedged item is measured as a partial-term hedge of interest rate risk in which the assumed maturity of the hedged items occur on the date in which the last hedged cash flow is due and payable~~in accordance with paragraph 815-25-35-13B.~~
  - b. There is no floor or cap on the variable interest rate of the interest rate swap.
  - c. The interval between repricings of the variable interest rate in the interest rate swap is frequent enough to justify an assumption that the variable payment or receipt is at a market rate (generally three to six months or less).
  - d. For fair value hedges of a proportion of the principal amount of the interest-bearing asset or liability, the notional amount of the interest rate swap designated as the hedging instrument ~~(see (a) in paragraph 815-20-25-104)~~ matches the portion of the asset or liability being hedged.
  - e. For fair value hedges of portfolios (or proportions thereof) of similar interest-bearing assets or liabilities, both of the following criteria are met:
    - i. The notional amount of the interest rate swap designated as the hedging instrument matches the aggregate notional amount of the hedged item (whether it is all or a proportion of the total portfolio).



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- ii. The remaining criteria for the shortcut method are met with respect to the interest rate swap and the individual assets or liabilities in the portfolio.
  - f. The index on which the variable leg of the interest rate swap is based matches the benchmark interest rate designated as the interest rate risk being hedged for that hedging relationship.
19. All of the following incremental conditions apply to cash flow hedges only: (815-20-25-106)
- a. All interest receipts or payments on the variable-rate asset or liability during the term of the interest rate swap are designated as hedged.
  - b. No interest payments beyond the term of the interest rate swap are designated as hedged.
  - c. Either of the following conditions is met:
    - i. There is no floor or cap on the variable interest rate of the interest rate swap.
    - ii. The variable-rate asset or liability has a floor or cap and the interest rate swap has a floor or cap on the variable interest rate that is comparable to the floor or cap on the variable-rate asset or liability. For purposes of this paragraph, comparable does not necessarily mean equal. For example, if an interest rate swap's variable rate is based on LIBOR and an asset's variable rate is LIBOR plus 2 percent, a 10 percent cap on the interest rate swap would be comparable to a 12 percent cap on the asset.
  - d. The repricing dates of the variable-rate asset or liability and the hedging instrument must occur on the same dates and be calculated the same way (that is, both shall be either prospective or retrospective). If the repricing dates of the hedged item occur on the same dates as the repricing dates of the hedging instrument but the repricing calculation for the hedged item is prospective whereas the repricing calculation for the hedging instrument is retrospective, those repricing dates do not match.
  - e. For cash flow hedges of the interest payments on only a portion of the principal amount of the interest-bearing asset or liability, the notional amount of the interest rate swap designated as the hedging instrument (~~see paragraph 815-20-25-104(a)~~) matches the principal amount of the portion of the asset or liability on which the hedged interest payments are based.
  - f. For a cash flow hedge in which the hedged forecasted transaction is a group of individual transactions (as permitted by [paragraph 28.a. of the SSAP guidance](#) ~~paragraph 815-20-25-15(a)~~), if both of the following criteria are met:
    - i. The notional amount of the interest rate swap designated as the hedging instrument (~~see paragraph (a)~~) matches the notional amount of the aggregate group of hedged transactions.
    - ii. The remaining criteria for the shortcut method are met with respect to the interest rate swap and the individual transactions that make up the group. For example, the interest rate repricing dates for the variable-rate assets or liabilities whose interest

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payments are included in the group of forecasted transactions shall match (that is, be exactly the same as) the reset dates for the interest rate swap.

- g. The index on which the variable leg of the interest rate swap is based matches the contractually specified interest rate designated as the interest rate being hedged for that hedging relationship.

20. The shortcut method may be applied to a hedging relationship that involves the use of an interest rate swap-in-arrears provided all of the applicable conditions are met. (815-20-25-107)

21. Any discount or premium in the hedged debt's carrying amount (including any related deferred issuance costs) is irrelevant to and has no direct impact on the determination of whether an interest rate swap contains a mirror-image call option under paragraph 17.e.i.(e). Typically, the call price is greater than the par or face amount of the debt instrument. The carrying amount of the debt is economically unrelated to the amount the issuer would be required to pay to exercise the call embedded in the debt. (815-20-25-108)

22. The fixed interest rate on a hedged item need not exactly match the fixed interest rate on an interest rate swap designated as a fair value hedge. Nor does the variable interest rate on an interest-bearing asset or liability need to be the same as the variable interest rate on an interest rate swap designated as a cash flow hedge. An interest rate swap's fair value comes from its net settlements. The fixed and variable interest rates on an interest rate swap can be changed without affecting the net settlement if both are changed by the same amount. That is, an interest rate swap with a payment based on LIBOR and a receipt based on a fixed rate of 5 percent has the same net settlements and fair value as an interest rate swap with a payment based on LIBOR plus 1 percent and a receipt based on a fixed rate of 6 percent. (815-20-25-109)

23. Comparable credit risk at inception is not a condition for assuming perfect effectiveness even though actually achieving perfect offset would require that the same discount rate be used to determine the fair value of the swap and of the hedged item or hedged transaction. To justify using the same discount rate, the credit risk related to both parties to the swap as well as to the debtor on the hedged interest-bearing asset (in a fair value hedge) or the variable-rate asset on which the interest payments are hedged (in a cash flow hedge) would have to be the same. However, because that complication is caused by the interaction of interest rate risk and credit risk, which are not easily separable, comparable creditworthiness is not considered a necessary condition for assuming perfect effectiveness in a hedge of interest rate risk. (815-20-25-111)

*(ASC paragraphs 815-20-25-112 through 815-20-25-143 not included in Exhibit A.)*

#### *Hedge Effectiveness – After Designation*

24. If a fair value hedge or cash flow hedge initially qualifies for hedge accounting, the entity would continue to assess whether the hedge meets the effectiveness test on either a quantitative basis (using either a dollar-offset test or a statistical method such as regression analysis) or a qualitative basis. ~~See paragraphs 815-20-35-2A through 35-2F for additional guidance on qualitative assessments of effectiveness.~~ If the hedge fails the effectiveness test at any time (that is, if the entity does not expect the hedge to be highly effective at achieving offsetting changes in fair values or cash flows), the hedge ceases to qualify for hedge accounting. At least quarterly, the hedging entity shall determine whether the hedging relationship has been highly effective in having achieved offsetting changes in fair value or cash flows through the date of the periodic assessment.) (815-20-35-2)

*Effectiveness Assessment on a Qualitative Basis*

25. An entity may qualitatively assess hedge effectiveness if both of the following criteria are met: (815-20-35-2A)

- a. An entity performs an initial quantitative test of hedge effectiveness on a prospective basis (that is, it is not assuming that the hedging relationship is perfectly effective at hedge inception ~~as described in paragraph 815-20-25-3(b)(2)(iv)(01)(A) through (H)~~), and the results of that quantitative test demonstrate highly effective offset.
- b. At hedge inception, an entity can reasonably support an expectation of high effectiveness on a qualitative basis in subsequent periods.

26. An entity may elect to qualitatively assess hedge effectiveness in accordance with paragraph 25-815-20-35-2A on a hedge-by-hedge basis. If an entity makes this qualitative assessment election, only the quantitative method specified in an entity's initial hedge documentation must comply with paragraph 7-815-20-25-81. (815-20-35-2B)

27. When an entity performs qualitative assessments of hedge effectiveness, it shall verify and document whenever financial statements or earnings are reported and at least every three months that the facts and circumstances related to the hedging relationship have not changed such that it can assert qualitatively that the hedging relationship was and continues to be highly effective. While not all-inclusive, the following is a list of indicators that may, individually or in the aggregate, allow an entity to continue to assert qualitatively that the hedging relationship is highly effective: (815-20-35-2C)

- a. An assessment of the factors that enabled the entity to reasonably support an expectation of high effectiveness on a qualitative basis has not changed such that the entity can continue to assert qualitatively that the hedging relationship was and continues to be highly effective. ~~This shall include an assessment of the guidance in paragraph 815-20-25-100 when applicable.~~
- b. There have been no adverse developments regarding the risk of counterparty default.

28. If an entity elects to assess hedge effectiveness on a qualitative basis and then facts and circumstances change such that the entity no longer can assert qualitatively that the hedging relationship was and continues to be highly effective in achieving offsetting changes in fair values or cash flows, the entity shall assess effectiveness of that hedging relationship on a quantitative basis in subsequent periods. In addition, an entity may perform a quantitative assessment of hedge effectiveness in any reporting period to validate whether qualitative assessments of hedge effectiveness remain appropriate. In both cases, the entity shall apply the quantitative method that it identified in its initial hedge documentation ~~in accordance with paragraph (b)(2)(iv)(03)~~. (815-20-35-2D)

29. When an entity determines that facts and circumstances have changed and it no longer can assert qualitatively that the hedging relationship was and continues to be highly effective, the entity shall begin performing subsequent quantitative assessments of hedge effectiveness as of the period that the facts and circumstances changed. If there is no identifiable event that led to the change in the facts and circumstances of the hedging relationship, the entity may begin performing quantitative assessments of effectiveness in the current period. (815-20-35-2E)

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30. After performing a quantitative assessment of hedge effectiveness for one or more reporting periods as discussed in paragraphs ~~28-29~~~~815-20-35-2D through 35-2E~~, an entity may revert to qualitative assessments of hedge effectiveness if it can reasonably support an expectation of high effectiveness on a qualitative basis for subsequent periods. ~~See paragraphs 815-20-55-79G through 55-79N for implementation guidance on factors to consider when determining whether qualitative assessments of effectiveness can be performed after hedge inception.~~ (815-20-35-2F)

*Quantitative Hedge Effectiveness Assessments After Hedge Designation*

31. Quantitative assessments can be based on regression or other statistical analysis of past changes in fair values or cash flows as well as on other relevant information. (815-20-35-2G)

32. If an entity elects at the inception of a hedging relationship to use the same regression analysis approach for both prospective considerations and retrospective evaluations of assessing effectiveness, then during the term of that hedging relationship both of the following conditions shall be met: (815-20-35-3)

- a. Those regression analysis calculations shall generally incorporate the same number of data points.
- b. That entity must periodically update its regression analysis (or other statistical analysis).

33. Electing to use a regression or other statistical analysis approach instead of a dollar-offset approach to perform retrospective evaluations of assessing hedge effectiveness may affect whether an entity can apply hedge accounting for the current assessment period. (815-20-35-4)

34. In periodically (that is, at least quarterly) assessing retrospectively the effectiveness of a fair value hedge (or a cash flow hedge) in having achieved offsetting changes in fair values (or cash flows) under a dollar-offset approach, an entity shall use either a period-by-period approach or a cumulative approach on individual fair value hedges (or cash flow hedges): (815-20-35-5)

- a. Period-by-period approach. The period-by-period approach involves comparing the changes in the hedging instrument's fair values (or cash flows) that have occurred during the period being assessed to the changes in the hedged item's fair value (or hedged transaction's cash flows) attributable to the risk hedged that have occurred during the same period. If an entity elects to base its comparison of changes in fair value (or cash flows) on a period-by-period approach, the period cannot exceed three months. Fair value (or cash flow) patterns of the hedging instrument or the hedged item (or hedged transaction) in periods before the period being assessed are not relevant.
- b. Cumulative approach. The cumulative approach involves comparing the cumulative changes (to date from inception of the hedge) in the hedging instrument's fair values (or cash flows) to the cumulative changes in the hedged item's fair value (or hedged transaction's cash flows) attributable to the risk hedged.

35. If an entity elects at inception of a hedging relationship to base its comparison of changes in fair value (or cash flows) on a cumulative approach, then that entity must abide by the results of that methodology as long as that hedging relationship remains designated. Electing to utilize a period-by-period approach instead of a cumulative approach (or vice versa) to perform retrospective evaluations of assessing

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hedge effectiveness under the dollar-offset method may affect whether an entity can apply hedge accounting for the current assessment period. (815-20-35-6)

*Assessing Effectiveness Based on Whether the Critical Terms of the Hedging Instrument and the Hedged Items Match*

36. If, at inception, the critical terms of the hedging instrument and the hedged forecasted transaction are the same (see paragraphs [10-11815-20-25-84 through 25-84A](#)), the entity can conclude that changes in cash flows attributable to the risk being hedged are expected to be completely offset by the hedging derivative. Therefore, subsequent assessments can be performed by verifying and documenting whether the critical terms of the hedging instrument and the forecasted transaction have changed during the period in review. (815-20-35-9)

37. Because the assessment of hedge effectiveness in a cash flow hedge involves assessing the likelihood of the counterparty's compliance with the contractual terms of the derivative instrument designated as the hedging instrument, the entity must also assess whether there have been adverse developments regarding the risk of counterparty default, particularly if the entity planned to obtain its cash flows by liquidating the derivative instrument at its fair value. (815-20-35-10)

38. If there are no such changes in the critical terms or adverse developments regarding counterparty default, the entity may conclude that the hedging relationship is perfectly effective. In that case, the change in fair value of the derivative instrument can be viewed as a proxy for the present value of the change in cash flows attributable to the risk being hedged. (815-20-35-11)

39. However, the entity must assess whether the hedging relationship is expected to continue to be highly effective using a quantitative assessment method (either a dollar-offset test or a statistical method such as regression analysis) if any of the following conditions exist: (815-20-35-12)

- a. The critical terms of the hedging instrument or the hedged forecasted transaction have changed.
- b. There have been adverse developments regarding the risk of counterparty default.

*Possibility of Default by the Counterparty to Hedging Derivative*

40. For an entity to conclude on an ongoing basis that the hedging relationship is expected to be highly effective in achieving offsetting changes in cash flows, the entity shall not ignore whether it will collect the payments it would be owed under the contractual provisions of the derivative instrument. In complying with the requirements of paragraph [2.b.815-20-25-75\(b\)](#), the entity shall assess the possibility of whether the counterparty to the derivative instrument will default by failing to make any contractually required payments to the entity as scheduled in the derivative instrument. In making that assessment, the entity shall also consider the effect of any related collateralization or financial guarantees. The entity shall be aware of the counterparty's creditworthiness (and changes therein) in determining the fair value of the derivative instrument. Although a change in the counterparty's creditworthiness would not necessarily indicate that the counterparty would default on its obligations, such a change shall warrant further evaluation. (815-20-35-14)

41. If the likelihood that the counterparty will not default ceases to be probable, an entity would be unable to conclude that the hedging relationship in a cash flow hedge is expected to be highly effective in achieving offsetting cash flows. (815-20-35-15)

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42. In contrast, a change in the creditworthiness of the derivative instrument's counterparty in a fair value hedge would have an immediate effect because that change in creditworthiness would affect the change in the derivative instrument's fair value, which would immediately affect both of the following: (815-20-35-16)

- a. The assessment of whether the relationship qualifies for hedge accounting
- b. The amount of mismatch between the change in the fair value of the hedging instrument and the hedged item attributable to the hedged risk recognized in earnings under fair value hedge accounting.

43. Paragraph ~~16815-20-25-103~~ states that, in applying the shortcut method, an entity shall consider the likelihood of the counterparty's compliance with the contractual terms of the hedging derivative that require the counterparty to make payments to the entity. That paragraph explains that implicit in the criteria for the shortcut method is the requirement that a basis exist for concluding on an ongoing basis that the hedging relationship is expected to be highly effective in achieving offsetting changes in fair values or cash flows. (815-20-35-18)

*Change in Hedge Effectiveness Method When Hedge Effectiveness is Assessed on a Quantitative Basis*

44. If the entity identifies an improved method of assessing hedge effectiveness in accordance with the guidance in paragraph ~~6815-20-25-80~~ and wants to apply that method prospectively, it shall do both of the following: (815-20-35-19)

- a. Discontinue the existing hedging relationship
- b. Designate the relationship anew using the improved method.

45. The new method of assessing hedge effectiveness shall be applied prospectively and shall also be applied to similar hedges unless the use of a different method for similar hedges is justified. A change in the method of assessing hedge effectiveness by an entity shall not be considered a change in accounting principle as defined in ~~Topic 250~~ [SSAP No. 3—Accounting Changes and Corrections of Errors](#). (815-20-35-20)

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### U.S. GAAP ASC Excerpts Excluded from Exhibit A

This information is included to illustrate the guidance within the adopted ASC references that are not captured in Exhibit A. The guidance within these paragraphs is considered part of the statutory adoption unless they include specific accounting and reporting guidance.

**815-20-25-79A** See paragraphs 815-20-25-139 through 25-142 about the timing of hedge effectiveness assessments required by paragraph 815-20-25-79 for a private company that is not a financial institution or a not-for-profit entity (except for a not-for-profit entity that has issued, or is a conduit bond obligor for, securities that are traded, listed, or quoted on an exchange or an over-the-counter market).

**815-20-25-86** The remainder of this guidance on hedge effectiveness criteria applicable to both fair value hedges and cash flow hedges is organized as follows:

- a. Hedge effectiveness when the hedging instrument is an option or combination of options
- b. Hedge effectiveness when hedged exposure is more limited than hedging instrument
- c. Hedge effectiveness during designated hedge period
- d. Assuming perfect effectiveness in a hedge with an interest rate swap (the shortcut method).

#### Hedge Effectiveness When the Hedging Instrument Is an Option or Combination of Options

**815-20-25-87** The hedge effectiveness criteria applicable to options and combinations of options are organized as follows:

- a. Determining whether a combination of options is net written
- b. Hedge effectiveness of written options
- c. Hedge effectiveness of options in general.

#### Determining Whether a Combination of Options Is Net Written

**815-20-25-88** This guidance addresses how an entity shall determine whether a combination of options is considered a net written option subject to the requirements of paragraph 815-20-25-94. A combination of options (for example, an interest rate collar) entered into contemporaneously shall be considered a written option if either at inception or over the life of the contracts a net premium is received in cash or as a favorable rate or other term. Furthermore, a derivative instrument that results from combining a written option and any other non-option derivative instrument shall be considered a written option. The determination of whether a combination of options is considered a net written option depends in part on whether strike prices and notional amounts of the options remain constant.

#### Strike Prices and Notional Amounts Remain Constant

**815-20-25-89** For a combination of options in which the strike price and the notional amount in both the written option component and the purchased option component remain constant over the life of the respective component, that combination of options would be considered a net purchased option or a zero



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cost collar (that is, the combination shall not be considered a net written option subject to the requirements of paragraph 815-20-25-94) provided all of the following conditions are met:

- a. No net premium is received.
- b. The components of the combination of options are based on the same underlying.
- c. The components of the combination of options have the same maturity date.
- d. The notional amount of the written option component is not greater than the notional amount of the purchased option component.

**815-20-25-90** If the combination of options does not meet all of those conditions, it shall be subject to the test in paragraph 815-20-25-94. For example, a combination of options having different underlying indexes, such as a collar containing a written floor based on three-month U.S. Treasury rates and a purchased cap based on three-month London Interbank Offered Rate (LIBOR), shall not be considered a net purchased option or a zero cost collar even though those rates may be highly correlated.

#### **Strike Prices and Notional Amounts Do Not Remain Constant**

**815-20-25-91** If either the written option component or the purchased option component for a combination of options has either strike prices or notional amounts that do not remain constant over the life of the respective component, the assessment to determine whether that combination of options can be considered not to be a written option under paragraph 815-20-25-88 shall be evaluated with respect to each date that either the strike prices or the notional amounts change within the contractual term from inception to maturity.

**815-20-25-92** Even though that assessment is made on the date that a combination of options is designated as a hedging instrument (to determine the applicability of paragraph 815-20-25-94), it shall consider the receipt of a net premium (in cash or as a favorable rate or other term) from that combination of options at each point in time that either the strike prices or the notional amounts change, such as either of the following circumstances:

- a. If strike prices fluctuate over the life of a combination of options and no net premium is received at inception, a net premium will typically be received as a favorable term in one or more reporting periods within the contractual term from inception to maturity.
- b. If notional amounts fluctuate over the life of a combination of options and no net premium is received at inception, a net premium or a favorable term will typically be received in one or more periods within the contractual term from inception to maturity.

**815-20-25-93** In addition, a combination of options in which either the written option component or the purchased option component has either strike prices or notional amounts that do not remain constant over the life of the respective component shall satisfy all of the conditions in paragraph 815-20-25-89 to be considered not to be a written option (that is, to be considered to be a net purchased option or zero cost collar) under paragraph 815-20-25-88. For example, if the notional amount of the written option component is greater than the notional amount of the purchased option component at any date that the notional amount changes within the contractual term from inception to maturity, the combination of options shall be considered to be a written option under paragraph 815-20-25-88 and, thus, subject to the criteria in the following paragraph.



### Hedge Effectiveness of Written Options

**815-20-25-94** If a written option is designated as hedging a recognized asset or liability or an unrecognized firm commitment (if a fair value hedge) or the variability in cash flows for a recognized asset or liability or an unrecognized firm commitment (if a cash flow hedge), the combination of the hedged item and the written option provides either of the following:

- a. At least as much potential for gains as a result of a favorable change in the fair value of the combined instruments (that is, the written option and the hedged item, such as an embedded purchased option) as exposure to losses from an unfavorable change in their combined fair value (if a fair value hedge)
- b. At least as much potential for favorable cash flows as exposure to unfavorable cash flows (if a cash flow hedge).

**815-20-25-95** The written-option test in the preceding paragraph shall be applied only at inception of the hedging relationship and is met if all possible percentage favorable changes in the underlying (from zero percent to 100 percent) would provide either of the following:

- a. At least as much gain as the loss that would be incurred from an unfavorable change in the underlying of the same percentage (if a fair value hedge)
- b. At least as much favorable cash flows as the unfavorable cash flows that would be incurred from an unfavorable change in the underlying of the same percentage (if a cash flow hedge).

**815-20-25-96** The time value of a written option (or net written option) may be excluded from the written-option test if, in defining how hedge effectiveness will be assessed, the entity specifies that it will base that assessment on only changes in the option's intrinsic value. In that circumstance, the change in the time value of the options would be excluded from the assessment of hedge effectiveness in accordance with paragraph 815-20-25-82(a).

**815-20-25-97** When applying the written-option test to determine whether there is symmetry of the gain and loss potential of the combined hedged position for all possible percentage changes in the underlying, an entity is permitted to measure the change in the intrinsic value of the written option (or net written option) combined with the change in fair value of the hedged item.

### Hedge Effectiveness When Hedged Exposure Is More Limited Than Hedging Instrument

**815-20-25-100** An entity may designate as the hedging instrument in a fair value hedge or cash flow hedge a derivative instrument that does not have a limited exposure comparable to the limited exposure of the hedged item to the risk being hedged. However, to make that designation, in accordance with paragraph 815-20-25-75, the entity shall establish that the hedging relationship is expected to be highly effective in achieving offsetting changes in fair value or cash flows attributable to the hedged risk during the period that the hedge is designated. See paragraph 815-20-25-79(a) for additional guidance on prospective considerations of hedge effectiveness in this circumstance.

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**Hedge Effectiveness during Designated Hedge Period**

**815-20-25-101** It is inappropriate under this Subtopic for an entity to designate a derivative instrument as the hedging instrument if the entity expects that the derivative instrument will not be highly effective in achieving offsetting changes in fair value or cash flows attributable to the hedged risk during the period that the hedge is designated, unless the entity has documented undertaking a dynamic hedging strategy in which it has committed itself to an ongoing repositioning strategy for its hedging relationship.

**>>>> Application of Prepayable Criterion**

**815-20-25-112** An interest-bearing asset or liability shall be considered prepayable under the provisions of paragraph 815-20-25-104(e) if one party to the contract has the right to cause the payment of principal before the scheduled payment dates unless either of the following conditions is met:

- a. The debtor has the right to cause settlement of the entire contract before its stated maturity at an amount that is always greater than the then fair value of the contract absent that right.
- b. The creditor has the right to cause settlement of the entire contract before its stated maturity at an amount that is always less than the then fair value of the contract absent that right.

**815-20-25-113** However, none of the following shall be considered a prepayment provision:

- a. Any term, clause, or other provision in a debt instrument that gives the debtor or creditor the right to cause prepayment of the debt contingent upon the occurrence of a specific event related to the debtor's credit deterioration or other change in the debtor's credit risk, such as any of the following:
  1. The debtor's failure to make timely payment, thus making it delinquent
  2. The debtor's failure to meet specific covenant ratios
  3. The debtor's disposition of specific significant assets (such as a factory)
  4. A declaration of cross-default
  5. A restructuring by the debtor.
- b. Any term, clause, or other provision in a debt instrument that gives the debtor or creditor the right to cause prepayment of the debt contingent upon the occurrence of a specific event that meets all of the following conditions:
  1. It is not probable at the time of debt issuance.
  2. It is unrelated to changes in benchmark interest rates, contractually specified interest rates, or any other market variable.
  3. It is related either to the debtor's or creditor's death or to regulatory actions, legislative actions, or other similar events that are beyond the control of the debtor or creditor.

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- c. Contingent acceleration clauses that permit the debtor to accelerate the maturity of an outstanding note only upon the occurrence of a specified event that meets all of the following conditions:
1. It is not probable at the time of debt issuance.
  2. It is unrelated to changes in benchmark interest rates, contractually specified interest rates, or any other market variable.
  3. It is related to regulatory actions, legislative actions, or other similar events that are beyond the control of the debtor or creditor.

**815-20-25-114** Furthermore, a right to cause a contract to be prepaid at its then fair value would not cause the interest-bearing asset or liability to be considered prepayable because that right would have a fair value of zero at all times and essentially would provide only liquidity to the holder.

**815-20-25-115** Application of this guidance to specific debt instruments is illustrated in paragraph 815-20-55-75.

#### **Application of the Shortcut Method to a Portfolio of Hedged Items**

**815-20-25-116** Portfolio hedging cannot be used to circumvent the application of the shortcut method criteria beginning in paragraph 815-20-25-102 to a fair value hedge of an individual interest-bearing asset or liability. A portfolio of interest-bearing assets or interest-bearing liabilities cannot qualify for the shortcut method if it contains an interest-bearing asset or liability that individually cannot qualify for the shortcut method.

**815-20-25-117** The fair value hedge requirements of paragraph 815-20-25-12(b)(1) ensure that the individual items in a portfolio share the same risk exposure and have fair value changes attributable to the hedged risk that are expected to respond in a generally proportionate manner to the overall fair value changes of the entire portfolio. That requirement restricts the types of portfolios that can qualify for portfolio hedging; however, it also permits the existence of a mismatch between the change in the fair value of the individual hedged items and the change in the fair value of the hedged portfolio attributable to the hedged risk in portfolios that do qualify. As a result, the assumption of perfect effectiveness required for the shortcut method generally is inappropriate for portfolio hedges of similar assets or liabilities that are not also nearly identical (except for their notional amounts). Application of the shortcut method to portfolios that meet the requirements of paragraph 815-20-25-12(b)(1) is appropriate only if the assets or liabilities in the portfolio meet the same stringent criteria in paragraphs 815-20-25-104(e), 815-20-25-104(g), and 815-20-25-105(a) as required for hedges of individual assets and liabilities.

#### **Application of Whether the Shortcut Method Was Not or No Longer Is Appropriate**

**815-20-25-117A** In the period in which an entity determines that use of the shortcut method was not or no longer is appropriate, the entity may use a quantitative method to assess hedge effectiveness and measure hedge results without dedesignating the hedging relationship if both of the following criteria are met:

- a. The entity documented at hedge inception in accordance with paragraph 815-20-25-3(b)(2)(iv)(04) which quantitative method it would use to assess hedge effectiveness and

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measure hedge results if the shortcut method was not or no longer is appropriate during the life of the hedging relationship.

- b. The hedging relationship was highly effective on a prospective and retrospective basis in achieving offsetting changes in fair value or cash flows attributable to the hedged risk for the periods in which the shortcut method criteria were not met.

**815-20-25-117B** If the criterion in paragraph 815-20-25-117A(a) is not met, the hedging relationship shall be considered invalid in the period in which the criteria for the shortcut method were not met and in all subsequent periods. If the criterion in paragraph 815-20-25-117A(a) is met, the hedging relationship shall be considered invalid in all periods in which the criterion in paragraph 815-20-25-117A(b) is not met.

**815-20-25-117C** If an entity cannot identify the date on which the shortcut criteria ceased to be met, the entity shall perform the quantitative assessment of effectiveness documented at hedge inception for all periods since hedge inception.

**815-20-25-117D** The terms of the hedged item and hedging instrument used to assess effectiveness, in accordance with paragraph 815-20-25-117A(b), shall be those existing as of the date that the shortcut criteria ceased to be met. For cash flow hedges, if the hypothetical derivative method is used as a proxy for the hedged item, the value of the hypothetical derivative shall be set to zero as of hedge inception.

**Hedge Effectiveness Criterion Applicable to Fair Value Hedges Only—Effectiveness Horizon**

**815-20-25-118** In documenting its risk management strategy for a fair value hedge, an entity may specify an intent to consider the possible changes (that is, not limited to the likely or expected changes) in value of the hedging derivative instrument and the hedged item only over a shorter period than the derivative instrument's remaining life in formulating its expectation that the hedging relationship will be highly effective in achieving offsetting changes in fair value for the risk being hedged. The entity does not need to contemplate the offsetting effect for the entire term of the hedging instrument.

**Consideration of Prepayment Risk Using the Last-of-Layer Method**

**815-20-25-118A** In a fair value hedge of interest rate risk designated under the last-of-layer method in accordance with paragraph 815-20-25-12A, an entity may exclude prepayment risk when measuring the change in fair value of the hedged item attributable to interest rate risk.

**Hedge Effectiveness Criteria Applicable to Cash Flow Hedges Only**

**815-20-25-119** The hedge effectiveness criteria applicable to cash flow hedges only are organized as follows:

- a. Consideration of the time value of money
- b. Consideration of counterparty credit risk
- c. Additional considerations for options in cash flow hedges
- d. Assuming perfect hedge effectiveness in a cash flow hedge of a variable-rate borrowing with a receive-variable, pay-fixed interest rate swap recorded under the simplified hedge accounting approach.

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### Consideration of the Time Value of Money

**815-20-25-120** In assessing the effectiveness of a cash flow hedge, an entity generally shall consider the time value of money, especially if the hedging instrument involves periodic cash settlements.

**815-20-25-121** An example of a situation in which an entity likely would reflect the time value of money is a tailing strategy with futures contracts. When using a tailing strategy, an entity adjusts the size or contract amount of futures contracts used in a hedge so that earnings (or expense) from reinvestment (or funding) of daily settlement gains (or losses) on the futures do not distort the results of the hedge. To assess offset of expected cash flows when a tailing strategy has been used, an entity could reflect the time value of money, perhaps by comparing the present value of the hedged forecasted cash flow with the results of the hedging instrument.

### Consideration of Counterparty Credit Risk

**815-20-25-122** For a cash flow hedge, an entity shall consider the likelihood of the counterparty's compliance with the contractual terms of the hedging derivative instrument that require the counterparty to make payments to the entity. Paragraph 815-20-35-14 states that, for an entity to conclude on an ongoing basis that a cash flow hedging relationship is expected to be highly effective in achieving offsetting changes in cash flows, the entity shall not ignore whether it will collect the payments it would be owed under the contractual provisions of the derivative instrument. See paragraphs 815-20-35-14 through 35-18 for further guidance.

### Additional Considerations for Options in Cash Flow Hedges

**815-20-25-123** When an entity has documented that the effectiveness of a cash flow hedge will be assessed based on changes in the hedging option's intrinsic value pursuant to paragraph 815-20-25-82(a), that assessment (and the related cash flow hedge accounting) shall be performed for all changes in intrinsic value—that is, for all periods of time when the option has an intrinsic value, such as when the underlying is above the strike price of the call option.

**815-20-25-124** When a purchased option is designated as a hedging instrument in a cash flow hedge, an entity shall not define only limited parameters for the risk exposure designated as being hedged that would include the time value component of that option. An entity cannot arbitrarily exclude some portion of an option's intrinsic value from the hedge effectiveness assessment simply through an articulation of the risk exposure definition. It is inappropriate to assert that only limited risk exposures are being hedged (for example, exposures related only to currency-exchange-rate changes above \$1.65 per pound sterling as illustrated in Example 26 [see paragraph 815-20-55-205]).

**815-20-25-125** If an option is designated as the hedging instrument in a cash flow hedge, an entity may assess hedge effectiveness based on a measure of the difference, as of the end of the period used for assessing hedge effectiveness, between the strike price and forward price of the underlying, undiscounted. Although assessment of cash flow hedge effectiveness with respect to an option designated as the hedging instrument in a cash flow hedge shall be performed by comparing the changes in present value of the expected future cash flows of the forecasted transaction to the change in fair value of the derivative instrument (aside from any excluded component under paragraph 815-20-25-82), that measure of changes in the expected future cash flows of the forecasted transaction based on forward rates, undiscounted, is not prohibited. With respect to an option designated as the hedging instrument in a cash flow hedge, assessing hedge effectiveness based on a similar measure with respect to the hedging instrument eliminates any difference that the effect of discounting may have on the hedging instrument and the hedged transaction.

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Pursuant to paragraph 815-20-25-3(b)(2)(iv), entities shall document the measure of intrinsic value that will be used in the assessment of hedge effectiveness. As discussed in paragraph 815-20-25-80, that measure must be used consistently for each period following designation of the hedging relationship.

### Assessing Hedge Effectiveness Based on an Option's Terminal Value

**815-20-25-126** The guidance in paragraph 815-20-25-129 addresses a cash flow hedge that meets all of the following conditions:

- a. The hedging instrument is a purchased option or a combination of only options that comprise either a net purchased option or a zero-cost collar.
- b. The exposure being hedged is the variability in expected future cash flows attributed to a particular rate or price beyond (or within) a specified level (or levels).
- c. The assessment of effectiveness is documented as being based on total changes in the option's cash flows (that is, the assessment will include the hedging instrument's entire change in fair value, not just changes in intrinsic value).

**815-20-25-127** This guidance has no effect on the accounting for fair value hedging relationships. In addition, in determining the accounting for seemingly similar cash flow hedging relationships, it would be inappropriate to analogize to this guidance.

**815-20-25-128** For a hedging relationship that meets all of the conditions in paragraph 815-20-25-126, an entity may focus on the hedging instrument's terminal value (that is, its expected future pay-off amount at its maturity date) in determining whether the hedging relationship is expected to be highly effective in achieving offsetting cash flows attributable to the hedged risk during the term of the hedge. An entity's focus on the hedging instrument's terminal value is not an impediment to the entity's subsequently deciding to dedesignate that cash flow hedge before the occurrence of the hedged transaction. If the hedging instrument is a purchased cap consisting of a series of purchased caplets that are each hedging an individual hedged transaction in a series of hedged transactions (such as caplets hedging a series of hedged interest payments at different monthly or quarterly dates), the entity may focus on the terminal value of each caplet (that is, the expected future pay-off amount at the maturity date of each caplet) in determining whether each of those hedging relationships is expected to be highly effective in achieving offsetting cash flows. The guidance in this paragraph applies to a purchased option regardless of whether at the inception of the cash flow hedging relationship it is at the money, in the money, or out of the money.

**815-20-25-129** A hedging relationship that meets all of the conditions in paragraph 815-20-25-126 may be considered to be perfectly effective if all of the following conditions are met:

- a. The critical terms of the hedging instrument (such as its notional amount, underlying, maturity date, and so forth) completely match the related terms of the hedged forecasted transaction (such as the notional amount, the variable that determines the variability in cash flows, the expected date of the hedged transaction, and so forth).
- b. The strike price (or prices) of the hedging option (or combination of options) matches the specified level (or levels) beyond (or within) which the entity's exposure is being hedged.
- c. The hedging instrument's inflows (outflows) at its maturity date completely offset the change in the hedged transaction's cash flows for the risk being hedged.

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- d. The hedging instrument can be exercised only on a single date—its contractual maturity date.

The condition in (d) is consistent with the entity's focus on the hedging instrument's terminal value. If the holder of the option chooses to pay for the ability to exercise the option at dates before the maturity date (for example, by acquiring an American-style option), the hedging relationship would not be perfectly effective.

**815-20-25-129A** In a hedge of a group of forecasted transactions in accordance with paragraph 815-20-25-15(a)(2), an entity may assume that the timing in which the hedged transactions are expected to occur and the maturity date of the hedging instrument match in accordance with paragraph 815-20-25-129(a) if those forecasted transactions occur and the derivative matures within the same 31-day period or fiscal month.

### **Hedge Effectiveness of a Net-Purchased Combination of Options**

**815-20-25-130** The guidance in the following paragraph addresses a cash flow hedging relationship that meets both of the following conditions:

- a. A combination of options (deemed to be a net purchased option) is designated as the hedging instrument.
- b. The effectiveness of the hedge is assessed based only on changes in intrinsic value of the hedging instrument (the combination of options).

**815-20-25-131** The assessment of effectiveness of a cash flow hedging relationship meeting the conditions in the preceding paragraph may be based only on changes in the underlying that cause a change in the intrinsic value of the hedging instrument (the combination of options). Thus, the assessment can exclude ranges of changes in the underlying for which there is no change in the hedging instrument's intrinsic value.

### **Hedge Accounting Provisions Applicable to Certain Private Companies**

#### **Assuming Perfect Hedge Effectiveness in a Cash Flow Hedge of a Variable-Rate Borrowing with a Receive-Variable, Pay-Fixed Interest Rate Swap Recorded under the Simplified Hedge Accounting Approach**

**815-20-25-133** Paragraphs 815-10-35-1A through 35-1C, 815-10-50-3, 815-20-25-3A, 815-20-25-119, 815-20-25-134 through 25-138, 815-20-55-79A through 55-79B, 825-10-50-3, and 825-10-50-8 provide guidance for an entity electing the simplified hedge accounting approach. See paragraph 815-10-65-6 for transition guidance on applying the simplified hedge accounting approach.

**815-20-25-134** The conditions for the simplified hedge accounting approach determine which cash flow hedging relationships qualify for a simplified version of hedge accounting. If all of the conditions in paragraphs 815-20-25-135 and 815-20-25-137 are met, an entity may assume perfect effectiveness in a cash flow hedging relationship involving a variable-rate borrowing and a receive-variable, pay-fixed interest rate swap.

**815-20-25-135** Provided all of the conditions in paragraph 815-20-25-137 are met, the simplified hedge accounting approach may be applied by a **private company** except for a financial institution as described in paragraph 942-320-50-1. An entity may elect the simplified hedge accounting approach for any receive-variable, pay-fixed interest rate swap, provided that all of the conditions for applying the simplified hedge

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accounting approach specified in paragraph 815-20-25-137 are met. Implementation guidance on the conditions set forth in paragraph 815-20-25-137 is provided in paragraphs 815-20-55-79A through 55-79B.

**815-20-25-136** In applying the simplified hedge accounting approach, the documentation required by paragraph 815-20-25-3 to qualify for hedge accounting must be completed by the date on which the first annual **financial statements are available to be issued** after hedge inception rather than concurrently at hedge inception.

**815-20-25-137** An eligible entity under paragraph 815-20-25-135 must meet all of the following conditions to apply the simplified hedge accounting approach to a cash flow hedge of a variable-rate borrowing with a receive-variable, pay-fixed interest rate swap:

- a. Both the variable rate on the swap and the borrowing are based on the same index and reset period (for example, both the swap and borrowing are based on one-month London Interbank Offered Rate [LIBOR] or both the swap and borrowing are based on three-month LIBOR).
- b. The terms of the swap are typical (in other words, the swap is what is generally considered to be a “plain-vanilla” swap), and there is no floor or cap on the variable interest rate of the swap unless the borrowing has a comparable floor or cap.
- c. The repricing and settlement dates for the swap and the borrowing match or differ by no more than a few days.
- d. The swap’s fair value at inception (that is, at the time the derivative was executed to hedge the interest rate risk of the borrowing) is at or near zero.
- e. The notional amount of the swap matches the principal amount of the borrowing being hedged. In complying with this condition, the amount of the borrowing being hedged may be less than the total principal amount of the borrowing.
- f. All interest payments occurring on the borrowing during the term of the swap (or the effective term of the swap underlying the forward starting swap) are designated as hedged whether in total or in proportion to the principal amount of the borrowing being hedged.

**815-20-25-138** A cash flow hedge established through the use of a forward starting receive-variable, pay-fixed interest rate swap may be permitted in applying the simplified hedge accounting approach only if the occurrence of forecasted interest payments to be swapped is probable. When forecasted interest payments are no longer probable of occurring, a cash flow hedging relationship will no longer qualify for the simplified hedge accounting approach and the General Subsections of this Topic shall apply at the date of change and on a prospective basis.

### **Timing of Hedge Documentation for Certain Private Companies If Simplified Hedge Accounting Approach Is Not Applied**

#### **Concurrent Hedge Documentation**

**815-20-25-139** Concurrent with hedge inception, a **private company** that is not a financial institution as described in paragraph 942-320-50-1 shall document the following:



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- a. The hedging relationship in accordance with paragraph 815-20-25-3(b)(1)
- b. The hedging instrument in accordance with paragraph 815-20-25-3(b)(2)(i)
- c. The hedged item in accordance with paragraph 815-20-25-3(b)(2)(ii), including (if applicable) firm commitments or the analysis supporting a last-of-layer designation in paragraph 815-20-25-3(c), or forecasted transactions in paragraph 815-20-25-3(d)
- d. The nature of the risk being hedged in accordance with paragraph 815-20-25-3(b)(2)(iii).

**815-20-25-140** A private company that is not a financial institution is not required to perform or document the following items concurrent with hedge inception but rather is required to perform or document them within the time periods discussed in paragraph 815-20-25-142:

- a. The method of assessing hedge effectiveness at inception and on an ongoing basis in accordance with paragraph 815-20-25-3(b)(2)(iv) and (vi)
- b. Initial hedge effectiveness assessments in accordance with paragraph 815-20-25-3(b)(2)(iv)(01) through (04).

**815-20-25-141** Example 1A beginning in paragraph 815-20-55-80A illustrates hedge documentation when the critical terms of the hedging instrument and hedged forecasted transaction match. Although that Example illustrates the documentation of the method of assessing hedge effectiveness, private companies that are not financial institutions may complete hedge documentation requirements in accordance with paragraphs 815-20-25-139 through 25-140.

### **Hedge Effectiveness Assessments**

**815-20-25-142** For a private company that is not a financial institution, the performance and documentation of the items listed in paragraph 815-20-25-140, as well as required subsequent quarterly hedge effectiveness assessments, may be completed before the date on which the next interim (if applicable) or annual financial statements are available to be issued. Even though the completion of the initial and ongoing assessments of effectiveness may be deferred to the date on which financial statements are available to be issued the assessments shall be completed using information applicable as of hedge inception and each subsequent quarterly assessment date when completing this documentation on a deferred basis. Therefore, the assessment should be performed to determine whether the hedge was highly effective at achieving offsetting changes in fair values or cash flows at inception and in each subsequent quarterly assessment period up to the reporting date.

### **Hedge Accounting Provisions Applicable to Certain Not-for-Profit Entities**

**815-20-25-143** Not-for-profit entities (except for not-for-profit entities that have issued, or are a conduit bond obligor for, securities that are traded, listed, or quoted on an exchange or an over-the-counter market) may apply the guidance on the timing of hedge documentation and hedge effectiveness assessments in paragraphs 815-20-25-139 through 25-142. Specifically, those entities shall document the items listed in paragraph 815-20-25-139 concurrent with hedge inception, but they may perform and document the items listed in paragraph 815-20-25-140 and perform the required subsequent quarterly hedge effectiveness assessments in accordance with paragraph 815-20-25-142 within the time periods discussed in paragraph 815-20-25-142.

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**Exhibit 3 – Revisions adopted to SSAP No. 86 on December 12, 2022 (Agenda Item 2022-09)****Fair Value Hedges** (Note – Paragraphs 26.a. through 26.c. are not affected and are omitted for brevity.)

26. Fair value hedges qualify for hedge accounting if all of the following criteria are met:

- d. The hedged item is specifically identified as either all ~~or~~ a specific portion, or the partial term of a recognized asset, or all or a specific portion of ~~or~~ a recognized liability or of an unrecognized firm commitment. The hedged item is a single asset or liability (or a specific portion or partial term thereof) or is a portfolio of similar assets or a portfolio of similar liabilities (or a specific portion thereof) or a closed portfolio of assets (pursuant to paragraph 26.f. and Exhibit A, paragraph 46) where assumed layer or layers is anticipated to be outstanding (or a specific portion thereof)<sup>3</sup>. For a partial term hedge of one or more consecutive selected contractual cash flows where the hedged item begins when the first hedge cash flow begins to accrue and ends at the end of the designation hedge period, the assumed maturity of the hedged item occurs at the end of the designated hedge period; (ASC 815-25-35-13B Partial Term Hedging.)
- e. If similar assets or similar liabilities are aggregated and hedged as a portfolio, the individual assets or individual liabilities must share the risk exposure for which they are designated as being hedged. The change in fair value attributable to the hedged risk for each individual item in a hedged portfolio must be expected to respond in a generally proportionate manner to the overall change in fair value of the aggregate portfolio attributable to the hedged risk; and
- f. For a closed portfolio of financial assets or one or more beneficial interests secured by a portfolio of financial instruments, an entity may designate as the hedged item or items a hedged layer or layers (this designation is referred to throughout as the “portfolio layer method” (detailed in Exhibit A). (ASC 815-20-25-12A Portfolio Layer Method)
- ~~f.g.~~ If the hedged item is a financial asset or liability, a recognized loan servicing right, or a nonfinancial firm commitment with financial components, the designated risk being hedged is:
- i. The risk of changes in the overall fair value of the entire hedged item;
  - ii. The risk of changes in its fair value attributable to changes in benchmark interest rate;
  - iii. The risk of changes in its fair value attributable to changes in the related foreign currency exchange rates; or
  - iv. The risk of changes in its fair value attributable to both changes in the obligor’s creditworthiness and changes in the spread over the benchmark interest rate with respect to the related financial asset’s or liability’s credit sector at inception of the hedge (referred to as credit risk).

<sup>3</sup> For clarity, partial-term hedges and portfolio hedges addressed in paragraph 26.f. are limited to the situations in which the hedged item(s) is a recognized asset or a closed portfolio of financial assets. These hedging accounting methods are not permitted to hedge liabilities.

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If the risk designated as being hedged is not the risk in paragraph 26.f.i., two or more of the other risks (benchmark interest rate risk, foreign currency exchange risk, and credit risk) may simultaneously be designated as being hedged.

The benchmark interest rate being hedged in a hedge of interest rate risk must be specifically identified as part of the designation and documentation at the inception of the hedging relationship. In calculating the change in the hedged item's fair value attributable to changes in the benchmark interest rate, the estimated coupon cash flows used in calculating fair value shall must be based on either all of the full contractual cash flows of the entire hedged item or the benchmark rate component of the contractual coupon cash flows of the hedged item determined at hedge inception. An entity may designate a fair value hedge of interest rate risk in which the hedged item is a prepayment instrument. The entity may consider only how changes in the benchmark interest rate affect the decision to settle the hedged item before its scheduled maturity (for example, an entity may consider only how change in the benchmark interest rate affect an obligor's decision to call a debt instrument when it has the right to do so.) The entity need not consider other factors that would affect this decision (for example, credit risk) when assessing hedge effectiveness. (ASU 815-25-35-13 & 815-20-25-6B) Excluding some of the hedged item's contractual cash flows (for example, the portion of the interest coupon in excess of the benchmark interest rate) from the calculation is not permitted.<sup>4</sup>-An entity may not simply designate prepayment risk as the risk being hedged for a financial asset. However, it can designate the option component of a prepayable instrument as the hedged item in a fair value hedge of the entity's exposure to changes in the fair value of that "prepayment" option, perhaps thereby achieving the objective of its desire to hedge prepayment risk. The effect of an embedded derivative of the same risk class must be considered in designating a hedge of an individual risk. For example, the effect of an embedded prepayment option must be considered in designating a hedge of benchmark interest rate risk.

**Disclosure Requirements**

62. Reporting entities shall disclose the following for all derivative contracts used:
- a. General disclosures:
    - vii. The net gain or loss recognized in unrealized gains or losses during the perioding period resulting from derivatives that no longer qualify for hedge accounting. For portfolio layer method hedges, disclose circumstances that led to the breach. (ASC 815-10-50-5C.)

**Relevant Literature**

64. This statement adopts the framework established by FAS 133, *FASB Statement No. 137, Accounting for Derivative Instruments and Hedging Activities—Deferral of the Effective Date of FASB Statement No. 133, An amendment of FASB Statement No. 133* (FAS 137) and *FASB Statement No. 138, Accounting for Certain Derivative Instruments and Certain Hedging Activities, An amendment of FASB Statement No. 133* (FAS 138), for fair value and cash flow hedges, including its technical guidance to the extent such guidance is consistent with the statutory accounting approach to derivatives utilized in this statement. This statement adopts the provisions of FAS 133 and 138 related to foreign currency hedges.

<sup>4</sup>~~The first sentence of paragraph 26.d. that specifically permits the hedged item to be identified as either all or a specific portion of a recognized asset or liability or of an unrecognized firm commitment is not affected by the provisions in this subparagraph.~~

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With the exception of guidance specific to foreign currency hedges and amendments specific to refining the hedging of interest rate risk (under FAS 138, the risk of changes in the benchmark interest rate would be a hedged risk), this statement rejects FAS No. 137 and 138 as well as the various related Emerging Issues Task Force interpretations. This statement adopts paragraphs 4 and 25 of *FASB Statement No. 149: Amendment of Statement 133 on Derivative Instruments and Hedging Activities* (FAS 149) regarding the definition of an underlying and guidance for assessing hedge effectiveness. (The adoption from FAS 149 on the assessment of hedge effectiveness is impacted by the adoption with modification of guidance from ASU 2017-12 as detailed in paragraph 65.b., with the guidance from ASU 2017-12 superseding the prior adoption to the extent applicable.) All other paragraphs in FAS 149 are rejected as not applicable for statutory accounting. This statement adopts FSP FAS 133-1 and FIN 45-5: *Disclosures about Credit Derivatives and Certain Guarantees, An Amendment of FASB Statement No. 133 and FASB Interpretation No. 45 and Clarification of the Effective Date of FASB Statement No. 161* (FSP FAS 133-1 and FIN 45-4) and requires disclosures by sellers of credit derivatives. This statement rejects *FSP FIN 39-1, Amendments of FASB Interpretation No. 39, and ASU 2014-03, Derivatives and Hedging – Accounting for Certain Receive-Variable, Pay-Fixed Interest Rate Swaps – Simplified Hedge Accounting Approach*.

65. This statement adopts, with modification, certain revisions to ASC 815-20 included in ASU 2017-12. Remaining provisions of ASU 2017-12 will be subsequently assessed for statutory accounting and shall not be considered adopted for statutory accounting until that assessment is complete.
- a. Revisions effective January 1, 2019 with early adoption permitted, are limited to specific provisions, and related transition guidance, pertaining to the documentation and assessment of hedge effectiveness and only includes: 1) provisions allowing more time to perform the initial quantitative hedge effectiveness assessment; 2) provisions allowing subsequent assessments of hedge effectiveness to be performed qualitatively if certain conditions are met; and 3) revisions regarding use of the critical terms and short-cut methods for assessing hedge effectiveness.
  - b. Revisions effective January 1, 2023, with early adoption permitted, are limited to the criteria for initial and subsequent hedge effectiveness detailed in the FASB Accounting Standards Codification (ASC) paragraphs 815-20-25-72 through 815-20-35-20, as modified through the issuance of ASU 2017-12. This adoption reflects statutory modifications to specify that the accounting and reporting of hedging instruments, including excluded components of the instruments, shall follow statutory specific guidance detailed in the statement. The intent of this guidance is to clarify that the determination of whether a hedging instrument qualifies as an effective hedge shall converge with U.S. GAAP, but that the measurement method shall continue to follow statutory specific provisions. The adoption of the referenced ASC paragraphs only extends to revisions incorporated through ASU 2017-12; therefore, any subsequent U.S. GAAP edits would require statutory accounting consideration before considered adopted.
  - c. [Revisions effective January 1, 2022, with early adoption permitted, are limited to the criteria for the portfolio layer method detailed in ASU 2022-01, criteria to only consider how changes in the benchmark interest rate affect the decision to settle the hedged item before its scheduled maturity date in 815-20-25-6B, adding option in calculating the change in the hedged item's fair value attributed to changes in the benchmark interest rate based on the benchmark rate components of the contractual cash flows detailed in FASB ASC 815-25-35-13, and the partial-term hedging method detailed in FASB ASC 815-25-35-13B. The adoption of the partial term hedging method reflects statutory modifications that limits its use only when the hedged item is a recognized asset. This is different than U.S.](#)

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GAAP, which permits the partial term method for hedged liabilities. The statutory limitation is established to prevent interim basis adjustments to hedged liabilities that could present a reduction of reported liabilities on the financial statements when the actual liability has not been reduced. Reconsideration of this statutory limitation may occur after a broader project to consider how derivative basis adjustments to hedged liabilities shall be reflected in the financial statements.

### Effective Date and Transition

~~74.73~~ This statement is effective for derivative transaction entered into or modified on or after January 1, 2003. A modification is any revision or change in contractual terms of the derivative. SSAP No. 31 applies to derivative transaction prior to January 1, 2003. Alternatively, an insurer may choose to apply this statement to all derivatives to which the insurer is a party as of January 1, 2003. In either case, the insurer is to disclose the transition approach that is being used.

- a. Revisions adopted to paragraph 64 to reject FSP FIN 39-1 is effective January 1, 2013, for companies that have previously reported a position in the balance sheet that was net of counterparty agreements. (Companies that have previously reported derivative instruments and/or related collateral gross shall not be impacted by these revisions.)
- b. Revisions adopted in paragraph 16 clarify the reporting for amounts received/paid to adjust variation margin until the derivative contract has ended and are effective January 1, 2018, on a prospective basis, for reporting entities that have previously considered these amounts to reflect settlement or realized gains/losses. (Companies that have previously reported variation margin changes in line with the revisions shall not be impacted by these revisions.)
- c. Revisions to incorporate limited provisions from ASU 2017-12 pertaining to the documentation of hedge effectiveness (detailed in paragraph 65) are effective January 1, 2019, with early adoption permitted for year-end 2018. However, if the reporting entity is a U.S. GAAP filer, the reporting entity may only elect early adoption if the entity has also elected early adoption of ASU 2017-12 for year-end 2018.
- d. Revisions adopted April 2019 to explicitly include structured notes in scope of this statement are effective December 31, 2019. Revisions adopted July 2020 to define “derivative premium,” require gross reporting of derivatives without the impact of financing premiums and require separate recognition of premiums payable and premiums receivable, are effective January 1, 2021.
- e. Revisions adopted August 2022 that adopt with modification the criteria for initial and subsequent hedge effectiveness detailed in the FASB ASC paragraphs 815-20-25-72 through 815-20-35-20, as modified through the issuance of ASU 2017-12 and that incorporate statutory accounting revisions for the accounting and reporting of excluded components are effective January 1, 2023, with early adoption permitted. These revisions shall be applied prospectively for all new and existing hedges. Entities shall detail the adoption of this guidance as a change in accounting principle pursuant to *SSAP No. 3—Accounting Changes and Corrections of Errors*.
- f. Revisions adopted December 12, 2022 that adopt U.S. GAAP guidance for the portfolio layer method, U.S. GAAP guidance to only consider how changes in the benchmark

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interest rate affect the decision to settle the hedged item before its scheduled maturity, U.S. GAAP guidance adding option in calculating the change in the hedged item's fair value attributed to changes in the benchmark interest rate based on the benchmark rate component of the contractual coupon cash flows, that and adopt with modification U.S. GAAP guidance for partial term hedging are effective January 1, 2023, with early adoption permitted. These revisions shall be applied prospectively to qualifying new hedges.

### Edits to New Exhibit A – Discussion of Hedge Effectiveness

17. All of the following conditions apply to both fair value hedges and cash flow hedges: (815-20-25-104)
- e. The interest-bearing asset or liability is not prepayable, that is, able to be settled by either party before its scheduled maturity, or the assumed maturity date if the hedged item is measured as a partial-term hedge of interest rate risk in which the assumed maturity of the hedged items occur on the date in which the last hedged cash flow is due and payable ends at the end of the designated hedge period. in accordance with paragraph 815-25-35-13B, with the following qualifications:
    - i. This criterion does not apply to an interest-bearing asset or liability that is prepayable solely due to an embedded call option (put option) if the hedging instrument is a compound derivative composed of an interest rate swap and a mirror-image call option (put option).
    - ii. The call option embedded in the interest rate swap is considered a mirror image of the call option embedded in the hedged item if all of the following conditions are met:
18. All of the following incremental conditions apply to fair value hedges only: (815-20-25-105 & 815-25-35-13B)
- a. The expiration date of the interest rate swap matches the maturity date of the interest-bearing asset or liability or the assumed maturity date if the hedged item is measured as a partial-term hedge of interest rate risk in which the assumed maturity of the hedged items ends at the end of the designated hedge period occur on the date in which the last hedged cash flow is due and payable in accordance with paragraph 815-25-35-13B.

Portfolio Layer Method (New paragraphs at the end of Exhibit A.)

46. For a closed portfolio of financial assets or one or more beneficial interests secured by a portfolio of financial instruments, an entity may designate as the hedged item or items a hedged layer or layers (this designation is referred to throughout as the “portfolio layer method.”) (ASU 815-20-25-12A)

- a. As part of the initial hedge documentation, an analysis is completed and documented to support the entity's expectation that the hedged item or items (that is, the hedged layer or layers in aggregate) is anticipated to be outstanding for the designated hedge period. That analysis shall incorporate the entity's current expectations of prepayments, defaults, and other factors affecting the timing and amount of cash flows associated with the closed portfolio.

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- b. For purposes of its analysis in paragraph 46.a., the entity assumes that as prepayments, defaults, and other factors affecting the timing and amount of cash flows occur, they first will be applied to the portion of the closed portfolio that is not hedged; and
- c. The entity applies the partial-term hedging guidance to the assets or beneficial interest used to support the entity's expectation in paragraph 46.a. An asset that matures on a hedged layer's assumed maturity date meets this requirement.

47. After a closed portfolio is established in accordance with paragraph 46, and entity may designate new hedging relationships associated with the closed portfolio without dedesignating any existing hedging relationships associated with the closed portfolio if the criteria of paragraph 46 are met for those newly designated hedging relationships. (ASU 815-20-25-12B)

48. For the portfolio layer method if both of the following conditions exist, the quantitative test described for similar assets (shared risk exposure) may be performed qualitatively on a hedge-by-hedge basis and only at hedge inception:

- a. The hedged item is a hedged layer in a portfolio layer hedge and designated in accordance with paragraph 26.f. of SSAP No. 86.
- b. An entity measures the change in fair value of the hedged item based on the benchmark rate component of the contractual coupon cash flows.

Using the benchmark rate component of the contractual coupon cash flows when all assets have the same assumed maturity date and prepayment risk does not affect the measurement of the hedged item results in all hedged items having the same benchmark rate component coupon cash flows. (ASU 815-20-55-14A)

49. For one or more hedging relationships designated under the portfolio layer method, an entity shall discontinue (or partially discontinue) hedge accounting in the following circumstances: (ASU 815-25-40-8)

- a. If the entity cannot support on a subsequent testing date that the hedged layer or layers are anticipated to be outstanding for the designated hedge (that is, a breach is anticipated), it shall discontinue (or partially discontinue) hedge accounting for one or more hedging relationships for the portion of the hedged item that is no longer anticipated to be outstanding for the designated hedge period.
- b. If on a subsequent testing date the outstanding amount of the closed portfolio of financial assets or one or more beneficial interests is less than the hedged layer or layers (that is, a breach has occurred), the entity shall discontinue (or partially discontinue) hedge accounting for one or more hedging relationships for the portion of the hedged item that is no longer outstanding.

50. In the event of either an anticipated breach (as described in paragraph 49.a.) or a breach that has occurred (as described in paragraph 49.b.) for portfolio layer method, if multiple hedged layers are associated with a closed portfolio, an entity shall determine which hedge or hedges to discontinue (or partially discontinue) in accordance with an accounting policy election. That accounting policy election shall specify a systematic and rational approach to determining which hedge or hedges to discontinue (or partially discontinue). An entity shall establish its accounting policy no later than when it first anticipates



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a breach or when a breach has occurred (whichever comes first). After an entity establishes its accounting policy, it shall consistently apply its accounting policy to all portfolio layer method breaches (anticipated and occurred). (ASU 815-25-40-8A)

**U.S. GAAP references not pulled into Exhibit will also be updated as follows:**

***Consideration of Prepayment Risk Using the ~~Last-of-Layer~~ Portfolio Layer Method***

**815-20-25-118A** In a fair value hedge of interest rate risk designated under the portfolio layer ~~last-of-layer~~ method in accordance with paragraph 815-20-25-12A, an entity may exclude prepayment risk when measuring the change in fair value of the hedged item attributable to interest rate risk.

**Edits to Exhibit ~~C~~B – Specific Hedge Accounting Procedures for Derivatives**

2. Swaps, Collars, and Forwards (see also discussion in Introduction above):
  - d. Gain/Loss on Termination of a swap, collar or forward accounted for under hedge accounting (includes closing, exercise, maturity, and expiry):
    - i. Exercise—The remaining book value of the derivative shall become an adjustment to the cost or proceeds of the hedged item(s) received or disposed of individually or in aggregate;
    - ii. Sale, maturity, expiry, or other closing transaction of a derivative which is an effective hedge—Any gain or loss on the transaction, except for excluded components, will adjust the basis (or proceeds) of the hedged item(s) individually or in aggregate. If a portfolio layer method hedging relationship is discontinued (or partially discontinued) in a voluntary dedesignation or in anticipation of a breach, the basis adjustment associated with the dedesignated amount as of the discontinuation date shall be allocated to the remaining individual assets in the closed portfolio that supported the dedesignated hedged layer using a systematic and rational method. Alternatively, if the item being hedged is subject to IMR, the gain or loss on the terminated hedging derivative may be realized and shall be subject to IMR upon termination. (ASU 815-25-40-9)
    - iii. Gain/loss on termination of derivatives will be recognized currently in net income (realized gain/loss) to the extent they ceased to be effective hedges.
    - iv. Upon the redesignation of a derivative from a currently effective hedging relationship,
      - (a) with an item(s) carried at amortized cost to another effective hedging relationship with an item(s) carried at amortized cost, the derivative shall continue to be recorded at amortized cost and no gain or loss on the derivative shall be recognized.
      - (b) with an item(s) carried at amortized cost or fair value to an effective relationship with an item(s) carried at fair value, the accounting for the derivative shall be consistent with (ii) above.



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- (c) with an item(s) carried at fair value to an effective relationship with an item(s) carried at amortized cost, the accounting for the derivative shall be consistent with (ii.) above.

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**Statutory Accounting Principles (E) Working Group  
Maintenance Agenda Submission Form  
Form A**

**Issue: SSAP No. 25 – Affiliate Reporting Clarification**

**Check (applicable entity):**

	P/C	Life	Health
Modification of Existing SSAP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
New Issue or SSAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Description of Issue:**

At its May 24, 2022, meeting, the Statutory Accounting Principles (E) Working Group adopted agenda item 2021-21: Related Party Reporting, which included revisions to clarify application of the existing affiliate definition as well as to incorporate new disclosure requirements for investments acquired through, or in, related parties, regardless of if they meet the affiliate definition. During the meeting discussion, it was suggested that there needs to be a clarification of when an investment is considered to be and affiliated investment and reported on the affiliated line in the investment schedules. When agenda item 2021-21 was adopted, it included a recommendation that NAIC staff look to further clarify when investments should be classified as affiliated in the reporting schedules. This agenda item intends to clarify that an investment held from an affiliate is considered an affiliated investment.

**Existing Authoritative Literature:**

The *Insurance Holding Company System Regulatory Act* (Model #440) establishes the laws for holding company structures. The Act also establishes the concept of an affiliate in Section 1A, and this definition is used for statutory accounting purposes.

A. "Affiliate." An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

*SSAP No. 25—Affiliates and Other Related Parties* establishes statutory accounting principles for affiliates and related parties. This definition is the language that is used to help define when an investment is affiliated or nonaffiliated for reporting in the various investment schedules.

5. An affiliate is defined as an entity that is within the holding company system or a party that, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the reporting entity. An affiliate includes a parent or subsidiary and may also include partnerships, joint ventures, and limited liability companies as defined in *SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies*. Those entities are accounted for under the guidance provided in *SSAP No. 48*, which requires an equity method for all such investments. An affiliate is any person that is directly or indirectly, owned or controlled by the same person or by the same group of persons, that, directly or indirectly, own or control the reporting entity.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):**

In March 2021, the Statutory Accounting Principles (E) Working Group adopted revisions to *SSAP No. 25* pursuant to agenda item 2019-34: Related Parties, Disclaimers of Affiliation and Variable Interest Entities. Additionally, a new reporting Schedule Y, Part 3 was adopted by the Blanks (E) Working Group in proposal 2020-37BWG, with

an initial effective date of Dec. 31, 2021, to capture information on all entities with ownership greater than 10%, the ultimate controlling parties of those owners and other entities that the ultimate controlling party controls.

On May 24, 2022, the Working Group adopted revisions to SSAP No. 25 and *SSAP No. 43R—Loan-Backed and Structured Securities*, to clarify application of the existing affiliate definition as well as to incorporate new disclosure requirements for investments acquired through, or in, related parties, regardless of if they meet the affiliate definition, and included a new disclosure that was adopted by the Blanks (E) Working Group in proposal 2021-22BWG, which adds a new electronic-only column for the investment schedules and the related instructions which describes the nature of any related party relationship that exists related to the investment.

**Information or issues (included in *Description of Issue*) not previously contemplated by the Working Group:**  
None

**Convergence with International Financial Reporting Standards (IFRS):** None

**Staff Recommendation:** NAIC staff recommends that the Working Group move this item to the active listing, categorized as a SAP clarification, and expose revisions to SSAP No. 25 to clarify that any invested asset held by a reporting entity which is issued by an affiliated entity, or which includes the obligations of an affiliated entity is an affiliated investment. Staff also recommend that Working Group direct the Blanks (E) Working Group to modify the Annual Statement Instructions as illustrated below.

**Proposed edits to SSAP No. 25:**

5. An affiliate is defined as an entity that is within the holding company system or a party that, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the reporting entity. An affiliate includes a parent or subsidiary and may also include partnerships, joint ventures, and limited liability companies as defined in *SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies*. Those entities are accounted for under the guidance provided in SSAP No. 48, which requires an equity method for all such investments. An affiliate is any person that is directly or indirectly, owned or controlled by the same person or by the same group of persons, that, directly or indirectly, own or control the reporting entity. [Any invested asset held by a reporting entity which is issued by an affiliated entity, or which includes the obligations of an affiliated entity is an affiliated investment.](#)

**Proposed Annual Statement Reporting Changes: (These will be captured in a blanks proposal.)**

This will be included in the Investment Schedules General Instructions in several places covering several different types of investment, and this revision is proposed to be included in each place under the header “Parent, Subsidiaries and Affiliates.”

Parent, Subsidiaries and Affiliates:

Defined by *SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities*. [Any invested asset held by a reporting entity which is issued by an affiliated entity, or which includes the obligations of an affiliated entity is an affiliated investment.](#)

**Staff Review Completed by:** Jake Stultz—NAIC Staff, November 2022

**Status:**

On December 13, 2022, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to SSAP No. 25 to clarify that any invested asset held by a reporting entity which is issued by an affiliated entity, or which includes the obligations of an affiliated entity is an affiliated investment.

On March 22, 2023, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions illustrated above to SSAP No. 25 which clarify that any invested asset held by a reporting entity which is issued by an affiliated entity, or which includes the obligations of an affiliated entity is an affiliated investment.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-1 Spring/Summary and Minutes/SAPWG/C\\_22-15 - Affiliate Reporting.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-1%20Spring/Summary%20and%20Minutes/SAPWG/C_22-15-Affiliate%20Reporting.docx)

**Statutory Accounting Principles (E) Working Group  
Maintenance Agenda Submission Form  
Form A**

**Issue:** *ASU 2022-03, Fair Value Measurement of Equity Securities Subject to Contractual Sale Restrictions*

**Check (applicable entity):**

	P/C	Life	Health
Modification of Existing SSAP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
New Issue or SSAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Description of Issue:**

In June 2022, the Financial Accounting Standards Board (FASB) issued *ASU 2022-03, Fair Value Measurement of Equity Securities Subject to Contractual Sale Restrictions* to 1) clarify the guidance in Topic 820, Fair Value Measurement, when measuring the fair value of an equity security subject to contractual restrictions that prohibit the sale of an equity security, 2) amend a related illustrative example, and 3) add a new disclosure of the fair value of equity securities subject to contractual sale restrictions, nature and remaining duration of the restrictions, and circumstances that could cause a lapse in the restrictions, in accordance with Topic 820.

These amendments do not change the principles of fair value measurement. They provide clarity in situations involving equity securities that have restrictions related to the sale of the asset. This ASU provides updated guidance for two specific scenarios, one where the restriction is based on the entity holding the equity security and one where the restriction is a characteristic of the equity security.

- First, it clarifies situations where an equity security cannot be sold on the measurement date because of a contractual sale restriction where the entity is not allowed to sell an asset. An example of this would be lock-up periods, where the assets cannot be sold for a set period but can be readily priced based on a public security exchange.
- Second, it provides guidance for situations where the restriction is based on characteristics of the asset that limits if it can be sold in regular markets. An example would be an equity security issued through a private placement and not SEC registered and are legally restricted from being sold on a national securities exchange or an over-the-counter market. These assets would be available to be sold on an existing market (not on the public exchange) but would have a fair value based on the market price of the similar unrestricted equity security adjusted to reflect the effect of the restriction.

Guidance for restricted assets is in *SSAP No. 4—Assets and Nonadmitted Assets*, and additional guidance specific to securities in ASU 2022-03 are included in *SSAP No. 30R—Unaffiliated Common Stock*, *SSAP No. 32R—Preferred Stock*, and *SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies*. Under these SSAPs, restricted securities are generally considered to be admitted assets to the extent that they can be used to cover policyholder obligations.

**Existing Authoritative Literature:**

The primary guidance for fair value is in *SSAP No. 100R—Fair Value*. *SSAP No. 30R—Unaffiliated Common Stock* and *SSAP No. 32R—Preferred Stock*, include some guidance on restricted investments involving common and preferred stock, but neither goes into detail on the specific guidance discussed in ASU 2022-03. Additionally, *SSAP No. 1—Accounting Policies, Risks & Uncertainties, and Other Disclosures* and *SSAP No. 4—Assets and Nonadmitted Assets* include references to restricted assets, primarily related to disclosures.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):** None  
**Information or issues (included in *Description of Issue*) not previously contemplated by the Working Group:** None

**Convergence with International Financial Reporting Standards (IFRS):** None

**Staff Recommendation:**

NAIC staff recommends that the Working Group move this item to the active listing, categorized as a SAP clarification, and expose revisions to *SSAP No. 100R—Fair Value* to adopt *ASU 2022-03, Fair Value Measurement of Equity Securities Subject to Contractual Sale Restrictions* with modification to be consistent with statutory language in the respective statutory accounting statements. Proposed revisions are illustrated below.

**Proposed edits to SSAP No. 100R:**

**Equity Securities Subject to Contractual Sale Restrictions**

15. An equity security that an entity cannot sell on the measurement date because of a contractual sale restriction shall be measured at fair value on the basis of the price in the principal (or most advantageous) market<sup>FN</sup>. A contractual sale restriction does not change the market in which that equity security would be sold. A discount applied to the price of an equity security because of a contractual sale restriction is not a characteristic of the equity security. A contractual sale restriction is a characteristic of the reporting entity holding the equity security rather than a characteristic of the asset and, therefore, is not considered in measuring the fair value of an equity security. A contractual sale restriction prohibiting the sale of an equity security is a characteristic of the reporting entity holding the equity security and shall not be separately recognized as its own unit of account.

16. The effect on a fair value measurement arising from a restriction on the sale or use of an asset by a reporting entity will differ depending on whether the restriction would be taken into account by market participants when pricing the asset. When the restriction is a characteristic of the asset, the restriction ~~is a characteristic of the asset and~~ should be considered in measuring the fair value of the asset. For example, an equity security issued through a private placement is not registered and is legally restricted from being sold on a national securities exchange or an over-the-counter market until the shares are registered or the conditions necessary for an exemption from registration have been satisfied. A market participant would sell the private placement equity securities in a different market than the market used for registered equity securities on the measurement date. Because that restriction would be a characteristic of the equity security, a market participant would consider the inability to resell the security on a national securities exchange or an over-the-counter market when pricing the equity security; therefore, the reporting entity that holds the Class A shares acquired through a private placement transaction would consider that restriction a characteristic of the asset, and the reporting entity should measure the fair value of the equity security on the basis of the market price of the similar unrestricted equity security adjusted to reflect the effect of the restriction<sup>FN</sup>.

FN—Refer to *SSAP No. 4—Assets and Nonadmitted Assets* for admissibility guidance for restricted equity securities.

60. For equity securities that are subject to contractual sales, disclose the fair value of equity securities subject to contractual sale restrictions.

65. This standard adopts ASU 2022-03, Fair Value Measurement of Equity Securities Subject to Contractual Sale Restrictions, with modification to be consistent with statutory language in the respective statutory accounting statements.

**Staff Review Completed by:** Jake Stultz– NAIC Staff, November 2022

**Status:**

On December 13, 2022, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to SSAP No. 100R to adopt *ASU 2022-03, Fair Value Measurement of Equity Securities Subject to Contractual Sale Restrictions* with modification to be consistent with statutory language in the respective statutory accounting statements, as illustrated above. Note that this agenda item does not recommend incorporating the new proposed GAAP disclosures on sales restrictions, but identifies that items restricted as to sale would be captured as restricted assets per SSAP No. 1 and subject to admittance considerations under SSAP No. 4.

On March 22, 2023, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions, as illustrated above, to SSAP No. 100R to adopt ASU 2022-03 with modification to be consistent with statutory language in the respective statutory accounting statements. The adoption does not incorporate the new GAAP disclosures on sales restrictions, as items restricted as to sale would be captured as restricted assets per SSAP No. 1 and subject to admittance considerations under SSAP No. 4.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-1 Spring/Summary and Minutes/SAPWG/D\\_22-16 - ASU 2022-03 - FV.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-1 Spring/Summary and Minutes/SAPWG/D_22-16 - ASU 2022-03 - FV.docx)

**Statutory Accounting Principles (E) Working Group  
 Maintenance Agenda Submission Form  
 Form A**

**Issue: ASU 2022-04, Disclosure of Supplier Finance Program Obligations**

**Check (applicable entity):**

	P/C	Life	Health
Modification of Existing SSAP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
New Issue or SSAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Description of Issue:**

In September 2022, the Financial Accounting Standards Board (FASB) issued *Accounting Standards Update 2022-04, Liabilities—Supplier Finance Programs (Subtopic 405-50) Disclosure of Supplier Finance Program Obligations*. The Board issued ASU 2022-04 to enhance the transparency of supplier finance programs. ASU 2022-04 is effective for fiscal years beginning after December 15, 2022.

The amendments in ASU 2022-04 apply to all entities that use supplier finance programs in connection with the purchase of goods and services (described as buyer parties). Supplier finance programs, which also may be referred to as reverse factoring, payables finance, or structured payables arrangements, allow a buyer to offer its suppliers the option to access payment in advance of an invoice due date through a third-party finance provider or intermediary on the basis of invoices that the buyer has confirmed as valid.

Typically, a buyer in a program 1) enters into an agreement with a finance provider or an intermediary to establish the program, 2) purchases goods and services from suppliers with a promise to pay at a later date, and 3) notifies the finance provider or intermediary of the supplier invoices that it has confirmed as valid. Suppliers may then request early payment from the finance provider or intermediary for those confirmed invoices. Suppliers generally agree to accept an amount less than owed to receive payment from the intermediary timelier than the invoice due date. The full amount owed by the buyer is then paid to the intermediary, resulting in a spread income to the financing intermediary.

The ASU amendments require that a buyer in a supplier finance program disclose sufficient information about the program to allow a user of financial statements to understand the program’s nature, activity during the period, changes from period to period, and potential magnitude. These disclosures were supported as buyers who utilize these programs are getting a form of financing, but the amounts owed to the financial intermediaries have been reported differently, with some entities reporting as trade payables and others reporting as debt. As such, users of the financial statements do not have clear information on the use of these financing structures. ASU 2022-04 requires the buyer to make the following annual disclosures of qualitative and quantitative information about its supplier finance programs:

1. The key terms of the program, including a description of the payment terms (including payment timing and basis for its determination) and assets pledged as security or other forms of guarantees provided for the committed payment to the finance provider or intermediary
2. For the obligations that the buyer has confirmed as valid to the finance provider or intermediary:
  - a. The amount outstanding that remains unpaid by the buyer as of the end of the annual period (the outstanding confirmed amount)



- b. A description of where those obligations are presented in the balance sheet
- c. A rollforward of those obligations during the annual period, including the amount of obligations confirmed and the amount of obligations subsequently paid.

In each interim reporting period, the buyer should disclose the amount of obligations outstanding that the buyer has confirmed as valid to the finance provider or intermediary as of the end of the interim period.

*SSAP No. 105R—Working Capital Finance Investments* addresses programs similar to some of the ones described in ASU 2022-04, however it addresses such programs from the perspective of evaluating investments in such programs for admissibility for the **investor** in such programs. That is, the insurers tend to act as a finance provider or an investor in the supplier chain finance program, not the “buyer.” Insurers are not typically “buyers” in such programs as they are described in ASU 2022-04. The guidance in SSAP No. 105R would describe the “buyer” in the ASU 2022-04 as an obligor of the working capital finance program. Therefore, since the disclosures in ASU 2022-04 are for buyers/obligors of supplier finance programs, not for providers of liquidity – the investors, the disclosures do not seem relevant to require of the investors in such programs for statutory accounting.

Note that if an insurer were to sell its premium receivables, existing guidance in *SSAP No. 42—Sale of Premium Receivables* and *SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishment of Liabilities* provide guidance which distinguishes sales from financing transactions. Therefore, the new GAAP disclosures in ASU 2022-04 are not recommended for incorporation into statutory accounting.

#### **Existing Authoritative Literature:**

*SSAP No. 105R—Working Capital Finance Investments*

1. This statement establishes statutory accounting principles for working capital finance investments held by reporting entities. This statement amends *SSAP No. 20—Nonadmitted Assets* (SSAP No. 20) to allow working capital finance investments as admitted assets to the extent they conform to the requirements of this statement.

#### **Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):**

The Working Group most recently updated SSAP No. 105R with substantive revisions which were effective June 30, 2020. Revisions to SSAP No. 105R were from agenda item 2019-25: Working Capital Finance Notes which also resulted in *Issue Paper No. 163—Working Capital Finance Investment Updates*. In agenda item 2019-25 the Working Group reviewed ten industry requests and incorporated 7 out of 10 revisions to SSAP No. 105R.

#### **Information or issues (included in *Description of Issue*) not previously contemplated by the Working Group:**

None

#### **Convergence with International Financial Reporting Standards (IFRS):** None

#### **Staff Recommendation:**

NAIC staff recommends that the Working Group move this item to the active listing, categorized as a SAP clarification, and expose revisions to SSAP No. 105R to reject ASU 2022-04 as illustrated below. As insurance reporting entities are not the buyers (obligors) of supplier chain finance programs, the disclosures in ASU 2022-04 are not relevant. Reporting entities that invest in working capital finance programs are the providers of capital (investors) not the buyers (obligors) of such programs. Revisions to SSAP No. 105R:

[33. ASU 2022-04, Disclosure of Supplier Finance Program Obligations is rejected.](#)

**Staff Review Completed by:** Robin Marcotte– NAIC Staff, November 2022

**Status:**

On December 13, 2022, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to SSAP No. 105R to reject ASU 2022-04 for statutory accounting as the disclosures are not relevant for insurance entity preparers.

On March 22, 2023, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to SSAP No. 105R, as illustrated above, to reject ASU 2022-04 for statutory accounting.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-1 Spring/Summary and Minutes/SAPWG/E\\_22-18 ASU 2022-04 supply chain .docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-1 Spring/Summary and Minutes/SAPWG/E_22-18 ASU 2022-04 supply chain .docx)

**Statutory Accounting Principles (E) Working Group  
 Maintenance Agenda Submission Form  
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**Issue: Interest Income Disclosure Update**

**Check (applicable entity):**

	P/C	Life	Health
Modification of Existing SSAP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
New Issue or SSAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Description of Issue:**

This agenda item is the result of comments received from interested parties from the Principles-Based Bond Project. In the Oct. 7, 2022, comment letter, which provided comments on the Aug. 10 exposure by the Working Group, interested parties suggested some revisions to further enhance reporting of interest income on Schedule D-1-1 Bonds, and recommended that NAIC staff look further at if this should be added to any of the other reporting schedules where interest income is reported in accordance with *SSAP No. 34—Investment Income Due and Accrued*.

There were two distinct items noted in the interested parties’ comments that are addressed by this agenda item. First, they suggested data capturing the gross, nonadmitted and admitted amounts for interest income due and accrued. Second, they suggested that a data element that is included in the bond proposal project be changed to reflect the cumulative amount of paid-in-kind (PIK) interest included in the current principal balance.

With this agenda item, the Working Group will sponsor a proposal at the Blanks (E) Working Group to expand disclosures, with data capturing, to include gross, nonadmitted and admitted amounts for interest income due and accrued. The blanks proposal will also include cumulative amounts of paid-in-kind (PIK) interest included in the current principal balances.

**Existing Authoritative Literature:**

The guidance for disclosure of interest income is included in *SSAP No. 34—Investment Income Due and Accrued*.

**Disclosures**

7. The following disclosures shall be made for investment income due and accrued in the financial statements. (SSAP No. 37 captures disclosures for mortgage loans on nonaccrual status pursuant to paragraph 6.)
  - a. The bases by category of investment income for excluding (nonadmitting) any investment income due and accrued;
  - b. Disclose total amount excluded.
8. Refer to the Preamble for further discussion regarding disclosure requirements.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):**

As noted above, this agenda item comes from a suggestion from interested parties, which was included in their Oct. 7, 2022, comment letter.

**Information or issues (included in *Description of Issue*) not previously contemplated by the Working Group:**  
None

**Convergence with International Financial Reporting Standards (IFRS):** None

**Staff Recommendation:** NAIC staff recommends that the Working Group move this item to the active listing, categorized as a SAP clarification, and expose revisions to *SSAP No. 34—Investment Income Due and Accrued* to add additional disclosures to data capture the gross, nonadmitted and admitted amounts for interest income due and to add disclosure of the cumulative amount of paid-in-kind (PIK) interest included in the current principal balance. Adoption of this agenda item will also signify support for a corresponding Blanks (E) Working Group proposal to add these disclosures to Note 7 of the annual statement blanks.

**Proposed edits to SSAP No. 34:**

#### Disclosures

7. The following disclosures shall be made for investment income due and accrued in the financial statements. (SSAP No. 37 captures disclosures for mortgage loans on nonaccrual status pursuant to paragraph 6.)

- a. The bases by category of investment income for excluding (nonadmitting) any investment income due and accrued;
  - b. Disclose total amount excluded;
  - c. Disclose the gross, nonadmitted and admitted amounts for interest income due and accrued.
  - d. Disclose aggregate deferred interest and cumulative amounts of paid-in-kind (PIK) interest included in the current principal balance.
8. Refer to the Preamble for further discussion regarding disclosure requirements.

**Staff Review Completed by:** Jake Stultz—NAIC Staff, November 2022

#### Status:

On December 13, 2022, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to SSAP No. 34, to add additional disclosures, as illustrated above, and to data-capture the disclosures.

On March 22, 2023, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions, with minor edits as illustrated below, to SSAP No. 34 to add additional disclosures to data capture the gross, nonadmitted and admitted amounts for interest income due and to add disclosure of the cumulative amount of paid-in-kind (PIK) interest included in the current principal balance. These disclosures are effective for year-end 2023 reporting.

#### Disclosures

7. The following disclosures shall be made for investment income due and accrued in the financial statements. (SSAP No. 37 captures disclosures for mortgage loans on nonaccrual status pursuant to paragraph 6.)

- a. The bases by category of investment income for excluding (nonadmitting) any investment income due and accrued;
- b. Disclose total amount excluded;
- c. [Disclose the gross, nonadmitted and admitted amounts for interest income due and accrued;](#)
- d. [Disclose aggregate deferred interest;](#)
- e. [Disclose cumulative amounts of paid-in-kind \(PIK\) interest included in the current principal balance.](#)

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-1 Spring/Summary and Minutes/SAPWG/F\\_22-17 - Interest Income.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-1%20Spring/Summary%20and%20Minutes/SAPWG/F_22-17%20-%20Interest%20Income.docx)



TO: Elizabeth Kelleher Dwyer, Chair, Financial Conditions (E) Committee  
 Marlene Caride, Chair, Financial Stability (E) Task Force  
 Bob Kasinow, Chair, Macroprudential (E) Working Group  
 Thomas Botsko, Chair, Capital Adequacy (E) Task Force  
 Phillip Barlow, Chair, Risk-Based Capital Investment Risk and Evaluation (E) Working Group  
 Cassie Brown, Chair, Life Actuarial (A) Task Force  
 Judy Weaver, Chair, Financial Analysis (E) Working Group  
 Dale Bruggeman, Chair, Statutory Accounting Principles (E) Working Group  
 Fred Andersen, Chair, Valuation Analysis (E) Working Group

FROM: Carrie Mears, Chair, Valuation of Securities (E) Task Force

CC: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)  
 Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau  
 Dan Daveline, Director, NAIC Financial Regulatory Services  
 Todd Sells, Director, NAIC Financial Regulatory Policy & Data  
 Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)  
 Julie Gann, Assistant Director, NAIC Solvency Policy  
 Bruce Jenson, Assistant Director, NAIC Solvency Monitoring  
 Pat Allison, Managing Life Actuary, NAIC Financial Regulatory Affairs  
 Jane Koenigsman, Sr. Manager II, NAIC L/H Financial Analysis  
 Andy Daleo, Sr. Manager I, NAIC P/C Domestic and International Analysis  
 Dave Fleming, Sr. Life RBC Analyst, NAIC Financial Regulatory Affairs  
 Jennifer Frasier, Life Examination Actuary, NAIC Financial Regulatory Affairs  
 Scott O'Neal, Life Actuary, NAIC Financial Regulatory Affairs  
 Eva Yeung, Sr. P/C RBC Analyst/Technical Lead, NAIC Financial Regulatory Affairs

RE: Referral on Additional Market and Analytical Information for Bond Investments

DATE: February 13, 2023

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**Summary** – The Investment Analysis Office (IAO) staff recommended in its Feb. 25, 2022, memorandum to the Valuation of Securities (E) Task Force (VOSTF) (attached hereto, Blanks Market Data Disclosure v2.pdf) that it would like additional market-data fields added to the annual statement instructions for bond investments. This was, in part, based upon the NAIC's adoption in 2010 of the recommendations of

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Kansas City 1100 Walnut Street NW, Suite 1500, Kansas City, MO 64106-2197 p | 816 842 3600 f | 816 783 8175

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the Rating Agency (E) Working Group (RAWG), which was formed following the Great Financial Crisis of 2007-2008 to study the NAIC's reliance on rating agencies, and the IAO staff's recent findings in its Nov. 2021 memo regarding disparities between rating agencies. RAWG recommended that: 1) regulators explore how reliance on rating agencies can be reduced when evaluating new, structured, or alternative asset classes, particularly by introducing additional or alternative ways to measure risk; and 2) consider alternatives for regulators' assessment of insurers' investment risk, including expanding the role of the NAIC Securities Valuation Office ("SVO"); and 3) VOSTF should continue to develop independent analytical processes to assess investment risks. These mechanisms can be tailored to address unique regulatory concerns and should be developed for use either as supplements or alternatives to ratings, depending on the specific regulatory process under consideration.

The NAIC's need for alternative measures of investment risk has only increased since RAWG made its recommendations, as privately issued and rated complex structured finance transactions have become commonplace without adequate ways of identifying them. The SVO recommended the following market data fields to be added to the annual statement instructions: Market Yield, Market Price, Purchase Yield, Weighted Average Life, Spread to Average Life UST, Option Adjusted Spread, Effective Duration, Convexity and VISION Issue ID. Please refer to the attached memo for more detail on each data field.

In comments received from industry there were question as to how the SVO, VOSTF and/or other regulators who would receive the analytic data included in the proposal would utilize that information and why it is of value to them. The SVO was also asked to consider industry's recommendation that the NAIC be responsible for calculating this analytical information by utilizing commercially available data sources and investment models instead of having each individual insurance company incur the costs to implement system changes. The SVO shared their thoughts on the alternatives in the Jul. 14, 2022, memorandum to the VOSTF (attached, Blanks\_Market\_Data\_Options\_v3.pdf).

Capabilities like this within the SVO would permit it to calculate for regulators all the analytic values previously mentioned for any Schedule D investment along with additional measures such as key rate duration (a measure of interest rate sensitivity to maturity points along the yield curve), sensitivity to interest rate volatility, principal and interest cash flow projections for any security or portfolio for any given interest rate projection, loss estimates for any security for any given scenario and many others measures.

**Referral** – VOSTF refers this matter to the above referenced Committees, Task Forces and Working Groups for consideration and requests a response from you by May 15<sup>th</sup> outlining:

1. Indicate if your group is supportive of creating this capability within the SVO.
2. List the investment analytical measures and projections that would be most helpful to support the work performed by your respective group.
3. Describe how your group would utilize the data and why it would be of value.
4. Are there other investment data or projection capabilities that would be useful to your group that could be provided by commercially available data sources or investment models? And if so, please list them.
5. Any other thoughts you may have on this initiative.

Please contact Charles Therriault or Marc Perlman with any questions.

VOSTF\_Referral\_Bond\_Risk\_Measures\_2023-02-13.docx

**D. Keith Bell, CPA**  
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**Rose Albrizio, CPA**  
Vice President  
Accounting Practices  
Equitable  
Phone: 201-743-7221  
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January 9, 2023

Michael F. Consedine, Chief Executive Officer  
Andrew Beal, Chief Operating Officer and Chief Legal Officer  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

RE: Request for Accounting Practices and Procedures Manual PDF

Dear Messrs. Consedine and Beal:

We would like to like to raise an issue that has become an impediment for industry and others that need access to the guidance in the *NAIC Accounting Practices and Procedures Manual* (the “AP&P Manual”). The current product offered by the NAIC, i.e., the BookShelf® Online Subscription AP&P Manual, does not provide an effective search capability or print function, the two most important functionalities needed by users of the product.

For the reasons discussed below, we respectfully request that the NAIC make available for purchase by industry a licensed PDF version of the AP&P Manual that is both searchable and printable. There is great frustration with our current online product as evidenced by a survey of companies that we conducted during 2022. The dissatisfaction with the online system was exacerbated when in 2022 the hard copy manual was no longer available and the online Bookshelf became the sole source for authoritative guidance. This has resulted in the overwhelming support from insurance companies for a PDF version of the AP&P Manual.

What would be the usage of the PDF by companies?

1. The desire for a searchable PDF (outside of bookshelf) rather than hardcopy printing as the feedback reflected difficulty printing from bookshelf as well as limited search capability.
2. If a license for a PDF was provided, we expect the majority will print by SSAP, some will print out the full AP&P Manual and require multiple copies.
3. Insurers are looking at this on a group basis (providing access to insurers within an insurance group in one license) as insurers have centralized accounting functions.
4. If acquiring a PDF with searchable and printing capability, some insurers may still want bookshelf licenses. It will depend on the functionality of PDF (searchable and printable PDF) and the ability to access updates. The lack of functionality in the online bookshelf product is driving the need for a searchable and printable PDF

As mentioned above, we sent out a request to industry as to provide feedback to the NAIC on industry’s interest in an alternative to the online version of the AP&P Manual asking, *if* the NAIC would be willing to sell a licensed PDF version of the AP&P Manual that is printable, would you be interested? We



received a very strong response from 52 companies who supported a printable and searchable PDF version of the accounting manual. We have included the comments provided by member companies below, unedited. Note that several comments, notably a request to publish newly adopted revisions in PDF format, have been addressed already by NAIC Staff. However, the responses highlight the difficulties that companies have experienced using the Bookshelf software overall and suggest that a PDF version of the AP&P Manual would provide substantial benefit to industry.

Response
<p>Bookshelf is a product for individuals who read materials by flipping pages as if they are holding a hardcopy; however, the functionality is slow and unreliable. Sometimes pages of text take a long time to load or fail to load. As a result “flipping” back and forth between the electronic pages in cumbersome. Finance professionals are looking for an accounting and reporting research tool that requires functionality to search for terms and viewing pertinent sections in streaming form, allowing readers to quickly scroll through multiple pages of text. A softcopy solution, like a PDF file, that enables searching all standards with ability to scroll through each standard would greatly improve our efficiency and effectiveness in researching accounting and reporting matters.”</p>
<p>I’d be willing to buy anything more convenient than the current Bookshelf version. And that goes for all NAIC manuals, including the Annual Statement Instructions.</p>
<p>Using the APPM has been a pain point for us ever since the introduction of the Bookshelf product.</p> <p>We would also suggest that SAPWG make PDF copies of newly adopted changes available on the website (similar to how Blanks operates), as this practice appears to have been discontinued along with hard copy manuals. Implementation of new guidance routinely involves distribution of new guidance to different areas of our company that do not have reason to access the APPM in the normal course. Carving out these changes and printing from the Bookshelf product is unnecessarily difficult and time-consuming.</p>
<p>Yes, I feel very strongly that they need an alternative online version and prefer they provide an option for a manual copy. The current Bookshelf program is not user friendly, too slow, and stalls out frequently. For example, if you know you need something in SSAP No. 54, but don’t know what specific page it is on, the program is very inefficient if you are trying to flip the pages quickly to find the section needed. We would buy a licensed, printable version of the Manual. We had actually budgeted for two copies this year because of the remote environment and the hindrances of the program.</p>
<p>When we say printable – are we talking about that bookshelf version (which only lets you download 10 pages at a time) or something else. We like the printed version too so that we can share in our office but if it was a PDF version that wasn’t on that bookshelf system that would interest us. We will say that the bookshelf system is horrible and incredible hard to read with the watermark on it and to download the entire more than 10 pages is VERY time consuming.</p>
<p>I would love to be able to access a PDF version of the NAIC Accounting P&amp;P manual. The online tool that we were accessing the manual through is an impediment, my team has generally reverted to using old paper copies of the manual. Having it in PDF would be ideal, given so many folks in Accounting are now working remotely. This would make citations of the manual as easy as snipping and pasting.</p>

<p>To the best of my knowledge, XXX has one subscription to the on-line manual for which I am the (lucky?) user. I question how lucky I am, because I find it a huge pain in the rear to use, print, share somehow (no matter how infrequent even with others at XXX who are paying for the service). And the subscription process itself is a disaster. So, yes, I would be interested in a sane alternative.</p>
<p>The Vital Source web-based tool is not good and our IT department wouldn't approve the desktop version.</p>
<p>Would be very much interested in more manageable, printable and searchable document.</p>
<p>Would be very supportive of getting a licensed PDF version back. We have a ton of technical difficulties in accessing the online manual. Further, it seems like their licenses expire before they are supposed to so it feels like we've had to buy extra licenses to make sure we can access the content. In short, it's not a user-friendly tool.</p>
<p>Yes, I would be interested. It needs to be "searchable". At a minimum, encourage them to move away from Bookshelf.</p>
<p>We would be 100% interested. A PDF version would be very useful for us. Perhaps there could be an all-company license paid per year. We have a handful of active users, but we have countless requests where a single person may request to read a single SSAP on an ad-hoc basis. So making the guidance widely available, even at a cost, would be beneficial for us, and I would think it would good for the NAIC as well.</p>
<p>I would be very interested in a *.pdf version of the APP Manual. The current online version al is terrible with seemingly intentionally poor functionality.</p>
<p>Yes, we would be interested as it may be a more usable version than what we have today.</p>
<p>I would definitely be interested. I have a number of years of experience with the online version and it is very slow and clunky. The hardcopy version is no longer relevant in today's day and age. Not to mention, the individuals who utilize the manual for reference across a Company is continuing to grow and is not confined to only a couple individuals like it used to be a number of years ago.</p>
<p>This has been extremely challenging to manage the cost/availability of the AP&amp;P since it moved to online.</p>
<p>Any way to make the APPM more accessible would be appreciated! Bookshelf is so cumbersome and limiting.</p>
<p>The NAIC <b>should</b> have a system where it could easily be maintained via loose-leaf (as a compromise between bound/on-line) . We'd keep it in a couple 3-ring binders, the NAIC could issue updates via new pages properly sequenced, and we'd just hole punch/ replace and move on.</p>
<p>We would definitely be interested in a licensed .pdf version or another way to print/source the Manual. As of right now, it is cumbersome to only be able to print 20 pages at a time and at times, the watermark used (to not distribute) makes parts difficult to read depending upon the printer.</p>

We would be interested in a printable pdf version of the manual if the cost makes sense. I like the online version, but I have been disappointed that access is only provided on a per person basis. We have a large number of people that may have a need to look at the AP&P manual, but many of those people may only need it for a short period of time, making it cost prohibitive for everyone that may have a need for it. In addition, as people rotate through our different Finance areas for development purposes, the people that need access to the AP&P manual can change frequently throughout the year. For these reasons, a site license for a set number of concurrent users or a printable pdf version that can be shared would work better than the current arrangement.

It would also be good if the NAIC would not put the watermark across every page when printing from the online version to a pdf. It just makes it hard to read and seems overkill.

We appreciate your consideration of this matter. This is very important to our companies in complying with the statutory accounting requirements and in supporting the NAIC in their initiatives to keep the guidance current.

Thank you for considering our request. If you have any questions, please do not hesitate to contact us.

Sincerely,

D. Keith Bell

Rose Albrizio

cc: Mr. Dale Bruggeman, Chairman, Statutory Accounting Principles Working Group  
NAIC staff  
Interested parties

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cmt/apptf/2023-1 spring/summary and minutes/sapwg/h\\_comment letter - app manual.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cmt/apptf/2023-1%20spring/summary%20and%20minutes/sapwg/h_comment%20letter%20-%20app%20manual.docx)



To: D. Keith Bell (The Travelers Companies, Inc.), Rose Albrizio (Equitable), and interested parties of the Statutory Accounting Principles (E) Working Group

From: Michael Consedine, NAIC Chief Executive Officer  
Andy Beal, NAIC Chief Operating Officer and Chief Legal Officer

Re: Accounting Practices and Procedures Manual PDF

On Jan. 9, the NAIC received a comment letter from D. Keith Bell and Rose Albrizio, representing interested parties of the Statutory Accounting Principles (E) Working Group (SAPWG), requesting a product enhancement, specifically a PDF, to the *NAIC Accounting Practices and Procedures Manual* (AP&P Manual). As further detailed herein, due to system limitations of our third-party distributor, many purchasers are not able to effectively research or quickly reference certain key aspects of the manual – specifically users could not efficiently search for references or key phrases. This difficulty, along with the inability to quickly reference differing sections of the manual, sections in which reference complementary statutory guidance, made use of the manual overly burdensome. This memorandum summarizes the NAIC’s action plan to promptly resolve the issue presented.

### **Brief Background**

Organized under the Financial Condition (E) Committee, SAPWG is responsible for developing and adopting revisions and interpretations to the AP&P Manual, the manual which details and provides the accounting basis for insurers to prepare financial statements for financial regulation purposes. Updates to the manual take place quite often, generally occurring several times a year and are made to address new statutory issues or generally accepted accounting principles (GAAP) pronouncements. Accordingly, the SAPWG and its support staff take pride in the manual being complete and relevant to today’s overall accounting issues and to address specific, unique circumstances that are of concern to regulators.

In addition to completeness, transparency and usability are essential characteristics supported by the Financial Condition (E) Committee and SAPWG. Every proposed accounting revision undergoes a rigorous and methodical exposure process, providing an opportunity for regulators and interested parties to comment on any proposed revision. In many cases, regulators and interested parties (along with NAIC support staff) work in conjunction to ensure drafted language is understandable and operationally functional all while addressing the needs of regulators. In the same vein, transparency must go beyond the amendment process and must remain in place so that users have an efficient and effective method in which to access the manual. Compliance with the guidance is not only mandatory, but vitally important to ensure regulators have access to accurate, representative financial information so ease of use is critical.

Washington, DC 444 North Capitol Street NW, Suite 700, Washington, DC 20001-1509 p | 202 471 3990 f | 816 460 7493

Kansas City 1100 Walnut Street NW, Suite 1500, Kansas City, MO 64106-2197 p | 816 842 3600 f | 816 783 8175

New York One New York Plaza, Suite 4210, New York, NY 20004 p | 212 398 9000 f | 212 382 4207

[www.naic.org](http://www.naic.org)

**Access to the AP&P Manual**

Subscribers to the AP&P Manual have two avenues to access the publication. (One brief note, the printing and distribution of a hardcopy manual ended in 2021 as demand for such a product greatly declined.)

1. **Avenue 1:** The first is to download a desktop application. When this avenue is utilized, the manual is nearly as searchable and usable as an unrestricted PDF. However, we have found that many organizations, through their information technology security controls, do not allow for the installation of this type of software, so this preferred avenue is likely not often utilized.
2. **Avenue 2:** The second option is to access the manual through our vendor's web portal. While the initial impression is that the desktop versus the web portal should act in identical manners, unfortunately the two methods operate differently. As a simple example, a search of a particular phrase will produce different results between the two methods. The NAIC has reached out to the vendor on numerous occasions to correct this issue, but it is unlikely this issue will be addressed quickly due to system limitations.

The NAIC understands that as most industry users are likely utilizing the second avenue to access the manual, that the ability to search for specific phraseology, quickly reference or cross reference various guidance is less than optimal. The AP&P Manual, by its very design, is a highly technical document and the ability to search for guidance quickly and efficiently – guidance that is sometimes reflected in multiple locations, is recognized by the NAIC as an important use characteristic.

**Recent Steps Taken and Action Plan**

Recognizing the need for users to have ready and immediate access to newly adopted accounting guidance, starting in 2022, the NAIC began posting adoptions on the SAPWG website as a free PDF publication. These documents will be available for one year and include a summary of the revisions as well as the maintenance agenda submission form (Form A), which includes a description of the accounting issue, interim exposure drafts as well as the final adopted guidance. Posting of these documents was a welcome change as it provided further transparency for interested parties as well as quick and easy access to recent accounting developments. The comment letter also noted that this process change did address several of industry's prior concerns.

However, moving beyond recent adoptions, the AP&P Manual is a complex and frequently referenced publication thus the ability to efficiently search and reference its contents is critical. Accordingly for the 2023 manual, the NAIC is proud to announce that a copyrighted PDF will be made available, at no additional charge, to those who purchase a subscription to the manual. Similar to the current subscription process, access will be restricted to the individual level, however the PDF will be as searchable and printable as any other PDF document. We trust that this offering will be well received.

Moving forward to the 2024 manual, the NAIC is dedicated to finding an amicable, long-term solution that will result in ease of access for industry users.

If you have any questions in the interim, please feel free to reach out to Jim Pinegar, Assistant Director of Strategic Business Initiatives at [jpinegar@naic.org](mailto:jpinegar@naic.org).

cc: Superintendent Dwyer, Chair of the Financial Condition (E) Committee  
Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group  
Jeff Johnston, Managing Director, Financial Regulatory Affairs  
Jim Woody, Chief Financial Officer



February 23, 2023

Paul Lombardo, Co-Chair  
Fred Andersen, Co-Chair  
Long-Term Care Actuarial (B) Working Group  
National Association of Insurance Commissioners (NAIC)

Re: Accounting Interpretation Request: Interaction Between *Actuarial Guideline LI* (AG 51) and Appendix A-010

Dear Mr. Lombardo and Mr. Andersen,

On behalf of the Financial Reporting and Solvency Committee (“the committee”) of the Health Practice Council of the American Academy of Actuaries,<sup>1</sup> we are reaching out to you to ascertain whether the Long-Term Care Actuarial (B) Working Group might issue an accounting interpretation for the interaction between *Actuarial Guideline LI* (AG 51) and Appendix A-010.

In 2017, the National Association of Insurance Commissioners (NAIC) adopted AG 51, “The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves.” Subsequent to the adoption of AG 51, the committee has observed some diversity in practice across issuers of long-term care insurance with regard to how the new guidance in AG 51, and specifically Section 4.C thereof, interacts with existing guidance on accident & health insurance reserve adequacy, as found in paragraph 24 of the Statement of Statutory Accounting Principles (SSAP) No. 54R, “Individual and Group Accident and Health Contracts,” and paragraph 26 of Appendix A-010, “Minimum Reserve Standards for Individual and Group Accident and Health Insurance Contracts.”

To our knowledge, the Long-Term Care Actuarial (B) Working Group has not previously been made aware that a diversity of practice has developed, subsequent to the adoption of AG 51, regarding how AG 51 interacts with Appendix A-010.

It would be helpful for Long-Term Care Actuarial (B) Working Group to review the attached Form A, and issue an interpretation to clarify the intended interaction between AG 51 and Appendix A-010, along the lines of one of the suggested interpretation statement wording options contained in the form. Note that we are not advocating for one of these options over the other; instead, our interest is in having the NAIC provide greater clarity to actuaries to understand its underlying intent.

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<sup>1</sup> The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

We appreciate the opportunity to reach out to you on an accounting interpretation request for the interaction between *Actuarial Guideline LI* and Appendix A-010. We would welcome the opportunity to speak with you to provide more detail regarding these comments or on other issues. If you have any questions or would like to discuss further, please contact Matthew Williams, the American Academy of Actuaries senior health policy analyst, at [williams@actuary.org](mailto:williams@actuary.org).

Sincerely,

David Hutchins, MAAA, FSA  
Chairperson, Financial Reporting and Solvency Committee  
American Academy of Actuaries

CC: Dale Bruggeman, Chair, Statutory Accounting Principles (E) Working Group (SAPWG), Accounting Practices and Procedures (E) Task Force; Fred Andersen, Chair, Valuation Analysis (E) Working Group, Financial Condition (E) Committee. NAIC Support Staff: Eric King/Julie Gann/Patricia Allison

Attachment: Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form—Form A

**Spring National Meeting - Review of GAAP Exposures for Statutory Accounting:**

Pursuant to a 2014 direction from the SAPWG chair, there is a desire for the Statutory Accounting Principles (E) Working Group to be more proactive in considering FASB exposures that may be significant to statutory accounting and reporting. Historically, the SAPWG has commented on limited, key FASB exposures – mostly pertaining to insurance contracts and financial instruments. To ensure consideration of all FASB exposures, staff has prepared this memorandum to highlight the current exposures, comment deadlines, and to provide a high-level summary of the exposed item’s potential impact to statutory accounting. It is anticipated that this information would assist the Working Group in determining whether a comment letter should be submitted to the FASB on the issues. Regardless of the Working Group’s election to submit comments to the FASB on proposed accounting standards, under the NAIC Policy Statement on Statutory Accounting Principles Maintenance Agenda Process, issued US GAAP guidance noted in the hierarchy within Section V of the Preamble to the *Accounting Practices and Procedures Manual* must be considered by the Statutory Accounting Principles (E) Working Group.

FASB Exposures: [Exposure Documents and Public Comment Documents \(fasb.org\)](https://www.fasb.org/exposures)

Exposed FASB Guidance	Comment Deadline & Initial Staff Comments
Proposed Statement of Financial Accounting Concepts No. 8— <i>Conceptual Framework for Financial Reporting—Chapter 2: The Reporting Entity</i>	January 16, 2023
Proposed Statement of Financial Accounting Concepts No. 8— <i>Conceptual Framework for Financial Reporting—Chapter 5: Recognition and Derecognition</i>	February 21, 2023

**Proposed Statement of Financial Accounting Concepts No. 8—*Conceptual Framework for Financial Reporting—Chapter 2: The Reporting Entity***

The Financial Accounting Standards Board (FASB or Board) issued its first Concepts Statement in 1978 and issued six more by 2000. In 2004, the International Accounting Standards Board (IASB) and the FASB (the Boards) began a joint project to revise and converge their conceptual frameworks. The result of that joint project was FASB Concepts Statement No. 8, *Conceptual Framework for Financial Reporting—Chapter 1, The Objective of General Purpose Financial Reporting*, and *Chapter 3, Qualitative Characteristics of Useful Financial Information*. In late 2010, the Boards decided to postpone further action on their respective conceptual frameworks until after the completion of several joint projects and ultimately agreed to discontinue the effort to work on their frameworks on a joint basis.

In January 2014, the FASB reactivated its Conceptual Framework project. This proposed Concepts Statement, which would become Chapter 2 of Concepts Statement 8, describes a reporting entity.

This chapter of Concepts Statement 8 would be similar to the rest of the framework in that it establishes concepts that the Board would use in developing standards of financial accounting and reporting. In particular, this chapter would provide the Board with a framework for matters relating to the identification of a reporting entity. This chapter would provide the Board with a framework for developing standards that meet the objective of financial reporting and enhance the understandability of information for existing and potential investors, lenders, donors, and other resource providers of a reporting entity.



**Staff Review and Commentary:**

Comment deadline was January 16, 2023

NAIC staff recommend that ASU be reviewed under the SAP Maintenance Process as detail in *Appendix F—Policy Statements*.

**Proposed Statement of Financial Accounting Concepts No. 8—*Conceptual Framework for Financial Reporting—Chapter 5: Recognition and Derecognition***

The Financial Accounting Standards Board (FASB or Board) issued its first Concepts Statement in 1978 and issued six more by 2000. In 2004, the International Accounting Standards Board (IASB) and the FASB (the Boards) began a joint project to revise and converge their conceptual frameworks. The result of that joint project was FASB Concepts Statement No. 8, Conceptual Framework for Financial Reporting—Chapter 1, The Objective of General Purpose Financial Reporting, and Chapter 3, Qualitative Characteristics of Useful Financial Information. In late 2010, the Boards decided to postpone further action on their respective conceptual frameworks until after the completion of several joint projects and ultimately agreed to discontinue the effort to work jointly on their frameworks.

In January 2014, the FASB reactivated its conceptual framework project. This Exposure Draft, which would become Chapter 5 of Concepts Statement 8, addresses matters relating to the recognition and derecognition of an item in financial statements.

Paragraph 105-10-05-3 of the FASB Accounting Standards Codification® states that FASB Concepts Statements are not authoritative. Some standards are inconsistent with the Concepts Statements. This Concepts Statement or other Concepts Statements do not override authoritative standards. If accounting for a transaction or event is not specified in authoritative generally accepted accounting principles (GAAP), an entity first must consider accounting principles for similar transactions or events within authoritative GAAP and then consider nonauthoritative guidance from other sources (including Concepts Statements).

This chapter of Concepts Statement 8 would be similar to the rest of the framework in that it establishes concepts that the Board would use in developing standards of financial accounting and reporting. In particular, this chapter would provide the Board with a framework for conceptual matters relating to the recognition and derecognition of an item in financial statements. This chapter would provide the Board with a framework for developing standards in meeting the 2 objective of financial reporting that enhances the understandability of information to existing and potential investors, lenders, donors, and other resource providers of a reporting entity.

**Staff Review and Commentary:**

Comment deadline was February 21, 2023

NAIC staff recommend that ASU be reviewed under the SAP Maintenance Process as detail in *Appendix F—Policy Statements*.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-1 Spring/Summary and Minutes/SAPWG/S - Review of GAAP Exposures.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-1%20Spring/Summary%20and%20Minutes/SAPWG/S%20Review%20of%20GAAP%20Exposures.docx)

Draft: 3/15/23

Blanks (E) Working Group  
Virtual Meeting  
March 7, 2023

The Blanks (E) Working Group of the Accounting Practices and Procedures (E) Task Force met March 7, 2023. The following Working Group members participated: Pat Gosselin, Chair (NH); Kim Hudson, Vice Chair (CA); David Phifer (AK); Michael Shanahan (CT); N. Kevin Brown (DC); Tom Hudson (DE); Carolyn Morgan (FL); Carrie Mears (IA); Roy Eft (IN); Kristin Hynes (MI); Debbie Doggett (MO); Lindsay Crawford (NE); John Sirovetz (NJ); Dale Bruggeman and Tracy Snow (OH); Diane Carter (OK); Diana Sherman (PA); Shawn Frederick (TX); Jake Garn (UT); Steve Drutz (WA); Adrian Jaramillo (WI); and Mary Jo Lewis (WV).

1. Adopted its Nov. 17, 2022, Minutes

Gosselin referenced the Blanks (E) Working Group's Nov. 17, 2022, minutes. During that meeting, the Working Group took the following action: 1) adopted the following proposals: a) 2022-12BWG – Combine the Health Analysis of Operations by Lines of Business Supplement page and the Health Care Receivable Supplement pages (Exhibits 3 and 3A) into one supplement filing set for health blank pages filed as a supplement by life/fraternal companies; b) 2022-19BWG Modified – modify the Life Insurance (State Page) to include the line of business detail reported on the Analysis of Operations by Lines of Business pages. Adds definitions for life and annuity products to the lines of business definitions in the health appendix; 2) adopted its editorial listing; 3) exposed six new proposals; 4) approved language added to the blanks proposal form to address duplication of reporting; 5) reviewed its 2023 proposed charges; 6) received a memorandum from the Statutory Accounting Principles (E) Working Group regarding disclosures required as part of *Interpretation (INT) 22-02: Third Quarter 2022 Reporting of the Inflation Reduction Act – Corporate Alternate Minimum Tax*; and 8) reviewed State Filing Checklists.

Crawford made a motion, seconded by Doggett, to adopt the Working Group's Nov. 17, 2022, minutes (see *NAIC Proceedings – Fall 2022, Accounting Practices and Procedures (E) Task Force, Attachment Two*). The motion passed unanimously.

2. Adopted Items Previously Exposed

a. Agenda Item 2022-14BWG – Effective 12/31/2023

Hudson stated that this proposal modifies Exhibit 1, Parts 1 and 2, and Exhibit 8, Parts 1 and 2, in the life, accident and health/fraternal blank to include the lines of business detail reported on the Analysis of Operations by Lines of Business pages for consistency. There was a modification made to update crosscheck references on Summary of Operations, Analysis of Operations, Five-Year Historical, and Schedule S. This comment was received during the comment period and is highlighted in gray in the proposal. After discussions with interested parties, they agreed to support the annual 2023 effective date.

Hudson made a motion, seconded by Drutz, to adopt the modifications to the proposal. The motion passed unanimously. Hudson made a motion, seconded by Drutz, to adopt the modified proposal (Attachment Two-A). The motion passed unanimously.

b. Agenda Item 2022-15BWG

Doggett stated that this proposal impacts the life, accident and health/fraternal, and property/casualty (P/C) blanks. It revises the language of Schedule H, Part 5, to remove the 5% of premiums filing exemption. Before Schedule H was updated for Annual 2022 to bring uniformity in the accident and health lines of business, the P/C instructions for Schedule H, Part 5 had the “less than 5% filing exemption,” and the life/fraternal instructions did not have the 5% filing exemption. The removal of the 5% exemption would require both P/C and life/fraternal filers to file Schedule H, Part 5. There were no comments received.

Doggett made a motion, seconded by Garn, to adopt the proposal (Attachment Two-B). The motion passed unanimously.

c. Agenda Item 2022-16BWG

Drutz stated that this proposal removes Supplemental Health Care Exhibit Part 3 and Supplemental Health Care Exhibit’s Expense Allocation Report from the life, accident and health/fraternal, health and P&C blanks as they are no longer used regularly by regulators. Interested parties asked that the health care quality expenses definitions be added to the Appendix. These definitions pertain specifically to the Supplemental Health Care Exhibit as part of the federal Affordable Care Act (ACA) adoption, which has an April 1 filing deadline. Therefore, the most appropriate location for these definitions is with the supplemental exhibit.

Demetria Tittle (Blue Cross Blue Shield Association—BCBSA) stated that interested parties appreciate the nature of this proposal to remove information that regulators no longer frequently use, stating further that interested parties further support the new working group charge to consider proposals that address duplication in the financial reporting. She indicated that interested parties have begun to discuss and analyze the annual statement and other supplemental filings for similar additional opportunities to support this important project. She stated that examples would be shared in the near future, proposing recommendations for the Working Group to consider after the interested parties’ full vetting process. She stated that they share the goal of providing regulators with pertinent information in a form that creates mutual efficiencies while reducing redundancy where possible.

Tom Finnell (America’s Health Insurance Plans—AHIP) stated that AHIP members support the initiative of reducing redundancies within the reporting blank.

Gosselin stated that the Blanks (E) Working Group members would continue to appropriately assess redundancies and information that regulators no longer need through any proposals that are presented to the Working Group. This is with the understanding that before any such proposals are presented to the Working Group for consideration, the related policymaking task forces and working groups are made aware of the proposal. The discussions regarding any change and possible impact should be addressed with the policymaking groups. The process is consistent with the Working Group’s 2023 adopted charges.

Drutz made a motion, seconded by Shanahan, to adopt the proposal (Attachment Two-C). The motion passed unanimously.

d. Agenda Item 2022-18BWG

Gosselin stated that this proposal impacts the life, accident and health/fraternal blank, addressing instructional corrections on the handling of exchange-traded funds (ETFs) and/or Securities Valuation Office (SVO) identified funds within the interest maintenance reserve (IMR) and the asset valuation reserve (AVR). This relates to the classification of bond mutual funds being no longer used in statement reporting within the *Accounting Practices*

and Procedures Manual (AP&P Manual) or within the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual).

Interested parties suggested changes to line 2, for unaffiliated common stocks-private to exclude money market mutual funds appropriately reported on Schedule E, Part 2. However, NAIC staff supporting the Statutory Accounting Principles (E) Working Group indicated that paragraph 8 in the *Statement of Actuary Accounting Principles (SSAP) No. 2R—Cash, Cash Equivalents, Drafts, and Short-Term Investments* references this issue. In order for money market mutual funds (MMMFs) to be reported as cash equivalents, they must be registered with the U.S. Securities and Exchange Commission (SEC) as an MMMF and regulated under the 1940 Act. It is not permissible to apply the cash equivalent guidance to non-registered funds that may resemble an MMMF. As such, they should all be public.

Gosselin made a motion, seconded by Garn, to adopt the proposal (Attachment Two-D). The motion passed unanimously.

e. Agenda Item 2022-20BWG

Mary Caswell (NAIC) stated that this proposal modifies the instructions and blanks for various health exhibits to change the order of the vision and dental lines of business to be consistent with all other statement types. To address interested parties' comments, a "life (health supplement)" check box option has been added to the proposal form to identify changes that impact the health supplements in the life blank.

Hudson made a motion, seconded by Shanahan, to adopt the proposal (Attachment Two-E). The motion passed unanimously.

3. Re-Exposed Items

a. Agenda Item 2022-17BWG

Bruggeman stated that this proposal adds a new disclosure paragraph for Note 8 – Derivative Instruments and an illustration of new disclosure to be data captured. It adds electronic-only columns related to derivatives with excluded components to Schedule DB, Part A and Part B for both Section 1 and Section 2. It adds new code column instructions for Schedule DB, Part A and Part B. The purpose of the proposal is to reflect changes and disclosures adopted by the Statutory Accounting Principles (E) Working Group to *SSAP No. 86—Derivatives* in agenda item 2021-20. Interested parties have provided comments proposing to clarify certain aspects of the disclosure. The statutory accounting principles (SAP) guidance was permitted for early adoption at year-end 2022, so the proposed disclosure has had the benefit of being reviewed by companies as they initially applied the SAP guidance. NAIC staff supporting the Statutory Accounting Principles (E) Working Group have discussed the comments with interested parties' representatives and have come to an agreement on the current proposed clarifications. Although it is anticipated that the clarifications will address the interested parties' concerns, it is recommended that the blanks proposal be exposed with the revisions to allow for an additional public comment period. It is requested that the exposure timeframe continue to allow for adoption consideration during the Blanks (E) Working Group meeting in May for an annual 2023 effective date.

Bruggeman made a motion, seconded by Eft, to adopt the modifications to the proposal. The motion passed unanimously. Bruggeman made a motion, seconded by Eft, to re-expose the proposal for a public comment period ending April 28.

#### 4. Exposed New Items

##### a. Agenda Item 2023-01BWG

Doggett stated that this proposal removes pet insurance from the inland marine line of business and adds a new line of business to Appendix – Property and Casualty (P/C) Lines of Business definitions. It adds a pet insurance line within the existing P/C blank for the Underwriting and Investment Exhibits, Exhibit of Premiums and Losses (State Page), and Insurance Expense Exhibit. It adds new Schedule P, Parts 1 through 4, specific to pet insurance.

The primary reason for this proposal is that there is currently no public or regulatory visibility into the vast amount of pet insurance industry financial reporting other than one monoline insurer that writes pet insurance. The rest of the industry's business is buried within the inland marine line of business. The pet insurance industry has grown rapidly, and this high growth rate continues. The industry's self-reported data shows growth in annual gross written premiums from \$836.5 million in 2016 to \$2.59 billion in 2021, including more than 30% annual growth from 2020 to 2021. This growth rate makes the absence of visibility into each participating company's financial information more of an acute challenge with each passing year.

Doggett stated that getting information related to pet insurance currently relies on data calls, which is a very time-consuming process for all involved parties. The NAIC's Market Regulation and Consumer Affairs (D) Committee is proceeding to identify pet insurance on the Market Conduct Annual Statement (MCAS). Doing so on the financial statement appears to be appropriate at this time.

Hearing no objection, Gosselin stated that the proposal will be considered exposed for a 52-day public comment period ending April 28.

##### b. Agenda Item 2023-02BWG

Teresa Cooper (NAIC) stated that this proposal adds an exhibit to identify premiums that are reportable for MCAS purposes. The addition of MCAS premium reporting will allow accurate identification of required MCAS filing submissions. The request is to require the data by state. This would be in the life, accident and health/fraternal, health and property statements. This will eliminate industry and regulator work to submit and review annual waiver requests.

Hearing no objection, Gosselin stated that the proposal will be considered exposed for a 52-day public comment period ending April 28.

##### c. Agenda Item 2023-03BWG

Caswell stated that this proposal removes life, accident and health/fraternal blank crosschecks for Columns 2, 6, and 10 on the Accident & Health Policy Experience Exhibit. The life, accident and health/fraternal blank crosschecks are not working correctly because Columns 2, 6, and 10 on the Accident & Health Policy Experience Exhibit are on a direct basis, and Exhibit 6 is on an assumed basis.

Hearing no objection, Gosselin stated that the proposal will be considered exposed for a 52-day public comment period ending April 28.

d. Agenda Item 2023-04BWG

Angela McNabb (NAIC) stated that this proposal adds instructions for the appointed actuary and qualified actuary contacts to the jurat electronic-only section. In working with the principles-based reserving and the mortality experience data collection, staff has had instances where they needed to communicate directly with either the appointed actuary or qualified actuary. Currently, these are not identified in the blank. The additional contact information will help regulators in locating the appropriate actuaries to address any actuarial questions.

Hearing no objection, Gosselin stated that the proposal will be considered exposed for a 52-day public comment period ending April 28.

e. Agenda Item 2023-05BWG

Sara Robben (NAIC) stated that the cybersecurity supplement has been in effect since 2016. Staff have reviewed the information that has been collected on identity theft and concluded that the information was not beneficial. This is because there are a lot of non-insurance companies that write identity theft coverage. This proposal is requesting to discontinue collecting the identity theft information which would require removing the introductory questions along with additional changes.

Robben stated that the proposal removes the Identity Theft Insurance column from Parts 2 and 3. It removes the claims-made and occurrence breakdown, as well as first-party and third-party breakdown, from data collection. A cybersecurity insurance policy generally is written on a claims-made basis for the liability sections of the policy; therefore, the breakdown is unnecessary. It removes the question in the interrogatories regarding tail policies. This has provided no meaningful information due to the way cybersecurity insurance policies are written. Therefore, it is considered no longer needed.

Hearing no objection, Gosselin stated that the proposal will be considered exposed for a 52-day public comment period ending April 28.

f. Agenda Item 2023-06WG

Bruggeman stated that this proposal is in line with the Statutory Accounting Principles (E) Working Group bond project. Pursuant to that project, enhanced granularity and transparency of the bond investments held are proposed. To achieve that goal, the Statutory Accounting Principles (E) Working Group is proposing to split Schedule D, Part 1, into two sections: one for Issuer Credit Obligations and the other for Asset-Backed Securities. Additionally, the proposal removes the broad investment categories and incorporates new reporting lines for both schedules as well as instructions as to what should be captured in each reporting line. The proposal is very detailed, as the expansion of the schedule and the changes to the reporting lines impact a number of other schedules. The proposed concepts have previously been exposed by the Statutory Accounting Principles (E) Working Group with comments considered prior to sponsoring the blanks proposal. The anticipated effective date of the bond changes is Jan. 1, 2025. Therefore, the Blanks (E) Working Group is working to ensure that the blanks and accounting changes can be fully considered and adopted to allow reporting entities time to make any necessary system changes and assess the impact on their investment holdings.

Hearing no objection, Gosselin stated that the proposal will be considered exposed for a 115-day public comment period ending June 30.

g. Agenda Item 2023-07BWG

Bruggeman stated that this proposal has also been drafted in response to discussions that have occurred under the bond project to make the investment schedules consistent with the changes to Schedule D, Part 1, within proposal 2023-06BWG. Ultimately, this proposal recommends revisions to investment schedules to improve and streamline overall reporting. Specifically, this proposal updates the code column and deletes the Legal Entity Identifier (LEI) column for the following investment schedules: A, B, BA, D, Part 2, D, Part 6, and E, Part 1.

Hearing no objection, Gosselin stated that the proposal will be considered exposed for a 52-day public comment period ending April 28.

h. Agenda Item 2023-08BWG

Bruggeman stated that this proposal has been drafted to add language to clarify that mutual companies are to be included in Schedule Y, Part 3. This has been a consistent question that NAIC staff have received since Schedule Y, Part 3 was added, and this revision should clear that up for the companies.

Hearing no objection, Gosselin stated that the proposal will be considered exposed for a 52-day public comment period ending April 28.

i. Agenda Item 2023-09BWG

Bruggeman stated that this proposal has been drafted because the American Academy of Actuaries (Academy) and the Life Risk-Based Capital (E) Working Group developed and recommended an annual statement note to be used when updating the Life C-2 mortality changes. The new financial statement note will develop the net amounts at risk in the categories needed for the Life C-2 worksheet to create a direct link to a financial statement source. Because this impacts the annual statement notes, a corresponding proposal is planned for exposure at the Spring National Meeting to allow for 2023 year-end adoption.

Hearing no objection, Gosselin stated that the proposal will be considered exposed for a 52-day public comment period ending April 28.

5. Adopted the Editorial Listing

Hudson made a motion, seconded by Snow, to adopt the editorial listing (Attachment Two-F). The motion passed unanimously.

Having no further business, the Blanks (E) Working Group adjourned.

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member\\_meetings/e\\_cmte/apptf/2023-1\\_spring/summary\\_and\\_minutes/bwg/bwg\\_03\\_2023\\_minutes\\_tpr.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member_meetings/e_cmte/apptf/2023-1_spring/summary_and_minutes/bwg/bwg_03_2023_minutes_tpr.docx)

**NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

<p style="text-align: right;">DATE: <u>08/17/2022</u></p> <p><b>CONTACT PERSON:</b> _____</p> <p><b>TELEPHONE:</b> _____</p> <p><b>EMAIL ADDRESS:</b> _____</p> <p><b>ON BEHALF OF:</b> _____</p> <p><b>NAME:</b> <u>Kim Hudson</u></p> <p><b>TITLE:</b> _____</p> <p><b>AFFILIATION:</b> <u>California Department of Insurance</u></p> <p><b>ADDRESS:</b> <u>300 South Spring St.</u> <u>Los Angeles, CA 90013</u></p>	<p style="text-align: center;"><b>FOR NAIC USE ONLY</b></p> <p>Agenda Item # <u>2022-14BWG Mod</u></p> <p>Year <u>2023</u></p> <p>Changes to Existing Reporting [ X ]</p> <p>New Reporting Requirement [ ]</p> <hr/> <p style="text-align: center;"><b>REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</b></p> <p>No Impact [ X ]</p> <p>Modifies Required Disclosure [ ]</p> <hr/> <p style="text-align: center;"><b>DISPOSITION</b></p> <p>[ ] Rejected For Public Comment</p> <p>[ ] Referred To Another NAIC Group</p> <p>[ ] Received For Public Comment</p> <p>[ X ] Adopted Date <u>03/07/2023</u></p> <p>[ ] Rejected Date _____</p> <p>[ ] Deferred Date _____</p> <p>[ ] Other (Specify) _____</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- |                                                                       |                                                   |                                                 |
|-----------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------|
| <input checked="" type="checkbox"/> ANNUAL STATEMENT                  | <input checked="" type="checkbox"/> INSTRUCTIONS  | <input checked="" type="checkbox"/> CROSSCHECKS |
| <input checked="" type="checkbox"/> QUARTERLY STATEMENT               | <input checked="" type="checkbox"/> BLANK         |                                                 |
| <input checked="" type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts        | <input type="checkbox"/> Title                  |
| <input type="checkbox"/> Property/Casualty                            | <input type="checkbox"/> Protected Cell           | <input type="checkbox"/> Other _____            |
| <input type="checkbox"/> Health                                       | <input type="checkbox"/> Health (Life Supplement) |                                                 |

Anticipated Effective Date: Annual 2023

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Modify Exhibit 1, Part 1 and 2, and Exhibit 8, Part 1 and 2, in the life and accident and health (A&H)/fraternal blank, to include the line of business detail reported on the Analysis of Operations by Lines of Business pages. Update crosscheck references on Summary of Operations, Analysis of Operations, 5-Year Historical and Schedule S.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE\*\***

The purpose of this proposal is to make the lines of business reported on Exhibit 1 and Exhibit 8 consistent with the lines of business being reported on the Analysis of Operations by Lines of Business pages.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: \_\_\_\_\_

Other Comments:

\*\* This section must be completed on all forms.



ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

**EXHIBIT 1 – PART 1 – PREMIUMS AND ANNUITY CONSIDERATIONS FOR LIFE AND ACCIDENT AND HEALTH CONTRACTS**

Amounts reported should be reflected in U.S. dollars based on the foreign currency exchange rate. Refer to *SSAP No. 23—Foreign Currency Transactions and Translations* for accounting guidance. Any foreign currency exchange gain or loss is reported as a realized capital gain or loss.

The separation into first-year, single and renewal is required only for Columns ~~3~~2 and 4.

- Include: Contract, membership and other fees whether or not retained by agents.  
 Experience rating refunds and accrued return retrospective premiums. Refer to *SSAP No. 66—Retrospectively Rated Contracts* for accounting guidance.
- Exclude: Amounts attributable to uninsured plans and the uninsured portions of partially insured plans.
- Deduct: Refunds to policyholders for direct payment of industrial premiums.  
 Premiums and annuity considerations returned.
- Do not deduct: Commissions and allowances on reinsurance premiums assumed and ceded.

The reporting entity shall not omit the columns for any lines of business in which it is not engaged. All figures for the ordinary variable life insurance business of the reporting entity, excluding separate accounts items, shall be included in Column ~~3~~2.

Include premiums and annuity considerations that are transferred to the Separate Accounts Statement. They are also to be reported as premiums and annuity considerations in the Separate Accounts Statement.

~~Column 9 — Credit Accident and Health (Group and Individual)~~

~~Include: — Business not exceeding 120 months.~~

~~Column 10 — Other Accident and Health~~

~~Include: — All Medicare Part D Prescription Drug Coverage, whether sold on a stand-alone basis or through a Medicare Advantage product and whether sold directly to an individual or through a group.~~

Column ~~12~~7 – Fraternal

Transactions related to the fraternal mission.

Line 1 – Uncollected Premiums and Considerations First Year (Other Than Single) and }  
 Line 11 – Uncollected Premiums and Considerations Renewal }

These are premiums and considerations on contracts in force which were due before the end of the year and unpaid on the valuation date or have not been recorded in the premium or consideration account.

The ~~sum of~~ Column ~~8, 9 and 10~~6 should be included on Page 2, Line 15.1, Column 1.

- Line 2 – Deferred and Accrued Premiums and Considerations First Year (Other Than Single) and }
- Line 12 – Deferred and Accrued Premiums and Considerations Renewal }

Include: Change in experience rating refund liability and accrued return retrospective premiums.

These are premiums and considerations on policies in force that were due on policies in force extending from (and including) the modal (monthly, quarterly, semiannual) premium due date or dates following the valuation date to the next policy anniversary date when annualized premium was assumed to be collected in the reserve valuation.

- Line 4 – Advance Premiums and Considerations First Year (Other Than Single) and }
- Line 14 – Advance Premiums and Considerations Renewal }

Include: Premiums and considerations on certificates in force received by the reporting entity prior to the valuation date but that are due on or after the next certificate anniversary date.

Reporting entities may include here unearned premiums on accident and health business.

The total of these lines, excluding A&H unearned premium reserve, must balance to Page 3, Line 8, or to this item prior to deduction of discount depending upon the basis used for crediting advance premiums to the premium account.

The ~~sum of~~ Columns ~~68 through 10~~ should equal Schedule H, Part 2, Line A2, Column 1.

- Line 6 – Collected During Year – First Year (Other Than Single)

Include: All premiums and considerations (other than single premiums) pertaining to the first contract year.

Experience rating refunds and return retrospective premiums received.

Deduct: Experience rating refunds and return retrospective premiums paid.

- Line 10 – Single Premiums and Considerations – Single

Include: All single premiums and considerations and dividends/refunds, coupons, guaranteed annual pure endowments and similar benefits applied to provide paid-up additions and annuities.

- Line 16 – Collected During Year - Renewal

Include: All other premiums and considerations, including dividends/refunds, coupons, guaranteed annual pure endowments and similar benefits applied to pay renewal premiums and to shorten the endowment or premium-paying period.

Experience rating refunds and return retrospective premiums received.

Deduct: Experience rating refunds and return retrospective premiums paid.

- Line 20.4 – Net Total Premiums and Annuity Considerations – Total

Column 1 less Column ~~84~~ should agree with Summary of Operations, Line 1, and all appropriate columns should agree with Line 1 of Analysis of Operations by Lines of Business – [Summary \(Column 9 – YRT Mortality Risk Only on the Analysis of Operations by Lines of Business - Summary is not included in Exhibit 1, Part 1\)](#).

**EXHIBIT 1 – PART 2 – POLICYHOLDERS’ DIVIDENDS, REFUNDS TO MEMBERS AND COUPONS APPLIED, REINSURANCE COMMISSIONS AND EXPENSE ALLOWANCES AND COMMISSIONS INCURRED**

The separation into first-year, single and renewal is required only for Columns ~~3~~2 and 4.

~~Column 9 – Credit Accident and Health (Group and Individual)~~

~~Include: – Business not exceeding 120 months.~~

~~Column 10 – Other Accident and Health~~

~~Include: – All Medicare Part D Prescription Drug Coverage, whether sold on a stand-alone basis or through a Medicare Advantage product and whether sold directly to an individual or through a group.~~

Column ~~12~~7 – Fraternal

Transactions related to the fraternal mission.

Line 22 – Dividends and Coupons Applied All Other

Include: Coupons, guaranteed annual pure endowments and similar benefits.

Line 26.1 – Reinsurance Ceded

The ~~sum of~~ Columns ~~8 through 10~~6 should equal Schedule H, Part 4, Line B4, Column 1.

Line 26.2 – Reinsurance Assumed

The ~~sum of~~ Columns ~~8 through 10~~6 should equal Schedule H, Part 4, Line A4, Column 1.

**EXHIBIT 8 – CLAIMS FOR LIFE AND ACCIDENT AND HEALTH CONTRACTS**

Amounts relating to uninsured accident and health plans and the uninsured portion of partially insured accident and health plans should be excluded from this exhibit.

Do not include amounts for loss/claims adjusting expenses.

**PART 1 – LIABILITY END OF CURRENT YEAR**

This part of the exhibit provides an analysis of the contract liability reported in the balance sheet.

A reporting entity shall not omit the columns for any lines of business in which it is not engaged. All figures for the ordinary variable life insurance business of the reporting entity, excluding separate accounts items, shall be included in Column ~~3~~2. ~~Fraternal benefit societies do not need to complete Columns 2, 6, 7, 8, 9 and 10 since the columns reflect lines of business not written by fraternal.~~

Exclude liabilities reported in the Separate Accounts Statement.

For each item:

Net = Direct + Reinsurance Assumed – Reinsurance Ceded

~~Column 6 – Credit Life (Group and Individual) and~~

~~Column 10 – Accident and Health Credit (Group and Individual)~~

~~Include: – Business not exceeding 120 months duration.~~

~~**These columns are not applicable to Fraternal Benefit Societies.**~~

~~Column 11 – Other Accident and Health~~

~~Include: – All Medicare Part D Prescription Drug Coverage, whether sold on a stand-alone basis or through a Medicare Advantage product and whether sold directly to an individual or through a group.~~

Line 1 – Due and Unpaid

Include: Only claims which are complete except for the payment of the amount due, or the recording of the amount paid in the appropriate claims accounts.

Line 2 – In Course of Settlement

Include: Other contract claims that have been reported and are pending at the end of the year. They represent cases that are at different stages of completion of claim processing; ranging from the time of initial receipt of claims or notification of claims to the time where the cases are nearly complete, but not complete enough to be shown in Line 1. Claims in course of settlement are segregated between Resisted, Line 2.1 and Other, Line 2.2.

Line 2.1 – Resisted

Include: Resisted claims on life and annuity contracts. A claim is considered resisted when it is in dispute and not resolved on the statement date.

Line 2.2 – Other

Include: Claims in course of settlement, not shown in Line 2.1, including resisted accident and health claims.

Line 3 – Incurred but Unreported

Report all contract claims incurred on or prior to December 31 of the statement year but not reported to the company until after that date. Only the portion of disability benefits which pertain to disability periods prior to January 1 of the year following the statement year should be reported; for example, the amount which would be payable for the elapsed period if disability were approved. The liability for unaccrued benefits is included in the Certificate and Contract Reserves liability (Page 3, Lines 1 and 2 and Exhibits 5 and 6).

Line 4 – Totals

Line 4.1 = Line 1.1 + Line 2.11 + Line 2.21 + Line 3.1

Line 4.2 = Line 1.2 + Line 2.12 + Line 2.22 + Line 3.2

Line 4.3 = Line 1.3 + Line 2.13 + Line 2.23 + Line 3.3

Line 4.4 = Line 1.4 + Line 2.14 + Line 2.24 + Line 3.4

Line 4.4, Column 1 should agree with Page 3, the sum of Lines 4.1 and 4.2

**EXHIBIT 8 – CLAIMS FOR LIFE AND ACCIDENT AND HEALTH CONTRACTS**  
**PART 2 – INCURRED DURING THE YEAR**

A reporting entity shall not omit the columns for any lines of business in which it is not engaged. ~~Fraternal benefit societies do not need to complete Columns 2, 6, 7, 8, 9 and 10 since these columns reflect lines of business not written by fraternal.~~

Include benefits and withdrawals that are transferred from the Separate Accounts Statement. They are also to be reported as benefits and withdrawals in the Separate Accounts Statement.

~~Column 6 – Credit Life (Group and Individual) and  
Column 10 – Accident and Health Credit (Group and Individual)~~

~~Include: – Business not exceeding 120 months duration.~~

~~Column 11 – Other Accident and Health~~

~~Include: – All Medicare Part D Prescription Drug Coverage, whether sold on a stand alone basis or through a Medicare Advantage product and whether sold directly to an individual or through a group.~~

For Lines 1, 2, 4, and 6: Net = Direct + Reinsurance Assumed – Reinsurance Ceded

Line 1 – Settlements During the Year

Include: Contract claim amounts retained under supplementary contracts.

Line 3 – Amounts Recoverable from Reinsurers December 31, Current Year and }  
Line 5 – Amounts Recoverable from Reinsurers December 31, Prior Year }

Include Reinsurance recoveries billed on paid losses but not received.

These amounts should agree to the amounts reported in Schedule S, Part 2, Column 6.

Line 6 – Incurred Benefits

Line 6.1 = Line 1.1 + Line 2.1 – Line 4.1

Line 6.2 = Line 1.2 + Line 2.2 – Line 4.2

Line 6.3 = Line 1.3 + Line 2.3 + Line 3 – Line 4.3 – Line 5

Line 6.4 = Line 1.4 + Line 2.4 – Line 3 – Line 4.4 + Line 5

**ANALYSIS OF OPERATIONS BY LINES OF BUSINESS – SUMMARY**

**=====  
Detail Eliminated to Conserve Space  
=====**

Column 8 – Other Lines of Business

A company that is engaged in one or more insurance businesses (other than life business e.g., workers’ compensation, aviation reinsurance) that cannot be reported in the columns on pages for Individual Life Insurance, Group Life Insurance, Individual Annuities, Group Annuities and Accident and Health shall add the amounts for each additional line of business and shall enter the total in Column 8.

Include Any Business that is not reported in Columns 2 through 7 or Column 9.

Column 8, Line 21 should agree with Exhibit 1 Part 2, Line 31, Column 418.

**ANALYSIS OF OPERATIONS BY LINES OF BUSINESS – INDIVIDUAL LIFE INSURANCE**

**=====  
Detail Eliminated to Conserve Space  
=====**

Line 21 – Commissions on Premiums (Direct Business Only)

Columns 2 through 11 should agree with Exhibit 1 Part 2, Line 31, Column 2.

~~Columns 3, 4, 5, 6, 7, 8, 9 and 11 should agree with Exhibit 1 Part 2, Line 31, Column 3.~~

~~Column 10 plus Analysis of Operations—Group Life Insurance, column 7, line 21 should agree with Exhibit 1 Part 2, Line 31, Column 5.~~

**ANALYSIS OF OPERATIONS BY LINES OF BUSINESS – GROUP LIFE INSURANCE**

↓ **=====  
Detail Eliminated to Conserve Space  
=====** ↓

Line 21 – Commissions on Premiums (Direct Business Only)

Columns 2, ~~3, 4, 5, 6 and 8~~ through 8 should agree with Exhibit 1 Part 2, Line 31, Column ~~63~~.

~~Note: Column 7 is included in Exhibit 1 Part 2, Line 31, column 5 with individual credit life business.~~

**ANALYSIS OF OPERATIONS BY LINES OF BUSINESS – GROUP ANNUITIES**

↓ **=====  
Detail Eliminated to Conserve Space  
=====** ↓

Line 21 – Commissions on Annuity Considerations and Deposit-Type Contracts (Direct Business Only)

Columns 2, 3, 4, 5 and 7 should agree with Exhibit 1 Part 2, Line 31, Column ~~75~~.

**ANALYSIS OF OPERATIONS BY LINES OF BUSINESS – ACCIDENT AND HEALTH**

↓ **=====  
Detail Eliminated to Conserve Space  
=====** ↓

Line 21 – Commissions on Premiums (Direct Business Only)

Column 1 should agree with Exhibit 1 Part 2, Line 31, Columns ~~8, 9 and 10~~6.



**FIVE-YEAR HISTORICAL DATA**



**Detail Eliminated to Conserve Space**

**Premium Income - Lines of Business**  
**(Exhibit 1 – Part 1)**

**\*\*\* 2023 Reporting Note\*\*\* - Complete all columns with the new Lines of Business data.**

Line 14 – ~~Industrial~~ Individual Life

All years ..... Exhibit 1, Part 1, Line 20.4, Column 2

Line 15.1 – ~~Ordinary Life Insurance~~ Group Life

All years ..... Exhibit 1, Part 1, Line 20.4, Column 3

~~Line 15.2 — Ordinary Individual Annuities~~

~~All years ..... Exhibit 1, Part 1, Line 20.4, Column 4~~

Line 16 – ~~Credit Life (Group and Individual)~~ Individual Annuities

All years ..... Exhibit 1, Part 1, Line 20.4, Column ~~5~~4

Line 17.1 – ~~Group Life Insurance~~ Group Annuities

All years ..... Exhibit 1, Part 1, Line 20.4, Column ~~6~~5

~~Line 17.2 — Group Annuities~~

~~All years ..... Exhibit 1, Part 1, Line 20.4, Column 7~~

Line 18.1 – ~~A&H — Group~~ Accident & Health

All years ..... Exhibit 1, Part 1, Line 20.4, Column ~~8~~6

~~Line 18.2 — A&H — Credit~~

~~All years ..... Exhibit 1, Part 1, Line 20.4, Column 9~~

~~Line 18.3 — A&H — Other~~

~~All years ..... Exhibit 1, Part 1, Line 20.4, Column 10~~

Line 19 – ~~Aggregate of All~~ Other Lines of Business

All years ..... Exhibit 1, Part 1, Line 20.4, Column ~~11~~8

**SCHEDULE S – PART 1 – SECTION 1**

**REINSURANCE ASSUMED LIFE INSURANCE, ANNUITIES, DEPOSIT FUNDS AND OTHER LIABILITIES WITHOUT LIFE OR DISABILITY CONTINGENCIES, AND RELATED BENEFITS LISTED BY REINSURED COMPANY AS OF DECEMBER 31, CURRENT YEAR**

**=====  
=====  
Detail Eliminated to Conserve Space  
=====  
=====**

Column 10 – Premiums

To agree with Exhibit 1, Part 1, Line 20.2, Columns 2 through ~~75~~.

For deposit funds and other liabilities without life or disability contingencies leave this column blank.

Column 11 – Reinsurance Payable on Paid and Unpaid Losses

To agree with Exhibit 8, Part 1, Line 4.2, Columns 2 through ~~85~~. For deposit funds and other liabilities without life or disability contingencies, leave this column blank.

**SCHEDULE S – PART 1 – SECTION 2**

**REINSURANCE ASSUMED ACCIDENT AND HEALTH INSURANCE LISTED BY REINSURED COMPANY AS OF DECEMBER 31, CURRENT YEAR**

**=====  
=====  
Detail Eliminated to Conserve Space  
=====  
=====**

Column 8 – Premiums

To agree with Exhibit 1, Part 1, Line 20.2, Columns ~~8 through 106~~.

Column 11 – Reinsurance Payable on Paid and Unpaid Losses

To agree with Exhibit 8, Part 1, Line 4.2, Columns ~~9 through 116~~.

**SCHEDULE S – PART 3 – SECTION 1**

**REINSURANCE CEDED LIFE INSURANCE, ANNUITIES, DEPOSIT FUNDS AND OTHER LIABILITIES  
WITHOUT LIFE OR DISABILITY CONTINGENCIES, AND RELATED BENEFITS LISTED BY REINSURING  
COMPANY AS OF DECEMBER 31, CURRENT YEAR**

=====  
Column 11 – Premiums

**Detail Eliminated to Conserve Space**

=====

Amounts included in this column should represent reinsurance ceded premiums on an incurred basis, to agree with Line 20.3 of Exhibit 1, Part 1, Column 1 less Columns ~~8, 9 and 10~~6.

For deposit funds and other liabilities without life or disability contingencies, leave this column blank.

**SCHEDULE S – PART 3 – SECTION 2**

**REINSURANCE CEDED ACCIDENT AND HEALTH INSURANCE LISTED BY REINSURING COMPANY  
AS OF DECEMBER 31, CURRENT YEAR**

=====  
Column 8 – Premiums

**Detail Eliminated to Conserve Space**

=====

Amounts included in this column should represent reinsurance ceded premiums on an incurred basis and agree with Exhibit 1, Part 1, Line 20.3, Columns ~~8, 9 and 10~~6.

## QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

**EXHIBIT 1****DIRECT PREMIUMS AND DEPOSIT-TYPE CONTRACTS**

Report the Total Direct Life and Accident and Health Premiums, Annuity Considerations and Deposit-Type Contracts on a gross basis.

- Include: Contract, membership and other fees, whether or not retained by agents.
- Exclude: Amounts attributable to uninsured plans and the uninsured portions of partially insured plans.
- Deduct: Refunds to policyholders for direct payment of industrial premiums.  
Premiums and annuity considerations returned.

Column 2 – Prior Year to Date

Amounts in Lines 1 through ~~13~~7 should agree with the prior year's corresponding quarterly statement Exhibit 1, Column 1.

Column 3 – Prior Year Ended December 31

Line 1 – Amount should agree with the prior year's annual statement Exhibit 1, Part 1, Line 20.1 (Direct), Column 2.

**~~This line is not applicable to Fraternal Benefit Societies.~~**

Line 2 – Amount should agree with the prior year's annual statement Exhibit 1, Part 1, Line 20.1 (Direct), Column 3.

Line 3 – Amount should agree with the prior year's annual statement Exhibit 1, Part 1, Line 20.1 (Direct), Column 4.

Line 4 – Amount should agree with the prior year's annual statement Exhibit 1, Part 1, Line 20.1 (Direct), Column 5.

**~~This line is not applicable to Fraternal Benefit Societies.~~**

Line 5 – Amount should agree with the prior year's annual statement Exhibit 1, Part 1, Line 20.1 (Direct), Column 6.

**~~This line is not applicable to Fraternal Benefit Societies.~~**

Line 6 – Amount should agree with the prior year's annual statement Exhibit 1, Part 1, Line 20.1 (Direct), Column 7.

**~~This line is not applicable to Fraternal Benefit Societies.~~**

Line 7 – Amount should agree with the prior year's annual statement Exhibit 1, Part 1, Line 20.1 (Direct), Column 8.

**~~This line is not applicable to Fraternal Benefit Societies.~~**

Line 8 – Amount should agree with the prior year’s annual statement Exhibit 1, Part 1, Line 20.1 (Direct), ~~Column 9~~ Sum of Columns 2 through 8.

**~~This line is not applicable to Fraternal Benefit Societies.~~**

~~Line 9 – Amount should agree with the prior year’s annual statement Exhibit 1, Part 1, Line 20.1 (Direct), Column 10.~~

~~Line 10 – Amount should agree with the prior year’s annual statement Exhibit 1, Part 1, Line 20.1 (Direct), Column 11.~~

~~Line 11 – Amount should agree with the prior year’s annual statement Exhibit 1, Part 1, Line 20.1 (Direct), Sum of Columns 2 through 11.~~

~~Line 12 – Amount should agree with the prior year’s annual statement Exhibit 1, Part 1, Line 20.1 (Direct), Column 12.~~

**~~This line is not applicable to Life Accident and Health Companies.~~**

Line ~~149~~ – Amount should agree with the prior year’s annual statement Schedule T, Line 95 Column 7, Totals (Direct Business).

ANNUAL STATEMENT BLANKS – LIFE/FRATERNAL

EXHIBIT 1 – PART 1 – PREMIUMS AND ANNUITY CONSIDERATIONS FOR LIFE AND ACCIDENT AND HEALTH CONTRACTS

	Insurance										12 Fraternal (Fraternal Benefit Societies-Only)								
	1 Total	2 Individual Life		3 Group Life Insurance		4 Individual Annuities		5 Credit Life (Group and Individual) Group Annuities		6 Life Insurance Accident & Health		7 Group Annuities Fraternal		8 Group/Other Lines of Business	9 Credit (Group and Individual)	10 Other	11 Aggregate of All Other Lines of Business		
1. FIRST YEAR (other than single)																			
2. Uncollected.....																			
3. Deferred and accrued.....																			
3.1 Direct.....																			
3.2 Reinsurance assumed.....																			
3.3 Reinsurance ceded.....																			
3.4 Net (Line 1 + Line 2).....																			
4. Advance.....																			
5. Line 3.4 - Line 4.....																			
6. Collected during year.....																			
6.1 Direct.....																			
6.2 Reinsurance assumed.....																			
6.3 Reinsurance ceded.....																			
6.4 Net.....																			
7. Line 5 + Line 6.4.....																			
8. Prior year (uncollected + deferred and accrued - advance)																			
9. First year premiums and considerations:																			
9.1 Direct.....																			
9.2 Reinsurance assumed.....																			
9.3 Reinsurance ceded.....																			
9.4 Net (Line 7 - Line 8).....																			
10. SINGLE																			
10.1 Single premiums and considerations:																			
10.1 Direct.....																			
10.2 Reinsurance assumed.....																			
10.3 Reinsurance ceded.....																			
10.4 Net.....																			
11. RENEWAL																			
11.1 Renewal premiums and considerations:																			
11.1 Direct.....																			
11.2 Reinsurance assumed.....																			
11.3 Reinsurance ceded.....																			
11.4 Net (Line 11 + Line 12).....																			
12. Advance.....																			
13. Line 13.4 - Line 14.....																			
14. Collected during year.....																			
15.1 Direct.....																			
15.2 Reinsurance assumed.....																			
15.3 Reinsurance ceded.....																			
15.4 Net.....																			
16. Line 15 + Line 16.4.....																			
17. Prior year (uncollected + deferred and accrued - advance)																			
18. Renewal premiums and considerations:																			
18.1 Direct.....																			
18.2 Reinsurance assumed.....																			
18.3 Reinsurance ceded.....																			
18.4 Net (Line 17 - Line 18).....																			
19. TOTAL																			
19.1 Total premiums and annuity considerations:																			
20.1 Direct.....																			



**EXHIBIT 8 – CLAIMS FOR LIFE AND ACCIDENT AND HEALTH CONTRACTS**  
**PART 1 – Liability End of Current Year**

	1		2		3		4		5		6		7		8		9		10	
	Total	Individual Life	Group Life Insurance	Individual Annuities	Supplementary Contracts Group Annuities	Credit Life (Group and Individual) Accident & Health	Life Insurance Fraternal	Other Lines of Business	Group	Accident and Health	Other	Individual	Group	Accident and Health	Other	Individual	Group	Accident and Health	Other	
1. Due and unpaid:																				
1.1 Direct.....																				
1.2 Reinsurance assumed.....																				
1.3 Reinsurance ceded.....																				
1.4 Net.....																				
2. In course of settlement:																				
2.1 Resisted.....																				
2.1.1 Direct.....																				
2.1.2 Reinsurance assumed.....																				
2.1.3 Reinsurance ceded.....																				
2.1.4 Net.....																				
2.2 Other.....																				
2.2.1 Direct.....																				
2.2.2 Reinsurance assumed.....																				
2.2.3 Reinsurance ceded.....																				
2.2.4 Net.....																				
3. Incurred but unreported:																				
3.1 Direct.....																				
3.2 Reinsurance assumed.....																				
3.3 Reinsurance ceded.....																				
3.4 Net.....																				
4. TOTALS.....																				
4.1 Direct.....																				
4.2 Reinsurance assumed.....																				
4.3 Reinsurance ceded.....																				
4.4 Net.....																				

(a) Including matured endowments (but not guaranteed annual pure endowments) unpaid amounting to \$..... in Column 2- and \$..... in Column 3- and \$..... in Column 7-  
 (b) Include only portion of disability and accident and health claim liabilities applicable to assumed "accrued" benefits. Reserves (including reinsurance assumed and net of reinsurance ceded) for unaccrued benefits for Ordinary Life Insurance \$..... Individual Annuities \$..... Credit Life (Group and Individual) \$..... and Group Life \$..... are included in Page 3, Line 1. (See Exhibit 5, Section on Disability Lives); and for Group Accident and Health \$..... Credit Life (Group and Individual) Accident and Health \$..... and Other Accident and Health \$..... are included in Page 3, Line 2. (See Exhibit 6, Claim Reserve)

(b) Include only portion of disability and accident and health claim liabilities applicable to assumed "accrued" benefits. Reserves (including reinsurance assumed and net of reinsurance ceded) for unaccrued benefits for Individual Life \$..... Group Life \$..... and Individual Annuities \$..... are included in Page 3, Line 1. (See Exhibit 5, Section on Disability Lives); and for Accident and Health \$..... are included in Page 3, Line 2. (See Exhibit 6, Claim Reserve)



**EXHIBIT 8 – CLAIMS FOR LIFE AND ACCIDENT AND HEALTH CONTRACTS**  
**PART 2 – Incurred During the Year**

	PART 2 – Incurred During the Year									
	1	2	Ordinary		Group		Accident and Health			
Total	Individual Life (a)	Group Life Insurance (b)	Individual Amnities	Supplementary Contracts Group Amnities	Credit Life (Group and Individual) Accident & Health	Life Insurance (e) Fraternal	8	9	10	11
1. Settlements during the year:										
1.1 Direct.....										
1.2 Reinsurance assumed.....										
1.3 Reinsurance ceded.....										
1.4 Net.....										
2. Liability December 31, current year from Part 1:										
2.1 Direct.....										
2.2 Reinsurance assumed.....										
2.3 Reinsurance ceded.....										
2.4 Net.....										
3. Amounts recoverable from reinsurers December 31, current year.....										
4. Liability December 31, prior year:										
4.1 Direct.....										
4.2 Reinsurance assumed.....										
4.3 Reinsurance ceded.....										
4.4 Net.....										
5. Amounts recoverable from reinsurers December 31, prior year.....										
6. Incurred benefits:										
6.1 Direct.....										
6.2 Reinsurance assumed.....										
6.3 Reinsurance ceded.....										
6.4 Net.....										

(a) Including matured endowments (but not guaranteed annual pure endowments) amounting to \$..... in Line 1.1, \$..... in Line 1.4, \$..... in Line 6.1 and \$..... in Line 6.4.

(b) Including matured endowments (but not guaranteed annual pure endowments) amounting to \$..... in Line 1.1, \$..... in Line 1.4, \$..... in Line 6.1 and \$..... in Line 6.4.

(c) Includes \$..... premiums waived under total and permanent disability benefits.

**SUMMARY OF OPERATIONS**

	1 Current Year	2 Prior Year
1. Premiums and annuity considerations for life and accident and health contracts (Exhibit 1, Part 1, Line 20.4, Col. 1; less Col. 4+8).....	.....	.....
2. Considerations for supplementary contracts with life contingencies .....	.....	.....
3. Net investment income (Exhibit of Net Investment Income, Line 17).....	.....	.....
4. Amortization of Interest Maintenance Reserve (IMR, Line 5).....	.....	.....
5. Separate Accounts net gain from operations excluding unrealized gains or losses.....	.....	.....
6. Commissions and expense allowances on reinsurance ceded (Exhibit 1, Part 2, Line 26.1, Col. 1).....	.....	.....
7. Reserve adjustments on reinsurance ceded.....	.....	.....
8. Miscellaneous Income:		
8.1 Income from fees associated with investment management, administration and contract guarantees from Separate Accounts .....	.....	.....
8.2 Charges and fees for deposit-type contracts .....	.....	.....
8.3 Aggregate write-ins for miscellaneous income.....	.....	.....
9. Totals (Lines 1 to 8.3).....	.....	.....
10. Death benefits .....	.....	.....
11. Matured endowments (excluding guaranteed annual pure endowments).....	.....	.....
12. Annuity benefits (Exhibit 8, Part 2, Line 6.4, Cols. 4 + 5).....	.....	.....



Detail Eliminated to Conserve Space



**FIVE-YEAR HISTORICAL DATA**

Show amounts in whole dollars only, no cents; show percentages to one decimal place, i.e., 17.6  
 \$000 omitted for amounts of life insurance

	1 2023	2 2022	3 2021	4 2020	5 2019
<b>Life Insurance in Force</b>					
(Exhibit of Life Insurance)					
1. Ordinary-whole life and endowment (Line 34, Col. 4) .....					
2. Ordinary-term (Line 21, Col. 4, less Line 34, Col. 4).....					
3. Credit life (Line 21, Col. 6) .....					
4. Group, excluding FEGLI/SGLI (Line 21, Col. 9 less Lines 43 & 44, Col. 4).....					
5. Industrial (Line 21, Col. 2) .....					
6. FEGLI/SGLI (Lines 43 & 44, Col. 4).....					
7. Total (Line 21, Col. 10) .....					
7.1 Total in force for which VM-20 deterministic/stochastic reserves are calculated.....					
<b>New Business Issued</b>					
(Exhibit of Life Insurance)					
8. Ordinary-whole life and endowment (Line 34, Col. 2) .....					
9. Ordinary-term (Line 2, Col. 4, less Line 34, Col. 2).....					
10. Credit life (Line 2, Col. 6) .....					
11. Group (Line 2, Col. 9).....					
12. Industrial (Line 2, Col. 2) .....					
13. Total (Line 2, Col. 10) .....					
<b>Premium Income-Lines of Business</b>					
(Exhibit 1 – Part 1)					
14. <del>Industrial</del> <del>Individual</del> life (Line 20.4, Col. 2).....					
15.1 <del>Ordinary life insurance</del> <del>Group</del> life (Line 20.4, Col. 3) .....					
<del>15.2</del> <del>Ordinary individual annuities</del> (Line 20.4, Col. 4) .....					
16. <del>Credit life, (group and individual)</del> <del>Individual</del> annuities (Line 20.4, Col. 5).....					
17.1 <del>Group life insurance</del> <del>annuities</del> (Line 20.4, Col. 6) .....					
<del>17.2</del> <del>Group annuities</del> (Line 20.4, Col. 7) .....					
18.1 <del>A &amp; H group</del> <del>Accident &amp; health</del> (Line 20.4, Col. 8) .....					
<del>18.2</del> <del>A &amp; H credit (group and individual)</del> (Line 20.4, Col. 9) .....					
<del>18.3</del> <del>A &amp; H other</del> (Line 20.4, Col. 10) .....					
19. <del>Aggregate of all</del> <del>Other</del> lines of business (Line 20.4, Col. 11) .....					
20. Total .....					

↓ **Detail Eliminated to Conserve Space** ↓

QUARTERLY STATEMENT BLANKS – LIFE/FRATERNAL

EXHIBIT 1

DIRECT PREMIUMS AND DEPOSIT-TYPE CONTRACTS

	1 Current Year to Date	2 Prior Year to Date	3 Prior Year Ended December 31
1. <del>Industrial</del> Individual life .....	.....	.....	.....
2. <del>Ordinary life insurance</del> Group life .....	.....	.....	.....
3. <del>Ordinary individual</del> Individual annuities .....	.....	.....	.....
4. <del>Credit life (group and individual)</del> Group annuities .....	.....	.....	.....
5. <del>Group life insurance</del> Accident & Health .....	.....	.....	.....
6. <del>Group annuities</del> Fraternal .....	.....	.....	.....
7. <del>A &amp; H - group</del> Other Lines of Business .....	.....	.....	.....
<del>8. A &amp; H - credit (group and individual) .....</del>	.....	.....	.....
<del>9. A &amp; H - other .....</del>	.....	.....	.....
<del>10. Aggregate of all other lines of business .....</del>	.....	.....	.....
<del>11. Subtotal (Lines 1 through 10) .....</del>	.....	.....	.....
<del>12. Fraternal (Fraternal Benefit Societies Only) .....</del>	.....	.....	.....
<del>138. Subtotal (Lines 1+ through 7+2) .....</del>	.....	.....	.....
<del>149. Deposit-type contracts .....</del>	.....	.....	.....
<del>1510. Total (Lines 13-8 and 149) .....</del>	.....	.....	.....
<b>DETAILS OF WRITE-INS</b>			
<del>1001. ....</del>	.....	.....	.....
<del>1002. ....</del>	.....	.....	.....
<del>1003. ....</del>	.....	.....	.....
<del>1098. Summary of remaining write-ins for Line 10 from overflow page .....</del>	.....	.....	.....
<del>1099. Total (Lines 1001 through 1003 plus 1098) (Line 10 above) .....</del>	.....	.....	.....

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cmte/apptf/2023-1 spring/summary and minutes/bwg/att two-a\\_2022-14bwg\\_modified.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cmte/apptf/2023-1%20spring/summary%20and%20minutes/bwg/att%20two-a_2022-14bwg_modified.docx)

**NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

<p style="text-align: right;"><b>DATE:</b> <u>08/19/2022</u></p> <p><b>CONTACT PERSON:</b> _____</p> <p><b>TELEPHONE:</b> _____</p> <p><b>EMAIL ADDRESS:</b> _____</p> <p><b>ON BEHALF OF:</b> _____</p> <p><b>NAME:</b> <u>Debbie Doggett</u></p> <p><b>TITLE:</b> _____</p> <p><b>AFFILIATION:</b> <u>Missouri Department of Insurance</u></p> <p><b>ADDRESS:</b> <u>301 W High St #630</u> <u>Jefferson City, MO 65101</u></p>	<p style="text-align: center;"><b>FOR NAIC USE ONLY</b></p> <p>Agenda Item # <u>2022-15BWG</u></p> <p>Year <u>2023</u></p> <p>Changes to Existing Reporting [ X ]</p> <p>New Reporting Requirement [ ]</p> <hr/> <p style="text-align: center;"><b>REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</b></p> <p>No Impact [ X ]</p> <p>Modifies Required Disclosure [ ]</p> <hr/> <p style="text-align: center;"><b>DISPOSITION</b></p> <p>[ ] Rejected For Public Comment</p> <p>[ ] Referred To Another NAIC Group</p> <p>[ ] Received For Public Comment</p> <p>[ X ] Adopted Date <u>03/07/2023</u></p> <p>[ ] Rejected Date _____</p> <p>[ ] Deferred Date _____</p> <p>[ ] Other (Specify) _____</p>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- |                                                                       |                                                   |                                                 |
|-----------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------|
| <input checked="" type="checkbox"/> ANNUAL STATEMENT                  | <input checked="" type="checkbox"/> INSTRUCTIONS  | <input checked="" type="checkbox"/> CROSSCHECKS |
| <input type="checkbox"/> QUARTERLY STATEMENT                          | <input type="checkbox"/> BLANK                    |                                                 |
| <input checked="" type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts        | <input type="checkbox"/> Title                  |
| <input checked="" type="checkbox"/> Property/Casualty                 | <input type="checkbox"/> Protected Cell           | <input type="checkbox"/> Other _____            |
| <input type="checkbox"/> Health                                       | <input type="checkbox"/> Health (Life Supplement) |                                                 |

Anticipated Effective Date: Annual 2023

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Revise the language of the Schedule H, Part 5 to remove the 5% of premiums filing exemption (FE).

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE\*\***

The purpose of the proposal is to remove the 5% of premium filing exemption on the Schedule H, Part 5. Before Schedule H was updated for Annual 2022 to bring uniformity in the accident and health lines of business, the Property/Casualty instructions for Schedule H, Part 5 had the less than 5% filing exemption and the Life/Fraternal instructions did not have the 5% filing exemption. The removal of the 5% exemption would require both Property/Casualty and Life/Fraternal filers to file the Schedule H, Part 5.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: \_\_\_\_\_

Other Comments:

\*\* This section must be completed on all forms.

**ANNUAL STATEMENT INSTRUCTIONS – LIFE\FRATERNAL AND PROPERTY**

**SCHEDULE H**

**ACCIDENT AND HEALTH EXHIBIT**

↓  
=====  
↑      **Detail Eliminated to Conserve Space**      ==  
↓

**PART 5 – HEALTH CLAIMS**

~~Companies with less than 5% of premiums in Accident and Health business should not complete this schedule.~~

**A.      DIRECT**

Line 1    –    Incurred Claims

Should agree with Line 3 plus Line 4 minus Line 2.

↓  
=====  
↑      **Detail Eliminated to Conserve Space**      ==  
↓

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cmte/apptf/2023-1 spring/summary and minutes/bwg/att two-b 2022-15bwg.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cmte/apptf/2023-1%20spring/summary%20and%20minutes/bwg/att%20two-b%202022-15bwg.docx)

**NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

<p style="text-align: right;"><b>DATE:</b> <u>08/23/2022</u></p> <p><b>CONTACT PERSON:</b> _____</p> <p><b>TELEPHONE:</b> _____</p> <p><b>EMAIL ADDRESS:</b> _____</p> <p><b>ON BEHALF OF:</b> _____</p> <p><b>NAME:</b> <u>Steve Drutz</u></p> <p><b>TITLE:</b> <u>Chief Financial Analyst</u></p> <p><b>AFFILIATION:</b> <u>WA Office of the Insurance Commissioner</u></p> <p><b>ADDRESS:</b> _____</p>	<p style="text-align: center;"><b>FOR NAIC USE ONLY</b></p> <p>Agenda Item # <u>2022-16BWG</u></p> <p>Year <u>2023</u></p> <p>Changes to Existing Reporting [ X ]</p> <p>New Reporting Requirement [ ]</p> <hr/> <p style="text-align: center;"><b>REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</b></p> <p>No Impact [ X ]</p> <p>Modifies Required Disclosure [ ]</p> <hr/> <p style="text-align: center;"><b>DISPOSITION</b></p> <p>[ ] Rejected For Public Comment</p> <p>[ ] Referred To Another NAIC Group</p> <p>[ ] Received For Public Comment</p> <p>[ X ] Adopted Date <u>03/07/2023</u></p> <p>[ ] Rejected Date _____</p> <p>[ ] Deferred Date _____</p> <p>[ ] Other (Specify) _____</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- |                                                                       |                                                   |                                                 |
|-----------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------|
| <input checked="" type="checkbox"/> ANNUAL STATEMENT                  | <input checked="" type="checkbox"/> INSTRUCTIONS  | <input checked="" type="checkbox"/> CROSSCHECKS |
| <input type="checkbox"/> QUARTERLY STATEMENT                          | <input checked="" type="checkbox"/> BLANK         |                                                 |
| <input checked="" type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts        | <input type="checkbox"/> Title                  |
| <input checked="" type="checkbox"/> Property/Casualty                 | <input type="checkbox"/> Protected Cell           | <input type="checkbox"/> Other _____            |
| <input checked="" type="checkbox"/> Health                            | <input type="checkbox"/> Health (Life Supplement) |                                                 |

Anticipated Effective Date: Annual 2023

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Remove Supplemental Health Care Exhibit Part 3 and Supplemental Health Care Exhibit’s Expense Allocation Report

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE\*\***

The purpose of this proposal is to remove parts of the Supplemental Health Care Exhibit that are no longer used regularly as part of a review of the Annual Statement for duplication or items not regularly used by regulators.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: \_\_\_\_\_

Other Comments:

\*\* This section must be completed on all forms.

Revised 7/18/2022

**ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, AND PROPERTY****SUPPLEMENTAL HEALTH CARE EXHIBIT – PARTS 1 AND 2 AND 3**

The purpose of this supplemental exhibit is to assist state and federal regulators in identifying and defining elements that make up the medical loss ratio as described in Section 2718(b) of the Public Health Service Act (PHSA) and for purposes of submitting a report to the HHS Secretary, as required by Section 2718(a) of the PHSA. The supplemental exhibit is also intended to track and compare financial results of health care business as reported in the annual financial statements. Thus, the numbers included in this supplemental exhibit are not the exact numbers that will be utilized for rebate purposes due to possible revisions for claim reserve run-off subsequent to year-end, statistical credibility concerns and other defined adjustments.

A schedule must be prepared and submitted for each jurisdiction in which the company has written direct comprehensive major medical health business, or has direct amounts paid, incurred or unpaid for provisions of health care services. In addition, a schedule must be prepared and submitted that contains the grand total (GT) for the company. However, insurers that have no business that would be included in Columns 1 through 9 or 12 of Part 1 for ANY of the states are not required to complete this supplement at all. If an insurer is required to file the supplement, then the insurer must complete Parts 1 and 2 for each state in which the insurer has any health business, even if a particular state will show \$0 earned premiums reported in Columns 1 through 9 or 12 of Part 1. ~~Also, Part 3 must be completed for any state in which there are non zero amounts in Columns 1 through 9 of Part 1. Companies should contact their domiciliary regulator to obtain a waiver of the filing if the only reportable business in Columns 1 through 9 are comprised of closed blocks of small group, large group or individual business that, if totaled across all states, does not equal 1,000 lives in total.~~



**Detail Eliminated to Conserve Space**



**Improving Health Care Quality Expenses – General Definition:**

Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for all plan activities that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage, as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self-insured plans.

Qualifying QI expenses should be grounded in evidence-based medicine, widely accepted best clinical practice or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

They should not be designed primarily to control or contain cost, although they may have cost-reducing or cost-neutral benefits, as long as the primary focus is to improve quality.

Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHSA and Section 1311 of the PPACA:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates;
- Increase wellness and promote health activities; or
- Enhance the use of health care data to improve quality, transparency and outcomes.

NOTE: Expenses that otherwise meet the definitions for QI but were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses.



**SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1**

(To Be Filed By April 1 – Not for Rebate Purposes – See Cautionary Statement at [www.naic.org/cmt\\_e\\_app\\_blanks.htm](http://www.naic.org/cmt_e_app_blanks.htm).)

**=====  
Detail Eliminated to Conserve Space  
=====**

Line 4 – Deductible Fraud and Abuse Detection/Recovery Expenses

This amount is ~~the lesser of the expense reported in Part 3, Column 7, Lines 1.11, 2.11, 3.11, 4.11, 5.11, 6.11, 7.11, 8.11 and 9.11, and the fraud and abuse recoveries reported in Part 2, Line 3, Columns 1, 2, 3, 4, 5, 6, 7, 8 and 9, respectively.~~

**=====  
Detail Eliminated to Conserve Space  
=====**

Line 6.1 – Improve Health Outcomes

Include expenses meeting the definition of Improve Health Outcomes in [Improving Health Care Quality Expenses – General Definition](#) ~~Part 3, Column 1~~ that are not health information technology expenses.

- ~~Part 1, Column 1, Line 6.1 should tie to Part 3, Column 1, Line 1.10~~
- ~~Part 1, Column 2, Line 6.1 should tie to Part 3, Column 1, Line 2.10~~
- ~~Part 1, Column 3, Line 6.1 should tie to Part 3, Column 1, Line 3.10~~
- ~~Part 1, Column 4, Line 6.1 should tie to Part 3, Column 1, Line 4.10~~
- ~~Part 1, Column 5, Line 6.1 should tie to Part 3, Column 1, Line 5.10~~
- ~~Part 1, Column 6, Line 6.1 should tie to Part 3, Column 1, Line 6.10~~
- ~~Part 1, Column 7, Line 6.1 should tie to Part 3, Column 1, Line 7.10~~
- ~~Part 1, Column 8, Line 6.1 should tie to Part 3, Column 1, Line 8.10~~
- ~~Part 1, Column 9, Line 6.1 should tie to Part 3, Column 1, Line 9.10~~

Line 6.2 – Activities to Prevent Hospital Readmissions

Include expenses meeting the definition of Improving Activities to Prevent Hospital Readmissions in [Improving Health Care Quality Expenses – General Definition](#) ~~Part 3, Column 2~~ that are not health information technology expenses.

- ~~Part 1, Column 1, Line 6.2 should tie to Part 3, Column 2, Line 1.10~~
- ~~Part 1, Column 2, Line 6.2 should tie to Part 3, Column 2, Line 2.10~~
- ~~Part 1, Column 3, Line 6.2 should tie to Part 3, Column 2, Line 3.10~~
- ~~Part 1, Column 4, Line 6.2 should tie to Part 3, Column 2, Line 4.10~~
- ~~Part 1, Column 5, Line 6.2 should tie to Part 3, Column 2, Line 5.10~~
- ~~Part 1, Column 6, Line 6.2 should tie to Part 3, Column 2, Line 6.10~~
- ~~Part 1, Column 7, Line 6.2 should tie to Part 3, Column 2, Line 7.10~~
- ~~Part 1, Column 8, Line 6.2 should tie to Part 3, Column 2, Line 8.10~~
- ~~Part 1, Column 9, Line 6.2 should tie to Part 3, Column 2, Line 9.10~~

## Line 6.3 – Improve Patient Safety and Reduce Medical Errors

Include expenses meeting the definition of Improve Patient Safety and Reduce Medical Errors in [Improving Health Care Quality Expenses – General Definition](#) ~~Part 3, Column 3~~ that are not health information technology expenses.

~~Part 1, Column 1, Line 6.3 should tie to Part 3, Column 3, Line 1.10~~

~~Part 1, Column 2, Line 6.3 should tie to Part 3, Column 3, Line 2.10~~

~~Part 1, Column 3, Line 6.3 should tie to Part 3, Column 3, Line 3.10~~

~~Part 1, Column 4, Line 6.3 should tie to Part 3, Column 3, Line 4.10~~

~~Part 1, Column 5, Line 6.3 should tie to Part 3, Column 3, Line 5.10~~

~~Part 1, Column 6, Line 6.3 should tie to Part 3, Column 3, Line 6.10~~

~~Part 1, Column 7, Line 6.3 should tie to Part 3, Column 3, Line 7.10~~

~~Part 1, Column 8, Line 6.3 should tie to Part 3, Column 3, Line 8.10~~

~~Part 1, Column 9, Line 6.3 should tie to Part 3, Column 3, Line 9.10~~

## Line 6.4 – Wellness and Health Promotion Activities

Include expenses meeting the definition of Wellness and Health Promotion Activities in [Improving Health Care Quality Expenses – General Definition](#) ~~Part 3, Column 4~~ that are not health information technology expenses.

~~Part 1, Column 1, Line 6.4 should tie to Part 3, Column 4, Line 1.10~~

~~Part 1, Column 2, Line 6.4 should tie to Part 3, Column 4, Line 2.10~~

~~Part 1, Column 3, Line 6.4 should tie to Part 3, Column 4, Line 3.10~~

~~Part 1, Column 4, Line 6.4 should tie to Part 3, Column 4, Line 4.10~~

~~Part 1, Column 5, Line 6.4 should tie to Part 3, Column 4, Line 5.10~~

~~Part 1, Column 6, Line 6.4 should tie to Part 3, Column 4, Line 6.10~~

~~Part 1, Column 7, Line 6.4 should tie to Part 3, Column 4, Line 7.10~~

~~Part 1, Column 8, Line 6.4 should tie to Part 3, Column 4, Line 8.10~~

~~Part 1, Column 9, Line 6.4 should tie to Part 3, Column 4, Line 9.10~~

Line 6.5 – Health Information Technology Expenses related to Health Improvement

Include expenses meeting the definition of HIT Expenses for Health Care Quality Improvements in [Improving Health Care Quality Expenses – General Definition Part 3, Column 5](#) that are health information technology expenses.

~~Part 1, Column 1, Line 6.5 should tie to Part 3, Column 5, Line 1.10~~

~~Part 1, Column 2, Line 6.5 should tie to Part 3, Column 5, Line 2.10~~

~~Part 1, Column 3, Line 6.5 should tie to Part 3, Column 5, Line 3.10~~

~~Part 1, Column 4, Line 6.5 should tie to Part 3, Column 5, Line 4.10~~

~~Part 1, Column 5, Line 6.5 should tie to Part 3, Column 5, Line 5.10~~

~~Part 1, Column 6, Line 6.5 should tie to Part 3, Column 5, Line 6.10~~

~~Part 1, Column 7, Line 6.5 should tie to Part 3, Column 5, Line 7.10~~

~~Part 1, Column 8, Line 6.5 should tie to Part 3, Column 5, Line 8.10~~

~~Part 1, Column 9, Line 6.5 should tie to Part 3, Column 5, Line 9.10~~

Line 8.1 – Cost Containment Expenses not Included in Quality of Care Expenses in Line 6.6

Include: Expenses that actually serve to reduce the number of health services provided or the cost of such services. Exclude cost containment expenses that improve the quality of health care (reported in Line 6.6). The following are examples of items that shall be considered “cost containment expenses” only if they result in reduced levels of costs or services (see the instructions for [Improving Health Care Quality Expenses – General Definition Part 3](#) of this supplement for items that qualify for Quality Improvement instead of “cost containment”):

**Detail Eliminated to Conserve Space**

**SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3**

~~This exhibit is intended to provide disclosure of expenses by major type of activity that improves health care quality, as defined below, as well as the amount of those expenses that is used for other activities and reported separately for the comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business), expatriate plans (small group and large group business) and student health plans.~~

~~This exhibit also shows the amount of qualifying HIT expenses, reported separately for the comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business), expatriate plans (small group and large group business) and student health plans, broken down into the four categories of Quality Improvement expenses (see below); similarly, the Other than HIT qualifying Quality Improvement expenses are disclosed for each of the four categories of Quality Improvement expenses.~~

~~The definitions of Individual, Small Group and Large Group are found in the instructions for Parts 1 and 2 of this supplement exhibit.~~

**Improving Health Care Quality Expenses – General Definition:**

~~Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for all plan activities that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.~~

~~The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage, as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self-insured plans.~~

~~Qualifying QI expenses should be grounded in evidence-based medicine, widely-accepted best clinical practice or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations.~~

~~They should not be designed primarily to control or contain cost, although they may have cost-reducing or cost-neutral benefits, as long as the primary focus is to improve quality.~~

~~Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHS Act and Section 1311 of the PPACA:~~

- ~~• Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;~~
- ~~• Prevent hospital readmissions;~~
- ~~• Improve patient safety and reduce medical errors, lower infection and mortality rates;~~
- ~~• Increase wellness and promote health activities; or~~
- ~~• Enhance the use of health care data to improve quality, transparency and outcomes.~~

~~NOTE: Expenses that otherwise meet the definitions for QI but were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses.~~

~~Column 1 — Improve Health Outcomes~~

~~Expenses for the direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representatives (e.g., face to face, telephonic, Web-based interactions or other means of communication) to improve health outcomes as defined above.~~

~~This category can include costs for associated activities such as:~~

- ~~● Effective case management, care coordination and chronic disease management, including:
 
  - ~~○ Patient-centered intervention, such as:
 
    - ~~▪ Making/verifying appointments;~~
    - ~~▪ Medication and care compliance initiatives;~~
    - ~~▪ Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center);~~
    - ~~▪ Programs to support shared decision-making with patients, their families and the patient's representatives; and~~
    - ~~▪ Reminding insured of physician appointment, lab tests or other appropriate contact with specific providers;~~~~
  - ~~○ Incorporating feedback from the insured to effectively monitor compliance;~~
  - ~~○ Providing coaching or other support to encourage compliance with evidence-based medicine;~~
  - ~~○ Activities to identify and encourage evidence-based medicine;~~
  - ~~○ Use of the medical homes model as defined for purposes of Section 3602 of PPACA;~~
  - ~~○ Activities to prevent avoidable hospital admissions;~~
  - ~~○ Education and participation in self-management programs; and~~
  - ~~○ Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance;~~~~
- ~~● Accreditation fees by a nationally recognized accrediting entity directly related to quality of care activities included in Columns 1 through 5;~~
- ~~● Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence-based medicine;~~
- ~~● Quality reporting and documentation of care in non-electronic format; and~~
- ~~● Health information technology expenses to support these activities (report in Column 5—see instructions) including:
 
  - ~~○ Data extraction, analysis and transmission in support of the activities described above; and~~
  - ~~○ Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care.~~~~

~~Column 2 — Activities to Prevent Hospital Readmission~~~~Expenses for implementing activities to prevent hospital readmissions as defined above, including:~~

- ~~● Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help ensure appropriate care that will, in all likelihood, avoid readmission to the hospital;~~
- ~~● Personalized post-discharge counseling by an appropriate health care professional;~~
- ~~● Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and~~
- ~~● Health information technology expenses to support these activities (report in Column 5—see instructions) including:
 
  - ~~○ Data extraction, analysis and transmission in support of the activities described above; and~~
  - ~~○ Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care.~~~~

~~Column 3 — Improve Patient Safety and Reduce Medical Errors~~~~Expenses for implementing activities to improve patient safety and reduce medical errors (as defined above) through:~~

- ~~● The appropriate identification and use of best clinical practices to avoid harm;~~
- ~~● Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns;~~
- ~~● Activities to lower risk of facility-acquired infections;~~
- ~~● Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions;~~
- ~~● Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and~~
- ~~● Health information technology expenses to support these activities (report in Column 5—see instructions), including:
 
  - ~~○ Data extraction, analysis and transmission in support of the activities described above; and~~
  - ~~○ Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care.~~~~

~~Column 4 — Wellness & Health Promotion Activities~~~~Expenses for programs that provide wellness and health promotion activity as defined above (e.g., face-to-face, telephonic or Web-based interactions or other forms of communication), including:~~

- ~~● Wellness assessment;~~
- ~~● Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;~~
- ~~● Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition; and~~
- ~~● Public health education campaigns that are performed in conjunction with state or local health departments.~~

- ~~• Actual rewards/incentives/bonuses/reductions in co-pays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI with the following restrictions:~~
  - ~~○ Only allowed for small and large employer groups, not individual business; and the expense amount is limited to the same percentage as the HIPAA incentive amount limit;~~
- ~~• Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;~~
- ~~• Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); and~~
- ~~• Health information technology expenses to support these activities (Report in Column 5—See instructions).~~

#### ~~Column 5—HIT Expenses for Health Care Quality Improvements~~

~~The PPACA also contemplates “Health Information Technology” as a function that may in whole or in part improve quality of care or provide the technological infrastructure to enhance current QI or make new QI initiatives possible. Include HIT expenses required to accomplish the activities reported in Columns 1 through 4 that are designed for use by health plans, health care providers or enrollees for the electronic creation, maintenance, access or exchange of health information, consistent with Medicare/Medicaid meaningful use requirements, in the following ways:~~

- ~~1. Monitoring, measuring or reporting clinical effectiveness, including reporting and analysis costs related to maintaining accreditation by nationally recognized accrediting organizations, such as NCQA or URAC; or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., CAHPS surveys or chart review of HEDIS measures) and costs for public reporting mandated or encouraged by law;~~
- ~~2. Advancing the ability of enrollees, providers, insurers or other systems to communicate patient-centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care—this may include electronic health records accessible by enrollees and appropriate providers to monitor and document an individual patient’s medical history;~~
- ~~3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;~~
- ~~4. Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease; or~~
- ~~5. Provision of electronic health records and patient portals.~~

~~Exclude:—Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (e.g., costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d 2, as amended.~~

- ~~NOTE: a. Health Care Professional Hotlines: Expenses for health care professional hotlines should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities.~~
- ~~b. Prospective Utilization Review: Expenses for prospective utilization review should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities, AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.~~

The following items are broadly excluded as not meeting the definitions above:

- ~~• All retrospective and concurrent utilization review;~~
- ~~• Fraud prevention activities (all are reported as cost containment, but Part 1, Line 4 includes MLR recognition of fraud detection/recovery expenses up to the amount recovered that reduces incurred claims);~~
- ~~• The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;~~
- ~~• Provider credentialing;~~
- ~~• Marketing expenses;~~
- ~~• Any accreditation fees that are not directly related to activities included in Columns 1 through 5;~~
- ~~• Costs associated with calculating and administering individual enrollee or employee incentives; and~~
- ~~• Any function or activity not expressly included in Columns 1 through 5.~~

~~NOTE: The NAIC will review requests to include expenses for broadly excluded activities and activities not described under Columns 1 through 5 above. Upon an adequate showing that the activity's costs support the definitions and purposes therein, or otherwise support monitoring, measuring, or reporting health care quality improvement, the NAIC may recommend that the HHS Secretary certify those expenses as Quality Improvement.~~

~~The sections for comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business) and expatriate plans (small group and large group business) are defined as per the comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business), expatriate plans (small group and large group business) and student health plans columns in Parts 1 and 2 of this supplement.~~

~~For questions on definitions, refer to the instructions for the Annual Statement Expenses Schedule (i.e., the Underwriting and Investment Exhibit, Part 3 for P/C and Health, and Exhibit 2 for Life and Fraternal), for the line references provided below. **DIFFERENT FROM A/S EXPENSE REPORTING:** For non-affiliated management agreements/outsourced services, report all amounts in the supplement's Line 1.2, 2.2, 3.2, 4.2, 5.2, 6.2, 7.2, 8.2 or 9.2 for Outsourced Services (not just those amounts less than 10% of total expenses). Continue to allocate all affiliated management agreements/outsourced services to the appropriate expense lines as if the costs had been borne directly by the insurer.~~



~~Lines 1.1, 2.1,  
3.1, 4.1, 5.1,  
6.1, 7.1, 8.1  
& 9.1 ——— Salaries~~

Life/Fraternal Statement:

~~Exhibit 2, Line 2 Salaries and wages  
Exhibit 2, Line 3.11 Contributions for benefit plans for employees  
Exhibit 2, Line 3.12 Contributions for benefit plans for agents  
Exhibit 2, Line 3.21 Payments to employees under non-funded benefit plans  
Exhibit 2, Line 3.22 Payments to agents under non-funded benefit plans  
Exhibit 2, Line 3.31 Other employee welfare  
Exhibit 2, Line 3.32 Other agent welfare~~

Health Statement:

~~U&I Part 3, Line 2 Salaries, wages and other benefits~~

P/C Statement:

~~U&I Part 3, Line 8.1 Salaries  
U&I Part 3, Line 9 Employee relations and welfare  
U&I Part 3, Line 11 Directors' fees~~

~~Lines 1.2, 2.2,  
3.2, 4.2, 5.2,  
6.2, 7.2, 8.2  
& 9.2 ——— Outsourced Services~~

~~Include: ——— All non-affiliated expenses for administrative services, claim management services, new programming, membership services, and other similar services, regardless of amount. Thus, non-affiliated amounts greater than the 10% threshold that are reported in the various expense categories (e.g., salaries, rent) for A/S Expense Exhibit reporting will be backed out of the expense categories and reported in Outsourced Services in the Supplemental Health Care Exhibit, Part 3. In addition, the non-affiliated amounts less than the 10% threshold will be included in Outsourced Services (reported as follows in the A/S Expense Exhibit):~~

Life/Fraternal Statement:

~~Exhibit 2, Line 4.5 Expense of investigation and settlement of policy claims  
Outsourced portion of Exhibit 2, Line 7.1 Agency expense allowance~~

Health Statement:

~~U&I Part 3, Line 14 Outsourced services including EDP, claims, and other services~~

P/C Statement:

~~Outsourced portion of U&I Part 3, Line 1.4 Net claim adjustment services  
Outsourced portion of U&I Part 3, Line 2.8 Net commission/brokerage  
Outsourced portion of U&I Part 3, Line 3 Allowances to manager and agents~~

~~Exclude: ——— Services provided by affiliates under management agreements.~~

~~Lines 1.3, 2.3,  
3.3, 4.3, 5.3,  
6.3, 7.3, 8.3  
& 9.3 ——— EDP Equipment and Software~~

Life/Fraternal Statement:

~~Exhibit 2, Line 5.7 Cost or depreciation of EDP equipment and software~~

Health Statement:

~~U&I Part 3, Line 13 Cost or depreciation of EDP equipment and software~~

P/C Statement:

~~U&I Part 3, Line 15 Cost or depreciation of EDP equipment and software~~

~~Lines 1.4, 2.4,  
3.4, 4.4, 5.4,  
6.4, 7.4, 8.4  
& 9.4 ——— Other Equipment (excluding EDP)~~

Life/Fraternal Statement:

~~Exhibit 2, Line 5.6 Rental of equipment~~

~~Equipment amounts from Exhibit 2, Line 5.5 Cost or depreciation of furniture/equipment~~

Health Statement:

~~U&I Part 3, Line 12 Equipment~~

P/C Statement:

~~U&I Part 3, Line 14 Equipment~~

~~Lines 1.5, 2.5,  
3.5, 4.5, 5.5,  
6.5, 7.5, 8.5  
& 9.5 ——— Accreditation and Certification~~

~~Include: ——— Fees associated with the certification and accreditation of a health plan, including but not limited to: fees paid to Joint Commission on Accreditation of Health Care Organizations (JCAHO), National Committee on Quality Assurance (NCQA), and American Accreditation Health Care Commission (URAC).~~

Life/Fraternal Statement:

~~Applicable portion of Exhibit 2, Line 6.2 Bureau and association fees~~

Health Statement:

~~U&I Part 3, Line 5 Certification and Accreditation~~

P/C Statement:

~~Applicable portion of U&I Part 3, Line 5 Boards, bureaus and associations~~

~~Exclude: ——— Rating agencies and other similar organizations.~~

~~Lines 1.6, 2.6,  
3.6, 4.6, 5.6,  
6.6, 7.6, 8.6  
& 9.6 — Other Expenses~~

~~Include: — Any additional expenses not included in another category.~~

~~Life/Fraternal Statement:~~

~~Exhibit 2, Line 1 Rent~~

~~Exhibit 2, Line 4.1 Legal fees and expenses~~

~~Exhibit 2, Line 4.2 Medical examination fees~~

~~Exhibit 2, Line 4.3 Inspection report fees~~

~~Exhibit 2, Line 4.4 Fees of public accountants and consulting actuaries~~

~~Exhibit 2, Line 5.1 Traveling expenses~~

~~Exhibit 2, Line 5.2 Advertising~~

~~Exhibit 2, Line 5.3 Postage, express, telegraph and telephone~~

~~Exhibit 2, Line 5.4 Printing and stationery~~

~~Furniture portion of Exhibit 2, Line 5.5 Cost or depreciation of  
furniture/equipment~~

~~Exhibit 2, Line 6.1 Books and periodicals~~

~~Non-accreditation portion of Exhibit 2, Line 6.2 Bureau and association fees~~

~~Exhibit 2, Line 6.3 Insurance, except on real estate~~

~~Exhibit 2, Line 6.4 Miscellaneous losses~~

~~Exhibit 2, Line 6.5 Collection and bank service charges~~

~~Exhibit 2, Line 6.6 Sundry general expenses~~

~~In house portion of Exhibit 2, Line 7.1 Agency expense allowance~~

~~Exhibit 2, Line 7.2 Agents' balances charged off (less \$\_\_\_ recovered)~~

~~Exhibit 2, Line 7.3 Agency conferences other than local meetings~~

~~Exhibit 2, Line 9.1 Real estate expenses~~

~~Exhibit 2, Line 9.2 Investment expenses not included elsewhere~~

~~Exhibit 2, Line 9.3 Aggregate write ins for expenses~~

Health Statement:~~U&I Part 3, Line 1 Rent~~~~U&I Part 3, Line 3 Commissions~~~~U&I Part 3, Line 4 Legal fees~~~~U&I Part 3, Line 6 Auditing, actuarial and other consulting~~~~U&I Part 3, Line 7 Traveling expenses~~~~U&I Part 3, Line 8 Marketing and advertising~~~~U&I Part 3, Line 9 Postage, express and telephone~~~~U&I Part 3, Line 10 Printing and office supplies~~~~U&I Part 3, Line 11 Occupancy, depreciation and amortization~~~~U&I Part 3, Line 15 Boards, bureaus and association fees~~~~U&I Part 3, Line 16 Insurance, except on real estate~~~~U&I Part 3, Line 17 Collection and bank service charges~~~~U&I Part 3, Line 18 Group service and administration fees~~~~U&I Part 3, Line 21 Real estate expenses~~~~U&I Part 3, Line 24 Investment expenses not included elsewhere~~~~U&I Part 3, Line 25 Aggregate write ins~~P/C Statement:~~In house portion of U&I Part 3, Line 1.4 Net claim adjustment services~~~~In house portion of U&I Part 3, Line 2.8 Net commission/brokerage~~~~In house portion of U&I Part 3, Line 3 Allowances to manager and agents~~~~U&I Part 3, Line 4 Advertising~~~~Non-accreditation portion of U&I Part 3, Line 5 Boards, bureaus and associations~~~~U&I Part 3, Line 6 Surveys and underwriting reports~~~~U&I Part 3, Line 7 Audit of assured's records~~~~U&I Part 3, Line 10 Insurance~~~~U&I Part 3, Line 12 Travel and travel items~~~~U&I Part 3, Line 13 Rent and rent items~~~~U&I Part 3, Line 16 Printing and stationery~~~~U&I Part 3, Line 17 Postage, telephone and telegraph, exchange and express~~~~U&I Part 3, Line 18 Legal and auditing~~~~U&I Part 3, Line 21 Real estate expenses~~~~U&I Part 3, Line 24 Aggregate write ins~~

~~Lines 1.8, 2.8,  
3.8, 4.8, 5.8,  
6.8, 7.8, 8.8  
& 9.8 ——— Reimbursement by uninsured plans and fiscal intermediaries~~

Life Statement:

~~Exhibit 2, Line 6.7 Group service and administration fees~~

~~Exhibit 2, Line 6.8 Reimbursements by uninsured plans~~

Health Statement:

~~U&I Part 3, Line 19 Reimbursements by uninsured plans~~

~~U&I Part 3, Line 20 Reimbursements from fiscal intermediaries (e.g., Medicare, CHAMPUS, other governmental)~~

P/C Statement:

~~U&I Part 3, Line 23 Reimbursements by uninsured plans~~

~~Lines 1.9, 2.9,  
3.9, 4.9, 5.9,  
6.9, 7.9, 8.9  
& 9.9 ——— Taxes, Licenses and Fees~~

Life/Fraternal Statement:

~~Exhibit 3, Line 1 Real estate taxes~~

~~Exhibit 3, Line 2 State insurance department licenses and fees~~

~~Exhibit 3, Line 3 State taxes on premiums~~

~~Exhibit 3, Line 4 Other state taxes, incl \$\_\_\_ for employee benefits~~

~~Exhibit 3, Line 5 U.S. Social Security taxes~~

~~Exhibit 3, Line 6 All other taxes~~

Health Statement:

~~U&I Part 3, Line 22 Real Estate Taxes~~

~~U&I Part 3, Line 23.1 State and local insurance taxes~~

~~U&I Part 3, Line 23.2 State premium taxes~~

~~U&I Part 3, Line 23.3 Regulatory authority licenses and fees~~

~~U&I Part 3, Line 23.4 Payroll taxes~~

~~U&I Part 3, Line 23.5 Other (excluding federal income and real estate)~~

P/C Statement:

~~U&I Part 3, Line 8.2 Payroll taxes~~

~~U&I Part 3, Line 20.1 State and local insurance taxes, deducting guaranty association credits of \$\_\_\_~~

~~U&I Part 3, Line 20.2 Insurance department licenses and fees~~

~~U&I Part 3, Line 20.3 Gross guaranty association assessments~~

~~U&I Part 3, Line 20.4 All other taxes, licenses and fees (excluding federal and foreign income and real estate)~~

~~U&I Part 3, Line 22 Real estate taxes~~

~~Lines 1.11, 2.11,  
3.11, 4.11, 5.11,  
6.11, 7.11, 8.11~~

~~& 9.11 Total Fraud and Abuse Detection/Recovery Expenses Included in Column 7 (Informational Only)~~

~~Include: Fraud and abuse detection and recovery expenses as well as prevention expenses.~~

**EXPENSE ALLOCATION SUPPLEMENTAL FILING**

~~A single (not state by state), separate, regulator only supplemental filing must be made by the insurer to provide a description of the method utilized to allocate QI expenses to each state and to each line and column on Part 3.~~

~~Additionally, companies reporting QI expenses in Part 3, Columns 1 through 5 must include a detailed description of such expense elements, including how the specific expenses meet the definitions above.~~

~~The definitions established in the Supplemental Health Care Exhibit apply to this supplemental filing, as well. For a **new initiative** that otherwise meets the definition of QI above but has not yet met the objective, verifiable results requirement, include an “X” in the “New” column of the supplement and include in the description the expected time frame for the activity to accomplish the objective, verifiable results.~~

~~Expenses for prospective utilization review and the costs of reward or bonuses associated with wellness and health promotion that are included in QI should include an “E” in the “New” column. These will be reviewed for adherence to the definition and standards of QI and may be specifically incorporated into, or excluded from, the instructions for QI for future reporting purposes.~~

<u>Expense Type from Part 3</u>	<u>Line Number</u>
<del>Improve Health Outcomes .....</del>	<del>1.0001 – 1.9999</del>
<del>Activities to Prevent Hospital Readmission.....</del>	<del>2.0001 – 2.9999</del>
<del>Improve Patient Safety and Reduce Medical Errors.....</del>	<del>3.0001 – 3.9999</del>
<del>Wellness &amp; Health Promotion Activities.....</del>	<del>4.0001 – 4.9999</del>
<del>HIT Expenses for Health Care Quality Improvements.....</del>	<del>5.0001 – 5.9999</del>

ANNUAL STATEMENT BLANK – LIFE/FRATERNAL, HEALTH, AND PROPERTY

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3

(To Be Filled By April 1 – Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION \_\_\_\_\_ 2. \_\_\_\_\_

(LOCATION)

NAIC Group Code \_\_\_\_\_ BUSINESS IN THE STATE OF \_\_\_\_\_ DURING THE YEAR \_\_\_\_\_ NAIC \_\_\_\_\_ Company \_\_\_\_\_ Code \_\_\_\_\_

	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIP Expenses	6 Total (1 to 5)	7 Claims Adjustment Expenses		9 General Administrative Expenses	10 Total Expenses (6 to 9)
							8 Cost Containment Expenses	8 Other Claims Adjustment Expenses		
1 All Expenses										
Individual Comprehensive Coverage Expenses:										
1.1 Salaries (including \$ _____ for affiliated services)										
1.2 Outsource services										
1.3 EDP equipment and software (net \$ _____ for affiliated services)										
1.4 Other equipment (incl. EDP) (net \$ _____ for affiliated services)										
1.5 Accreditation and certification (net \$ _____ for affiliated services)										
1.6 Other expenses (net \$ _____ for affiliated services)										
1.7 Subtotal before reimbursements and taxes (1.1 to 1.6)										
1.8 Reimbursements by uninsured plans and fiscal intermediaries										
1.9 Taxes, license and fees (in total, for filing purposes)										
1.10 Total (1.7 to 1.9)										
1.11 Total Fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
Small Group Comprehensive Coverage Expenses:										
2.1 Salaries (including \$ _____ for affiliated services)										
2.2 Outsource Services										
2.3 EDP equipment and software (net \$ _____ for affiliated services)										
2.4 Other equipment (incl. EDP) (net \$ _____ for affiliated services)										
2.5 Accreditation and certification (net \$ _____ for affiliated services)										
2.6 Other expenses (net \$ _____ for affiliated services)										
2.7 Subtotal before reimbursements and taxes (2.1 to 2.6)										
2.8 Reimbursements by uninsured plans and fiscal intermediaries										
2.9 Taxes, license and fees (in total, for filing purposes)										
2.10 Total (2.7 to 2.9)										
2.11 Total Fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
Large Group Comprehensive Coverage Expenses:										
3.1 Salaries (including \$ _____ for affiliated services)										
3.2 Outsource services										
3.3 EDP equipment and software (net \$ _____ for affiliated services)										
3.4 Other equipment (incl. EDP) (net \$ _____ for affiliated services)										
3.5 Accreditation and certification (net \$ _____ for affiliated services)										
3.6 Other expenses (net \$ _____ for affiliated services)										
3.7 Subtotal before reimbursements and taxes (3.1 to 3.6)										
3.8 Reimbursements by uninsured plans and fiscal intermediaries										
3.9 Taxes, license and fees (in total, for filing purposes)										
3.10 Total (3.7 to 3.9)										
3.11 Total Fraud and abuse detection/recovery expenses included in Column 7 (informational only)										



**SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3 (Continued)**  
(To Be Filed By April 1 – Not for Rebate Purposes)

	All Expenses										9	10	
	1	2	3	4	5	6	7	8	9	10			
	Improve Health Outcomes	Activities to Prevent Hospital Readmissions	Improve Patient Safety and Reduce Medical Errors	Wellness & Health Promotion Activities	HR Expenses	Total (1 to 5)	Cost Containment Expenses	Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (6 to 10)			
4.	Individual Mini-Med Plans Expenses												
	4.1	Salaries (including \$_____ for affiliated services)											
	4.2	Outsourced services _____											
	4.3	EDP equipment and software (net \$_____ for affiliated services)											
	4.4	Other equipment (excl. EDP) (net \$_____ for affiliated services)											
	4.5	Accreditation and certification (net \$_____ for affiliated services)	XXX			XXX							
	4.6	Other expenses (net \$_____ for affiliated services)											
	4.7	Subtotal before reimbursements and taxes (4.1 to 4.6)	XXX			XXX							
	4.8	Reimbursements by unissued plans and fiscal intermediaries											
	4.9	Taxes, license and fees (in total, for tying purposes)	XXX			XXX							
	4.10	Total (4.7 to 4.9)											
4.11	Total fraud and abuse detection/recovery expenses included in Column 7 (informational only)												
5.	Small Group Mini-Med Plans Expenses												
	5.1	Salaries (including \$_____ for affiliated services)											
	5.2	Outsourced services _____											
	5.3	EDP equipment and software (net \$_____ for affiliated services)											
	5.4	Other equipment (excl. EDP) (net \$_____ for affiliated services)											
	5.5	Accreditation and certification (net \$_____ for affiliated services)	XXX			XXX							
	5.6	Other expenses (net \$_____ for affiliated services)											
	5.7	Subtotal before reimbursements and taxes (5.1 to 5.6)	XXX			XXX							
	5.8	Reimbursements by unissued plans and fiscal intermediaries											
	5.9	Taxes, license and fees (in total, for tying purposes)	XXX			XXX							
	5.10	Total (5.7 to 5.9)											
5.11	Total fraud and abuse detection/recovery expenses included in Column 7 (informational only)												
6.	Large Group Mini-Med Plans Expenses												
	6.1	Salaries (including \$_____ for affiliated services)											
	6.2	Outsourced services _____											
	6.3	EDP equipment and software (net \$_____ for affiliated services)											
	6.4	Other equipment (excl. EDP) (net \$_____ for affiliated services)											
	6.5	Accreditation and certification (net \$_____ for affiliated services)	XXX			XXX							
	6.6	Other expenses (net \$_____ for affiliated services)											
	6.7	Subtotal before reimbursements and taxes (6.1 to 6.6)	XXX			XXX							
	6.8	Reimbursements by unissued plans and fiscal intermediaries											
	6.9	Taxes, license and fees (in total, for tying purposes)	XXX			XXX							
	6.10	Total (6.7 to 6.9)											
6.11	Total fraud and abuse detection/recovery expenses included in Column 7 (informational only)												

**SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3 (Continued)**  
(To Be Filed By April 1 – Not for Rebate Purposes)

	All Expenses	Improving Health Care Quality Expenses				Claims-Adjustment Expenses			9 General Administrative Expenses	10 Total Expenses (6-to-9)
		1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIP Expenses	6 Total (1-to-5)	7 Cost Containment Expenses		
7.	Small Group Expendable Plans Expenses									
	7.1 Salaries (including \$_____ for affiliated services)									
	7.2 Outsourced services _____									
	7.3 EDP equipment and software (net \$_____ for affiliated services)									
	7.4 Other equipment (excl. EDP) (net \$_____ for affiliated services)									
	7.5 Accreditation and certification (net \$_____ for affiliated services)			XXX		XXX				
	7.6 Other expenses (net \$_____ for affiliated services)									
	7.7 Subtotal before reimbursements and taxes (7.1 to 7.6)									
	7.8 Reimbursements by unissued plans and fiscal intermediaries			XXX		XXX				
	7.9 Taxes, licenses and fees (in total, for tying purposes)								XXX	
7.10 Total (7.7 to 7.9)									XXX	
7.11 Total fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
8.	Large Group Expendable Plans Expenses									
	8.1 Salaries (including \$_____ for affiliated services)									
	8.2 Outsourced services _____									
	8.3 EDP equipment and software (net \$_____ for affiliated services)									
	8.4 Other equipment (excl. EDP) (net \$_____ for affiliated services)									
	8.5 Accreditation and certification (net \$_____ for affiliated services)			XXX		XXX				
	8.6 Other expenses (net \$_____ for affiliated services)									
	8.7 Subtotal before reimbursements and taxes (8.1 to 8.6)									
	8.8 Reimbursements by unissued plans and fiscal intermediaries			XXX		XXX				
	8.9 Taxes, licenses and fees (in total, for tying purposes)									XXX
8.10 Total (8.7 to 8.9)									XXX	
8.11 Total fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
9.	Student Health Plans Expenses									
	9.1 Salaries (including \$_____ for affiliated services)									
	9.2 Outsourced services _____									
	9.3 EDP equipment and software (net \$_____ for affiliated services)									
	9.4 Other equipment (excl. EDP) (net \$_____ for affiliated services)									
	9.5 Accreditation and certification (net \$_____ for affiliated services)			XXX		XXX				
	9.6 Other expenses (net \$_____ for affiliated services)									
	9.7 Subtotal before reimbursements and taxes (9.1 to 9.6)									
	9.8 Reimbursements by unissued plans and fiscal intermediaries			XXX		XXX				
	9.9 Taxes, licenses and fees (in total, for tying purposes)									XXX
9.10 Total (9.7 to 9.9)									XXX	
9.11 Total fraud and abuse detection/recovery expenses included in Column 7 (informational only)										

**SUPPLEMENTAL HEALTH CARE EXHIBIT'S EXPENSE ALLOCATION REPORT**  
(To Be Filed by April 1)

NAIC Group Code: \_\_\_\_\_ NAIC \_\_\_\_\_ Company \_\_\_\_\_ Code: \_\_\_\_\_

Description of allocation methodology:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Detailed Description of Quality Improvement Expenses:

Expense Type from Part 3	New	Detailed Description of Expense
<b>1. Improve Health Outcomes:</b>		
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
<b>2. Activities to Prevent Hospital Readmission:</b>		
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
<b>3. Improve Patient Safety and Reduce Medical Errors:</b>		
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
<b>4. Wellness &amp; Health Promotion Activities:</b>		
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
<b>5. HIT Expenses for Health Care Quality Improvements:</b>		
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____
—	_____	_____

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cmte/apptf/2023-1 spring/summary and minutes/bwg/att two-c\\_2022-16bwg.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cmte/apptf/2023-1%20spring/summary%20and%20minutes/bwg/att%20two-c_2022-16bwg.docx)

**NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

<p style="text-align: right;">DATE: <u>09/06/2022</u></p> <p>CONTACT PERSON: _____</p> <p>TELEPHONE: _____</p> <p>EMAIL ADDRESS: _____</p> <p>ON BEHALF OF: _____</p> <p>NAME: <u>Patricia Gosselin</u></p> <p>TITLE: _____</p> <p>AFFILIATION: <u>New Hampshire Insurance Department</u></p> <p>ADDRESS: <u>215 S. Fruit St., Ste. 14</u> <u>Concord, NH 03301</u></p>	<p style="text-align: center;"><b>FOR NAIC USE ONLY</b></p> <p>Agenda Item # <u>2022-18BWG</u></p> <p>Year <u>2023</u></p> <p>Changes to Existing Reporting [ X ]</p> <p>New Reporting Requirement [ ]</p> <hr/> <p style="text-align: center;"><b>REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</b></p> <p>No Impact [ X ]</p> <p>Modifies Required Disclosure [ ]</p> <hr/> <p style="text-align: center;"><b>DISPOSITION</b></p> <p>[ ] Rejected For Public Comment</p> <p>[ ] Referred To Another NAIC Group</p> <p>[ ] Received For Public Comment</p> <p>[ X ] Adopted Date <u>03/07/2023</u></p> <p>[ ] Rejected Date _____</p> <p>[ ] Deferred Date _____</p> <p>[ ] Other (Specify) _____</p>
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**BLANK(S) TO WHICH PROPOSAL APPLIES**

- |                                                                       |                                                       |                                      |
|-----------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------|
| <input checked="" type="checkbox"/> ANNUAL STATEMENT                  | <input type="checkbox"/> INSTRUCTIONS                 | <input type="checkbox"/> CROSSCHECKS |
| <input type="checkbox"/> QUARTERLY STATEMENT                          | <input type="checkbox"/> BLANK                        |                                      |
| <input checked="" type="checkbox"/> Life, Accident & Health/Fraternal | <input checked="" type="checkbox"/> Separate Accounts | <input type="checkbox"/> Title       |
| <input type="checkbox"/> Property/Casualty                            | <input type="checkbox"/> Protected Cell               | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Health                                       | <input type="checkbox"/> Health (Life Supplement)     |                                      |

Anticipated Effective Date: Annual 2023

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Instructional corrections on the handling of Exchange Traded Funds (ETFs) and/or Securities Valuation Office (SVO) Identified Funds within the Interest Maintenance Reserve (IMR) and the Asset Valuation Reserve (AVR).

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE\*\***

The classification of Bond Mutual Funds is no longer used in statement reporting, within the *Accounting Practices and Procedures Manual* nor within the *Purposes and Procedures Manual of the NAIC's Investment Analysis Office*. However, the IMR/AVR instructions have not been updated to reflect the new terminology.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: \_\_\_\_\_

Other Comments:

\*\* This section must be completed on all forms.

Revised 7/18/2022

ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

**INTEREST MAINTENANCE RESERVE**

This exhibit is designed to capture the realized capital gains/(losses) that result from changes in the overall level of interest rates and amortize them into income over the approximate remaining life of the investment sold.

=====  
Detail Eliminated to Conserve Space  
=====

Line 2 – Current Year’s Realized Pre-tax Capital Gains/(Losses) of \$ \_\_\_\_\_ Transferred into the Reserve Net of Taxes of \$ \_\_\_\_\_

=====  
Detail Eliminated to Conserve Space  
=====

Include realized capital gains/(losses) on:

Debt securities (excluding loan-backed and structured securities) and preferred stocks whose National Association of Insurance Commissioners (NAIC)/Securities Valuation Office (SVO) designation at the end of the holding period is **NOT** different from its NAIC designation at the beginning of the holding period by more than one NAIC designation. Exclude any such gains/(losses) exempt from the IMR.

~~Bond Mutual Funds—as Identified by the SVO. Exchange Traded Funds (ETFs) as listed on the SVO Identified Bond ETF List (thereafter subject to bond IMR guidelines) and the SVO Identified Preferred Stock ETF List (thereafter subject to preferred stock IMR guidelines). Include any capital gains/(losses) realized by the Company, whether from sale of the Fund-ETF or capital gains distributions by the Fund-ETF. If, during the course of the year, the SVO removes the designation of “NAIC 1” from a Bond Mutual Fund—as Identified by the SVO, the company shall not report capital gains/(losses) in this schedule. If the ETF is removed from either SVO ETF list, the ETF is reported and treated as common stock, with any capital gains/(losses) excluded from the IMR. Any such removal of the “NAIC 1” designation will cause the Fund to be reported as common stock on the applicable schedules.~~

SVO Identified Funds designated for systematic value

Called bonds, tendered bonds, and sinking fund payments.

=====  
Detail Eliminated to Conserve Space  
=====

Additional Provisions for Including/Excluding Gains (Losses) from IMR:

Mortgage loan prepayment penalties are not included in IMR. Treat them as regular investment income.

Interest-related gains/(losses) realized on directly held capital and surplus notes reported on Schedule BA should be transferred to the IMR in the same manner as similar gains and losses on fixed income assets held on Schedule D. A capital gain/(loss) on such a note is classified as an interest rate gain if the note is eligible for amortized-value accounting at both the time of acquisition and the time of disposition.

Determination of IMR gain/(loss) on multiple lots of the same securities should follow the underlying accounting treatment in determining the gain/(loss). Thus, the designation, on a purchase lot basis, should be compared to the designation at the end of the holding period to determine IMR or AVR gain or loss.

Realized capital gains/(losses) on any debt security (excluding loan-backed and structured securities) that has had an NAIC/SVO designation of 6 at any time during the holding period should be excluded from the IMR and included as a non-interest-related gain/(loss) in the AVR.

Realized capital gains/(losses) on any preferred stock that had an NAIC/SVO designation of RP4, RP5 or RP6 or P4, P5 or P6 at any time during the holding period should be reported as non-interest-related gains/(losses) in the AVR.

The holding period for debt securities (excluding loan-backed and structured securities) and preferred stocks is defined as the period from the date of purchase to the date of sale. For the end of period classification, the most recent available designation should be used. For bonds acquired before Jan. 1, 1991, the holding period is presumed to have begun on Dec. 31, 1990. For preferred stocks acquired before Jan. 1, 1993, the holding period is presumed to have begun on Dec. 31, 1992. For ~~Bond Mutual Fund — as Identified by the~~ SVO Identified ETFs, the holding period is defined as one calendar year to expected maturity. For SVO Identified Funds designated for systematic value, the holding period is the weighted-average life of the underlying bonds.



**Detail Eliminated to Conserve Space**

**AMORTIZATION**

This supporting schedule calculates the amount of the Interest Maintenance Reserve to be amortized in each year.

Column 1 – Reserve as of December 31, Prior Year

Enter the amount from Column 4 of the prior year’s schedule.

Column 2 – Current Year’s Realized Capital Gains/(Losses) Transferred into the Reserve Net of Taxes




**Detail Eliminated to Conserve Space**

**Expected Maturity Date**

The presence of sinking fund payments, amortization schedules, expected prepayments, and adjustable interest rates complicate the determination of the number of calendar years to expected maturity. The expected maturity date is:

- For fixed income instruments with fixed contractual repayment dates and amounts (including bonds, preferred stock, callable or convertible bonds and preferred(s)), the expected maturity is defined as the contractual retirement date which produces the lowest amortization value for annual statement purposes (lowest internal rate of return or “yield to worst”). Potential retirement dates include all possible call dates, and the contractual maturity date. However, where a convertible bond or convertible preferred stock is sold while its conversion value exceeds its book/adjusted carrying value and the gain is included in IMR, the expected maturity date is defined as the next conversion date. Conversion value is defined to mean the number of shares of common stock available currently or at next conversion date, multiplied by the stock’s current market price. When the instrument’s contractual terms include scheduled sinking fund payments of fixed amounts, an additional calculation of yield to average life should be included in the analysis where average life is defined

as the date at which the instrument is 50% repaid. For puttable instruments, where the exercise option rests with the investor, expected maturity is the put or maturity date that produces the highest internal rate of return. For ~~Bond Mutual Funds—as Identified by~~ SVO [Identified ETFs](#), use one calendar year to expected maturity. For SVO Identified Funds designated for systematic value, the expected maturity is the weighted-average life of the underlying bonds. For perpetual instruments, the expected maturity is 30 years from the current date.



### Detail Eliminated to Conserve Space

For purposes of the grouped method, the following additional assumptions are applicable:

- For fixed income investments, other than residential mortgages and residential mortgage pass-throughs, without a maturity date or sinking fund schedule, a maturity date 30 years from the current year should be used.
- For mortgage-backed/asset-backed securities, use the remaining weighted average life of principal and interest payments consistent with the prepayment assumptions that would have been used to value the security had the security been repurchased at its sale price.
- For ~~Bond Mutual Funds—as Identified by the~~ SVO [Identified ETFs](#), use one calendar year to expected maturity.

**ASSET VALUATION RESERVE**

**DEFAULT COMPONENT –  
BASIC CONTRIBUTION, RESERVE OBJECTIVE AND MAXIMUM RESERVE CALCULATIONS**

This supporting form is used to calculate the basic contribution, reserve objective and maximum reserve amount for the bond, preferred stock, derivative instruments and mortgage loan sub-components of the default component of the AVR. Instructions apply to the general account and the separate accounts, if applicable.



**Detail Eliminated to Conserve Space**

Lines 1  
through 7 – Long-Term Bonds

Report the book/adjusted carrying value of all bonds and other fixed income instruments owned in Columns 1 and 4. “Book/Adjusted Carrying Value,” when applied to ~~Bond Mutual Funds—as Identified by the SVO, equals the “Fair Value” shown in Column 9 of Schedule D, Part 1. “Bond Mutual Fund—as Identified by the SVO”~~ [ETFs on the SVO Identified Bond ETF List](#) shall have the same meaning as set forth in the instructions to Schedule D, Part 1. Categorize the bonds and other fixed income instruments into NAIC designations 1 through 6 as directed by the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*, except that, exempt obligations should be reported separately. Multiply the amount in Column 4 for each designation by the reserve factors provided in Columns 5, 7 and 9, and report the products by designation in Columns 6, 8 and 10, respectively.



**Detail Eliminated to Conserve Space**



**ASSET VALUATION RESERVE**

**EQUITY AND OTHER INVESTED ASSET COMPONENT –  
BASIC CONTRIBUTION, RESERVE OBJECTIVE AND MAXIMUM RESERVE CALCULATIONS**

This supporting form is used to calculate the basic contribution, reserve objective and maximum reserve targets for the common stock, real estate and other invested assets sub-components of the equity component of the AVR. Instructions apply to the general account and to the separate accounts, if applicable.

**↓** **====** **Detail Eliminated to Conserve Space** **====** **↓**

Line 1 – Unaffiliated Common Stocks – Public

Report the book/adjusted carrying value of all publicly issued common stock, including mutual funds ~~(except money market mutual funds appropriately reported on Schedule E, Part 2)~~, unit investment trusts, closed-end funds and ETFs (reported as common stock) in unaffiliated companies in Columns 1 and 4. Exclude money market mutual funds appropriately reported on Schedule E, Part 2. Multiply Column 4 by the reserve factor calculated for Columns 5, 7 and 9, and report the products in Columns 6, 8 and 10, respectively.

**↓** **====** **Detail Eliminated to Conserve Space** **====** **↓**

Line 2 – Unaffiliated Common Stocks – Private

Report the book/adjusted carrying value of all privately held common stocks, including mutual funds, unit investment trusts, closed-end funds and ETFs (reported as common stock) owned in unaffiliated companies in Columns 1 and 4. Multiply Column 4 by the reserve factor provided in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively.

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cmte/apptf/2023-1 spring/summary and minutes/bwg/att two-d\\_2022-18bwg.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cmte/apptf/2023-1%20spring/summary%20and%20minutes/bwg/att%20two-d_2022-18bwg.docx)

**NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

<p style="text-align: right;">DATE: <u>09/28/2022</u></p> <p>CONTACT PERSON: _____</p> <p>TELEPHONE: _____</p> <p>EMAIL ADDRESS: _____</p> <p>ON BEHALF OF: _____</p> <p>NAME: <u>Mary Caswell and Jill Youtsey</u></p> <p>TITLE: _____</p> <p>AFFILIATION: <u>NAIC</u></p> <p>ADDRESS: _____</p>	<p style="text-align: center;"><b>FOR NAIC USE ONLY</b></p> <p>Agenda Item # <u>2022-20BWG</u></p> <p>Year <u>2023</u></p> <p>Changes to Existing Reporting [ X ]</p> <p>New Reporting Requirement [ ]</p> <hr/> <p style="text-align: center;"><b>REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</b></p> <p>No Impact [ X ]</p> <p>Modifies Required Disclosure [ ]</p> <hr/> <p style="text-align: center;"><b>DISPOSITION</b></p> <p>[ ] Rejected For Public Comment</p> <p>[ ] Referred To Another NAIC Group</p> <p>[ ] Received For Public Comment</p> <p>[ X ] Adopted Date <u>03/07/2023</u></p> <p>[ ] Rejected Date _____</p> <p>[ ] Deferred Date _____</p> <p>[ ] Other (Specify) _____</p>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- |                                                            |                                                   |                                                              |
|------------------------------------------------------------|---------------------------------------------------|--------------------------------------------------------------|
| <input checked="" type="checkbox"/> ANNUAL STATEMENT       | <input checked="" type="checkbox"/> INSTRUCTIONS  | <input checked="" type="checkbox"/> CROSSCHECKS              |
| <input checked="" type="checkbox"/> QUARTERLY STATEMENT    | <input checked="" type="checkbox"/> BLANK         |                                                              |
| <input type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts        | <input type="checkbox"/> Title                               |
| <input type="checkbox"/> Property/Casualty                 | <input type="checkbox"/> Protected Cell           | <input type="checkbox"/> Other _____                         |
| <input checked="" type="checkbox"/> Health                 | <input type="checkbox"/> Health (Life Supplement) | <input checked="" type="checkbox"/> Life (Health Supplement) |

Anticipated Effective Date: Annual 2023

**IDENTIFICATION OF ITEM(S) TO CHANGE**

\*\*\*See next page for details\*\*\*

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE\*\***

The purpose of this proposal is to reorder the listing of Vision and Dental lines of business in the Health Annual/Quarterly Statement Instructions and Blank to be consistent with all other statement types.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: \_\_\_\_\_

Other Comments:

\*\* This section must be completed on all forms.

Revised 7/18/2022

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Modify the instructions and blanks for the following Health exhibits to change the order of the Vision and Dental lines of business to be consistent with all other statement types. *(The detailed instructions are not shown in this proposal, but the instructions will also be updated with the column header changes.)*

## Annual Health

- Analysis of Operations by Lines of Business
- Underwriting and Investment Exhibit
  - Part 1
  - Part 2
  - Part 2A
  - Part 2B
  - Part 2D

## Annual Life (Health Supplement)

- Analysis of Operations by Lines of Business

## Quarterly Health

- Quarterly Underwriting and Investment Exhibit

ANNUAL STATEMENT BLANKS – HEALTH

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

	1		2		4	5	6	7	8	9	10	11	12	13	14
	Total	Individual	Comprehensive (Hospital & Medical) Group	Medicare Supplement											
1. Net premium income.....															
2. Change in unearned premium reserves and reserve for rate credit.....															
3. Fee-for-service (net of \$..... medical expenses).....															
4. Risk revenue.....															
5. Aggregate write-ins for other health care related revenues.....															
6. Aggregate write-ins for other non-health care related revenues.....															
7. Total revenues (Lines 1 to 6).....															
8. Hospital/medical benefits.....															
9. Other professional services.....															
10. Outside referrals.....															
11. Emergency room and out-of-area.....															
12. Prescription drugs.....															
13. Aggregate write-ins for other hospital and medical amounts.....															
14. Incentive pool, withhold adjustments and bonus amounts.....															
15. Subtotal (Lines 8 to 14).....															
16. Net reinsurance recoveries.....															
17. Total hospital and medical (Lines 15 minus 16).....															
18. Non-health claims (net).....															
19. Claims adjustment expenses including \$..... cost containment expenses.....															
20. General administrative expenses.....															
21. Increase in reserves for accident and health contracts.....															
22. Increase in reserves for life contracts.....															
23. Total underwriting deductions (Lines 17 to 22).....															
24. Net underwriting gain or (loss) (Line 7 minus Line 23).....															
<b>DETAILS OF WRITE-INS</b>															
0501.....															
0502.....															
0503.....															
0598.....															
0599.....															
0601.....															
0602.....															
0603.....															
0698.....															
0699.....															
1301.....															
1302.....															
1303.....															
1398.....															
1399.....															

**UNDERWRITING AND INVESTMENT EXHIBIT**  
**PART 1 – PREMIUMS**

Line of Business	1 Direct Business	2 Reinsurance Assumed	3 Reinsurance Ceded	4 Net Premium Income (Cols. 1+2-3)
1. Comprehensive (hospital and medical) individual.....	.....	.....	.....	.....
2. Comprehensive (hospital and medical) group.....	.....	.....	.....	.....
3. Medicare Supplement.....	.....	.....	.....	.....
4. <del>Dental</del> Vision only.....	.....	.....	.....	.....
5. <del>Vision</del> Dental only.....	.....	.....	.....	.....
6. Federal Employees Health Benefits Plan.....	.....	.....	.....	.....
7. Title XVIII – Medicare.....	.....	.....	.....	.....
8. Title XIX – Medicaid.....	.....	.....	.....	.....
9. Credit A&H.....	.....	.....	.....	.....
10. Disability Income.....	.....	.....	.....	.....
11. Long-Term Care.....	.....	.....	.....	.....
12. Other health.....	.....	.....	.....	.....
13. Health subtotal (Lines 1 through 12).....	.....	.....	.....	.....
14. Life.....	.....	.....	.....	.....
15. Property/casualty.....	.....	.....	.....	.....
16. Totals (Lines 13 to 15).....	.....	.....	.....	.....

**UNDERWRITING AND INVESTMENT EXHIBIT**  
**PART 2 – CLAIMS INCURRED DURING THE YEAR**

	1 Total	Comprehensive (Hospital & Medical)		4 Medicare Supplement	5 Partial Vision Only	6 Vision/Dental Only	7 Federal Employees Health Benefits Plan	8 Title XVIII Medicare	9 Title XIX Medicaid	10 Credit A&H	11 Disability Income	12 Long-Term Care	13 Other Health	14 Other Non-Health
		2 Individual	3 Group											
1. Payments during the year:														
1.1 Direct														
1.2 Reinsurance assumed														
1.3 Reinsurance ceded														
1.4 Net														
2. Paid medical incentive pools and bonuses														
3. Claim liability December 31, current year from Part 2A:														
3.1 Direct														
3.2 Reinsurance assumed														
3.3 Reinsurance ceded														
3.4 Net														
4. Claim reserve December 31, current year from Part 2D:														
4.1 Direct														
4.2 Reinsurance assumed														
4.3 Reinsurance ceded														
4.4 Net														
5. Accrued medical incentive pools and bonuses, current year														
6. Net health care receivables (a)														
7. Amounts recoverable from reinsurers December 31, current year														
8. Claim liability December 31, prior year from Part 2A:														
8.1 Direct														
8.2 Reinsurance assumed														
8.3 Reinsurance ceded														
8.4 Net														
9. Claim reserve December 31, prior year from Part 2D:														
9.1 Direct														
9.2 Reinsurance assumed														
9.3 Reinsurance ceded														
9.4 Net														
10. Accrued medical incentive pools and bonuses, prior year														
11. Amounts recoverable from reinsurers December 31, prior year														
12. Incurred benefits:														
12.1 Direct														
12.2 Reinsurance assumed														
12.3 Reinsurance ceded														
12.4 Net														
13. Incurred medical incentive pools and bonuses														

(a) Excludes \$..... loans or advances to providers not yet expensed.

**UNDERWRITING AND INVESTMENT EXHIBIT  
PART 2A – CLAIMS LIABILITY END OF CURRENT YEAR**

	1 Total	Comprehensive (Hospital and Medical)		4 Medicare Supplement	5 <del>Dental</del> Vision Only	6 <del>Vision</del> Dental Only	7 Federal Employees Health Benefits Plan	8 Title XVIII Medicare	9 Title XIX Medicaid	10 Credit A&H	11 Disability Income	12 Long-Term Care	13 Other Health	14 Other Non- Health		
		2 Individual	3 Group													
		1. Reported in Process of Adjustment:														
1.1 Direct.....																
1.2 Reinsurance assumed.....																
1.3 Reinsurance ceded.....																
1.4 Net.....																
2. Incurred but Unreported:																
2.1 Direct.....																
2.2 Reinsurance assumed.....																
2.3 Reinsurance ceded.....																
2.4 Net.....																
3. Amounts Withheld from Paid Claims and Capitations:																
3.1 Direct.....																
3.2 Reinsurance assumed.....																
3.3 Reinsurance ceded.....																
3.4 Net.....																
4. TOTALS:																
4.1 Direct.....																
4.2 Reinsurance assumed.....																
4.3 Reinsurance ceded.....																
4.4 Net.....																

**UNDERWRITING AND INVESTMENT EXHIBIT**  
**PART 2B – ANALYSIS OF CLAIMS UNPAID – PRIOR YEAR-NET OF REINSURANCE**

Line of Business	Claims Paid During the Year		Claim Reserve and Liability December 31 of Current Year		Claims Incurred in Prior Years (Columns 1 + 3)	Estimated Claim Reserve and Claim Liability December 31 of Prior Year
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid December 31 of Prior Year	4 On Claims Incurred During the Year		
1. Comprehensive (hospital and medical) individual.....	.....	.....	.....	.....	.....	.....
2. Comprehensive (hospital and medical) group.....	.....	.....	.....	.....	.....	.....
3. Medicare Supplement.....	.....	.....	.....	.....	.....	.....
4. <del>Dental</del> Vision Only.....	.....	.....	.....	.....	.....	.....
5. <del>Vision</del> Dental Only.....	.....	.....	.....	.....	.....	.....
6. Federal Employees Health Benefits Plan.....	.....	.....	.....	.....	.....	.....
7. Title XVIII – Medicare.....	.....	.....	.....	.....	.....	.....
8. Title XIX – Medicaid.....	.....	.....	.....	.....	.....	.....
9. Credit A&H.....	.....	.....	.....	.....	.....	.....
10. Disability Income.....	.....	.....	.....	.....	.....	.....
11. Long-Term Care.....	.....	.....	.....	.....	.....	.....
12. Other health.....	.....	.....	.....	.....	.....	.....
13. Health subtotal (Lines 1 to 12).....	.....	.....	.....	.....	.....	.....
14. Health care receivables (a).....	.....	.....	.....	.....	.....	.....
15. Other non-health.....	.....	.....	.....	.....	.....	.....
16. Medical incentive pools and bonus amounts.....	.....	.....	.....	.....	.....	.....
17. Totals (Lines 13-14+15+16)	.....	.....	.....	.....	.....	.....

(a) Excludes \$..... loans or advances to providers not yet expensed.



**UNDERWRITING AND INVESTMENT EXHIBIT**  
**PART 2D – AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY**

	1 Total	Comprehensive (Hospital & Medical)		4 Medicare Supplement	5 <del>Dental</del> Vision Only	6 <del>Vision</del> Dental Only	7 Federal Employees Health Benefits Plan	8 Title XV III Medicare	9 Title XIX Medicaid	10 Credit A&H	11 Disability Income	12 Long-Term Care	13 Other
		2 Individual	3 Group										
1. Unearned premium reserves.....													
2. Additional policy reserves (a).....													
3. Reserve for future contingent benefits.....													
4. Reserve for rate credits or experience rating refunds (including \$..... for investment income).....													
5. Aggregate write-ins for other policy reserves.....													
6. Totals (gross).....													
7. Reinsurance ceded.....													
8. Totals (Net) (Page 3, Line 4).....													
9. Present value of amounts not yet due on claims.....													
10. Reserve for future contingent benefits.....													
11. Aggregate write-ins for other claim reserves.....													
12. Totals (gross).....													
13. Reinsurance ceded.....													
14. Totals (Net) (Page 3, Line 7).....													
<b>DETAILS OF WRITE-INS</b>													
0501. ....													
0502. ....													
0503. ....													
0598. Summary of remaining write-ins for Line 5 from overflow page.....													
0599. Totals (Lines 0501 through 0503 plus 0598) (Line 5 above).....													
1101. ....													
1102. ....													
1103. ....													
1198. Summary of remaining write-ins for Line 11 from overflow page.....													
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above).....													

(a) Includes \$..... premium deficiency reserve.

ANNUAL STATEMENT BLANKS – LIFE (HEALTH SUPPLEMENT)

HEALTH SUPPLEMENT

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

	1 Total	Comprehensive (Hospital & Medical)		4 Medicare Supplement	5 Dental-Vision Only	6 Hearing-Dental Only	7 Federal Employees Health Benefits Plan	8 Title XVIII Medicare	9 Title XIX Medicaid	10 Credit A&H	11 Disability Income	12 Long-Term Care	13 Other Health	14 Other Non-Health
		2 Individual	3 Group											
1. Net premium income.....														
2. Changes in unearned premium reserves and reserve for rate credit.....														
3. Fee-for-service (net of \$..... medical expenses).....														
4. Risk revenue.....														
5. Aggregate write-ins for other health care related revenues.....														
6. Aggregate write-ins for other non-health care related revenues.....														
7. Total charges (Lines 6).....														
8. Hospital medical benefits.....														
9. Other professional services.....														
10. Outside referrals.....														
11. Emergency room and out-of-area.....														
12. Prescription drugs.....														
13. Aggregate write-ins for other hospital and medical incentive pool, withhold adjustments and bonus amounts.....														
14. Subtotal (Lines 8 to 14).....														
15. Net reinsurance recoveries.....														
16. Total (Lines 14 plus 15).....														
17. Total (Lines 16 minus 16).....														
18. Non-health claims (net).....														
19. Claims adjustment expenses including \$..... cost containment expenses.....														
20. General administrative expenses.....														
21. Increase in reserves for accident and health contracts.....														
22. Increase in reserves for life contracts.....														
23. Total underwriting deductions (Lines 17 to 22).....														
24. Net underwriting gain or (loss).....														
<b>DETAILS OF WRITE-INS</b> (Line 2 minus Line 23)														
0501.....														
0502.....														
0503.....														
0598. Summary of remaining write-ins for Line 5 from overflow page.....														
0599. Totals (Lines 0501 through 0503 plus 0598) (Line 5 above).....														
0601.....														
0602.....														
0603.....														
0698. Summary of remaining write-ins for Line 6 from overflow page.....														
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 6 above).....														
1301.....														
1302.....														
1303.....														
1398. Summary of remaining write-ins for Line 13 from overflow page.....														
1399. Totals (Lines 1301 through 1303 plus 1398) (Line 13 above).....														

QUARTERLY STATEMENT BLANKS – HEALTH

**UNDERWRITING AND INVESTMENT EXHIBIT**  
**ANALYSIS OF CLAIMS UNPAID-PRIOR YEAR-NET OF REINSURANCE**

Line of Business	Claims Paid Year to Date		Liability End of Current Quarter		5 Claims Incurred in Prior Years (Columns 1 + 3)	6 Estimated Claim Reserve and Claim Liability Dec. 31 of Prior Year
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid Dec. 31 of Prior Year	4 On Claims Incurred During the Year		
1. Comprehensive (hospital and medical) individual.....						
2. Comprehensive (hospital and medical) group .....						
3. Medicare Supplement.....						
4. <del>Dental</del> Vision only.....						
5. <del>Vision</del> Dental only.....						
6. Federal Employees Health Benefits Plan.....						
7. Title XVIII – Medicare.....						
8. Title XIX – Medicaid.....						
9. Credit A&H .....						
10. Disability income.....						
11. Long-term care .....						
12. Other health.....						
13. Health subtotal (Lines 1 to 8).....						
14. Health care receivables (a).....						
15. Other non-health.....						
16. Medical incentive pools and bonus amounts .....						
17. Totals (Lines 13-14+15+16)						

(a) Excludes \$..... loans or advances to providers not yet expensed.

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/membermeetings/e\\_cmte/apptf/2023-1\\_spring/summaryandminutes/bwg/atttwoe\\_2022-20bwg.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/membermeetings/e_cmte/apptf/2023-1_spring/summaryandminutes/bwg/atttwoe_2022-20bwg.docx)

**Blanks (E) Working Group  
Editorial Revisions to the Blanks and Instructions  
(presented at the March 7, 2023, Meeting)**

Statement Type:  
**H** = Health; **L/F** = Life/Fraternal Combined; **P/C** = Property/Casualty; **SA** = Separate Accounts; **T** = Title

Effective	Table Name	Description	Statement Type	Filing Type
2023	Accident and Health Policy Experience Exhibit	<p><b>CHANGE TO INSTRUCTION</b></p> <p>Change the formula to CY-PY</p> <p>Column 6 – Direct Incurred Claims Amount</p> <p>This column does not include the “Increase in Policy Reserves.”</p> <p>The grand total reported should equal:</p> <p>Life\Fraternal Exhibit 8, Part 2, Line 6.1, Columns (9+10+11).  <del>M###</del> Plus Exhibit 6, Line 14, Column 1 CY.  <del>P###</del> Minus Exhibit 6, Line 14, Column 1 PY.</p>	H, L/F, P/C	Annual
2023	General Interrogatories Part 2	<p><b>CHANGE TO INSTRUCTION</b></p> <p>Change premiums from written to earned for the Numerator to be consistent with the Denominator</p> <p>Item 2.1 – Premium Numerator</p> <p>Health Premium values listed in the Net Premiums <del>W###</del> Earned During Year column (Column <del>64</del>) of the reporting year’s U&amp;I Part <del>1B</del>:</p> <p>Lines 13.1 and 13.2</p> <p>Lines 15.1, 15.2, 15.4, 15.6, and 15.8</p> <p>Line 15.5 (should include Medicare Pass-Through Payments Reported as Premium)</p> <p>Line 15.9 in part (include only Medicare Part D and Stop Loss and Minimum Premium)</p>	P/C	Annual

Effective	Table Name	Description	Statement Type	Filing Type
2023	General Interrogatories Part 2	<p><b>CHANGE TO INSTRUCTION</b></p> <p>Update the Underwriting and Investment Exhibit, Part 2B Line references for Reporting Year Data and Prior Year Data columns</p> <p>Item 2.4 – Reserve Numerator</p> <p><b>Reporting Year Annual Statement Data</b> Health Reserve – Underwriting and Investment Exhibit, Part 2B (Column 3 + 4, Line <del>13-17</del> minus Line <del>11</del>15) exclude <u>Line 9 credit A&amp;H, Line 10 disability income, Line 11 long-term care, Line 14 health care receivables, and dread disease coverage</u><del> and credit A&amp;H</del> + Part 2D (Line 8, Column <del>1-2</del> <del>#####</del> <u>through Column 9 + Column 13 (in part)</u>) include stand-alone health care related plans only (i.e. stand-alone prescription drug plans, etc.), exclude dread disease coverage, <del>credit A&amp;H, LTC, Disability Income</del>, etc. of the reporting year’s annual statement.</p> <p><b>Prior Year Annual Statement Data</b> Health Reserve – Underwriting and Investment Exhibit, Part 2B (Column 3 + 4, Line <del>13-17</del> minus Line <del>11</del>15) exclude <u>Line 9 credit A&amp;H, Line 10 disability income, Line 11 long-term care, Line 14 health care receivables, and dread disease coverage</u><del> and credit A&amp;H</del> + Part 2D (Line 8, Column <del>1-2</del> <del>#####</del> <u>through Column 9 + Column 13 (in part)</u>) include stand-alone health care related plans only (i.e. stand-alone prescription drug plans, etc.), exclude dread disease coverage, <del>credit A&amp;H, LTC, Disability Income</del>, etc. of the reporting year’s annual statement.</p>	H	Annual
2023	Schedule T	<p><b>CHANGE TO INSTRUCTION</b></p> <p>Add clarifying language to the Details of Aggregate Write-ins for Other Alien</p> <p>Details of Write-ins Aggregated on Line 58 for Other Alien</p> <p>List separately each alien jurisdiction for which there is no pre-printed line on Schedule T.</p> <p><del>Exclude all</del> premium adjustments (both increases and decreases), including but not limited to Affordable Care Act (ACA) premium adjustments related to the risk adjustment program<del>-. These should</del> <del>###</del> be allocated as premium in the respective jurisdiction.</p>	H, L/F, P/C	Annual
2023	Actuarial Opinion	<p><b>CHANGE TO INSTRUCTION</b></p> <p>Correct the list of disclosure items</p> <p>4. The SCOPE paragraph should contain a sentence such as the following:</p>	T	Annual

Effective	Table Name	Description	Statement Type	Filing Type
2023	Notes to Financials	<p>“I have examined the actuarial assumptions and methods used in determining reserves listed in Exhibit A, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 20___, and reviewed information provided to me through XXX date.”</p> <p>Exhibit A should list those items and amounts with respect to which the Appointed Actuary is expressing an opinion.</p> <p>The Appointed Actuary should state that the items in the SCOPE paragraph, on which he or she is expressing an opinion, reflect the Disclosure items (8 through <del>14</del>13) in Exhibit B.</p>	H, L/F, P/C, T	Annual
		<p><b>CHANGE TO INSTRUCTION</b></p> <p>Add clarifying language to Note 11A to include FHLB borrowings per SSAP No. 15</p> <p><b>11. Debt</b></p> <p><u>Instruction:</u></p> <p>A. Disclose the following items related to debt, including capital notes and FHLB borrowings accounted for under SSAP No. 15: Refer to SSAP No. 15—Debt and Holding Company Obligations for accounting guidance:</p>		

https://haiconline.sharepoint.com/sites/haicsupportstaffhub/membermeetings/e crnte/apptf/2023-1 spring/summary and minutes/bwv/att two-f\_blanks editorial changes march 2023.docx

## CAPITAL ADEQUACY (E) TASK FORCE

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Draft: 4/3/23

Capital Adequacy (E) Task Force  
Louisville, Kentucky  
March 23, 2023

The Capital Adequacy (E) Task Force met March 23, 2023. The following Task Force members participated: Judith L. French, Chair, represented by Tom Botsko and Dale Bruggeman (OH); Grace Arnold, Vice Chair, represented by Fred Andersen (MN); Lori K. Wing-Heier represented by David Phifer (AK); Mark Fowler represented by Todrick Burks (AL); Ricardo Lara represented by Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by Philip Barlow (DC); Michael Yaworsky represented by Virginia Christy (FL); Doug Ommen represented by Carrie Mears and Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Amy L. Beard represented by Roy Eft (IN); Vicki Schmidt represented by Levi Nwasoria (KS); Sharon P. Clark represented by Vicki Lloyd (KY); Kathleen A. Birrane represented by Lynn Beckner (MD); Chlora Lindley-Myers represented by John Rehagen (MO); Troy Downing represented by Steve Matthews (MT); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Andrea Johnson and Lindsay Crawford (NE); Marlene Caride represented by David Wolf (NJ); Glen Mulready represented by Andrew Schallhorn (OK); Michael Wise represented by Daniel Morris (SC); Cassie Brown represented by Rachel Hemphill (TX); Mike Kreidler represented by Steve Drutz (WA); and Nathan Houdek and Amy Malm (WI).

1. Adopted its Feb. 3 and 2022 Fall National Meeting Minutes

Botsko said the Task Force conducted an e-vote that concluded Feb. 3 to adopt proposal 2022-12-CR (2022 U.S. and Non-U.S. Catastrophe Risk Event Lists).

Chou made a motion, seconded by Yanacheak, to adopt the Task Force's Feb. 3, 2023 (Attachment One) and Dec. 14, 2022 (*see NAIC Proceedings – Fall 2022, Capital Adequacy (E) Task Force*) minutes. The motion passed unanimously.

2. Adopted the Reports of its Working Groups

a. Health Risk-Based Capital (E) Working Group

Drutz said the Health Risk-Based Capital (E) Working Group met March 21 and took the following action: 1) adopted its Feb. 7 minutes, which included the following action: a) adopted its 2022 Fall National Meeting minutes; b) adopted proposal 2022-14-H (Trend Test Info Only Instruction), which the Working Group exposed for a 30-day public comment period ending Dec. 7, 2022; c) referred the runoff company response letter to the Task Force; d) exposed proposal 2022-16-CA (Underwriting Risk Factors – Investment Income Adjustment) for a 30-day public comment period ending March 9; and e) received an update from the American Academy of Actuaries (Academy) on the H2 – Underwriting Risk Review project; 2) adopted proposal 2022-15-H (Re-number XR008); 3) referred proposal 2022-16-CA to the Task Force for it to expose on a late April call; 4) adopted its working agenda; 5) exposed proposal 2023-01-CA (Stop Loss Instructions) for a 20-day public comment period ending April 10; 6) discussed the stop loss data and factors; 7) received an update on the Health Test Ad Hoc Group and the draft proposal with revisions to the health test language and general interrogatories; 8) discussed the effects of the COVID-19 pandemic and the pandemic risk on the Health Risk-Based Capital (RBC) formula; and 9) received an update that the Academy continues its work on the review of the H2 – Underwriting Risk component.



b. Life Risk-Based Capital (E) Working Group

Barlow said the Life Risk-Based Capital (E) Working Group met March 22 and took the following action: 1) adopted its Jan. 26 minutes, which included the following action: a) exposed the Academy's C-2 Mortality Risk Work Group's proposal for a 30-day public comment period ending March 1; b) exposed proposed revisions to the CM6 and CM7 mortgage RBC factors and formula, which the Working Group exposed for a 45-day public comment period ending March 16; and c) exposed proposed revisions to remove the dual presentation of the trend test, which the Working Group exposed for a 15-day public comment period ending Feb. 14; 2) adopted its 2022 Fall National Meeting minutes; 3) discussed C-2 mortality risk; 4) discussed its 2023 working agenda; 5) discussed runoff companies and agreed that no change is needed in the Life RBC formula; and 6) heard the status on the formation of the Economic Scenarios (E/A) Subgroup.

c. RBC Investment Risk and Evaluation (E) Working Group

Barlow said the RBC Investment Risk and Evaluation (E) Working Group met March 23 and took the following action: 1) adopted its Feb. 27 minutes, which included the following action: a) discussed the Academy follow-up to the presentation on collateralized loan obligations (CLOs); and b) discussed comment letters; 2) adopted its 2022 Fall National Meeting minutes; 3) received updates from the Valuation of Securities (E) Task Force and the Statutory Accounting Principles (E) Working Group; 4) continued discussion of CLOs; 5) discussed a residual tranche structure change; and 5) discussed factors and next steps.

d. Property and Casualty Risk-Based Capital (E) Working Group

Botsko said the Property and Casualty Risk-Based Capital (E) Working Group met March 22 and took the following action: 1) adopted its Jan. 30 minutes, which included the following action: a) adopted proposal 2022-12-CR, which the Working Group exposed for a seven-day public comment period ending Jan. 25; 2) adopted its 2022 Fall National Meeting minutes; 3) adopted the report of the Catastrophe Risk (E) Subgroup, which took the following action: a) adopted its Jan. 30 and 2022 Fall National Meeting minutes; b) discussed its working agenda; c) received a status update from its Catastrophe Model Technical Review Ad Hoc Group; d) heard a presentation from Travelers on the climate overview and scenario analysis; and e) discussed the wildfire peril impact analysis; 4) exposed proposal 2023-02-P (Underwriting Risk Line 1 Factors) for a 30-day public comment period ending April 21; 5) discussed the annual statement proposal 2023-01BWG, which removes pet insurance from the inland marine line of business and adds new schedule P parts to pet insurance; 6) discussed the annual statement proposal 2022-15BWG, which removes the 5% premium filing exemption (FE) on Schedule H, Part 5; 7) discussed its 2023 working agenda; 8) heard an update on current property/casualty (P/C) RBC projects from the Academy; and 9) discussed the possibility of reviewing or analyzing the P/C RBC charges that have not been reviewed since developed.

Phifer made a motion, seconded by Nwasoria, to adopt the reports of the Health Risk-Based Capital (E) Working Group (Attachment Two), the Life Risk-Based Capital (E) Working Group (Attachment Three), the Property and Casualty Risk-Based Capital (E) Working Group (Attachment Four), the Catastrophe Risk (E) Subgroup, and the RBC Investment Risk and Evaluation (E) Working Group (Attachment Five). The motion passed unanimously.

3. Adopted Proposal 2022-09-CA

Botsko said the Task Force referred proposal 2022-09-CA (Revised Affiliated Investments Structure and Instructions) to the Blanks (E) Working Group and the Statutory Accounting Principles (E) Working Group at the 2022 Fall National Meeting. There were no comments received from either group.

Crawford made a motion, seconded by Lloyd, to adopt proposal 2022-09-CA (Attachment Six). The motion passed unanimously.

#### 4. Adopted Proposal 2022-13-CA

Botsko said the purpose of proposal 2022-13-CA (Health Premiums and Underwriting Risk Premium References) is to modify the following line references to be consistent with the changes in the Annual Statement, Schedule H, which was adopted under Blanks proposal 2021-14BWG MOD: 1) Life RBC formula LR019 and LR020; and 2) P/C RBC formula PR019 and PR020. There were no comments received during the exposure period.

Rehagen made a motion, seconded by Andersen, to adopt proposal 2022-13-CA (Attachment Seven). The motion passed unanimously.

#### 5. Adopted Proposal 2022-14-H

Drutz said the purpose of proposal 2022-14-H is to remove the sentence, “The calculation is informational-only until state statutes are implemented so that the trend test would trigger a Company Action Level RBC regulatory action per the statute,” given that all states have adopted the trend test. He stated that the Health Risk-Based Capital (E) Working Group exposed this proposal for a 30-day comment period ending March 9, and no comments were received during the exposure period. The Working Group adopted this proposal on Feb. 7.

Drutz made a motion, seconded by Chou, to adopt proposal 2022-14-H (Attachment Eight). The motion passed unanimously.

#### 6. Adopted Proposal 2022-15-H

Drutz said the purpose of proposal 2022-15-H is to renumber all the lines on page XR008 as the line numbers carry over from the bond page. He also stated that the renumbering of the lines on page XR008 will allow for easier updates in the future for any adjustments to the bonds. He said the Health Risk-Based Capital (E) Working Group was exposed for a 30-day comment period ending Feb. 28. There were no comments received during the exposure period. The Working Group adopted this proposal at the Spring National Meeting.

Drutz made a motion, seconded by Chou, to adopt proposal 2022-15-H (Attachment Nine). The motion passed unanimously.

#### 7. Adopted its Working Agenda

Botsko summarized the changes to the 2023 working agenda. He said there is no change on the Life Risk-Based Capital (E) Working Group and RBC Investment Risk and Evaluation (E) Working Group sections in the working agenda. He also stated that the Property and Casualty Risk-Based Capital (E) Working Group eliminated the following items: 1) evaluate the possibility of allowing additional third-party models or adjustments to the vendor models to calculate the catastrophe model losses; and 2) evaluate the possibility of enhancing the independent model instructions. He also indicated that three new items were added to the new items section: 1) review and analyze the P/C RBC charges that have not been reviewed since developed; 2) quantify the R5 ex-catastrophe factors for wildfire peril (for informational purposes only); and 3) evaluate the impact of flood peril on the insurance market. He also said the revisions to the Health RBC working agenda items are editorial in nature: 1) Line X1 was updated to: a) remove the reference to the 0.05% factor adjustment; and b) add the related proposal to the comments column; 2) the expected completion date column was updated for Lines X4, X6, X7, X8, and X9; 3) Line X5 was updated to remove the reference to “review possible annual statement changes for reporting health business in the Life and P/C blanks”; and 4) Line X10 was removed from the “New Items” section to the

“Carryover Items Currently being Addressed” section. In addition, he stated that the Task Force working agenda was updated as follows: 1) the exposure and referral comments were added in the item CA1 “comments” column; 2) the item CA5 was moved from the “New Items” section to the “Carryover Items Currently being Addressed” section; and 3) item CA6 was added to the “New Items” section.

Nwasoria made a motion, seconded by Burks, to adopt the Task Force’s revised 2023 working agenda (Attachment Ten). The motion passed unanimously.

#### 8. Discussed the Response from the Health Risk-Based Capital (E) Working Group Regarding Runoff Companies

Drutz said the Health Risk-Based Capital (E) Working Group received a request from the Task Force last year regarding the runoff companies. He stated that a response for the request (Attachment Eleven) was sent to the Task Force on Dec. 12, 2022, which indicated the Working Group’s agreement with the recommendations included in the Property and Casualty Risk-Based Capital (E) Working Group’s response letter as well as the definition of a health runoff company. The letter was exposed for a 30-day public comment period, and no comments were received. Botsko said he appreciated the prompt response from the Health Risk-Based Capital (E) Working Group. He said the Task Force will forward the responses to the Restructuring Mechanisms (E) Subgroup after receiving all the responses from the working groups.

#### 9. Discussed Referrals from the Valuation of Securities (E) Task Force

Mears said the Valuation of Securities (E) Task Force sent two referrals to the Capital Adequacy (E) Task Force last month. She stated that the first referral, which is regarding a proposed *Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual)* amendment to define and add guidance for structured equity and funds (Attachment Twelve). She indicated that this is an informational referral, and no direct action is required by the Capital Adequacy (E) Task Force. She also said another referral is regarding additional market and analytical information for bond investments. She asked the Task Force members to review the items listed in the referral and provide responses by May 15. Botsko said the Task Force and RBC Investment Risk and Evaluation (E) Working Group exposed this referral jointly and requested comments from the interested party by March 31. He stated that discussion on this item will be continued at the next meeting.

#### 10. Discussed The Current Turmoil in the Banking Sector, Including Fallout and Possible Implications

Ed Toy (Risk & Regulatory Consulting LLC—RRC) provided a brief overview of the current turmoil in the banking sector. He stated that the current situation continues to evolve. Also, the problems at the regional banks and Credit Suisse Group may be separated, but the current underlying issues might have led to or exacerbated what happened. This eventually may affect the insurance industry, as the current interest rates are significantly higher, and the market volatility, including risks that may be idiosyncratic across different markets, which are also much higher. Toy said he anticipated that it would affect the life industry more since the regional banks provided over 60% of lending to the commercial real estate developers, and the values of commercial real estate were already hitting a dip since the end of last year. Botsko thanked Toy for providing this useful information to the Task Force. He said the Task Force will monitor this issue closely, and it welcomes Toy to provide constant updates regarding this issue.

#### 11. Discussed Other Matters

##### a. Health Test Exposure Updates

Drutz said the Health Test Ad Hoc Group has been working on drafting a proposal that would revise the premium and the reserve ratio calculation by using a net basis in the health test. He stated that this proposal will create

greater transparency in the calculation of both the numerator and denominator of the ratio formula, as the amounts in the formula will be pulling from the same schedule. He also said the Ad Hoc Group plans to: 1) implement the changes across each statement type; and 2) consider re-evaluating the data in a few years after the implementation. He said he anticipated that this proposal will be finalized and considered for exposure by the Health Risk-Based Capital (E) Working Group in April.

- b. Forwarded a Statutory Accounting Principles (E) Working Group Referral for Negative IMR to the Life Risk-Based Capital (E) Working Group

Botsko said the Task Force expects to receive a referral from the Statutory Accounting Practices (E) Working Group on the potential to permit admittance of negative interest maintenance reserve (IMR) shortly after the Spring National Meeting. Since this is primarily a life RBC issue, Botsko suggested forwarding the referral to the Life Risk-Based Capital (E) Working Group after the Task Force receives it. Without hearing objection, the Task Force agreed to forward the Statutory Accounting Practices (E) Working Group referral to the Life Risk-Based Capital (E) Working Group after receiving it.

- c. Revised a Proposal Form

Botsko said the 2023 RBC proposal form was modified to: 1) include working group and subgroup proposal status in the “disposition” section; 2) include each line of business formula in the “identification of source and form(s)/instructions to be changed” section; and 3) combine the description/reason or justification of changes into one section. Without hearing objection, the Task Force agreed with the modifications in the proposal form.

- d. Established an Ad Hoc Group to Review and Analyze the RBC Charges that Have Not Been Reviewed Since Their Development

Botsko said some of the Task Force members may be aware that some of the RBC formulas, factors, and methodologies have never been reviewed since developed. He asked the Task Force to consider establishing an ad hoc group to: 1) re-evaluate some of the missing risks to determine if the Task Force should now include them in the RBC calculation or whether it appropriately handle those risks utilizing other regulatory methods; and 2) review those factors and instructions that have never been reviewed since developed to determine if modifications should be made. He encouraged all parties to contact NAIC staff if interested in joining the new ad hoc group.

Having no further business, the Capital Adequacy (E) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/E Cmte/CADF/CapitalAdequacyTFmin\_032323.docx

Draft: 2/7/23

Capital Adequacy (E) Task Force  
E-Vote  
February 3, 2023

The Capital Adequacy (E) Task Force conducted an e-vote that concluded Feb. 3, 2023. The following Task Force members participated: Judith L. French, Chair, represented by Tom Botsko (OH); Lori K. Wing-Heier represented by David Phifer (AK); Mark Fowler represented by Charles Hale (AL); Ricardo Lara represented by Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by Philip Barlow (DC); TBD represented by Christina Huff (FL); Amy L. Beard represented by Roy Eft (IN); Doug Ommen, Vice Chair, represented by Mike Yanacheak (IA); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Russell Coy (KY); Kathleen Birrane represented by Lynn Beckner (MD); Chlora Lindley-Myers represented by John Rehagen (MO); Troy Downing represented by Bob Biskupiak (MT); Eric Dunning represented by Lindsay Crawford (NE); Glen Mulready represented by Andrew Schallhorn (OK); Cassie Brown represented by Rachel Hemphill (TX); Mike Kreidler represented by Steve Drutz (WA) and Nathan Houdek represented by Amy J. Malm (WI).

1. Adopted the Updated 2022 U.S. and Non-U.S. Catastrophe Risk Event Lists

The Task Force conducted an e-vote to consider adoption of proposal 2022-12-CR (2022 U.S. and Non-U.S. Catastrophe Risk Event Lists).

Chou made a motion, seconded by Hemphill, to adopt the 2022 U.S. and non-U.S. catastrophe risk event lists (Attachment One-A). The motion passed unanimously.

Having no further business, the Capital Adequacy (E) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/ Member Meetings/E Cmte/CADTF/2023-1-Spring/CADTF Email Vote 020323

**Capital Adequacy (E) Task Force**  
**RBC Proposal Form**

- |                                                                   |                                                           |                                                      |
|-------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Capital Adequacy (E) Task Force          | <input type="checkbox"/> Health RBC (E) Working Group     | <input type="checkbox"/> Life RBC (E) Working Group  |
| <input checked="" type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> Investment RBC (E) Working Group | <input type="checkbox"/> Op Risk RBC (E) Subgroup    |
| <input type="checkbox"/> C3 Phase II/ AG43 (E/A) Subgroup         | <input type="checkbox"/> P/C RBC (E) Working Group        | <input type="checkbox"/> Stress Testing (E) Subgroup |

<p align="right"><b>DATE:</b> <u>11/1/2022</u></p> <p><b>CONTACT PERSON:</b> <u>Eva Yeung</u></p> <p><b>TELEPHONE:</b> <u>816-783-8407</u></p> <p><b>EMAIL ADDRESS:</b> <u>eveung@naic.org</u></p> <p><b>ON BEHALF OF:</b> <u>Catastrophe Risk (E) Subgroup</u></p> <p><b>NAME:</b> <u>Wanchin Chou</u></p> <p><b>TITLE:</b> <u>Chair</u></p> <p><b>AFFILIATION:</b> <u>Connecticut Department of Insurance</u></p> <p><b>ADDRESS:</b> <u>153 Market St.</u> <u>Hartford, CT 06103</u></p>	<p align="center"><b><u>FOR NAIC USE ONLY</u></b></p> <p>Agenda Item # <u>2022-12-CR</u></p> <p>Year <u>2022</u></p> <p align="center"><b><u>DISPOSITION</u></b></p> <p><input checked="" type="checkbox"/> ADOPTED <u>1<sup>st</sup> release: 11/18/22</u> <u>2<sup>nd</sup> release: 2/3/23</u></p> <p><input type="checkbox"/> REJECTED _____</p> <p><input type="checkbox"/> DEFERRED TO _____</p> <p><input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____</p> <p><input checked="" type="checkbox"/> EXPOSED <u>1<sup>st</sup> release: 11/2/22</u> <u>2<sup>nd</sup> release: 1/18/23</u></p> <p><input type="checkbox"/> OTHER (SPECIFY) _____</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

- |                                               |                                                       |                                                                  |
|-----------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Health RBC Blanks    | <input type="checkbox"/> Property/Casualty RBC Blanks | <input type="checkbox"/> Life RBC Instructions                   |
| <input type="checkbox"/> Fraternal RBC Blanks | <input type="checkbox"/> Health RBC Instructions      | <input type="checkbox"/> Property/Casualty RBC Instructions      |
| <input type="checkbox"/> Life RBC Blanks      | <input type="checkbox"/> Fraternal RBC Instructions   | <input checked="" type="checkbox"/> OTHER <u>Cat Event Lists</u> |

**DESCRIPTION OF CHANGE(S)**

2022 U.S. and non-U.S. Catastrophe Event Lists

**REASON OR JUSTIFICATION FOR CHANGE \*\***

New events were determined based on the sources from Swiss Re and Aon Benfield.

**Additional Staff Comments:**

11/2/22 – The Subgroup and the PC RBC WG exposed this proposal for a 7-public comment period ending 11/8/22.  
 11/15/22 – The Subgroup and the PC RBC WG conducted an e-vote to adopt the Jan 1 – Sept 30 U.S. and non-U.S. catastrophe event lists.  
 11/18/22 – The Task Force conducted an e-vote to adopt the Jan 1 – Sept 30 U.S. and non-U.S. catastrophe event lists.  
 1/18/23 - The Subgroup and the PC RBC WG exposed this proposal for a 7-public comment period ending 1/25/23.  
 1/30/23 – The Subgroup and the PC RBC WG adopted this proposal.  
 2/3/23 – The Task Force adopted the proposal on 2/3/23.

\*\* This section must be completed on all forms.

U.S. List of Catastrophes for Use in Reporting catastrophe Data in PR036 and PR100+

Type of Event	Name	Date	Location	Overall losses when occurred
Wildfire	Black Forest	2013	Colorado Springs	~ 420.5 million
Wildfire	Rim	2013	Sierra Nevada, California	> 100 million
Wildfire	Texas	2014	Texas, California	> 25 million
Earthquake		2014	California	25+ million
Hurricane	Patricia	2015		25+ million
Hurricane	Joaquin	2015		25+ million
Wildfire	Butte Fire	9/9/15-10/1/15	Amador County, California	~ 300 million
Wildfire	Valley Fire	9/12/15-10/15/15	Lake, Napa and Sonoma County, California	~ 700 million
Hurricane	Matthew	2016	Florida, North Carolina, South Carolina, Georgia and Virginia	\$ 2,698,400,000
Hurricane	Hermine	2016	Florida, North Carolina, South Carolina, Georgia and Virginia	\$ 245,640,000
Wildfire	Eskaite Fire	6/23/16-7/11/16	Lake Isabella, Kern County, California	~26 million
Wildfire	Soberanes Fire	7/22/16-9/30/16	Soberanes Creek, Garrapata State Park, Santa Lucia Preserve, Monterey County, California	> 200 million
Wildfire	Chimney Fire	8/13/16-9/6/16	Santa Lucia Range, San Luis Obispo County, California	> 25 million
Wildfire	Clayton Fire	8/13/16-8/26/16	Lake County, California	>25 million
Wildfire	Gatlinburg Wildfire	11/29/16-12/5/16	Sevier County, Gatlinburg, Pigeon Forge, Tennessee	~637 million
Wildfire	Northern California Wildfires	10/8/17-10/31/17	Northern California	~ 11 billion
Wildfire	Southern California Wildfires	12/4/17-12/23/17	Southern California	~ 2.2 billion
Hurricane	Harvey	2017	Texas, Louisiana	25+ million
Hurricane	Jose	2017	East Coast of the United States	25+ million
Hurricane	Irma	2017	Eastern United States	25+ million
Hurricane	Maria	2017	Southeastern United States, Mid-Atlantic States	25+ million
Hurricane	Nate	2017	Louisiana, Mississippi, Alabama, Tennessee and Eastern United States	25+ million
Tropical Storm	Alberto	2018	Southeast, Midwest	25+ million
Hurricane	Lane	2018	Hawaii	25+ million
Tropical Storm	Gordon	2018	Southeast, Gulf coast of the United States, Arkansas and Missouri	25+ million
Hurricane	Florence	2018	Southeast, Mid-Atlantic	25+ million
Hurricane	Michael	2018	Southeastern and East Coasts of United States	25+ million
Wildfire	Spring Creek Fire	6/27/18-7/11/18	Spring Creek, Colorado	< 100 million
Wildfire	Carr, Mendocino California Wildfires	7/23/18-8/15/18	Northern California	> 1,000 million
Wildfire	Northern California Camp Wildfire	11/8/18-11/25/18	Butte County, California	> 7.5 billion
Wildfire	Southern California Woolsey Wildfires	11/8/18-11/21/18	Los Angeles and Ventura County, California	2.9 billion
Hurricane	Dorian	2019	Southeast, Mid-Atlantic	500+ million
Hurricane	Barry	2019	Southeast, Midwest, Northeast	300+ million
Tropical Storm	Imelda	2019	Plains, Southeast	25+ million
Tropical Storm	Nestor	2019	Southeast	25+ million
Hurricane	Lorenzo	2019	Louisiana, Mississippi, Texas and Arkansas	25+ million
Wildfire	Saddleridge Wildfire	10/10/19-10/23/19	Sylmar, Los Angeles, Calimesa, Riverside County, California	< 1,000 million
Wildfire	Kincadee Wildfire	10/23/19-11/6/19	Northeast of Geyserville, Sonoma County, California	< 1,000 million
Tropical Storm	Cristobal	2020	Southeast, Plains, Midwest	150 million
Tropical Storm	Fay	2020	Southeast, Northeast	400 million
Hurricane	Hanna	2020	Texas	350 million
Hurricane	Isaias	2020	Southeast, Mid-Atlantic, Northeast	> 3 billion
Hurricane	Laura	2020	Plains, Southeast, Mid-Atlantic	> 4 billion
Hurricane	Sally	2020	Plains, Southeast	> 1 billion
Tropical Storm	Beta	2020	Plains, Southeast	25+ million
Hurricane	Delta	2020	Gulf Coast of United States, Southeast, Northeast (AL, GA, NC, SC, MS, LA, TX)	> 2 billion
Hurricane	Zeta	2020	Gulf coast of the United States, Southeastern United States, Mid-Atlantic	> 1.5 billion
Wildfire	Cameron Peak	08/13/20-12/02/20	Roosevelt National Forest, Larimer County, Colorado	~ 71 million
Wildfire	SCU Lighting Complex Wildfire	8/16/20-9/16/20	San Francisco Bay Area, Central Valley, Santa Clara, Alameda, Contra Costa, San Joaquin, Merced, Stanislaus	< 1,000 million
Wildfire	Beachie Creek Wildfire	8/16/20-10/10/20	Approx. 2 miles south of Law Bones flats in rugged terrain deep in the Opal Creek Wilderness.	> 1,000 million
Wildfire	CZU Lightning Complex Wildfire	8/16/20-9/22/20	San Mateo and Santa Cruz Counties, California	> 1,000 million

U.S. List of Catastrophes for Use in Reporting catastrophe Data in PR036 and PR100+

Wildfire	LNU Lightning Complex Wildfire	8/17/20-10/2/20	Lake, Napa, Sonoma, Solano, and Yolo Counties, California	> 1,000 million
Wildfire	Carmel Fire	8/18/20-9/4/20	Carmel Valley, California	<1,000 million
Wildfire	North Complex Fire	8/18/20-10/12/20	Plumas and Butte Counties, California	<1,000 million
Wildfire	Creek Fire	9/4/20-10/12/20	Fresno and Madera Counties, California	<1,000 million
Wildfire	Bobcat Fire	9/6/20-10/23/20	Central San Gabriel Mountains, in and around the Angeles National Forest California	<1,000 million
Wildfire	Babb Road Fire	9/7/20-9/18/20	Malden and Pine City, Palouse County of Eastern Washington	<1,000 million
Wildfire	Almeda Fire	9/7/20-9/16/20	Jackson County, Oregon	<1,000 million
Wildfire	Holiday Farm Fire	9/7/20-10/3/20	Willamette National Forest north of Lincoln City, Oregon	<100 million
Wildfire	Echo Mountain Complex Fire	9/7/20-9/23/20	Valley Drive between Misty Ridge Drive and Mitchell Avenue, Oregon	<100 million
Wildfire	Reverside Fire	9/8/20-10/3/20	Northern California and Southern Oregon	<100 million
Wildfire	Slater Fire	9/8/20-10/9/20	Napa and Sonoma Counties, California	> 1,000 million
Wildfire	Glass Fire	9/27/20-10/19/20	Grand County, Colorado	~\$43 million
Wildfire	East Troublesome Fire	10/14/20-11/9/20	Gulf Coast of the United States, Georgia, Carolinas	> 350 million
Tropical Storm	Claudette	2021	East Coast of the United States	1.2 billion
Hurricane	Elsa	2021	Eastern United States (particularly Florida and North Carolina)	1.3 billion
Tropical Storm	Fred	2021	Northeastern United States	550 million
Hurricane	Henri	2021	Gulf Coast of the United States (especially Louisiana), East Coast of the United States (especially the Northeastern United States)	44 billion
Hurricane	Ida	2021	L.A., TX	> 1.1b
Tropical Storm	Nicholas	2021	Southern United States, Mid-Atlantic United States, Northeastern United States	>200 million
Tropical Storm	Wanda	2021	Northwest of Beatty, Oregon	<1,000 million
Wildfire	Bootleg Wildfire	7/17/21-8/6/21	Butte, Plumas, Tehama, Lassen and Shasta Counties, California	> 1,000 million
Wildfire	Dixie Wildfire	7/14/21-10/5/21	El Dorado National Forest and other areas of the Sierra Nevada in El Dorado, Amador, and Alpine County, California	> 1,000 million
Wildfire	Caldor Fire	8/14/21-10/5/21	Ford, WA; Tum Tum, Springdale, City of Deer Park, Loon Lake, Clayton, H395; Scoop Mt	<1,000 million
Wildfire	Corkscrew Fire	8/15/21-8/30/21	Boulder County, Colorado	<100 million
Wildfire	Marshall Fire	12/30/21-1/1/22	San Miguel County, Mora County, Taos County	~2 billion
Wildfire	Calf Canyon/Hermits Peak Fire	4/6/22-8/22/22	Siskiyou County, Northern California	> 25 million
Wildfire	McKinney Fire	7/29/22-9/7/22	Central Oregon	> 25 million
Wildfire	Cedar Creek Fire	8/1/22-present	Northern California, Placer County, El Dorado County	> 25 million
Wildfire	Mosquito Fire	9/6/22-present		> 25 million
Hurricane	Hurricane Fiona	9/18/22-9/20/22	PR	>3 billion
Hurricane	Ian	9/23/22-10/2/22	Florida and the Carolinas, FL, GA, NC, SC, VA	>110 billion
Hurricane	Hurricane Nicole	11/9/22-11/11/22	FL, GA, SC	>1 billion



Non U.S. List of Catastrophes For Use in Reporting Catastrophe Data in PRO36 and PR100+

Year	Event Type	Begin	End	Event	Country	Affected Area (Detail)	Munich Re NatCAT Service Insured losses (in original values, US\$m) Criteria: insured losses equal/greater US\$ 25m. Tries to reflect non-US losses only	Swiss Re Sigma: Insured Loss Est. US\$m (mid point shown if range given) Mostly reflect total US and nonUS losses combined.
2013	Tropical Cyclone	08/11/2013	12/11/2013	Typhoon Haiyan	Philippines	Philippines, Vietnam, China	700	N/A
2013	Wildfire	11/01/12	04/01/13	Tasmanian Bushfires	Australia	Central Highlands, East coast (Bicheno), Forester and Tasman Peninsulas, Tasmania, Australia		~\$44m
2013	Wildfire	10/17/13	10/31/13	New South Wales Bushfires	Australia	New South Wales		~\$138m
2014	Earthquake	07/07/2014		Earthquake	Mexico, Guatemala		N/A	25+million
2014	Earthquake	04/07/14		Earthquake	Chile		N/A	100+million
2014	Earthquake	12/02/2014		Earthquake	China		N/A	350+million
2014	Earthquake	05/04/2014		Earthquake	China		N/A	80+million
2014	Earthquake	05/05/2014		Earthquake	Thailand		N/A	62+million
2014	Earthquake	05/24/14		Earthquake	China		N/A	60+million
2014	Tropical Storm	06/14/14	06/16/14	TS Hagibis	China		N/A	131+million
2014	Super Typhoon	07/08/14	07/11/14	STY Neoguri	Japan		N/A	100+million
2014	Super Typhoon	07/15/14	07/20/14	STY Rammasun		Philippines, China, Vietnam	N/A	570+million
2014	Typhoon	07/22/14	07/24/14	TY Matmo		Taiwan, China, Philippines	N/A	570+million
2014	Cyclone	01/10/14	01/12/14	CY Ian	Tonga		N/A	48+million
2014	Cyclone	04/10/14	04/14/14	CY Ita	Australia		N/A	1+million
2014	Wildfire	Summer 2014		Northwest Territories Fire	Canada	Northwest Territories, Canada		~\$3.6b
2015	Hurricane	08/16/92	08/28/92	Hurricane Andrew	Bahamas	Bahamas		> 25 million
2015	Hurricane	10/20/15	10/24/15	Hurricane Patricia	Bahamas	Central America, Mexico	N/A	> 25 million
2015	Typhoon	06/26/15	07/13/15	Typhoon Chan-hom (Falcon)		Guam, Northern Mariana Islands, Philippines, Japan, Taiwan, Chian, Korea, Russian Far East	N/A	> 25 million
2015	Severe Tropical Storm	07/01/15	07/10/15	Severe Tropical Storm Linta (Egay)		Philippines, Taiwan, China	N/A	> 25 million
2015	Typhoon	07/02/15	07/18/15	Typhoon Nangka		Marshall Islands, Mariana Islands and Japan	N/A	> 25 million
2015	Typhoon	07/29/15	08/12/15	Typhoon Soudelor (Hanna)		Mariana Islands, Japan, Philippines, Taiwan, Eastern China and South Korea	N/A	> 25 million
2015	Typhoon	08/13/15	08/30/15	Typhoon Goni (Ineng)		Mariana Islands, Japan, Philippines, Taiwan, Russia and Korea	N/A	> 25 million
2015	Severe Tropical Storm	09/06/15	09/11/15	Severe Tropical Storm Etou		Japan, Russian Far East	N/A	> 25 million
2015	Typhoon	09/19/15	09/30/15	Typhoon Dujan (Jenny)		Ryukyu Islands, Taiwan, East China	N/A	> 25 million
2015	Typhoon	09/30/15	10/05/15	Typhoon Mujigae (Kabayann)		Philippines, Vietnam and China	N/A	> 25 million
2015	Typhoon	10/12/15	10/21/15	Typhoon Koppu (Lando)		Northern Mariana Islands, Philippines, Taiwan, Ryukyu Islands	N/A	> 25 million
2015	Typhoon	12/03/15	12/08/15	Storm Desmond		Ireland, Isle of Man, United Kingdom, Iceland, Norway and Sweden	N/A	> 25 million
2015	Hurricane	09/28/15	10/15/15	Hurricane Joaquin		Caribbean Islands, Portugal	N/A	> 25 million
2015	Earthquake	04/27/15		Earthquake	Nepal		N/A	> 25 million
2015	Earthquake	09/22/15		Earthquake	Chile		N/A	> 25 million
2015	Wildfire	11/25/15	12/02/15	Piney Bushfire	Australia	Lower Mid North, Light River, West Barossa, South Australia, Australia		\$75m
2015	Wildfire	12/25/15		Wye River, Separation Creek bushfires,	Australia	Great Ocean Road region of Victoria, Australia		~\$110m

Non U.S. List of Catastrophes For Use in Reporting Catastrophe Data in PRO36 and PR100+

2016	Hurricane	08/28/16	09/06/16	Hurricane Hermine				Dominican Republic, Cuba, The Bahamas	N/A	N/A	> 25 million
2016	Tropical Cyclone	02/16/16	02/22/16	TC Winston				South Pacific Islands	N/A	N/A	> 25 million
2016	Earthquake	02/06/16		Earthquake	Taiwan			Asia	N/A	N/A	> 25 million
2016	Earthquake	01/03/16		Kaohsiung EQ	India, Bangladesh, Myanmar			Asia	N/A	N/A	> 25 million
2016	Earthquake	02/14/16		Christchurch EQ	New Zealand			Oceania	N/A	N/A	> 25 million
2016	Earthquake	04/14/16	04/16/16	Kumamoto EQs	Japan			Asia	N/A	N/A	> 25 million
2016	Earthquake	04/16/16		Ecuador EQ	Ecuador			South America	N/A	N/A	> 25 million
2016	Tropical Cyclone	05/14/16	05/23/16	CY Roanu	Sri Lanka, India, Bangladesh, China			Asia	N/A	N/A	> 25 million
2016	Earthquake	08/24/16		Italy EQ	Italy			Europe	N/A	N/A	> 25 million
2016	Tropical Cyclone	09/14/16	09/16/16	STY Meranti	China, Taiwan, Philippines			Asia	N/A	N/A	> 25 million
2016	Tropical Cyclone	07/08/16	07/12/16	STY Nepartak	China, Taiwan			Asia	N/A	N/A	> 25 million
2016	Tropical Cyclone	09/26/16	09/29/16	TY Megi	Taiwan, China			Asia	N/A	N/A	> 25 million
2016	Earthquake	09/10/16		Kagera EQ	Tanzania, Uganda			Africa	N/A	N/A	> 25 million
2016	Tropical Cyclone	08/29/16	09/01/16	TY Lionrock	China, Japan, South Korea			Asia	N/A	N/A	> 25 million
2016	Tropical Cyclone	09/19/16	09/22/16	TY Malakas	Japan, China			Asia	N/A	N/A	> 25 million
2016	Tropical Cyclone	08/18/16	08/20/16	TS Dianmu	China, Vietnam			Asia	N/A	N/A	> 25 million
2016	Tropical Cyclone	07/31/16	08/03/16	TY Nidia	China, Philippines Vietnam			Asia	N/A	N/A	> 25 million
2016	Tropical Cyclone	08/02/16	08/10/16	HU Earl	Belize, Mexico, Caribbean Islands			Caribbean Islands, Mexico and Central America	N/A	N/A	> 25 million
2016	Tropical Cyclone	08/22/16	08/23/16	TS Mindulle	Japan			Asia	N/A	N/A	> 25 million
2016	Tropical Cyclone	09/06/16	09/08/16	HU Newton	Mexico			North America (non-U.S.)	N/A	N/A	> 25 million
2016	Tropical Cyclone	10/04/16	10/07/16	STY Chaba	Japan, Korea			Asia	N/A	N/A	> 25 million
2016	Tropical Cyclone	10/16/16	10/22/16	STY Haima	Philippines, China			Asia	N/A	N/A	> 25 million
2016	Tropical Cyclone	10/14/16	10/20/16	TY Sarika	Philippines, China, Vietnam			Asia	N/A	N/A	> 25 million
2016	Earthquake	10/26/16		Central Italy EQ	Italy			Europe	N/A	N/A	> 25 million
2016	Earthquake	10/27/16		Central Italy EQ	Italy			Europe	N/A	N/A	> 25 million
2016	Earthquake	10/21/16		Tottori	Japan			Asia	N/A	N/A	> 25 million
2016	Hurricane	09/28/16	10/10/16	Hurricane Matthew				Caribbean Islands and Eastern Canada	N/A	N/A	> 25 million
2016	Hurricane	08/28/16	09/06/16	Hurricane Hermine				Dominican Republic, Cuba, The Bahamas	N/A	N/A	> 25 million
2016	Wildfire	01/06/16		Waroona-Yarloop Bushfire	Western Australia				N/A	N/A	~\$71.25m
2016	Wildfire	05/01/16	05/26/16	Canada Wildfire	Canada			Fort McMurray	N/A	N/A	\$3.52b
2016	Wildfire	11/22/16	11/27/16	November 2016 Israel Fires	Israel			Various regions in Israel, mainly in Haifa, Judean Mountains and the Sharon Plain	N/A	N/A	>\$25m
2017	Earthquake	01/18/17		Earthquake	Italy			Europe	N/A	N/A	> 25 million
2017	Earthquake	01/28/17		Earthquake	China			Asia	N/A	N/A	> 25 million
2017	Earthquake	02/10/17		Earthquake	Philippines			Asia	N/A	N/A	> 25 million
2017	Earthquake	03/27/17		Earthquake	China			Asia	N/A	N/A	> 25 million
2017	Cyclone	03/28/17	04/05/17	CY Debbie	Australia			Queensland, New South Wales, New Zealand	N/A	N/A	> 25 million
2017	Earthquake	05/11/17		Earthquake	China			Asia	N/A	N/A	> 25 million
2017	Typhoon	07/29/17	07/31/17	TY Nesat & TS Haiyang	China, Taiwan, Philippines			Asia	N/A	N/A	> 25 million
2017	Typhoon	08/07/17	08/09/17	Typhoon Noru	Japan			Asia	N/A	N/A	> 25 million
2017	Earthquake	08/08/17		Earthquake	China			Asia	N/A	N/A	> 25 million
2017	Typhoon	08/23/17	08/24/17	TY Halo	China			Macau, Hong Kong	N/A	N/A	> 25 million
2017	Typhoon	08/25/17	08/28/17	TY Pakhar	China			Asia	N/A	N/A	> 25 million
2017	Hurricane	08/25/17	09/02/17	Hurricane Harvey				Caribbean Islands and Central America	N/A	N/A	> 25 million
2017	Hurricane	08/30/17	09/16/17	Hurricane Irma				Caribbean Islands and Cape Verde	N/A	N/A	> 25 million
2017	Hurricane	09/05/17	09/26/17	Hurricane Jose				Caribbean Islands and Eastern Canada	N/A	N/A	> 25 million
2017	Hurricane	09/16/17	10/03/17	Hurricane Maria				Caribbean Islands, UK, France and Spain	N/A	N/A	> 25 million
2017	Earthquake	09/07/17		Earthquake	Mexico, Guatemala			Mexico, Guatemala	N/A	N/A	> 25 million
2017	Earthquake	09/19/17		Earthquake	Mexico City			Mexico City	N/A	N/A	>200
2017	Hurricane	10/04/17		Hurricane Nate				Central America, Cayman Islands, Cuba Yucatan Peninsula	N/A	N/A	> 25 million

Non U.S. List of Catastrophes For Use in Reporting Catastrophe Data in PRO36 and PR100+

2017	Wildfire	06/06/17		Knysna Fires	South Africa		Knysna region of the Western Cape		~\$146m
2017	Wildfire	07/01/17	08/01/17	British Columbia Wildfires	Canada		British Columbia		>\$78m
2017	Wildfire	10/15/17	10/16/17	Iberian Wildfires	Portugal		Northern Portugal and Northwestern Spain		~\$210m
2018	Earthquake	02/06/18		Earthquake	Taiwan				> 25 million
2018	Earthquake	02/16/18		Earthquake	Mexico				> 25 million
2018	Cyclone	02/09/18	02/20/18	CY Gita	Tonga, Fiji, Samoa, New Zealand				> 25 million
2018	Earthquake	02/26/18		Earthquake	Papua New Guinea				> 25 million
2018	Earthquake	03/05/18		Earthquake	Papua New Guinea				> 25 million
2018	Cyclone	03/17/18		CY Marcus					> 25 million
2018	Tropical Storm	05/23/18	05/27/18	Tropical Storm Mekunu	Yemen, Oman , Saudi Arabia				> 25 million
2018	Tropical Storm	06/02/18	06/07/18	Tropical Storm Ewiniar	Vietnam, China, Taiwan, Philippines and Ryukyu Islands		Guangdong Province, Jiangxi, Fujian, Zhejiang Provinces, and Hainan Island,		> 25 million
2018	Earthquake	06/18/18		Earthquake	Japan				> 25 million
2018	Super Typhoon	07/10/18	07/12/18	STY Maria	China, Taiwan, Guam and Japan		Fujian province, Yantze River Basin, Japan's Ryukyu Islands		> 25 million
2018	Tropical Storm	07/17/18	07/24/18	TS South-Tinh	Vietnam, China, Laos				> 25 million
2018	Tropical Storm	07/22/18	07/25/15	TS Ampil	China		Jiangsu, Zhejiang, Shandong, and Hebei		> 25 million
2018	Typhoon	07/27/18	08/03/18	TY Jongdari	Japan, China				> 25 million
2018	Earthquake	08/05/18	08/09/18	Earthquake	Indonesia				> 25 million
2018	Tropical Storm	08/09/18	08/15/18	TS Yagi	Philippines, China		Zhejiang, Anhui, Jiangsu and Shandong Provinces		> 25 million
2018	Tropical Storm	08/13/18	08/19/18	TS Bebinca	China		Hong Kong, Guangdong and Hainan		> 25 million
2018	Typhoon	08/16/18	08/18/18	TY Rumbia	China		Shanghai, Jiangsu, Zhejiang, Anhui, Shandong and Henan		> 25 million
2018	Typhoon	08/23/18	08/25/18	TY Soulik	Japan, South Korea, China and Russia		Haenam County, South Jeolla Province		> 25 million
2018	Typhoon	09/04/18	09/05/18	RY Jebi	Japan, Mariana Islands, Taiwan, Japan, Russian Far East and Artic				> 25 million
2018	Earthquake	09/08/18		Earthquake	Japan				> 25 million
2018	Super Typhoon	09/15/18	09/18/18	STY Mangkhut	N. Mariana Islands, Philippines, China and Hong Kong				> 25 million
2018	Hurricane	Leslie	09/23/18	Hurricane Leslie	Azores, Bermuda, Europe		Azores, Bermuda, Madeira, Iberian Peninsula, France		> 25 million
2018	Hurricane	10/07/18	10/16/18	Hurricane Michael	Central American, Yucatan Peninsula, Cayman Islands, Cuba, Atlantic, Canada				> 25 million
2018	Wildfire	May-18	Aug-18	Sweden Wildfires	Sweden		ranging from north of Arctic Circle to the southern County of Scania.		>\$87m
2018	Wildfire	Jul-18		Greece Wildfires	Greece		Attica, Greece		~38.1m
2019	Cyclone	05/03/19	05/05/19	Cyclone Fani	India, Bangladesh				>500 million
2019	Earthquake	06/17/19		Earthquake	China				> 25 million
2019	Tropical Storm	08/01/19	08/08/19	Tropical Storm Wipha	China, Vietnam				> 25 million
2019	Typhoon	08/09/19	08/11/19	Typhoon Lekima	China				> 855 million
2019	Typhoon	08/15/19	08/16/19	Typhoon Krosa	Japan				>25 million
2019	Hurricane	08/31/19	09/07/19	Hurricane Dorian	Caribbean, Bahamas, Canada				>1 billion
2019	Typhoon	09/05/19	09/08/19	Typhoon Lingling	Japan, China, Korea				>5.78 billion
2019	Typhoon	09/08/19	09/09/19	Typhoon Faxai	Japan				> 7 billion
2019	Hurricane	09/19/19	09/22/19	Hurricane Humberto	Bermuda				>25+ million
2019	Hurricane	09/17/19	09/26/19	Hurricane Lorenzo	Portugal				>25+ million
2019	Earthquake	11/26/19		Earthquake	Albania				>25+ million
2019	Cyclone	10/01/19	11/11/19	Cyclone Maimo (Bulbul)	India, Bangladesh				>25+ million
2019	Typhoon	10/01/19	10/02/19	Typhoon Hagibis	Japan				> 7 billion
2019	Earthquake	12/18/19		Earthquake	Philippines				>25+ million
2019	Wildfire	Sep-19	Mar-20	Australian Bushfires	New South Wales, Queensland, Victoria, South Australia, Western Australia, Tasmania and Northern Territory				~910 million
2020	Earthquake	03/22/20		Earthquake	Croatia				>25+ million
2020	Cyclone	04/01/20	04/11/20	Cyclone Harold	Solomon Islands, Chuatu, Fiji, Tonga				> 25+ million

Non U.S. List of Catastrophes For Use in Reporting Catastrophe Data in PRO36 and PR100+

2020	Tropical Storm	05/31/20	Tropical Storm Amanda	El Salvador, Guatemala, Honduras				> 25+ million
2020	Tropical Storm	06/01/20	Tropical Storm Cristobal	Mexico, Guatemala, El Salvador				150 million
2020	Hurricane	07/25/20	Hurricane Hanna	Mexico				350 million
2020	Hurricane	07/28/20	Hurricane Isaias	Caribbean, Canada				> 3 billion
2020	Hurricane	08/22/20	Hurricane Laura	Caribbean				> 4 billion
2020	Typhoon	05/15/20	Typhoon Amphan	India, Bangladesh, Sri Lanka				15 billion
2020	Tropical Storm	06/03/20	Tropical Storm Nisarga	India				> 25+ million
2020	Typhoon	08/03/20	Typhoon Hagupit	China, Taiwan				> 100+ million
2020	Hurricane	10/05/20	Hurricane Delta	Jamaica, Nicaragua, Cayman Island, Yucatan Peninsula				> 2 billion
2020	Hurricane	10/24/20	Hurricane Zeta	Cayman Islands, Jamaica, Central America, Yucatan Peninsula, Ireland, United Kingdom				> 1.5 billion
2020	Cyclone	04/01/20	Cyclone Harold	Solomon Islands, Vanuatu, Fiji, Tonga				> 25+ million
2020	Hurricane	10/31/20	Hurricane Eta	Colombia, Jamaica, Central America, Cayman Islands, Cuba, The Bahamas				> 7.9 billion
2020	Hurricane	11/14/20	Hurricane Iota	ABC Islands, Colombia, Jamaica, Central America				> 1.4 billion
2020	Typhoon	11/22/20	Typhoon Goni	Philippines, Vietnam, Cambodia, Laos				> 400+ million
2020	Typhoon	11/08/20	Typhoon Vamco	Philippines, Vietnam, Laos, Thailand				> 400+ million
2020	Wildfire	10/04/20	Lake Ohau Fire	New Zealand				~\$25m
2020	Wildfire	02/05/21	Perth Hills Wildfire	Australia				~\$63m
2021	Earthquake	01/14/21	West Sulawesi	Indonesia				> 58.1 million
2021	Earthquake	02/13/21	Fukushima Prefecture Offshore	Japan				1.3 billion
2021	Tropical Cyclone	05/17/21	Tropical Cyclone Tauetae	India				> 25+ million
2021	Tropical Storm	06/19/21	Tropical Storm Claudette	Oaxaca, Veracruz, Atlantic Canada				> 25+ million
2021	Earthquake	06/21/21	China	Yunnan Dali				> 25+ million
2021	Earthquake	06/21/21	China	Southern Qinghai				> 25+ million
2021	Hurricane	07/01/21	Elsa	Lesser Antilles, Greater Antilles, Venezuela, Colombia, Atlantic Canada, Greenland, Iceland				50 million
2021	Typhoon	07/16/21	In-fa (Fabian)	Philippines, Ryukyu Islands, Taiwan, China, North Korea				> 25+ million
2021	Tropical Storm	08/11/21	Fred	Lesser Antilles, Greater Antilles, Southern Quebec, The Maritimes				25 million
2021	Hurricane	08/13/21	Grace	Lesser Antilles, Greater Antilles, Yucatan Peninsula, Central Mexico				513 million
2021	Earthquake	08/14/21	Haiti	Haiti				1 billion
2021	Hurricane	08/26/21	Ida	Venezuela, Colombia, Jamaica, Cayman Islands, Cuba, Atlantic Canada				> 250 million
2021	Earthquake	09/07/21	Guerrero	Mexico				200 million
2021	Earthquake	09/16/21	China	China				> 25+ million
2021	Hurricane	09/12/21	Nicholas	Yucatan Peninsula, Tamaulipas				1.1 billion
2021	Hurricane	09/10/21	Larry	Canada				80 million
2021	Cyclone	10/02/21	Cyclone Shaheen	Oman, Iran, India, Pakistan, United Arab Emirates, Saudi Arabia, Yemen				> 25+ million
2021	Earthquake	10/07/21	Japan	Japan				> 25+ million
2021	Tropical Storm	10/10/21	Tropical Storm Kompasu	Philippines, Hong Kong, China				245 million
2021	Earthquake	10/16/21	Indonesia	Indonesia				> 25+ million
2021	Tropical Cyclone	10/24/21	Apollo	Italy, Malta, Tunisia, Algeria, Libya, Turkey				> 25+ million
2021	Tropical Storm	10/31/21	Wanda	Atlantic Canada, Bermuda, Azores				> 25+ million
2021	Earthquake	11/14/21	Iran	Iran				> 25+ million
2021	Tropical Cyclone	12/14/21	Rai (Odette)	Caroline Islands, Palau, Philippines				> 25+ million
2022	Wildfire	01/15/22	Corrientes	Corrientes Province, Argentina				> 25+ million
2022	Earthquake	03/16/22	Fukushima Earthquake	Japan				2.8 billion
2022	Tropical Storm	04/08/22	Meg	Philippines				> 25+ million

Non U.S. List of Catastrophes For Use in Reporting Catastrophe Data in PRO36 and PR100+

2022	Typhoon	08/28/22	09/07/22	Hinnamor	Japan, Taiwan, Philippines, South Korea, Russian, Far East				>25+ million
2022	Earthquake	09/05/22		Luding Earthquake	Luding County in Sichuan province				>25+ million
2022	Hurricane	09/14/22	09/28/22	Fiona	Leeward Islands, Puerto Rico, Dominican Republic, Lucayan Archipelago, Bermuda, Eastern Canada, Saint Pierre and Miquelon, Greenland				660 million
2022	Hurricane	09/23/22	10/02/22	Ian	Trinidad and Tobago, Venezuela, Colombia, ABC Islands, Jamaica, Cayman Islands, Cuba				> 110 billion
2022	Hurricane	10/07/22	10/10/22	Julia	Trinidad and Tobago, Venezuela, ABC Islands, Colombia, Nicaragua, El Salvador, Honduras, Guatemala, Panama, Mexico				>400 million

Source: Munich Re's NAT CAT Service, Swiss Re Sigma and Aon Benfield

Draft: 3/28/23

Health Risk-Based Capital (E) Working Group  
Louisville, Kentucky  
March 21, 2023

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met in Louisville, KY, March 21, 2023. The following Working Group members participated: Steve Drutz, Chair, and David Hippen (WA); Matthew Richard, Vice Chair, Aaron Hodges, Allison Eberhart, Caroline Choi, R. Michael Markham, and Vicki Wang (TX); Wanchin Chou, Jennifer Dowty, and Philip Barrett (CT); Carolyn Morgan, Kyle Collins, Leean Chojnowski, and Margaret McCrary (FL); Tish Becker (KS); Danielle Smith (MO); Michael Muldoon (NE); Tom Dudek, Gail Ross, Richard Ramos, Shing Yuen, and Sylvia Lawson (NY); and Lorraine Badarzynski (PA). Also participating were: David Wolf (NJ); Tom Botsko (OH); and Andrew Schallhorn (OK).

1. Adopted is Feb. 7 Minutes

The Working Group met Feb. 7 and took the following action: 1) adopted its 2022 Fall National Meeting minutes; 2) adopted proposal 2022-14-H (Trend Test Instructions); 3) referred the Runoff Company Response letter to the Capital Adequacy (E) Task Force; 4) exposed proposal 2022-16-CA (Underwriting Risk – Experience Fluctuation Risk – Investment Income Adjustment); and 5) received an update from the American Academy of Actuaries (Academy) on the H2 – Underwriting Risk review.

Muldoon made a motion, seconded by Chou, to adopt the Working Group’s Feb. 7 minutes (Attachment Two-A). The motion passed unanimously.

2. Adopted Proposal 2022-15-H

Drutz said the purpose of proposal 2022-15-H (XR008 Renumbering) is to renumber all the lines on page XR008. The line numbers on page XR008 currently carry over from the bond page (XR007). Drutz said renumbering the lines will allow for easier updates in the future. The proposal was exposed for a 30-day public comment period that ended Feb. 28, and no comments were received.

Chou made a motion, seconded by Muldoon, to adopt proposal 2022-15-H (*see NAIC Proceedings – Spring 2023, Capital Adequacy (E) Task Force, Attachment Nine*). The motion passed unanimously.

3. Referred Proposal 2022-16-CA

Drutz said the purpose of proposal 2022-16-CA is to update the underwriting risk factors for the annual investment income adjustment to the comprehensive medical, Medicare supplement, and dental and vision factors. The proposal was originally exposed for a 30-day public comment period that ended March 9, and no comments were received. Drutz said this proposal affects all three lines of business, and it will need to be referred to the Capital Adequacy (E) Task Force for exposure. He said the \$0–3 million tier factors will decrease by 4–6%, and Medicare supplement will decrease by approximately 9% in the \$3–25 million tier. He said overall, the changes will result in a decrease of 4–9% for comprehensive medical, Medicare supplement, and dental and vision.

Hearing no objections, the Working Group referred proposal 2022-16-CA to the Capital Adequacy (E) Task Force for exposure during its late April call.

#### 4. Adopted its 2023 Working Agenda

Drutz said the 2023 working agenda was updated for the following editorial changes: 1) Line X1 was updated to remove the reference to the 0.5% factor adjustment and add the related proposal to the Comments column; 2) the expected completion date column was updated for Lines X4, X6, X7, X8, and X9; 3) Line X5 was updated to remove the reference to “review possible annual statement changes for reporting health business in the Life and P/C blanks”; and 4) Line X10 was moved from the New Items section to the Carryover Items Currently being Addressed section.

Becker made a motion, seconded by Chou, to adopt the Working Group’s 2023 working agenda (*see NAIC Proceedings – Spring 2023, Capital Adequacy (E) Task Force, Attachment Ten*). The motion passed unanimously.

#### 5. Exposed Proposal 2023-01-CA

Drutz said NAIC staff received several questions during the year-end reporting period related to the reporting of stop loss premiums and the stop loss electronic-only interrogatories. He said the purpose of proposal 2023-01-CA (Stop Loss Instructions) is to clarify the instructions for stop loss business in the risk-based capital (RBC) formulas; i.e., health, life, and property/casualty (P/C). The health RBC instructions were clarified for: 1) Other Health Coverages reported in Column 5 on page XR013; 2) reporting stop loss premiums on a net basis on Line 25 on page XR015; and 3) calendar year reporting on the stop loss electronic Table 1 if the contract year does not follow a calendar year. Drutz said this proposal will affect all three lines of business, and he suggested first exposing it at the Working Group level and then referring it to the Capital Adequacy (E) Task Force for exposure during its late April call for all lines of business.

Hearing no objections, the Working Group exposed proposal 2023-01-CA (Attachment Two-B) for a 20-day public comment period ending April 10.

#### 6. Discussed Stop Loss Data and Factors

Drutz said the stop loss factors were updated in 2017 based on 1998–2008 data, and a tiered risk factor was applied to stop loss premium. The electronic-only stop loss tables proposal was adopted in 2018 and added three tables for stop loss data to each of the RBC formulas. The purpose of these interrogatories was to collect this information for six years and then re-evaluate the stop loss factors with more current data that would reflect the implementation of the federal Affordable Care Act (ACA). Drutz said the 2022 year-end filing period marks year five of the data collection. He said the Working Group has reached out to the Academy to begin discussions on the review and analysis process for evaluating the stop loss data.

Drutz said stop loss business has evolved quite a bit in just the last five years, and he noted that stop loss is not broken out by type in the annual statement, whereas RBC breaks it out by type in the RBC electronic-only tables. He said the Working Group will continue to work with the Academy on this project.

#### 7. Received an Update on the Health Test Ad Hoc Group and Health Test Language

Drutz said the Health Test Ad Hoc Group is reaching a completion point on its work on the health test language and instructions. He said the Ad Hoc Group last met March 8 to review the final draft of the proposed changes, which includes revisions to the General Interrogatories, Part 2, Health Test Premium and Reserve Ratio calculations for life, property, and health (Attachment Two-C). He said the changes clarify and create greater transparency in the calculation of both the numerator and the denominator in both the premium and reserve

calculation. For both the premium and reserve ratios, the numerator and the denominator were calculated using separate schedules. These changes align the denominator to pull from the same schedules as the numerator when possible. For example, the denominator of the reserve ratio for the life general interrogatories is calculated using the Liabilities page, but the numerator utilizes Exhibits 6 and 8. He said the proposed change creates greater transparency by utilizing Exhibits 5, 6, and 8 to now calculate the denominator.

Drutz said the Ad Hoc Group found that the current calculation of the life reserve ratio utilizes both gross and net amounts, creating inconsistencies in the calculation. He said the Ad Hoc Group performed a thorough analysis and comparison to refine the calculation to be on an all-net or all-gross basis. He said the Ad Hoc Group concluded that the net basis is the best way to move forward, thus allowing the premium and reserve ratio to be calculated on a net basis.

Drutz said the Ad Hoc Group also discussed whether the 95% ratio should be lowered, but it determined that there should be no change at this time due to extensive changes to the life and property annual statement filings for capturing health data. The Ad Hoc Group concluded that all health data and proposed health test changes should be fully implemented and then the ratios re-evaluated in a few years.

Drutz said the Ad Hoc Group will meet again April 12, and it plans to complete its final review of the proposal and consider asking the Working Group to expose it, with the intent to also include the Life Risk-Based Capital (E) Working Group and Property and Casualty Risk-Based Capital (E) Working Group in that exposure.

#### 8. Discussed the Effect of the COVID-19 Pandemic and Pandemic Risk on the Health RBC Formula

Drutz said the working agenda item on the effect of the COVID-19 pandemic and the pandemic risk was added to the health RBC formula in 2020 at the height of the pandemic. He said the Working Group has touched on it briefly over the course of the last few years; however, it has not discussed it in detail due to the limited information available.

Drutz said the Working Group was previously tasked with looking at catastrophic risks, such as pandemic and biological risks, back in 2011. He said at that time, the Working Group added interrogatory questions for informational purposes only. The interrogatories were included in the formula for several years; however, the Working Group found that only a handful of companies indicated that they allocated a component of surplus for pandemic and biological risks; therefore, the interrogatories were removed. Drutz suggested that the Working Group begin discussing how to address pandemic risk in the health RBC formula.

#### 9. Discussed Other Matters

Drutz said the Academy continues to work on the H2 – Underwriting Risk review. Botsko asked if there is a timeframe for its completion. Crystal Brown (NAIC) said it will likely be at least 2024.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/



Draft: 2/14/23

Health Risk-Based Capital (E) Working Group  
Virtual Meeting  
February 7, 2023

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Feb. 7, 2023. The following Working Group members participated: Steve Drutz, Chair (WA); Matthew Richard, Vice Chair, and Aaron Hodges (TX); Wanchin Chou and Jack Broccoli (CT); Carolyn Morgan and Benjamin Ben (FL); Tish Becker (KS); Danielle Smith and Debbie Doggett (MO); Michael Muldoon and Margaret Garrison (NE); and Tom Dudek (NY).

1. Adopted its 2022 Fall National Meeting Minutes

Muldoon made a motion, seconded by Chou, to adopt the Working Group's Dec. 12, 2022, minutes (*see NAIC Proceedings – Fall 2022, Capital Adequacy (E) Task Force, Attachment Three*). The motion passed unanimously.

2. Adopted Proposal 2022-14-H

Drutz said the purpose of proposal 2022-14-H (Trend Test Instructions) is to remove the sentence, "The calculation is informational-only until state statutes are implemented so that the trend test would trigger a Company Action Level RBC regulatory action per the statute," given that all states have adopted the trend test. The proposal was exposed for a 30-day public comment period that ended on Dec. 7, 2022, and no comments were received.

Muldoon made a motion, seconded by Chou, to adopt proposal 2022-14-H (*see NAIC Proceedings – Spring 2023, Capital Adequacy (E) Task Force, Attachment Eight*). The motion passed unanimously.

3. Referred a Runoff Company Response Letter to the Capital Adequacy (E) Task Force

Drutz said the Working Group previously exposed its response letter to the Capital Adequacy (E) Task Force on health companies in runoff. The letter outlined the Working Group's agreement with the recommendations included in Property and Casualty Risk-Based Capital (E) Working Group's response letter, as well as a definition of a health runoff company. The letter was exposed for a 30-day public comment period, and no comments were received.

Muldoon made a motion, seconded by Dudek, to refer the letter to the Capital Adequacy (E) Task Force. The motion passed unanimously.

4. Exposed Proposal 2022-16-CA

Drutz said the investment yield for the six-month U.S. Treasury bond in January 2023 ranged from 4.77% to 4.83% (Attachment Two-A1). Given the increase in the investment yield, the Working Group reached out to the American Academy of Actuaries (Academy) to get updated factors that would reflect an adjustment up to a 6% yield on a 0.5% incremental basis. The health risk-based capital (RBC) instructions round the factors up to the nearest 0.5%.

Drutz said proposal 2022-16-CA reflects the updated factors for comprehensive medical, Medicare Supplement, and dental and vision, and they would apply to all lines of business to reflect the 5% investment adjustment. He said the change from the prior year to this year is interesting, given that the investment yield in 2021 was less than a 0.5 percentage point. Muldoon asked if there is an expected impact on RBC. Drutz said it would probably

be about a 5-10% reduction in the underwriting risk charge for the comprehensive line where the charge goes from 15% to 14.34% in the higher tier. Ray Nelson (America's Health Insurance Plans—AHIP) said the reduction would be closer to 3-4%. Drutz said ultimately, with a decrease in the underwriting risk charge, and all other components held constant, one would see the RBC ratios improving. The idea is that the higher investment income being earned helps to offset the underwriting charges. Derek Skoog (Academy) said the operative number that is probably worth looking at the most is the adjustment of the 9% factor to 8.38% for comprehensive medical. He said this is where the majority of the premium in the industry lies; therefore, regarding impact, that is probably the most important comparison. He said the base factor is about 9% for the lower tier compared to the 8.38%; therefore, there may be a slightly larger impact on those premiums in the lower tier than in the higher tier.

Hearing no objections, proposal 2022-16-CA (Underwriting Risk Factors – Investment Income Adjustment) was exposed at the Working Group level for a 30-day public comment period ending March 9.

#### 5. Received an Update from the Academy on the H2 – Underwriting Risk Review

Skoog said the Academy is beginning to imagine and mockup how the actual underwriting risk tabs and formula will look and work. He said they are also working to articulate their key questions, as well as the subsequent or related data analysis that would be needed to answer those questions. Some questions identified to date include “to what extent does diversification help or hurt from a risk perspective,” “what are the relevant size points,” and “where does the risk seem to change based on company size.” Skoog said the Academy is continuing to work through the analysis, data, and structure, and he would be able to provide an update to the Working Group at the Spring National Meeting.

#### 6. Discussed Other Matters

Drutz said proposal 2022-15-H (XR008 Renumbering) was exposed for a 30-day public comment period ending Feb. 28.

Drutz said the Working Group is tentatively scheduled to meet at the Spring National Meeting in Louisville, KY, on March 21.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/

**Capital Adequacy (E) Task Force**  
**RBC Proposal Form**

- |                                                                               |                                                           |                                                                             |
|-------------------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Capital Adequacy (E) Task Force           | <input type="checkbox"/> Health RBC (E) Working Group     | <input type="checkbox"/> Life RBC (E) Working Group                         |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup                        | <input type="checkbox"/> Investment RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup                      |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group        | <input type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

<b>DATE:</b> <u>01-30-23</u>	<b><u>FOR NAIC USE ONLY</u></b>
<b>CONTACT PERSON:</b> <u>Crystal Brown</u>	Agenda Item # <u>2022-16-CA</u>
<b>TELEPHONE:</b> <u>816-783-8146</u>	Year <u>2023</u>
<b>EMAIL ADDRESS:</b> <u>cbrown@naic.org</u>	<b><u>DISPOSITION</u></b>
<b>ON BEHALF OF:</b> <u>Health Risk-Based Capital (E) Working Grp</u>	<input type="checkbox"/> ADOPTED _____
<b>NAME:</b> <u>Steve Drutz</u>	<input type="checkbox"/> REJECTED _____
<b>TITLE:</b> <u>Chief Financial Analyst/Chair</u>	<input type="checkbox"/> DEFERRED TO _____
<b>AFFILIATION:</b> <u>WA Office of Insurance Commissioner</u>	<input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____
<b>ADDRESS:</b> <u>5000 Capitol Blvd SE</u>	<input checked="" type="checkbox"/> EXPOSED <u>2-7-23</u>
<u>Tumwater, WA 98501</u>	<input type="checkbox"/> OTHER (SPECIFY) _____

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

- Health RBC Blanks       Property/Casualty RBC Blanks       Life and Fraternal RBC Instructions  
 Health RBC Instructions     Property/Casualty RBC Instructions     Life and Fraternal RBC Blanks  
 OTHER \_\_\_\_\_

**DESCRIPTION OF CHANGE(S)**

Update the underwriting factors for Comprehensive Medical, Medicare Supplement and Dental & Vision on pages XR013, LR019, LR020, PR019 and PR020 for the investment income adjustment.

**REASON OR JUSTIFICATION FOR CHANGE \*\***

Annual update of the underwriting factors for Comprehensive Medical, Medicare Supplement and Dental & Vision for investment income adjustment.

**Additional Staff Comments:**

2-7-23 cgb Exposed for 30-day comment period ending on March 9.  
 2-28-23 cgb EDITORIAL CHANGE: An editorial correction was made to the Health portion of the instructions to change the investment income adjustment reference from 0.5% to 5.0%.  
 3-9-23 cgb No comments received.

\*\* This section must be completed on all forms.

Revised 7-2022

**UNDERWRITING RISK**

**Experience Fluctuation Risk**

	(1) Comprehensive Medical	(2) Medicare Supplement	(3) Dental & Vision	(4) Stand-Alone Medicare Part D Coverage	(5) Other Health	(6) Other Non-Health	(7) Total
Line of Business							
(1) † Premium							
(2) † Title XVIII-Medicare		XXX	XXX	XXX	XXX	XXX	
(3) † Title XIX-Medicaid		XXX	XXX	XXX	XXX	XXX	
(4) † Other Health Risk Revenue		XXX					
(5) Medicaid Pass-Through Payments Reported as Premiums		XXX	XXX	XXX	XXX	XXX	
(6) Underwriting Risk Revenue = Lines (1) + (2) + (3) + (4) - (5)							
(7) † Net Incurred Claims							
(8) Medicaid Pass-Through Payments Reported as Claims		XXX	XXX	XXX	XXX	XXX	
(9) Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims = Lines (7) - (8)							
(10) † Fee-For-Service Offset		XXX					
(11) Underwriting Risk Incurred Claims = Lines (9) - (10)							
(12) Underwriting Risk Claims Ratio = For Column (1) through (5), Line (11)/(6)					1.000	XXX	
(13) Underwriting Risk Factor*					0.130	0.130	XXX
(14) Base Underwriting Risk RBC = Lines (6) x (12) x (13)							
(15) Managed Care Discount Factor							XXX
(16) RBC After Managed Care Discount = Lines (14) x (15)							XXX
(17) † Maximum Per-Individual Risk After Reinsurance							XXX
(18) Alternate Risk Charge **							XXX
(19) Alternate Risk Adjustment							XXX
(20) Net Alternate Risk Charge***							XXX
(21) Net Underwriting Risk RBC (MAX{Line (16), Line (20)}) for Columns (1) through (5), Column (6), Line (14)							

**TIERED RBC FACTORS\***

	Comprehensive Medical	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	Other Health	Other Non-Health
\$0 - \$3 Million	0.1493-0.1434	0.1043-0.0980	0.1195-0.1148	0.251	0.130	0.130
\$3 - \$25 Million	0.1493-0.1434	0.0663-0.0603	0.0755-0.0711	0.251	0.130	0.130
Over \$25 Million	0.0893-0.0838	0.0663-0.0603	0.0755-0.0711	0.151	0.130	0.130

ALTERNATE RISK CHARGE\*\*

\*\* The Line (18) Alternate Risk Charge is calculated as follows:

LESSER OF:	\$1,500,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$150,000 or 6 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	N/A
------------	-----------------------------------------------------	--------------------------------------------------	--------------------------------------------------	---------------------------------------------------	--------------------------------------------------	-----

Denotes items that must be manually entered on filing software.

† The Annual Statement Sources are found on page XR014.

\* This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental/Vision managed care discount factor.

\*\*\* Limited to the largest of the applicable alternate risk adjustments, prorated if necessary.

**UNDERWRITING RISK**

**Experience Fluctuation Risk**

	(1) Comprehensive Medical	(2) Medicare Supplement	(3) Dental & Vision	(4) Stand-Alone Medicare Part D Coverage	(5) Total
Line of Business					
(1.1) Premium – Individual					
(1.2) Premium – Group					
(1.3) Premium – Total = Line (1.1) + Line (1.2)					
(2) Title XVIII-Medicare†	XXX				
(3) Title XIX-Medicaid‡	XXX				
(4) Other Health Risk Revenue‡	XXX				
(5) Underwriting Risk Revenue = Lines (1.3) + (2) + (3) + (4)					
(6) Net Incurred Claims					
(7) Fee-for-Service Offset‡	XXX				
(8) Underwriting Risk Incurred Claims = Line (6) – Line (7)					
(9) Underwriting Risk Claims Ratio = Line (8) / Line (5)					XXX
(10.1) Underwriting Risk Factor for Initial Amounts Of Premium‡	0.1493-0.1434	0.1043-0.0980	0.1195-0.1148	0.251	XXX
(10.2) Underwriting Risk Factor for Excess of Initial Amount‡	0.0893-0.0838	0.0663-0.0603	0.0755-0.0711	0.151	XXX
(10.3) Composite Underwriting Risk Factor					XXX
(11) Base Underwriting Risk RBC = Line (5) x Line (9) x Line (10.3)					
(12) Managed Care Discount Factor = LR022 Line (17)					XXX
(13) Base RBC After Managed Care Discount = Line (11) x Line (12)					
(14) RBC Adjustment For Individual = [(Line(1.1) x 1.2 + Line (1.2)) / Line (1.3)] x Line (13)§					
(15) Maximum Per-Individual Risk After Reinsurance‡					XXX
(16) Alternate Risk Charge*					
(17) Net Alternate Risk Charge‡					
(18) Net Underwriting Risk RBC (Maximum of Line (14) or Line (17))					

† Source is company records unless already included in premiums.  
‡ For Comprehensive Medical, the Initial Premium Amount is \$25,000,000 or the amount in Line (1.3) if smaller. For Medicare Supplement and Dental & Vision, the Initial Premium Amount is \$3,000,000 or the amount in Line (1.3) if smaller. For Stand-Alone Medicare Part D, the Initial Premium Amount is \$25,000,000 or the amount in Line (1.3) if smaller.  
§ Formula applies only to Column (1), for all other columns Line (14) should equal Line (13).  
\* The Line (16) Alternate Risk Charge is calculated as follows:

LESSER OF:	\$1,500,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$150,000 or 6 x Maximum Individual Risk	Maximum of Columns (1), (2), (3) and (4)
------------	-----------------------------------------------------	--------------------------------------------------	--------------------------------------------------	---------------------------------------------------	---------------------------------------------------

£ Applicable only if Line (16) for a column equals Line (16) for Column (5), otherwise zero.

Denotes items that must be manually entered on the filing software.

**UNDERWRITING RISK - PREMIUM RISK FOR COMPREHENSIVE MEDICAL, MEDICARE SUPPLEMENT AND DENTAL & VISION PRO20**

(Experience Fluctuation Risk in Life RBC Formula)

	(1) Comprehensive Medical	(2) Medicare Supplement	(3) Dental & Vision	(4) Stand-Alone Medicare Part D Coverage	(5) TOTAL
(1.1) Premium – Individual	0	0	0	0	0
(1.2) Premium – Group	0	0	0	0	0
(1.3) Premium – Total = Line (1.1) + Line (1.2)	0	0	0	0	0
(2) Title XVIII-Medicare†	0	XXX	XXX	XXX	0
(3) Title XIX-Medicaid†	0	XXX	XXX	XXX	0
(4) Other Health Risk Revenue‡	0	XXX	0	0	0
(5) Underwriting Risk Revenue = Lines (1.3) + (2) + (3) + (4)	0	0	0	0	0
(6) Net Incurred Claims	0	0	0	0	0
(7) Fee-for-Service Offset†	0	XXX	0	0	0
(8) Underwriting Risk Incurred Claims = Line (6) – Line (7)	0.0000	0.0000	0.0000	0.0000	XXX
(9) Underwriting Risk Claims Ratio = Line (8) / Line (5)	0.1434	0.0980	0.1148	0.251	XXX
(10.1) Underwriting Risk Factor for Initial Amounts Of Premium‡	0.0893	0.0603	0.0711	0.151	XXX
(10.2) Underwriting Risk Factor for Excess of Initial Amount‡	0.0000	0.0000	0.0000	0.0000	XXX
(10.3) Composite Underwriting Risk Factor	0	0	0	0	0
(11) Base Underwriting Risk RBC = Line (5) x Line (9) x Line (10.3)	0.0000	0.0000	0.0000	0.0000	XXX
(12) Managed Care Discount Factor = PR(021 Line (12)	0	0	0	0	0
(13) Base RBC After Managed Care Discount = Line (11) x Line (12)	0	0	0	0	0
(14) RBC Adjustment For Individual =					
	[(Line(1.1) x 1.2 + Line (1.2)) / Line (1.3)] x Line (13)§				
(15) Maximum Per-Individual Risk After Reinsurance†	0	0	0	0	0
(16) Alternate Risk Charge*	0	0	0	0	0
(17) Net Alternate Risk Charge‡	0	0	0	0	0
(18) Net Underwriting Risk RBC (Maximum of Line (14) or Line (17))	0	0	0	0	0

† Source is company records unless already included in premiums.

‡ For Comprehensive Medical the Initial Premium Amount is \$25,000,000 or the amount in Line (1.3) if smaller. For Medicare Supplement and Dental & Vision the Initial Premium

Amount is \$3,000,000 or the amount in Line (1.3) if smaller. For Stand-Alone Medicare Part D the Initial Premium Amount is \$25,000,000 or the amount in Line (1.3) if smaller.

§ Formula applies only to Column (1), for all other columns Line (14) should equal Line (13).

\* The Line (16) Alternate Risk Charge is calculated as follows:

LESSER OF:	\$1,500,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$150,000 or 6 x Maximum Individual Risk	Maximum of Columns (1),(2),(3) and (4)

‡ Applicable only if Line (16) for a column equals Line (16) for Column (5), otherwise zero.

§ Denotes items that must be manually entered on the filing software.

**HEALTH**

**UNDERWRITING RISK - L(1) THROUGH L(21)**

XR013



Line (13) Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (6), Underwriting Risk Revenue. The factors for Column (1) through (3) have incorporated an investment income yield of 5.40.5%.

	\$0 - \$3 Million	\$3 - \$25 Million	Over \$25 Million
Comprehensive Medical & Hospital	0.143493	0.143493	0.083893
Medicare Supplement	0.09804043	0.060363	0.060363
Dental & Vision	0.114895	0.071155	0.071155
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151
Other Health	0.130	0.130	0.130
Other Non-Health	0.130	0.130	0.130

The investment income yield was incorporated into the Comprehensive Medical & Hospital, Medicare Supplement and Dental & Vision lines of business. The purpose was to incorporate an offset to reduce the underwriting risk factor for investment income earned by the insurer. The Working Group incorporated a 0.5% income yield that was based on the yield of a 6-month US Treasury Bond. Each year, the Working Group will identify the yield of the 6-month Treasury bond ([U.S. Department of the Treasury](https://www.treasury.gov)) on each Monday through the month of January and determine if further modifications to the 5.40.5% adjustment ~~is~~ needed. Any adjustments will be rounded up to the nearest 0.5%.



**LIFE**

**Underwriting Risk – Experience Fluctuation Risk**

LR020



Line (10) Underwriting Risk Factor  
A weighted average factor based on the amount reported in Line (5), Underwriting Risk Revenue. The factors for Column 1-3 have incorporated investment income.

	\$0 - \$3 Million	\$3 - \$25 Million	Over \$25 Million
Comprehensive Medical	0.143493	0.143493	0.083893
Medicare Supplement	0.09804043	0.060363	0.060363
Dental	0.114895	0.071155	0.071155
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151



Detail Eliminated to Conserve Space



Detail Eliminated to Conserve Space

**PROPERTY/CASUALTY**  
**LRBC FORMULA APPLICATION FOR P&C COMPANY'S A&H BUSINESS**  
**PR019 – PR026**

Line (10) Underwriting Risk Factor  
 A weighted average factor based on the amount reported in Line (5), Underwriting Risk Revenue.

	\$0 - \$3 Million	\$3-\$25 Million	Over \$25 Million
Comprehensive Medical	0.143493	0.143493	0.083893
Medicare Supplement	0.0980403	0.060333	0.060363
Dental & Vision	0.114895	0.071155	0.071155
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151



Detail Eliminated to Conserve Space





**Capital Adequacy (E) Task Force**  
**RBC Proposal Form**

- |                                                                               |                                                           |                                                                             |
|-------------------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Capital Adequacy (E) Task Force           | <input type="checkbox"/> Health RBC (E) Working Group     | <input type="checkbox"/> Life RBC (E) Working Group                         |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup                        | <input type="checkbox"/> Investment RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup                      |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group        | <input type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

<p align="right">DATE: <u>03-03-23</u></p> <p>CONTACT PERSON: <u>Crystal Brown</u></p> <p>TELEPHONE: <u>816-783-8146</u></p> <p>EMAIL ADDRESS: <u>cbrown@naic.org</u></p> <p>ON BEHALF OF: <u>Health Risk-Based Capital (E) Working Grp</u></p> <p>NAME: <u>Steve Drutz</u></p> <p>TITLE: <u>Chief Financial Analyst/Chair</u></p> <p>AFFILIATION: <u>WA Office of Insurance Commissioner</u></p> <p>ADDRESS: <u>5000 Capitol Blvd SE</u>  <u>Tumwater, WA 98501</u></p>	<p align="center"><b>FOR NAIC USE ONLY</b></p> <p>Agenda Item # <u>2022-17-CA</u></p> <p>Year <u>2023</u></p> <p align="center"><b>DISPOSITION</b></p> <p><input type="checkbox"/> ADOPTED _____</p> <p><input type="checkbox"/> REJECTED _____</p> <p><input type="checkbox"/> DEFERRED TO _____</p> <p><input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____</p> <p><input type="checkbox"/> EXPOSED _____</p> <p><input type="checkbox"/> OTHER (SPECIFY) _____</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

- Health RBC Blanks     Property/Casualty RBC Blanks     Life and Fraternal RBC Instructions
- Health RBC Instructions     Property/Casualty RBC Instructions     Life and Fraternal RBC Instructions
- OTHER \_\_\_\_\_

**DESCRIPTION OF CHANGE(S)**

Clarify the instructions for stop loss premiums in the Underwriting Risk – Experience Fluctuation Risk, Other Underwriting Risk and Stop Loss Interrogatories.

**REASON OR JUSTIFICATION FOR CHANGE \*\***

Provide clarity on reporting stop loss premiums in the RBC formula.

**Additional Staff Comments:**

\*\* This section must be completed on all forms.

Revised 7-2022


  
 Detail Eliminated to Conserve Space
   
**UNDERWRITING RISK - L(1) THROUGH L(21)**
  
 XR013

Underwriting Risk is the largest portion of the risk-based capital charge for most reporting entities. The Underwriting Risk page generates the RBC requirement for the risk of fluctuations in underwriting experience. The credit that is allowed for managed care in this page comes from the Managed Care Credit Calculation page.

Underwriting risk is present when the next dollar of unexpected claim payments comes directly out of the reporting entity’s capital and surplus. It represents the risk that the portion of premiums intended to cover medical expenses will be insufficient to pay such expense. For example, a reporting entity may charge an individual \$100 in premium in exchange for a guaranty that all medical costs will be paid by that reporting entity. If the individual incurs \$101 in claims costs, the reporting entity’s surplus will decline because it did not charge a sufficient premium to pick up the additional risk for that individual.

There are other arrangements where the reporting entity is not at risk for excessive claims payments, such as when an HMO agrees to serve as a third-party administrator for a self-insured employer. The self-insured employer pays for actual claim costs, so the risk of excessive claims experience is borne by the self-insured employer, not the reporting entity. The underwriting risk section of the formula, therefore, requires some adjustments to remove non-underwriting risk business (both premiums and claims) before the RBC requirement is calculated. Appendix 1 contains commonly used terms for general types of health insurance. Refer to INT 05-05: Accounting for Revenue under Medicare Part D Cover for terms specifically used with respect to Medicare Part D coverage of prescription drugs.

**Claims Experience Fluctuation**

The RBC requirement for claims experience fluctuation is based on the greater of the following calculations:

A. Underwriting risk revenue, times the underwriting risk claims ratio, times a set of tiered factors. The tiered factors are determined by the underwriting risk revenue volume.

or

B. An alternative risk charge that addresses the risk of catastrophic claims on any single individual. The alternative risk charge is equal to multiple of the maximum retained risk on any single individual in a claims year. The maximum retained risk (level of potential claim exposure) is capped at \$750,000 per individual and \$1,500,000 total for medical coverage; \$25,000 per individual and \$50,000 total for all other coverage except Medicare Part D coverage and \$25,000 per individual and \$150,000 total for Medicare Part D coverage. Additionally, for multi-line organizations (e.g., writing more than one coverage type), the alternative risk charge for each subsequent line of business is reduced by the amount of the highest cap. For example, if an organization is writing both comprehensive medical (with a cap of \$1,500,000) and dental (with a cap of \$50,000), then only the larger alternative risk charge is considered when calculating the RBC requirement (i.e., the alternative risk charges for each line of business are not cumulative).

For RBC reports to be filed by a health organization commencing operations in this reporting year, the health organization shall estimate the initial RBC levels using operating (revenue and expense) projections (considering managed care arrangements) for its first full year (12 months) of managed care operations. The projections, including the risk-based capital requirement, should be the same as those filed as part of a comprehensive business plan that is submitted as part of the application for licensure. The Underwriting, Credit (capitation risk only), and Business Risk sections of the first RBC report submitted shall be completed using the health organization’s actual operating data for the period from the commencement of operations until year-end, plus projections for the number of months necessary to provide 12 months of data. The affiliate, asset and portions of the credit risk section that are based on balance sheet information shall be reported using actual data. For subsequent years’ reports, the RBC results for all of the formula components shall be calculated using actual data.

**L(1) through L(21)**

There are six lines of business used in the formula for calculating the RBC requirement for this risk: (1) Comprehensive Medical and Hospital; (2) Medicare Supplement; (3) Dental/Vision; (4) Stand-Alone Medicare Part D Coverage; (5) Other Health; and (6) Other Non-Health. Each of these lines of business has its own column in the Underwriting Risk – Experience Fluctuation Risk table. The categories listed in the columns of this page include all risk revenue and risk revenue that is received from another reporting entity in exchange for medical services provided to its members. The descriptions of the items are described as follows:

**Column (1) - Comprehensive Medical & Hospital.** Includes policies providing for medical coverages including hospital, surgical, major medical, Medicare risk coverage (but NOT Medicare Supplement), and Medicaid risk coverage. This category DOES NOT include administrative services contracts (ASC), administrative services only (ASO) contracts, or any non-underwritten business. These programs are reported in the Business Risk section of the formula. Neither does it include Federal Employees Health Benefit Plan (FEHBP) or TRICARE, which are handled in Line 24 of this section. Medicaid Pass-Through Payments reported as premiums should also be excluded from this category and should be reported in Line 25.2 of this section. The alternative risk charge, which is twice the maximum retained risk after reinsurance on any single individual, cannot exceed \$1,500,000. Prescription drug benefits included in major medical insurance plans (including Medicare Advantage plans with prescription drug coverage) should be reported in this line. These benefits should also be included in the Managed Care Credit calculation.

**Column (2) - Medicare Supplement.** This is business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement and includes Medicare Select. Medicare risk business is reported under comprehensive medical and hospital.

**Column (3) - Dental & Vision.** This is limited to policies providing for dental-only or vision-only coverage issued as a stand-alone policy or as a rider to a medical policy, which is not related to the medical policy through deductibles or out-of-pocket limits.

**Column (4) - Stand-Alone Medicare Part D Coverage.** This includes both individual coverage and group coverage of Medicare Part D coverage where the plan sponsor has risk corridor protection. See INT 05-05: Accounting for Revenue under Medicare Part D Coverage for definition of these terms. Medicare drug benefits included in major medical plans or benefits that do not meet the above criteria are not to be included in this line. Supplemental benefits within Medicare Part D (benefits in excess of the standard benefit design) are addressed separately on page XR015. Employer-based Part D coverage that is in an uninsured plan as defined in *SSAP No. 47—Uninsured Plans* is not to be included here.

**Column (5) – Other Health Coverages.** This includes other health coverages such as other stand-alone prescription drug benefit plans, that have not been specifically addressed in Columns (1) through (4) listed above and those lines of business addressed separately on page XR015, such as stop loss. Stop loss premiums are addressed separately in Line (25) on page XR015.

**Column (6) - Other Non-Health Coverages.** This includes life and property and casualty coverages.

The following paragraphs explain the meaning of each line of the table for computing the experience fluctuation underwriting risk RBC.

**Line (1) Premium.** This is the amount of money charged by the reporting entity for the specified benefit plan. It is the earned amount of prepayments (usually on a per member per month basis) made by a covered group or individual to the reporting entity in exchange for services to be provided or offered by such organization. However, it does not include receipts under administrative services only (ASO) contracts; or administrative services contracts (ASC); or any non-underwritten business. Nor does it include federal employees health benefit programs (FEHBP) and TRICARE. Report premium net of payments for stop-loss or other reinsurance. The amounts reported in the individual columns should come directly from Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement. For Stand-Alone Medicare Part D Coverage the premium includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D payment demonstration amounts and risk corridor payment adjustments. See INT 05-05: Accounting for Revenue under Medicare Part D Coverage for definition of these terms. It

does not include revenue received for reinsurance payments or low-income subsidy (cost-sharing portion), which are considered funds received for uninsured plans in accordance with Emerging Accounting Issues Working Group (EAIWG) INT. No. 05-05. Also exclude the beneficiary premium (supplemental benefit portion) for Stand-Alone Medicare Part D coverage.

**NOTE:** Where premiums are paid on a monthly basis, they are generally fully earned at the end of the month for which coverage is provided. In cases where the mode of payment is less frequent than monthly, a portion of the premium payment will be unearned at the end of any given reporting period.

Line (2) Title XVIII Medicare. This is the earned amount of money charged by the reporting entity (net of reinsurance) for Medicare risk business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicare subscribers. This includes the beneficiary premium and federal government's direct subsidy for prescription drug coverage under MA-PD plans. The total of this line will tie to the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement.

Line (3) Title XIX Medicaid. This is the earned amount of money charged by the reporting entity for Medicaid risk business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicaid subscribers. The total of this line will tie to the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement. Stand-Alone Medicare Part D coverage of low-income enrollees is not included in this line.

Line (4) Other Health Risk Revenue. This is earned amounts charged by the reporting entity as a provider or intermediary for specified medical (e.g., full professional, dental, radiology, etc.) services provided to the policyholders, or members of another insurer or health entity. Unlike premiums, which are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payments, made by another insurer or health entity to the reporting entity in exchange for services to be provided or offered by such organization. Payments to providers under risk revenue arrangements are included in the RBC calculation as underwriting risk revenue and are included in the calculation of managed care credits. Exclude fee-for-service revenue received by the reporting entity from another reporting entity. This revenue is reported in the Business Risk section of the formula as non-underwritten and limited risk revenue. The amounts reported in the individual columns will come directly from Page 7, Line 4 of the annual statement.

Line (5) Medicaid Pass-Through Payments Reported as Premiums. Medicaid Pass-Through Payments that are included as premiums in the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 should be reported in this line.

Line (6) Underwriting Risk Revenue. The sum of Lines (1) through (4) minus Line (5).

Line (7) Net Incurred Claims. Claims incurred (paid claims + change in unpaid claims) during the reporting year (net of reinsurance) that are arranged for or provided by the reporting entity. Paid claims include capitation and all other payments to providers for services to members of the reporting entity, as well as reimbursement directly to members for covered services. Paid claims also include salaries paid to reporting entity employees that provide medical services to members and related expenses. Do not include ASC payments or federal employees health benefit program (FEHBP) and TRICARE claims. These amounts are found on Page 7, Line 17 of the annual statement.

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in INT 05-05: Accounting for Revenue under Medicare Part D Coverage). Where there has been prepayment under the reinsurance coverage, paid claims should be offset from the cumulative deposits. Unpaid claims liabilities should reflect expected recoveries from the reinsurance coverage, for claims unpaid by the PDP or for amounts covered under the reinsurance coverage that exceed the cumulative deposits. Where there has not been any prepayment under the reinsurance coverage, unpaid claim liabilities should reflect expected amounts still due from CMS. Exclude the beneficiary incurred claims (supplemental benefit portion) for Stand-Alone Medicare Part D coverage and report the incurred claims amount (supplemental benefit portion) on Line (25.1) of page XR015.

Line (8) Medicaid Pass-Through Payments Reported as Claims. Medicaid Pass-Through Payments that are included as claims in the Analysis of Operations by Lines of Business, Page 7, Line 17 should be reported in this line.

Line (9) Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims, Line (7) minus Line (8).

Line (10) Fee-for-Service Offset. Report fee for service revenue that is directly related to medical expense payments. The fee for service line does not include revenue where there is no associated claim payment (e.g., fees from non-member patients where the provider receives no additional compensation from the reporting entity) and when such revenue was excluded from the pricing of medical benefits. The amounts reported in the individual columns should come directly from Page 7, Line 3 of the annual statement.

Line (11) Underwriting Risk Incurred Claims, Line (9) minus Line (10).

Line (12) Underwriting Risk Claims Ratio, For Columns (1) through (5), Line (11) / Line (6). If either Line (6) or Line (11) is zero or negative, Line (12) is zero.

Line (13) Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (6), Underwriting Risk Revenue. The factors for Column (1) through (3) have incorporated an investment income yield of 0.5%.

	\$0 – \$3 Million	\$3 – \$25 Million	Over \$25 Million
Comprehensive Medical & Hospital	0.1493	0.1493	0.0893
Medicare Supplement	0.1043	0.0663	0.0663
Dental & Vision	0.1195	0.0755	0.0755
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151
Other Health	0.130	0.130	0.130
Other Non-Health	0.130	0.130	0.130

The investment income yield was incorporated into the Comprehensive Medical & Hospital, Medicare Supplement and Dental & Vision lines of business. The purpose was to incorporate an offset to reduce the underwriting risk factor for investment income earned by the insurer. The Working Group incorporated a 0.5% income yield that was based on the yield of a 6-month US Treasury Bond. Each year, the Working Group will identify the yield of the 6-month Treasury bond (U.S. Department of the Treasury) on each Monday through the month of January and determine if further modifications to the 0.5% adjustment are needed. Any adjustments will be rounded up to the nearest 0.5%.

Line (14) Base Underwriting Risk RBC, Line (6) x Line (12) x Line (13).

Line (15) Managed Care Discount. For Comprehensive Medical & Hospital, Medicare Supplement (including Medicare Select) and Dental/Vision, a managed care discount, based on the type of managed care arrangements an organization has with its providers, is included to reflect the reduction in the uncertainty about future claim payments attributable to the managed care arrangements. The discount factor is from Column (3), Line (17) of the Managed Care Credit Calculation page. An average factor based on the combined results of these three categories is used for all three.

For Stand-Alone Medicare Part D Coverage, a separate managed care discount (or federal program credit) is included to reflect only the reduction in uncertainty about future claims payments attributable to federal risk arrangements. The discount factor is from Column (4), Line (17) of the Managed Care Credit Calculation page.

There is no discount given for the Other Health and Other Non-Health lines of business.

Line (16) RBC After Managed Care Discount, Line (14) x Line (15).



Line (17) Maximum Per-Individual Risk After Reinsurance. This is the maximum after-reinsurance loss for any single individual. Where specific stop-loss reinsurance protection is in place, the maximum per-individual risk after reinsurance is equal to the highest attachment point on such stop-loss reinsurance, subject to the following:

- Where coverage under the stop-loss protection (plus retention) with the highest attachment point is capped at less than \$750,000 per member, the maximum retained loss will be equal to such attachment point plus the difference between the coverage (plus retention) and \$750,000.
- Where the stop-loss layer is subject to participation by the reporting entity, the maximum retained risk as calculated above will be increased by the reporting entity's participation in the stop-loss layer (up to \$750,000 less retention).

If there is no specific stop-loss or reinsurance in place, enter \$9,999,999.

Examples of the calculation are presented below:

**EXAMPLE 1 (Reporting entity provides Comprehensive Care):**

Highest Attachment Point (Retention) Reinsurance Coverage	\$ 100,000
Maximum reinsured coverage	90% of \$500,000 in excess of \$100,000 \$600,000 (\$100,000 + \$500,000)
Maximum Ret. Risk =	\$100,000 deductible + \$150,000 (\$750,000 – \$600,000) + \$ 50,000 (10% of (\$600,000 – \$100,000) coverage layer) = \$300,000

**EXAMPLE 2 (Reporting entity provides Comprehensive Care):**

Highest Attachment Point (Retention) Reinsurance Coverage	\$75,000
Maximum reinsured coverage	90% of \$1,000,000 in excess of \$75,000 \$1,075,000 (\$75,000 + \$1,000,000)
Maximum Ret. Risk =	\$ 75,000 deductible + 0 (\$750,000 – \$1,075,000) + \$ 67,500 (10% of (\$750,000 – \$75,000)) coverage layer = \$142,500

Line (18) Alternate Risk Charge. This is twice the amount in Line (17) for columns (1), (2), (3) and (5) and Column (4) is six times the amount in Line (17), subject to a maximum of \$1,500,000 for Column (1), \$50,000 for Columns (2), (3) and (5) and \$150,000 for Column (4). Column (6) is excluded from this calculation.

Line (19) Alternate Risk Adjustment. This line shows the largest value in Line (18) for the column and all columns left of the column. Column (6) is excluded from this calculation.

Line (20) Net Alternate Risk Charge. This is the amount in Line (18), less the amount in the previous column of Line (19), but not less than zero. Column (6) is excluded from this calculation.

Line (21) Net Underwriting Risk RBC. This is the maximum of Line (16) and Line (20) for each of columns (1) through (5). This is the amount in Line (14), Column (6). The amount in Column (7) is the sum of the values in Columns (1) through (6).

#### **OTHER UNDERWRITING RISK – L(22) THROUGH L(45) XR015–XR017**

In addition to the general risk of fluctuations in the claims experience, there is an additional risk generated when reporting entities guarantee rates for extended periods beyond one year. If rate guarantees are extended between 15 and 36 months from policy inception, a factor of 0.024 is applied against the direct premiums earned for those guaranteed policies. Where a rate guaranty extends beyond 36 months, the factor is increased to 0.064. This calculation only applies to those lines of accident and health business, which include a medical trend risk, (i.e., Comprehensive Medical, Medicare Supplement, Dental/Vision, Stand-Alone Medicare Part D Coverage, Supplemental benefits within Medicare Part D Coverage, Stop-Loss, and Minimum Premium). Premiums entered should be earned premium for the current calendar year period and not for the entire period of the rate guarantees. Premium amounts should be shown net of reinsurance only when the reinsurance ceded premium is also subject to the same rate guarantee.

A separate risk factor has been established to recognize the reduced risk associated with safeguards built into the Federal Employees Health Benefit Program (FEHBP) created under Section 8909(f)(1) of Title 5 of the United States Code and TRICARE business. Claims incurred are multiplied by two percent to determine total underwriting RBC on this business.

The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group in 2016 to apply a tiered risk factor approach to the Stop-Loss Premium. The premiums for this coverage should not be included within Comprehensive Medical or Other Health Coverages (Page XR013) It is not expected that the transfer of risk through the various managed care credits will reduce the risk of stop-loss coverage. Medical Stop-Loss exhibits a much higher variability than Comprehensive Medical. A factor of 35 percent will be applied to the first \$25,000,000 in premium and a factor of 25 percent will be applied to premium in excess of \$25,000,000. Stop loss premiums should be reported on a net basis.

Line (25.1) Supplemental Benefits within Stand-Alone Medicare Part D Coverage. A separate risk factor has been established to recognize the different risk (as described in INT 05-05: Accounting for Revenue under Medicare Part D Coverage) for the incurred claims associated with the beneficiaries for these supplemental drug benefits.

Line (25.2) Medicaid Pass-Through Payments Reported as Premium. The treatment of Medicaid Pass-Through Payments varies from state to state, and in some instances is treated as premium. The Health Risk-Based Capital Working Group however, determined that the risk associated with these payments is more administrative in nature and similar to uninsured plans. As such, the Working Group determined that the charge should follow that of the uninsured plans (ASC and ASO) and apply a 2 percent factor charge to those Medicaid Pass-Through Payments reported as premiums. This amount should be equal to the amount reported on page XR013, Column (1), Line (5).

Lines (26) through (32) Disability Income. Disability Income Premiums are to be separately entered depending upon category (Individual and Group). For Individual Disability Income, a further split is between noncancellable (NC) or other (guaranteed renewable, etc.). For Group Disability Income, the further splits are between Credit Monthly Balance, Credit Single Premium (with additional reserves), Credit Single Premium (without additional reserves), Group Long-Term (benefit periods of two years or longer) and Group Short-Term (benefit periods less than two years). The RBC factors vary by the amount of premium reported such that a higher factor is applied to amounts below \$50,000,000 for similar types. In determining the premiums subject to the higher factors, Individual Disability Income NC and Other are combined. All types of Group and Credit Disability Income are combined in a different category from Individual.

#### **STOP LOSS ELECTRONIC ONLY TABLES**

The Health Risk-Based Capital (E) Working Group revised the stop loss factors in 2017. The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group and suggested that the factors be revised based on data from 1998-2008. The Health Risk-Based Capital (E) Working Group agreed to continue analyzing the stop loss factors as a result of the changes to life-time maximum amounts included in the Federal Affordable Care Act.

**Electronic Table 1 – Stop Loss Interrogatories**

The interrogatories are designed to gather the information by product type and will be reviewed on a go-forward basis. The data will be used in the continued evaluation of the factors. The data collected will be collected on a one-year run-out basis. For example, the RBC filed at year-end 2019, will reflect the incurred data for calendar year 2018 run-out through December 31, 2019.

For those insurers where the stop loss gross premium written is both under \$2,000,000 and is less than 10% of the insurer’s total gross premium written are exempt from completing Table 1.

The categories used in the interrogatories are separated as follows:

**Product Type**

Specific Stop Loss = (including aggregating specific). This coverage was included in the 1998 to 2008 factor development.

Aggregate Stop Loss = This coverage was included in the 1998 to 2008 factor development.

HMO Reinsurance = specific reinsurance of an HMO’s commercial, Medicare, Medicaid or Point of Service products. This coverage was not included in the 1998 to 2008 factor development.

Provider Excess = specific excess written on Providers including IPAs, hospitals, clinics. This coverage was not included in the 1998 to 2008 factor development.

Medical Excess Reinsurance = specific reinsurance of an insurance company’s medical business (first dollar or self-insured). This coverage was not included in the 1998 to 2008 factor development.

**Do not include quota share or excess reinsurance written on Stop Loss business.**

Calendar Year - Submit experience information for the calendar year preceding the year for which the RBC report is being filed, e.g., the RBC report filed for 2019 should provide experience information for calendar year 2018 with run-out through December 31, 2019. If the contract year does not follow a calendar year (i.e. 7/1-6/30), the impact on the interrogatories would be spread across two years in the same manner it would be reported in two annual statements (i.e., half of premium and the applicable portion of the liability/expense would hit the first year, the remainder would hit the second year). Report based on the calendar year even if the calendar year includes two separate contracts (For example: Contract 1 started on 7/1/2017 and ran through 6/30/2018. Contract 2 started on 7/1/2018 and ran through 6/30/2019. The 2018 calendar year experience information would be comprised of the experience information in Contract 1 from 1/1/2018 through 6/30/2018 AND Treaty 2 from 7/1/2018 to 12/31/2018.). Contracts that do not follow a calendar year should NOT be excluded.

Total [Gross/Net] Premium - This is the [gross/net] premium revenue, [before/after] ceded reinsurance and including commissions. Report the data as reported for the prior calendar year including amounts paid for the prior year through the end of the current calendar year. Do not adjust for any anomalies in the experience.

Total Gross Claims + Expenses =

Total Gross Claims – These are the gross incurred claims, before ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining gross claim liability.  
+



Expenses – These are the gross incurred expense during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Gross Combined Ratio - This is equal to (Total Gross Claims + Expenses) / Total Gross Premium.

Premiums Net of Reinsurance – This is the net premium revenue, net of reinsurance. Report data as reported in the annual statement and do not adjust for any anomalies in the experience.

Total Net Claims + Expenses =  
Total Net Claims – These are the net incurred claims after ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining net claim liability.  
 +  
Expenses – These are the net incurred expenses during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Net Combined Ratio – This is equal to (Total Net Claims + Expenses)/Premiums Net of Reinsurance.

**Electronic Table 2a – Calendar Year Specific Stop Loss Contracts by Group Size and Table 2b – Calendar Year Aggregate Stop Loss Contracts by Group Size**

For those insurers where the stop loss gross premium written is both under \$2,000,000 and is less than 10% of the insurer’s total gross premium written are exempt from completing Table 2.

Table 2a should reflect the specific stop loss data and Table 2b should reflect the aggregate stop loss data.

Report the number of groups, average specific attachment point and average aggregate attachment as of December 31<sup>st</sup> of the calendar (reporting) year. If the contract does not follow a calendar year (i.e. 7/1-6/30), report the policies written during the year of the annual statement and in effect at the end of the calendar year.

The number of covered lives in a group (group size) should be based on the size of the group as of December 31 of the calendar year. The number of covered lives counted should include all enrolled members (that is, total number of lives insured, including dependents).

Number of Groups – list the number of groups for each stop-loss contract based on the number of covered lives in the group.

Average Specific Attachment Point (Table 2a) – The average should be weighted by the number of covered lives in the respective group size bracket, excluding the count of covered lives within the denominator where specific/aggregate coverage was not provided.

Example: Average Specific Attachment Point (\$) (Table 2a, 50-99 Covered Lives in Group) =  
 (Sum of Specific Attachment Points X Reported Lives) / (Sum of Reported Lives)

Insured Group	Specific Att Point (\$)	Aggregate Att (%)	Number of Lives		Reason to Exclude	
			Include	Exclude	Include	Exclude
1	\$200,000	115%	90		Include	
2	\$100,000	120%	60		Include	
3	\$50,000	140%	40		Exclude	Not in Group Size Band

4                    \$120,000                    N/A                    50                    Include  
 Calculation:                     $(200,000 \times 90 + 100,000 \times 60 + 120,000 \times 50) / (90 + 60 + 50) = \$150,000$

Average Aggregate Attachment Percentage (Table 2b) – Is based on expected claims. Subgroups that have separate stop loss contracts should be aggregated in terms of determining the group size. The average should be weighted by expected claims in the respective group size bracket, excluding the expected claims within the denominator where aggregate coverage was not provided.

Example: Average Aggregate Attachment Percentage (%) (Table 2b, 50-99 Covered Lives in Group) =  $(\text{Sum of Expected Claims} \times \text{Attachment Percentage} \%) / (\text{Sum of Expected Claims})$

Insured Group	Specific Att Point (\$)	Aggregate Att (%)	Expected Claims	Number of Lives	Reason to	
					Exclude	Exclude
1	\$200,000	115%	\$ 500,000	90	Include	
2	\$100,000	120%	\$ 300,000	60	Include	
3	\$50,000	140%	\$ 200,000	40	Exclude	Not in Group Size Band
4	\$120,000	N/A	\$ 400,000	50	Exclude	Aggregate not purchased by group

Calculation:  $(500,000 \times 115\% + 300,000 \times 120\%) / (500,000 + 300,000) = 116.7\%$

Footnote – The number of covered lives for stop loss coverage is reported in the Accident and Health Policy Experience Exhibit for Year (April 1<sup>st</sup> filing) in Column 13, Section C. Other Business, Line 2.

If stop loss policies are sold on a Per Employee Per Month basis and the actual number of covered lives is unknown, it would be reasonable to estimate the number of covered lives if the exact information is not administratively available to the reporting entity. This method of estimation may be similar to estimations provided for the Accident and Health Policy Experience Exhibit for Year. If estimated, an explanation of the method used to estimate the number of covered lives should be provided in the footnote.



Detail Eliminated to Conserve Space

**APPENDIX 1 – COMMONLY USED TERMS**

The Definitions of Commonly Used Terms are frequently duplicates from the main body of the text. If there are any inconsistencies between the definitions in this section and the definitions in the main body of the instructions, the main body definition should be used.



Detail Eliminated to Conserve Space

**Stop-Loss Coverage** – Coverage for a self-insured group plan, a provider/provider group or non-proportional reinsurance of a medical insurance product. Coverage may apply on a specific basis, an aggregate basis or both. Specific coverage means that the stop-loss carrier's risk begins after a minimum of at least \$5,000 of claims for any

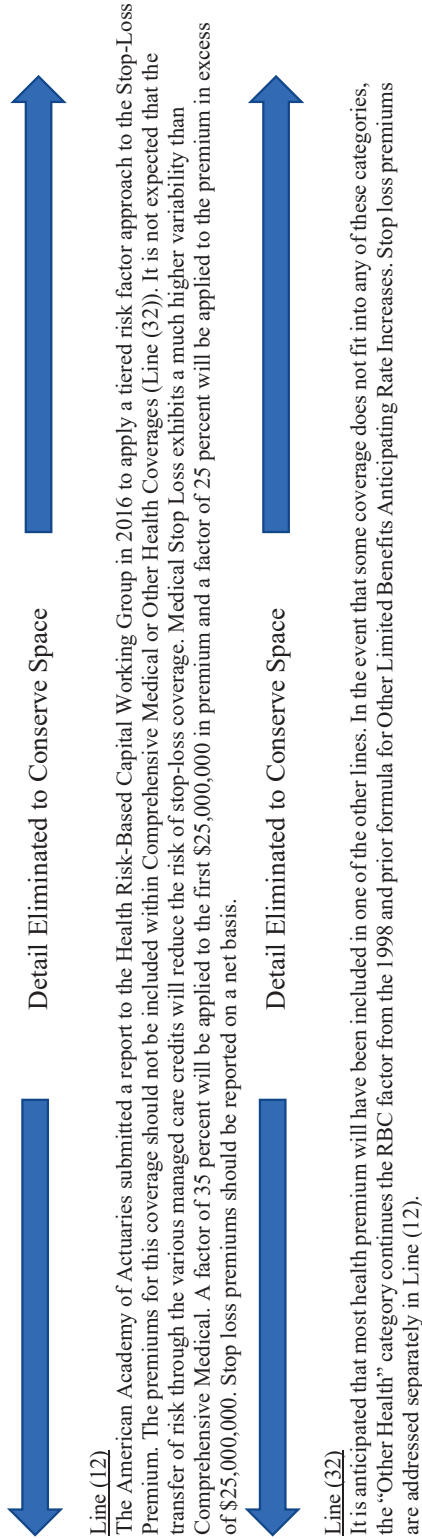
one covered Life has been covered by the group plan, provider/provider group or direct writer. Aggregate coverage means that the stop-loss carrier's risk begins after the group plan, provider/provider group or direct writer has retained at least 90 percent of expected claims, or the economic equivalent.



Detail Eliminated to Conserve Space

**HEALTH PREMIUMS and HEALTH CLAIMS RESERVES**

LR019, LR023 and LR024



Stop Loss Electronic Only Tables

The Health Risk-Based Capital (E) Working Group revised the stop loss factors in 2017. The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group and suggested that the factors be revised based on data from 1998-2008. The Health Risk-Based Capital (E) Working Group agreed to continue analyzing the stop loss factors as a result of the changes to life time maximum amounts included in the Federal Affordable Care Act.

Electronic Table 1 – Stop Loss Interrogatories

The interrogatories are designed to gather the information by product type and will be reviewed on a go forward basis. The data will be used in the continued evaluation of the factors. The data collected will be collected on a one-year run-out basis. For example, the RBC filed at year-end 2018, will reflect the incurred data for calendar year 2017 run-out through December 31<sup>st</sup>, 2018.

For those insurers where the stop loss gross premium written is both under \$2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 1.

The categories used in the interrogatories are separated as follows:

Product Type

Specific Stop Loss = (including aggregating specific). This coverage was included in the 1998 to 2008 factor development.  
Aggregate Stop Loss = This coverage was included in the 1998 to 2008 factor development.

HMO Reinsurance = specific reinsurance of an HMO’s commercial, Medicare, Medicaid or Point of Service products. This coverage was not included in the 1998 to 2008 factor development.  
 Provider Excess = specific excess written on Providers including IPAs, hospitals, clinics. This coverage was not included in the 1998 to 2008 factor development.  
 Medical Excess Reinsurance = specific reinsurance of an insurance company’s medical business (first dollar or self-insured). This coverage was not included in the 1998 to 2008 factor development.

Please do not include quota share or excess reinsurance written on Stop Loss business.

Calendar Year - Submit experience information for the calendar year preceding the year for which the RBC report is being filed; e.g., the RBC report filed for 2018 should provide experience information for calendar year 2017 with run-out through December 31<sup>st</sup>, 2018. If the contract year does not follow a calendar year (i.e. 7/1-6/30), the impact on the interrogatories would be spread across two years in the same manner it would be reported in two annual statements (i.e., half of premium and the applicable portion of the liability/expense would hit the first year, the remainder would hit the second year). Report based on the calendar year even if the calendar year includes two separate contracts (For example: Contract 1 started on 7/1/2017 and ran through 6/30/2018. Contract 2 started on 7/1/2018 and ran through 6/30/2019. The 2018 calendar year experience information would be comprised of the experience information in Contract 1 from 1/1/2018 through 6/30/2018 AND Treaty 2 from 7/1/2018 to 12/31/2018.). Contracts that do not follow a calendar year should NOT be excluded.

Total [Gross/Net] Premium - This is the [gross/net] premium revenue, [before/after] ceded reinsurance and including commissions. Report the data as reported for the prior calendar year including amounts paid for the prior year through the end of the current calendar year. Do not adjust for any anomalies in the experience.

Total Gross Claims + Expenses =

Total Gross Claims - These are the gross incurred claims, before ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining gross claim liability.

+

Expenses – These are the gross incurred expense during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Gross Combined Ratio - This is equal to (Total Gross Claims + Expenses) / Total Gross Premium.

Premiums Net of Reinsurance – This is the net premium revenue, net of reinsurance. Report data as reported in the annual statement and do not adjust for any anomalies in the experience.

Total Net Claims + Expenses =

Total Net Claims - These are the net incurred claims after ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining net claim liability.

+

Expenses – These are the net incurred expenses during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Net Combined Ratio – This is equal to I(Total Net Claims + Expenses)/Premiums Net of Reinsurance.

Table 2a – Calendar Year **Specific** Stop Loss Contracts By Group Size and Table 2b – Calendar Year Aggregate Stop Loss Contracts by Group Size

For those insurers where the stop loss gross premium written is both under \$2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 2.

**Table 2a should reflect the specific stop loss data and Table 2b should reflect the aggregate stop loss data.**

Report the number of groups, average specific attachment point and average aggregate attachment as of December 31<sup>st</sup> of the calendar (reporting) year. If the contract does not follow a calendar year (i.e. 7/1-6/30), report the policies written during the year of the annual statement and in effect at the end of the calendar year.

The number of covered lives in a group (group size) should be based on the size of the group as of December 31 of the calendar year. The number of covered lives counted should include all enrolled members (that is, **total number of lives insured, including dependents**).

Number of Groups – list the number of groups for each stop loss contract based on the number of covered lives in the group.

Average Specific Attachment Point (**Table 2a**) – The average should be weighted by the number of covered lives in the respective group size bracket, excluding the count of covered lives within the denominator where specific/aggregate coverage was not provided.

Example: Average Specific Attachment Point (\$) (Table 2a, 50-99 Covered Lives in Group) =  
(Sum of Specific Attachment Points X Reported Lives) / (Sum of Reported Lives)

Insured Group	Specific Att Point (\$)	Aggregate Att (%)	Number of Lives	Reason to	
				Include	Exclude
1	\$ 200,000	115%	90	Include	
2	\$ 100,000	120%	60	Include	
3	\$ 50,000	140%	40	Exclude	Not in Group Size Band
4	\$ 120,000	N/A	50	Include	

Calculation:  $(200,000 \times 90 + 100,000 \times 60 + 120,000 \times 50) / (90 + 60 + 50) = \$150,000$

Average Aggregate Attachment Percentage (Table 2b) – Is based on expected claims. Subgroups that have separate stop loss contracts should be aggregated in terms of determining the group size. The average should be weighted by expected claims in the respective group size bracket, excluding the count of covered lives within the denominator where aggregate coverage was not provided.

Example: Average Aggregate Attachment Percentage (%) (Table 2b, 50-99 Covered Lives in Group) =  
(Sum of Expected Claims x Attachment Percentage %) / (Sum of Expected Claims)

Insured Group	Specific Att Point (\$)	Aggregate Att (%)	Expected Claims	Number of Lives	Reason to	
					Include	Exclude
1	\$ 200,000	115%	\$ 500,000	90	Include	
2	\$ 100,000	120%	\$ 300,000	60	Include	

3	\$ 50,000	140%	\$ 200,000	40	Exclude	Not in Group Size Band
4	\$ 120,000	N/A	\$ 400,000	50	Exclude	Aggregate not purchased by group

Calculation:  $(500,000 \times 115\% + 300,000 \times 120\%) / (500,000 + 300,000) = 116.7\%$

Footnote – The number of covered lives for stop loss coverage is reported in the Accident and Health Policy Experience Exhibit for Year (April 1<sup>st</sup> filing) in Column 6, Section C. Other Business, Line 2.

If stop loss policies are sold on a Per Employee Per Month basis and the actual number of covered lives is unknown, it would be reasonable to estimate the number of covered lives if the exact information is not administratively available to the reporting entity. This method of estimation may be similar to estimations provided for the Accident and Health Policy Experience Exhibit for Year. If estimated, an explanation of the method used to estimate the number of covered lives should be provided in the footnote.



**LRBC FORMULA APPLICATION FOR P&C COMPANY'S A&H BUSINESS  
PR019 – PR026**

PR019 - Health Premiums



Detail Eliminated to Conserve Space



Line (9)

The American Academy of Actuaries submitted a report to the Health Risk-Based Capital Working Group in 2016 to apply a tiered risk factor approach to the Stop-Loss Premium. The premiums for this coverage should not be included within Comprehensive Medical or Other Health Coverages (Line (25)). It is not expected that the transfer of risk through the various managed care credits will reduce the risk of stop-loss coverage. Medical Stop Loss exhibits a much higher variability than Comprehensive Medical. A factor of 35 percent will be applied to the first \$25,000,000 in premium and a factor of 25 percent will be applied to the premium in excess of \$25,000,000. Stop loss premiums should be reported on a net basis.



Detail Eliminated to Conserve Space



Line (25)

Most Health Premium will have been included in one of the prior lines. In the event that some coverage does not fit into any of these categories, "Other Health" category is applied with a 12% factor, which is from 1998 formula for Other Limited Benefits Anticipating Rate Increases. Stop loss premiums are addressed separately in Line (9).

Stop Loss Electronic Only Tables

The Health Risk-Based Capital (E) Working Group revised the stop loss factors in 2017. The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group and suggested that the factors be revised based on data from 1998-2008. The Health Risk-Based Capital (E) Working Group agreed to continue analyzing the stop loss factors as a result of the changes to life-time maximum amounts included in the Federal Affordable Care Act.

Electronic Table 1 – Stop Loss Interrogatories

The interrogatories are designed to gather the information by product type and will be reviewed on a go-forward basis. The data will be used in the continued evaluation of the factors. The data collected will be collected on a one-year run-out basis. For example, the RBC filed at year-end **18**, will reflect the incurred data for calendar year **2017** run-out through December 31, **2018**.

For those insurers where the stop loss gross premium written is both under \$2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 1.

The categories used in the interrogatories are separated as follows:

Product Type



Specific Stop Loss = (including aggregating specific). This coverage was included in the 1998 to 2008 factor development.  
 Aggregate Stop Loss = This coverage was included in the 1998 to 2008 factor development.  
 HMO Reinsurance = specific reinsurance of an HMO's commercial, Medicare, Medicaid or Point of Service products. This coverage was not included in the 1998 to 2008 factor development.  
 Provider Excess = specific excess written on Providers including IPAs, hospitals, clinics. This coverage was not included in the 1998 to 2008 factor development.  
 Medical Excess Reinsurance = specific reinsurance of an insurance company's medical business (first dollar or self-insured). This coverage was not included in the 1998 to 2008 factor development.

Please do not include quota share or excess reinsurance written on Stop Loss business.

Calendar Year - Submit experience information for the calendar year preceding the year for which the RBC report is being filed; e.g., the RBC report filed for **2019** should provide experience information for calendar year **2018** with run-out through December 31, **2019**. If the contract year does not follow a calendar year (i.e. 7/1-6/30), the impact on the interrogatories would be spread across two years in the same manner it would be reported in two annual statements (i.e., half of premium and the applicable portion of the liability/expense would hit the first year, the remainder would hit the second year). Report based on the calendar year even if the calendar year includes two separate contracts (For example: Contract 1 started on 7/1/2017 and ran through 6/30/2018. Contract 2 started on 7/1/2018 and ran through 6/30/2019. The 2018 calendar year experience information would be comprised of the experience information in Contract 1 from 1/1/2018 through 6/30/2018 AND Treaty 2 from 7/1/2018 to 12/31/2018.). Contracts that do not follow a calendar year should NOT be excluded.

Total [Gross/Net] Premium - This is the [gross/net] premium revenue, [before/after] ceded reinsurance and including commissions. Report the data as reported for the prior calendar year including amounts paid for the prior year through the end of the current calendar year. Do not adjust for any anomalies in the experience.

Total Gross Claims + Expenses =

Total Gross Claims - These are the gross incurred claims, before ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining gross claim liability.

+

Expenses - These are the gross incurred expense during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Gross Combined Ratio - This is equal to (Total Gross Claims + Expenses) / Total Gross Premium.

Premiums Net of Reinsurance - This is the net premium revenue, net of reinsurance. Report data as reported in the annual statement and do not adjust for any anomalies in the experience.

Total Net Claims + Expenses =

Total Net Claims - These are the net incurred claims after ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining net claim liability.

+

Expenses - These are the net incurred expenses during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Net Combined Ratio - This is equal to (Total Net Claims + Expenses)/Premiums Net of Reinsurance.

Table 2a – Calendar Year Specific Stop Loss Contracts by Group Size and Table 2b – Calendar Year Aggregate Stop Loss Contract by Group Size

For those insurers where the stop loss gross premium written is both under \$2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 2.

Table 2a should reflect the specific stop loss data and Table 2b should reflect the aggregate stop loss data.

Report the number of groups, average specific attachment point and average aggregate attachment as of December 31<sup>st</sup> of the calendar (reporting) year. If the contract does not follow a calendar year (i.e. 7/1-6/30), report the policies written during the year of the annual statement and in effect at the end of the calendar year.

The number of covered lives in a group (group size) should be based on the size of the group as of December 31 of the calendar year. The number of covered lives counted should include all enrolled members (that is, total number of lives insured, including dependents).

Number of Groups – list the number of groups for each stop loss contract based on the number of covered lives in the group.

Average Specific Attachment Point (Table 2a) - The average should be weighted by the number of covered lives in the respective group size bracket, excluding the count of covered lives within the denominator where specific/aggregate coverage was not provided.

Example: Average Specific Attachment Point (\$) (Table 2a, 50-99 Covered Lives in Group) =  
(Sum of Specific Attachment Points X Reported Lives) / (Sum of Reported Lives)

Insured Group	Specific Att Point (\$)	Aggregate Att (%)	Number of Lives	Reason to	
				Include	Exclude
1	\$ 200,000	115%	90	Include	
2	\$ 100,000	120%	60	Include	
3	\$ 50,000	140%	40	Exclude	Not in Group Size Band
4	\$ 120,000	N/A	50	Include	

Calculation:  $(200,000 \times 90 + 100,000 \times 60 + 120,000 \times 50) / (90 + 60 + 50)$   
= \$150,000

Average Aggregate Attachment Percentage (Table 2b) – Is based on expected claims. Subgroups that have separate stop loss contracts should be aggregated in terms of determining the group size. The average should be weighted by expected claims in the respective group size bracket, excluding the expected claims within the denominator where aggregate coverage was not provided.

Example: Average Aggregate Attachment Percentage (%) (Table 2b, 50-99 Covered Lives in Group) =  
(Sum of Expected Claims x Attachment Percentage %) / (Sum of Expected Claims)

Insured	Specific	Aggregate	Expected	Number	Include
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Group	Att Point (\$)	Att (%)	Claims	of Lives	Exclude
1	\$ 200,000	115%	\$ 500,000	90	Include
2	\$ 100,000	120%	\$ 300,000	60	Include
3	\$ 50,000	140%	\$ 200,000	40	Exclude
4	\$ 120,000	N/A	\$ 400,000	50	Exclude

Calculation:  $(500,000 \times 115\% + 300,000 \times 120\%) / (500,000 + 300,000)$   
= 116.7%

Footnote – The number of covered lives for stop loss coverage is reported in the Accident and Health Policy Experience Exhibit for Year (April 1<sup>st</sup> filing) in Column 13, Section C. Other Business, Line 2.

If stop loss policies are sold on a Per Employee Per Month basis and the actual number of covered lives is unknown, it would be reasonable to estimate the number of covered lives if the exact information is not administratively available to the reporting entity. This method of estimation may be similar to estimations provided for the Accident and Health Policy Experience Exhibit for Year. If estimated, an explanation of the method used to estimate the number of covered lives should be provided in the footnote.

**NAIC BLANKS (E) WORKING GROUP**

Blanks Agenda Item Submission Form

<p style="text-align: right;">DATE: <u>1-26-23</u></p> <p><b>CONTACT PERSON:</b> <u>Crystal Brown</u></p> <p><b>TELEPHONE:</b> <u>816-783-8146</u></p> <p><b>EMAIL ADDRESS:</b> <u>cbrown@naic.org</u></p> <p><b>ON BEHALF OF:</b> <u>Health Risk-Based Capital (E) Working Group</u></p> <p><b>NAME:</b> <u>Steve Drutz</u></p> <p><b>TITLE:</b> <u>Chair</u></p> <p><b>AFFILIATION:</b> <u>WA Office of Insurance Commissioner</u></p> <p><b>ADDRESS:</b> _____</p>	<p style="text-align: center;"><b>FOR NAIC USE ONLY</b></p> <p>Agenda Item # _____</p> <p>Year <u>2024</u></p> <p>Changes to Existing Reporting [ ]</p> <p>New Reporting Requirement [ ]</p> <hr/> <p style="text-align: center;"><b>REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</b></p> <p>No Impact [ ]</p> <p>Modifies Required Disclosure [ ]</p> <hr/> <p style="text-align: center;"><b>DISPOSITION</b></p> <p>[ ] Rejected For Public Comment</p> <p>[ ] Referred To Another NAIC Group</p> <p>[ ] Received For Public Comment</p> <p>[ ] Adopted Date _____</p> <p>[ ] Rejected Date _____</p> <p>[ ] Deferred Date _____</p> <p>[ ] Other (Specify) _____</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- |                                                                       |                                                   |                                      |
|-----------------------------------------------------------------------|---------------------------------------------------|--------------------------------------|
| <input checked="" type="checkbox"/> ANNUAL STATEMENT                  | <input checked="" type="checkbox"/> INSTRUCTIONS  | <input type="checkbox"/> CROSSCHECKS |
| <input type="checkbox"/> QUARTERLY STATEMENT                          | <input type="checkbox"/> BLANK                    |                                      |
| <input checked="" type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts        | <input type="checkbox"/> Title       |
| <input checked="" type="checkbox"/> Property/Casualty                 | <input type="checkbox"/> Protected Cell           | <input type="checkbox"/> Other _____ |
| <input checked="" type="checkbox"/> Health                            | <input type="checkbox"/> Health (Life Supplement) |                                      |

Anticipated Effective Date: \_\_\_\_\_

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Revise the Health Test Language and General Interrogatories.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE\*\***

The purpose of this change is to clarify and create better transparency in the calculation of the premium and reserve ratios in the health test.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: \_\_\_\_\_

Other Comments:

\*\* This section must be completed on all forms.

Revised 7/18/202

**INSTRUCTIONS****For Completing Health Annual Statement Blank****GENERAL**

The annual statement is to be completed in accordance with the *Annual Statement Instructions* and *Accounting Practices and Procedures Manual* except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the health annual statement will be filed pursuant to such state's filing requirements. The domiciliary state's insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

**1. Health Statement Test:**

If a reporting entity completes the health annual statement for the reporting year, the reporting entity must complete the Health Statement Test.

The Health Statement Test is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies.

**Passing the Test:**

A reporting entity is deemed to have passed the Health Statement Test if the values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year and will continue to report on the Health Statement

**Failing the Test:**

If a reporting entity, licensed as a life, accident and health or property and casualty insurer in its domiciliary state, is required to file the health annual statement for the reporting year and does not pass the Health Statement Test in the reporting year, it will revert to the annual statement form and risk-based capital report associated with the type of license held in its domestic state in the first quarter of the second year following the reporting year. If a reporting entity, licensed as a health insurer in its domiciliary state, is required to file the health annual statement for the reporting year and does not pass the Health Statement Test in the reporting year, it should continue to file the health annual statement.

**Variances from following these instructions:**

If a reporting entity's domestic regulator requires the reporting entity to complete an annual statement form and risk-based capital report that differs from these instructions, the domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which a Health Statement Test is submitted.

**INSTRUCTIONS****GENERAL**

The annual statement is to be completed in accordance with the *Annual Statement Instructions* and *Accounting Practices and Procedures Manual* except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the life, accident and health annual statement will be filed pursuant to such state's filing requirements. The domiciliary state's insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

**1. Health Statement Test:**

If a reporting entity is licensed as a life and health insurer and completes the life, accident and health annual statement for the reporting year, the reporting entity must complete the Health Statement Test. However, a reporting entity that is required to also file the Separate Accounts Statement is not subject to the results of the Health Statement Test, and should continue to complete the life, accident and health/fraternal blank.

The Health Statement Test is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies.

**Passing the Test:**

A reporting entity is deemed to have passed the Health Statement Test if:

The values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.

If a reporting entity is a) licensed as a life and health insurer; b) completes the Life, Accident and Health annual statement for the reporting year; and c) passes the Health Statement Test (as described above), the reporting entity must complete the health statement beginning with the first quarter's statement for the second year following the reporting year in which the reporting entity passes the Health Statement Test and must also file the corresponding risk-based capital report and the life supplements for that year-end.

**Variations from following these instructions:**

If a reporting entity's domestic regulator requires the reporting entity to complete an annual statement form and risk-based capital report that differs from these instructions, the domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which a Health Statement Test is submitted.

**INSTRUCTIONS****For Completing Property and Casualty Annual Statement Blank****GENERAL**

The annual statement is to be completed in accordance with the *Annual Statement Instructions* and *Accounting Practices and Procedures Manual* except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the property and casualty annual statement will be filed pursuant to such state's filing requirements. The domiciliary state's insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

**1. Health Statement Test:**

If a reporting entity is licensed as a property and casualty insurer and completes the property and casualty annual statement for the reporting year, the reporting entity must complete the Health Statement Test. However, a reporting entity that is required to also file the Protected Cell Statement is not subject to the results of the Health Statement Test and should continue to complete the property blank.

The Health Statement Test is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies.

**Passing the Test:**

A reporting entity is deemed to have passed the Health Statement Test if:

The values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.

If a reporting entity is a) licensed as a property and casualty insurer; b) completes the property and casualty annual statement for the reporting year; and c) passes the Health Statement Test (as described above), the reporting entity must complete the health statement beginning with the first quarter's statement for the second year following the reporting year in which the reporting entity passes the Health Statement Test and must also file the corresponding risk-based capital report and the property/casualty supplements for that year-end.

**Variances from following these instructions:**

If a reporting entity's domestic regulator requires the reporting entity to complete an annual statement form and risk-based capital report that differs from these instructions, the domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which a Health Statement Test is submitted.

**PART 2 – HEALTH INTERROGATORIES**

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies.

All reporting entities should file the test.

Premium and reserve information is obtained from the annual statement sources referenced on the form ~~or from the related risk-based capital report for the corresponding premium descriptions~~ relating to the current and prior reporting periods. The premium and reserve ratios are calculated on the net basis reporting.

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Item	Description	Reporting Year Annual Statement Data	Prior Year Annual Statement Data
2.1	Premium Numerator	Health Premium values listed in the Analysis of Operations by Lines of Business, Line 1 plus Line 2, Column 2 through Column 89 plus Line 1 plus Line 2, Column 913 in part (excluding credit A&H and dread disease coverage, LTC, Disability Income) of the reporting year's annual statement.	Health Premium values listed in the Analysis of Operations by Line of Business, Line 1 plus Line 2, Column 1 through Column 9 plus Line 1 plus Line 2, Column 139 (in part (excluding for credit A&H and dread disease coverage, LTC, Disability Income) Column 10 of the reporting prior year's annual statement.
2.2	Premium Denominator	<del>Analysis of Operations by Lines of Business</del> Net Premium Income (Page 4, Line 2, Column 2) Column 1, Line 1 plus Line 2 of the reporting year's annual statement.	<del>Net Premium Income (Page 4, Line 2, Column 2)</del> Analysis of Operations by Lines of Business, Column 1, Line 1 plus Line 2 of the prior year's annual statement.
2.3	Premium Ratio	2.1/2.2	2.1/2.2
2.4 (a)	Reserve Numerator	Health Reserve – Underwriting and Investment Exhibit, Part 2B (Column 3 + 4, Line 13 minus (Lines 9, 10, 11 and any dread disease coverage reported in Line 12) plus Line 16)13 minus Line 11) exclude Line 10 health care receivables, dread disease coverage, and credit A&H) + Part 2D (Line 8+14, Column 1 minus (Columns 910, 11, 12 and any dread disease coverage reported in Column 13) )-include stand-alone health care related plans only (i.e. stand-alone prescription drug plans, etc.), exclude dread disease coverage, credit A&H, LTC, Disability Income, etc. of the reporting year's annual statement.	Health Reserve – Underwriting and Investment Exhibit, Part 2B (Column 3 + 4, Line 13 minus (Lines 9, 10, 11 and any dread disease coverage reported in Line 12) plus Line 16) 13 minus Line 11) exclude Line 10 health care receivables, dread disease coverage, and credit A&H + Part 2D (Line 8+14, Column 1 minus Columns 10, 11, 12 and any dread disease coverage reported in Column 139) include stand-alone health care related plans only (i.e. stand-alone prescription drug plans, etc.), exclude dread disease coverage, credit A&H, LTC, Disability Income, etc. of the reporting year's annual statement.
2.5	Reserve Denominator	Underwriting and Investment Exhibit, Part 2A, Col. 1, Line 4.4 plus Underwriting and Investment Exhibit, Part 2, Column 1, Line 5 plus Underwriting and Investment Exhibit, Part 2D, Col. 1, Lines 8+14 plus Page 3, Column 3, Lines 5 + 6 Claims Unpaid and Aggregate Reserves (Page 3, Column 3, Lines 1 + 2 + 4 + 7) of the reporting year's annual statement.	Underwriting and Investment Exhibit, Part 2A, Col. 1, Line 4.4 plus Underwriting and Investment Exhibit, Part 2, Column 1, Line 5 plus Underwriting and Investment Exhibit, Part 2D, Col. 1, Lines 8+14 plus Page 3, Column 3, Lines 5 + 6Claims Unpaid and Aggregate Reserves (Page 3, Column 3, Lines 1 + 2 + 4 + 7) of the prior year's annual statement.
2.6	Reserve Ratio	2.4/2.5	2.4/2.5

- (a) Alternative Reserve Numerator – Alternative Reserve Numerator – Company records may be used to adjust the reserve numerator to provide consistency between the values reported in the reserve numerator (2.4) and the premium numerator (2.1).

**PART 2 – LIFE ACCIDENT HEALTH COMPANIES/FRATERNAL BENEFIT SOCIETIES INTERROGATORIES**

**Life and Accident Health Companies/Fraternal Benefit Societies:**

- This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers compensation, accidental death and dismemberment policies and long-term care policies.

All reporting entities should file the test; however, a reporting entity that is required to also file the Separate Accounts Statement is not subject to the results of the Health Statement Test, and should continue to complete the life, accident and health/fraternal blank.

Premium and reserve information is obtained from the annual statement sources referenced on the form ~~or from the related risk based capital report for the corresponding premium descriptions~~ relating to the current and prior reporting periods. The premium and reserve ratios are calculated on the net basis reporting.

Item	Description	Reporting Year Annual Statement Data	Prior Year Annual Statement Data
2.1	Premium Numerator	<p>Health Premium values listed in the Analysis of Operations by Lines of Business – Accident and Health:</p> <p><u>The sum of Line 1, Columns 2-9 (Column 9 Medicaid should include Medicaid Pass-Through Payments Reported as Premium) plus</u></p> <p><u>Line 1, Column 13 in part (include only Medicare Part D and Stop Loss and Minimum Premium) of the reporting year’s annual statement.</u></p>	<p><u>Health Premium values listed in the Analysis of Operations by Lines of Business – Accident and Health:</u></p> <p><u>The sum of Line 1, Columns 2-9 (Column 9 Medicaid should include Medicaid Pass-Through Payments Reported as Premium) plus Line 1, Column 13 in part (include only Medicare Part D and Stop Loss and Minimum Premium) of the prior year’s annual statement.</u></p> <p><del>Health Premium values listed in the statement value column (Column 1) of the reporting year’s Life RBC report:</del></p> <p><u>Individual Lines:</u>                      Usual and Customary Major Medical and Hospital                      Medicare Supplement                      Medicare Part D                      Dental and Vision</p> <p><u>Group Lines:</u>                      Usual and Customary Major Medical and Hospital                      Medicare Supplement                      Medicare Part D                      Stop Loss and Minimum Premium                      Dental and Vision                      Federal Employee Health and Benefit Plan</p>
2.2	Premium Denominator	<p><del>Premium and Annuity Considerations (Page 4, Line 1) of the reporting year’s annual statement</del></p> <p><u>Analysis of Operations – Summary, Column 1, Line 1 of the reporting year’s annual statement.</u></p>	<p><u>Analysis of Operations – Summary, Column 1, Line 1</u></p> <p><del>Premium and Annuity Considerations (Page 4, Line 1) of the prior year’s annual statement</del></p>
2.3	Premium Ratio	<b>2.1/2.2</b>	<b>2.1/2.2</b>
2.4(a)	Reserve Numerator	<p>Net A&amp;H Policy and Contract Claims without Credit Health (Exhibit 8, Part 1, Line 4.4, Column 9 and Column 11 (excluding Dread Disease, Disability Income and Long-Term Care)) plus</p>	<p>Net A&amp;H Policy and Contract Claims without Credit Health (Exhibit 8, Part 1, Line 4.4, Columns 9 and 11 <u>(excluding Dread Disease, Disability Income and Long-Term Care))</u> plus Aggregate Reserves</p>

		Aggregate Reserves for A&H Policies without Credit Health (Exhibit 6, Column 1 less Columns 10, 11, 12 and Dread Disease included in Column 13) for <u>Total (Net) Unearned Premiums (Line 17), and Future Contingent Benefits (Line 4)</u>	for A&H Policies without Credit Health (Exhibit 6, Column 1 less Columns <u>10, 11, 12 and Dread Disease included in Column 13</u> ) for <u>Unearned Premiums Total (Net) (Line 17), and Future Contingent Benefits (Line 4)</u>
2.5	Reserve Denominator	Aggregate Reserve ( <del>Page 3, Column 1, Lines 1+2+4.1+4.2</del> Exhibit 5, Column 2, Line 9999999 plus Exhibit 6, Column 1, Line 9999999 plus Exhibit 8, Part 1, Column 1, Line 17 plus Exhibit 8, Part 1, Column 1, Line 4.4) <del>minus additional actuarial reserves (Exhibit 6, Column 1, Lines 3+11 plus Exhibit 5, Misc. Reserves Section, Line 0799999)</del>	Aggregate Reserve ( <u>Exhibit 5, Column 2, Line 9999999 plus Exhibit 6, Column 1, Line 17 plus Exhibit 8, Part 1, Column 1, Line 4.4</u> ) <del>Page 3, Column 1, Lines 1+2+4.1+4.2) minus additional actuarial reserves (Exhibit 6, Column 1, Lines 3+11 plus Exhibit 5, Misc. Reserves Section, Line 0799999)</del>
2.6	Reserve Ratio	<b>2.4/2.5</b>	<b>2.4/2.5</b>

(a) Alternative Reserve Numerator – Company records may be used to adjust the reserve numerator to provide consistency between the values reported in the reserve numerator (2.4) and the premium numerator (2.1).



**PART 2 – PROPERTY AND CASUALTY INTERROGATORIES**

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers compensation, accidental death and dismemberment policies and long-term care policies.

All reporting entities should file the test; however, a reporting entity that is required to also file the Protected Cell Statement is not subject to the results of the Health Statement Test and should continue to complete the property blank.

Premium and reserve information is obtained from the annual statement sources referenced on the form ~~or from the related risk based capital report for the corresponding premium descriptions~~ relating to the current and prior reporting periods. The premium and reserve ratios are calculated on the net basis reporting.

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Item	Description	Reporting Year Annual Statement Data	Prior Year Annual Statement Data
2.1	Premium Numerator	<p><u>Health Premium</u> values listed in the <u>Net Premiums Earned During Year</u> column (Column 46) of the reporting year's U&amp;I Part 1B:</p> <p>Lines 13.1 and 13.2</p> <p>Lines 15.1, 15.2, 15.4, 15.6, and 15.8</p> <p>Line 15.5 (should include Medicare Pass-Through Payments Reported as Premium)</p> <p>Line 15.9 in part (include only Medicare Part D and Stop Loss and Minimum Premium)</p>	<p><u>Health Premium</u> values listed in the <u>Premiums Earned During Year</u> (Column 4) of the reporting year's U&amp;I Part 1:</p> <p>Lines 13.1 and 13.2</p> <p>Lines 15.1, 15.2, 15.4, 15.6, and 15.8</p> <p>Line 15.5 (should include Medicare Pass-Through Payments Reported as Premium)</p> <p>Line 15.9 in part (include only Medicare Part D and Stop Loss and Minimum Premium)</p> <p><u>Health Premium</u> values as listed in the statement value column (Column 1) of the prior year's P&amp;C RBC report:</p> <p><u>Individual Lines</u></p> <ul style="list-style-type: none"> <li>Usual and Customary Major Medical and Hospital</li> <li>Medicare Supplement</li> <li>Medicare Part D</li> <li>Dental and Vision</li> </ul> <p><u>Group Lines</u></p> <ul style="list-style-type: none"> <li>Usual and Customary Major Medical and Hospital</li> <li>Medicare Supplement</li> <li>Medicare Part D</li> <li>Stop Loss and Minimum Premium</li> <li>Dental and Vision</li> <li>Federal Employee Health and Benefit Plan</li> </ul>
2.2	Premium Denominator	<p><u>Premiums Earned</u> (Page 4, Line 1) of the reporting year's annual statement <u>Underwriting and Investment Exhibit, Part 1, Column 4, Line 35</u></p>	<p><u>Underwriting and Investment Exhibit, Part 1, Column 4, Line 35</u> <u>Premium Earned</u> (Page 4, Line 1) of the prior year's annual statement</p>
2.3	Premium Ratio	2.1/2.2	2.1/2.2
2.4(a)	Reserve Numerator	<p>Part 2A, Unpaid Losses and Loss Adjustment Expenses (Columns 8+9, Lines 13+15 (excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care), Line 15.9 in part (include only Medicare Part D and Stop Loss and Minimum Premium)) plus Part 1A, Recapitulation of all Premiums (Columns 1+2, Lines 13+15 (excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care), Line 15.9 in part (include only Medicare Part D and Stop Loss and Minimum Premium)) of the reporting year's annual statement.</p>	<p>Part 2A, Unpaid Losses and Loss Adjustment Expenses (Columns 8+9, Lines 13+15 (excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care), Line 15.9 in part (include only Medicare Part D and Stop Loss and Minimum Premium)) plus Part 1A, Recapitulation of all Premiums (Columns 1+2, Lines 13+15 (excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care), Line 15.9 in part (include only Medicare Part D and Stop Loss and Minimum Premium)) of the prior year's annual statement.</p>
2.5	Reserve Denominator	<p><u>Unpaid Loss and LAE</u> (Page 3, Column 1, Lines 1+2+3) <u>Part 2A, Unpaid</u></p>	<p><u>Part 2A, Unpaid Losses and Loss Adjustment Expenses, (Line 35, Columns</u></p>

		<u>Losses and Loss Adjustment Expenses, (Line 35, Columns 8+9) plus Part 1A, Recapitulation of all Premiums (Line 35, Columns 1+2) of the reporting year's annual statement.</u>	<del>8+9) Unpaid Loss and LAE (Page 3, Column 1, Lines 1+2+3) plus Part 1A, Recapitulation of all Premiums (Line 35, Columns 1+2) of the prior year's annual statement.</del>
<b>2.6</b>	Reserve Ratio	<b>2.4/2.5</b>	<b>2.4/2.5</b>

- (a) Alternative Reserve Numerator – Company records may be used to adjust the reserve numerator to provide consistency between the values reported in the reserve numerator (2.4) and the premium numerator (2.1).

DRAFT

Draft: 4/3/23

Life Risk-Based Capital (E) Working Group  
Louisville, Kentucky  
March 22, 2023

The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met March 22, 2023. The following Working Group members participated: Philip Barlow, Chair (DC); Sanjeev Chaudhuri (AL); Thomas Reedy (CA); Lei Rao-Knight (CT); Carolyn Morgan (FL); Mike Yanacheak (IA); Vincent Tsang and Bruce Sartain (IL); Fred Andersen and Ben Slutsker (MN); William Leung (MO); Michael Muldoon (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andy Schallhorn (OK); Aaron Hodges (TX); and Tomasz Serbinowski (UT). Also participating was: Tom Botsko (OH).

1. Adopted its Jan. 26, 2023, and 2022 Fall National Meeting Minutes

The Working Group met Jan. 26, 2023, and took the following action: 1) exposed the American Academy of Actuaries (Academy) C2 Mortality Risk Work Group's proposal for a 30-day public comment period ending March 1; 2) exposed proposed revisions to the CM6 and CM7 mortgage risk-based capital (RBC) factors and formula for a 45-day public comment period ending March 16; and 3) exposed proposed revisions to remove the dual presentation of the trend test for a 15-day public comment period ending Feb. 14.

Yanacheak made a motion, seconded by Schallhorn, to adopt the Working Group's Jan. 26, 2023 (Attachment Three-A) and Dec. 13, 2022 (see *NAIC Proceedings – Fall 2022, Capital Adequacy (E) Task Force, Attachment Four*) minutes. The motion passed unanimously.

2. Discussed C-2 Mortality Risk

Chris Trost (American Academy of Actuaries—Academy), chair of the Academy's C2 Mortality Risk Work Group, reminded the Working Group that the updates that the Academy proposed were to add a new category for group permanent life and to add a new financial statement note that would include the information necessary to populate the risk-based capital (RBC) schedule. Dave Fleming (NAIC) said the proposed structural change will be considered for adoption in a meeting to be scheduled in April. He said the Blanks (E) Working Group has exposed the new financial note for a public comment period.

2. Discussed its Working Agenda and Priorities

Nancy Bennett (Academy) said her comments would be at a higher level as opposed to discussing specific changes on where some formula enhancements could be put in place with the purpose of getting feedback from the Working Group on its priorities. She discussed the individual risk components and the current status of work being done on them. With respect to the C1 risk component, she noted the recent updating of the bond factors along with the current discussion of updating other asset factors by the Risk-Based Capital Investment Risk and Evaluation (E) Working Group and asked about the interest in having a similar discussion in this Working Group. Noting the update on the work being done on C2, Bennett discussed the C3 risk component. She said this has been a carryover item on the working agenda for several years, and the Academy is looking to see when the Working Group is interested in restarting the project and discussing possible convergence among the different phases, which involve different methods that have been implemented over different time periods. She said there was a field study conducted in 2014, which, ultimately, had no action taken on it. While work in this area may be somewhat stalled due to the current work on the economic scenario generator (ESG), she said there are other concepts that have to be worked through irrespective of the generator that is used in the calculations. With the

current interest rate environment, she said it is probably a good time to start looking at this area again to ensure that the methodology is capturing the interest rate risk as intended, so the Academy would appreciate the Working Group's input.

Bennett said another possible area of work is the covariance adjustment, and apart from a change made to separate the common stock component, there really has not been any update to the adjustment made to reflect the correlation of risks. She said things to consider could include the correlation of risks within a component, such as mortality and longevity, and whether the original square root formula still makes sense or if there is a reason to make a change to that. This would be a large project, and she said it could have a material impact, so the Academy would like to see if there is interest in moving forward in this area.

Bennett said there may be an opportunity to have a discussion on the aggregate effectiveness of the life RBC formula in actually identifying weakly capitalized companies. While that is its often-stated purpose, she said it is well known that the actual purposes extend far beyond that and include use by rating agencies and use in the investment decisions made by insurers. She suggested it might be useful to have analysis to provide insight as to where the formula is, or more importantly, is not working, which would then drive the appropriate enhancements. She said it is known that there are inconsistencies that exist within the formula, as well as inconsistencies between RBC and statutory reserves and other parts of the balance sheet. In looking at the effectiveness of the formula or the overarching solvency framework, she said the Academy is looking to see if there is an appetite in trying to eliminate those inconsistencies or move some of these topics onto the Working Group's priority list.

Barlow said the work being done by the Risk-Based Capital Investment Risk and Evaluation (E) Working Group would eventually come to the individual RBC working groups but asked the Working Group how much update it believes is needed. Slutsker said the Working Group has many initiatives to focus on while that work is ongoing and believes some brief updates would be adequate until something comes to the Working Group. With respect to C-3, Barlow asked how much of this work can be done solely through this Working Group and how much has ramifications for the Life Actuarial (A) Task Force on the reserve side. Slutsker said he chairs the Valuation Manual (VM)-22 (A) Subgroup, and there is a lot of work on the principle-based reserve methodology for non-variable annuities that would potentially connect to any update for C-3 Phase I. He said he is not necessarily concerned about pursuing any specific C-3 projects right now but believes it would be good to get things in motion as it is likely a multiyear process, and there is probably enough progress on the reserve side that there can be some work done on the RBC side.

Slutsker and Eom noted different field tests, and Barlow asked if these would assist with the C-3 working agenda item, which he believes is more comprehensive. Bennett said she believes so and said she believes there are some basic threshold decisions that need to be made based upon the Working Group's discussion of the various aspects. She said she agrees that it is a good time to get this work started.

Brian Bayerle (American Council of Life Insurers—ACLI) agreed that it is critical to determine what questions there are and let the Working Group determine what direction it wishes to pursue. He suggested approaching this work as holistically as possible because there are so many inter-dependencies. If possible, Barlow said he would like to have an all-encompassing approach.

With respect to the covariance adjustment, Barlow said this is something he has been in favor of reviewing for a long time. He said he believes the ability to properly reflect covariance, and the understanding of how to do that in the RBC calculation has probably improved significantly since the inception of the formula. He asked if this was an item for the Capital Adequacy (E) Task Force as each of the RBC formulas has a covariance adjustment. Botsko said the Task Force is going to recommend starting ad hoc groups to look at different aspects of RBC, and this could be one. Barlow asked if the Academy has a group looking at this and if there is input from the Working Group



it would like. Bennett said the Academy has formed a group that is developing some conceptual ideas about correlation and higher-level considerations. Barlow said it would be helpful for the Academy to provide something for consideration whether it be for this Working Group or the Task Force.

With respect to reviewing the overall effectiveness of the formula, Barlow said several Working Group members have been working on reviewing the RBC statistics to attempt to determine better ways to evaluate formula results. He said there has been some good work done in this area, and while it has stalled a bit due to other projects, he would like to see that work continue.

### 3. Discussed Runoff Companies

Barlow said the Working Group discussed this previously, and he believes the consensus of the Working Group is that nothing specific to life insurance companies is needed for RBC. The Working Group agreed that no changes were needed to the life formula specific to runoff companies.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/CADTF/2023-1-Spring/LRBCWG/Life RBC 3-22-23.docx

Draft: 3/15/23

Life Risk-Based Capital (E) Working Group  
Virtual Meeting  
January 26, 2023

The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Jan. 26, 2023. The following Working Group members participated: Philip Barlow, Chair (DC); Thomas Reedy (CA); Wanchin Chou (CT); Hannah Howard (FL); Vincent Tsang (IL); Mike Yanacheak and Carrie Mears (IA); Laura Rickbell (MN); William Leung (MO); Michael Muldoon (NE); Seong-min Eom (NJ); Bill Carmello (NY); Jennifer Li (TX); and Tomasz Serbinowski (UT).

1. Exposed the Academy's C2 Mortality Risk Work Group's Proposal

Chris Trost (American Academy of Actuaries—Academy), chair of the Academy's C2 Mortality Risk Work Group, said there are two updates identified as additional items needed as part of the implementation of the Academy's work. The first relates to structural changes and instruction updates to address the treatment of group permanent life policies, as well as some additional instructional changes to provide clarity. The second relates to a new financial statement note that will develop the net amounts at risk (NAR) in the categories needed for the Life C-2 schedule to create a direct link to a financial statement source. Ryan Fleming (Academy) detailed the changes. He noted one of the changes to the instructions is to remove what was labeled as the permanent and term flexibility factors as they may have created some confusion with the actual capital factors when they were intended to represent the difference between categories. The Working Group discussed how to coordinate with other NAIC groups with respect to the financial statement note for 2023 implementation.

The Working Group agreed to expose the Academy's proposal for a 30-day public comment period ending March 1.

2. Exposed Proposed Revisions to CM6 and CM7 Mortgage RBC Factors and Formula

John Waldeck (Pacific Life) presented an update from the Mortgage Bankers Association (MBA) and the American Council of Life Insurers (ACLI) in response to the questions that the Working Group raised with respect to the proposed revisions.

The Working Group agreed to expose the proposal for a 45-day public comment period ending March 16.

3. Exposed Proposed Revisions to Remove the Dual Presentation of the Trend Test

Dave Fleming (NAIC) said the dual presentation was no longer needed as all states have adopted the higher trend test threshold.

The Working Group agreed to expose the proposal for a 15-day public comment period ending Feb. 14.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Meetings/E CMTE/CADTF/2023-1-Spring/LRBCWG/Att Life RBC 1-26-23 Minutes.docx

Draft: 3/23/23

Property and Casualty Risk-Based Capital (E) Working Group  
Louisville, Kentucky  
March 22, 2023

The Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met in Louisville, KY, March 22, 2023. The following Working Group members participated: Tom Botsko, Chair (OH); Wanchin Chou, Vice Chair (CT); Charles Hale (AL); Rolf Kaumann (CO); Virginia Christy (FL); Judy Mottar and Bruce Sartain (IL); Sandra Darby (ME); Will Davis (SC); Miriam Fisk (TX); and Amy Malm (WI). Also participating were: Kevin Dyke (MI); Michael Muldoon (NE); and Michael McKenney (PA).

1. Adopted its Jan. 30, 2023, and 2022 Fall National Meeting Minutes

Botsko said the Working Group conducted an e-vote that concluded Jan. 30, 2023, to adopt proposal 2022-12-CR (2022 U.S. and Non-U.S. Catastrophe Risk Event Lists), which the Working Group had exposed for a seven-day public comment period ending Jan. 25, 2023.

Chou made a motion, seconded by Darby, to adopt the Working Group's Jan. 30, 2023 (Attachment Four-A) and Dec. 13, 2022 (see *NAIC Proceedings – Fall 2022, Capital Adequacy (E) Task Force, Attachment Five*) minutes. The motion passed unanimously.

2. Adopted the Report of the Catastrophe Risk (E) Subgroup

Chou said the Catastrophe Risk (E) Subgroup met March 21, 2023, and took the following action: 1) adopted its Jan. 30, 2023, and 2022 Fall National Meeting minutes; 2) discussed its working agenda; 3) received a status update from its Catastrophe Model Technical Review Ad Hoc Group; 4) heard a presentation from Travelers on climate overview and scenario analysis; and 5) discussed the wildfire peril impact analysis.

Chou made a motion, seconded by Christy, to adopt the report of the Catastrophe Risk (E) Subgroup (Attachment Four-B). The motion passed unanimously.

3. Exposed Proposal 2023-02-P (Underwriting Risk Line 1 Factors)

Botsko said proposal 2023-02-P (Attachment Four-C) provided a routine annual update to the Line 1 premium and reserve industry underwriting factors in the property/casualty (P/C) risk-based capital (RBC) formula. He indicated that, as the Working Group discussed during the last April 2022 meeting, in some lines of business with smaller populations, such as the international line of business, both reserve and premium are driven by a handful of companies and could fluctuate or be biased due to different factors. Botsko also stated that the American Academy of Actuaries (Academy) is in the process of reviewing the Line 1 calculation methodology. Based on the Working Group's last discussion, the new methodology may not completely fix this issue entirely. He encouraged all the interested parties to participate in the discussion after receiving recommendations from the Academy in the near future.

The Working Group agreed to expose proposal 2023-02-P for a 30-day public comment period ending April 21.

#### 4. Discussed Annual Statement Blanks Proposal 2023-01BWG

Botsko said this proposal (Attachment Four-D) removes pet insurance from the inland marine line of business and adds a pet insurance line within the existing P/C Annual Statement Blank for the Underwriting and Investment Exhibits, Exhibit of Premiums and Losses (State Page), and Insurance Expense Exhibit. It also adds new Schedule P, Parts 1 through 4, specific to pet insurance for 2024 reporting. He also stated that the primary reason for this proposal is that the pet insurance industry has grown rapidly, and there is currently no public or regulatory visibility into the vast amount of pet insurance industry financial reporting. Botsko indicated that the Blanks (E) Working Group is currently exposing this proposal for a 52-day public comment period ending April 28. He encouraged the industry to: 1) review the proposal and provide feedback to the Blanks (E) Working Group; and 2) determine how to quantify this line of business in the RBC formula. Kaumann suggested that the Working Group may want to reach out to the Property and Casualty (C) Committee and the Market Regulation and Consumer Affairs (D) Committee to gain more information related to this proposal before the next meeting. Botsko said the Working Group will continue this discussion during its upcoming meeting.

#### 5. Discussed Annual Statement Blanks Proposal 2022-15BWG

Botsko said the Blanks (E) Working Group adopted proposal 2022-15BWG (Attachment Four-E) during its March 7 meeting. He stated that the proposal's purpose is to remove the current 5% of premium filing exemption on the Schedule H, Part 5 for P/C annual statement filing to be consistent with the life annual statement since the life annual statement does not have 5% of premium file exemption in the Schedule H, Part 5. Botsko raised a question on whether the 5% rule should be removed in the P/C RBC formula to be consistent with the change in the annual statement, Schedule H, Part 5. He urged the interested parties to review this proposal and provide comments to the Working Group during its upcoming meeting.

#### 6. Discussed its Working Agenda

Botsko summarized the changes to the Working Group's 2023 working agenda. He said the Working Group eliminated the following items: 1) evaluate the possibility of allowing additional third-party models or adjustments to the vendor models to calculate the catastrophe (CAT) model losses; and 2) evaluate the possibility of enhancing the independent model instructions. He also indicated that the following three items were added to the new items section: 1) review and analyze the P/C RBC charges that have not been reviewed since being developed; 2) quantify the R5 Ex-CAT factors for wildfire peril (for informational purposes only); and 3) evaluate the impact of flood peril to the insurance market.

Chou made a motion, seconded by Kaumann, to adopt the revised 2023 working agenda (*see NAIC Proceedings – Spring 2023, Capital Adequacy (E) Task Force, Attachment Ten*). The motion passed unanimously.

#### 7. Heard Updates on Current P/C RBC Projects from the Academy

Botsko said the American Academy of Actuaries' (Academy's) Property and Casualty Risk-Based Capital Committee (Academy Committee) continues its effort to recalibrate portions of the reserve and premium risk of the R4 and R5 components. Ronald Wilkins (Academy) said this presentation (Attachment Four-F) includes the following items: 1) background of the components of the P/C RBC formula; 2) the need for the new present value methodology due to the 2022 interest rate increases; 3) investment income offset and adjustment for loss runoff risk horizon; 4) safety level for the reserve and premium charges of the formula; and 5) year-over-year capping approaches. Wilkins stated that the Academy Committee would like to receive feedback from the Working Group regarding: 1) present value methodology; 2) adjustment to match loss runoff horizon to risk horizon; 3) statistical

safety level; and 4) minimum risk charge and year-over-year capping approaches. Botsko said he agrees with the assumption that the Academy provided in this presentation, and the Working Group will provide further evaluation after final reports become available. He also said the Working Group appreciates Wilkins providing updates on their projects and is looking forward to reviewing the detailed report for each project.

8. Discussed the Possibility of Reviewing or Analyzing the P/C RBC Charges

Botsko said the P/C RBC formula, factors, and methodology have been in development for almost 30 years. He stated that some of the risks, such as underwriting risks and some of the investment risks, have been continuously evaluated over the years. However, some of them have never been reviewed since being developed. Botsko said the Capital Adequacy (E) Task Force is considering establishing an ad hoc group to: 1) re-evaluate some of the missing risks to determine if it should now include them in the RBC calculation, or whether it appropriately handles those risks utilizing other regulatory methods; and 2) review those factors and instructions that have never been reviewed since development to determine if modifications should be made. Botsko encouraged all the parties to contact NAIC staff if anyone interested is in joining the new ad hoc group.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/Spring 2023 National Meeting/Task Forces/CapAdequacy/PCRBCWG/03-22propertyrbcwg.docx

Draft: 1/31/23

Property and Casualty Risk-Based Capital (E) Working Group  
and Catastrophe Risk (E) Subgroup  
E-Vote  
January 30, 2023

The Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force conducted an e-vote with the Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force that concluded Jan. 30, 2023. The following Working Group members participated: Tom Botsko, Chair (OH); Wanchin Chou, Vice Chair (CT); Rolf Kaumann (CO); Judy Mottar (IL); Sandra Darby (ME); Anna Krylova (NM); Alexander Vajda (NY); Miriam Fisk (TX); and Adrian Jaramillo (WI). The following Subgroup members participated: Wanchin Chou, Chair (CT); Laura Clements (CA); Rolf Kaumann (CO); Travis Grassel (IA); Judy Mottar (IL); Sandra Darby (ME); Anna Krylova (NM); Alexandra Vajda (NY); Tom Botsko (OH); Andrew Schallhorn (OK); Will Davis (SC) and Miriam Fisk (TX).

1. Adopted the Updated 2022 U.S. and Non-U.S. Catastrophe Risk Event Lists

The Working Group and the Subgroup conducted an e-vote to consider adoption of proposal 2022-12-CR (2022 U.S. and Non-U.S. Catastrophe Risk Event Lists).

Darby made a motion, seconded by Mottar, to adopt the 2022 U.S. and Non-U.S. Catastrophe Risk Event Lists (see *NAIC Proceedings – Spring 2023, Capital Adequacy (E) Task Force, Attachment One-A*). The motion passed unanimously.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group and the Catastrophe Risk (E) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/ Member Meetings/E Cmte/CADTF/2023-1-Spring/Cat Risk Email Vote 013023

Draft: 3/22/23

Catastrophe Risk (E) Subgroup  
Louisville, Kentucky  
March 21, 2023

The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met March 21, 2023. The following Subgroup members participated: Wanchin Chou, Chair (CT); Virginia Christy, Vice Chair (FL); Rolf Kaumann (CO); Susan Berry and Judy Mottar (IL); Sandra Darby (ME); Tom Botsko (OH); Andrew Schallhorn (OK); and Miriam Fisk (TX). Also participating were: Travis Grassel (IA); Julie Lederer (MO); Liz Ammerman (RI); and Steve Drutz (WA).

1. Adopted its Jan. 30, 2023, and 2022 Fall National Meeting Minutes

Chou said the Subgroup conducted an e-vote that concluded Jan. 30, 2023, to adopt proposal 2022-12-CR (2022 U.S. and Non-U.S. Catastrophe Risk Event Lists), which the Subgroup had exposed for a seven-day public comment period ending Jan. 25, 2023.

Schallhorn made a motion, seconded by Botsko, to adopt the Subgroup's Jan. 30, 2023 (*see NAIC Proceedings – Spring 2023, Capital Adequacy (E) Task Force, Attachment Four-A*) and Dec. 12, 2022 (*see NAIC Proceedings – Fall 2022, Capital Adequacy (E) Task Force, Attachment Five-B*) minutes. The motion passed unanimously.

2. Received an Update from its Catastrophe Model Technical Review Ad Hoc Group

Chou said that the Catastrophe Model Technical Review Ad Hoc Group met once a month with different modeling vendors to gain a better understanding of different vendor models. He invited Shaveta Gupta (NAIC) to provide an update for the Ad Hoc Group at the meeting. Gupta said the Ad Hoc Group was re-established in late 2022 to conduct a more in-depth review of various severe convective storm catastrophe (CAT) vendor model assumptions, limitations, and impact analysis. Ultimately, recommendations will be provided to the Subgroup for consideration. She stated that so far, four model vendors have given presentations to the ad hoc group on their respective severe convective storm models. She said the ad hoc group is in the process of collecting technical questions from its members based on the materials that modeling vendors presented. Also, she anticipated that follow-up meetings with each modeling vendor to provide further responses and explanations would be scheduled after the Spring National Meeting.

3. Discussed the Wildfire Peril Impact Analysis

Chou said in order to ease the CAT modelers' concerns regarding their proprietary information while evaluating the impacts and determining the appropriate risk-based capital (RBC) catastrophe risk charge for wildfire peril, the Subgroup members will be required to sign nondisclosure agreements (NDAs) with the vendor modeling companies. He encouraged all the Subgroup members to sign the NDAs, which will be distributed shortly after the Spring National Meeting. Chou said he will continue providing updates during the Subgroup's next meeting.

4. Discussed its Working Agenda

Chou summarized the changes to the Working Group's 2023 working agenda, which included the following substantial changes: 1) moving item 1 from the "carryover items currently being addressed" section to the "ongoing items" section; 2) eliminating "evaluate the possibility of allowing additional third-party models or

adjustments to the vendor models to calculate the CAT model losses” and “evaluate the possibility of enhancing the independent model instructions”; and 3) adding “quantify the R5 ex-cat factors for wildfire peril (for informational purposes only)” and “evaluate the impact of flood peril to the insurance market.” Chou said the working agenda will be forwarded to the Property and Casualty Risk-Based Capital (E) Working Group for consideration.

5. Heard a Presentation from Travelers on the Climate Overview and Scenario Analysis

Chou said the Subgroup appreciates Travelers Insurance providing a climate overview and scenario analysis presentation to the Subgroup. Eric Nelson (Travelers) said this presentation includes the following items: 1) industry loss trends; 2) catastrophe risk management; 3) climate change overview; 4) market disclosure landscape; 5) vendor capabilities; 6) climate scenario analysis; 7) mitigation and resiliency; and 8) observations. Chou urged the interested parties to review the materials and provide feedback to the Subgroup during its next meeting.

Having no further business, the Catastrophe Risk (E) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/Spring 2023National Meeting/Task Forces/CapAdequacy/Cat Risk SG/03-21propertycatsg.docx



**Capital Adequacy (E) Task Force  
RBC Proposal Form**

- |                                                                               |                                                               |                                                                             |
|-------------------------------------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Capital Adequacy (E) Task Force                      | <input type="checkbox"/> Health RBC (E) Working Group         | <input type="checkbox"/> Life RBC (E) Working Group                         |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup                        | <input type="checkbox"/> Investment RBC (E) Working Group     | <input type="checkbox"/> Longevity Risk (A/E) Subgroup                      |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input checked="" type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

<p align="right">DATE: <u>3/22/23</u></p> <p>CONTACT PERSON: <u>Eva Yeung</u></p> <p>TELEPHONE: <u>816-783-8407</u></p> <p>EMAIL ADDRESS: <u>eyeung@naic.org</u></p> <p>ON BEHALF OF: <u>P/C RBC (E) Working Group</u></p> <p>NAME: <u>Tom Botsko</u></p> <p>TITLE: <u>Chair</u></p> <p>AFFILIATION: <u>Ohio Department of Insurance</u></p> <p>ADDRESS: <u>50 West Town Street, Suite 300</u>  <u>Columbus, OH 43215</u></p>	<p align="center"><b>FOR NAIC USE ONLY</b></p> <p>Agenda Item # <u>2023-02-P</u>                  Year _____</p> <p align="center"><b>DISPOSITION</b></p> <p><b>ADOPTED:</b></p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input type="checkbox"/> WORKING GROUP (WG) _____</p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p><b>EXPOSED:</b></p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input checked="" type="checkbox"/> WORKING GROUP (WG) <u>3/22/23</u></p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p><b>REJECTED:</b></p> <p><input type="checkbox"/> TF <input type="checkbox"/> WG <input type="checkbox"/> SG _____</p> <p><b>OTHER:</b></p> <p><input type="checkbox"/> DEFERRED TO _____</p> <p><input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____</p> <p><input type="checkbox"/> (SPECIFY) _____</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

- |                                                  |                                                                  |                                                              |
|--------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Health RBC Blanks       | <input checked="" type="checkbox"/> Property/Casualty RBC Blanks | <input type="checkbox"/> Life and Fraternal RBC Blanks       |
| <input type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions      | <input type="checkbox"/> Life and Fraternal RBC Instructions |
| <input type="checkbox"/> Health RBC Formula      | <input type="checkbox"/> Property/Casualty RBC Formula           | <input type="checkbox"/> Life and Fraternal RBC Formula      |
| <input type="checkbox"/> OTHER _____             |                                                                  |                                                              |

**DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)**

The proposed change would provide routine annual update of the industry underwriting factors (premium and reserve) in the PCRBC formula.

**Additional Staff Comments:**

\*\* This section must be completed on all forms.

Revised 2-2023

PR017 Line 1 Reserves

Schedule P Line of Business	LOB	Proposed for adoption - 2023 Industry Average Development Ratio	2022 Industry Average Development	2021 Industry Average Development	2020 Industry Average Development	2019 Industry Average Development	2018 Industry Average Development	2017 Industry Average Development	2016 Industry Average Development	2015 Industry Average Development	2014 Industry Average Development
H/F	A	1.001	0.998	0.993	0.989	0.989	0.989	0.984	0.972	0.962	0.967
PPA	B	1.022	1.025	1.035	1.026	1.026	1.022	1.012	1.002	1.002	0.994
CA	C	1.082	1.083	1.078	1.087	1.087	1.060	1.034	1.015	0.987	0.979
WC	D	0.906	0.912	0.916	0.955	0.955	0.952	0.971	0.971	0.961	0.986
CMP	E	1.037	0.999	1.016	0.992	0.992	0.967	0.956	0.942	0.938	0.941
MM Occurrence	F1	0.887	0.874	0.861	0.864	0.864	0.871	0.868	0.841	0.966	0.966
MM Clms Made	F2	0.983	0.973	0.940	0.907	0.907	0.886	0.854	0.822	0.839	0.808
SL	G	0.990	0.976	0.963	0.938	0.938	0.933	0.926	0.919	0.975	0.990
OL	H	0.995	0.964	0.968	0.971	0.971	0.966	0.952	0.929	0.923	0.916
Fidelity / Surety	K	0.842	0.915	0.907	0.995	0.995	0.996	1.016	1.035	1.016	1.050
Special Property	I	0.993	0.978	0.977	0.972	0.972	0.971	0.982	0.973	0.991	0.992
Auto Physical Damage	J	1.011	0.989	0.993	0.996	0.996	1.000	1.001	0.995	0.995	1.005
Other (Credit, A&H)	L	0.955	0.965	0.971	0.973	0.973	0.976	0.981	0.986	1.041	1.061
Financial / Mortgage Guaranty	S	0.694	0.723	0.682	0.788	0.788	0.870	0.820	0.853	1.185	1.444
Intl	M	3.041	1.104	1.162	1.037	1.037	0.851	0.855	0.897	1.350	0.742
Rein. Property & Financial Lines	NP	0.917	0.893	0.886	0.872	0.872	0.834	0.814	0.814	1.002	0.976
Rein. Liability	O	1.008	0.989	0.985	0.955	0.955	0.945	0.914	0.896	0.938	0.905
PL	R	0.867	0.879	0.900	0.913	0.913	0.921	0.935	0.937	1.072	1.018
Warranty	T	0.998	1.007	1.013	1.017	1.017	1.015	0.989	0.977	0.994	1.040

PR018 Line 1 Premiums

Schedule P Line of Business	LOB	Proposed 2023 Industry Average Loss & Expense Ratio	2022 Industry Average Loss & Expense Ratio	2021 Industry Average Loss & Expense Ratio	2020 Industry Average Loss & Expense Ratio	2019 Industry Average Loss & Expense Ratio	2018 Industry Average Loss & Expense Ratio	2017 Industry Average Loss & Expense Ratio	2016 Industry Average Loss & Expense Ratio	2015 Industry Average Loss & Expense Ratio	2014 Industry Average Loss & Expense Ratio
H/F	A		0.665	0.681	0.678	0.681	0.687	0.688	0.701	0.701	0.713
PPA	B		0.793	0.795	0.810	0.810	0.806	0.800	0.792	0.786	0.780
CA	C	<b>0.777</b>	0.761	0.761	0.759	0.737	0.724	0.706	0.689	0.684	0.676
WC	D	<b>0.651</b>	0.664	0.682	0.705	0.726	0.744	0.751	0.752	0.751	0.749
CMP	E	<b>0.671</b>	0.661	0.673	0.672	0.666	0.664	0.647	0.648	0.655	0.652
MM Occurrence	F1	<b>0.767</b>	0.750	0.731	0.726	0.730	0.780	0.777	0.767	0.780	0.883
MM Clims Made	F2	<b>0.815</b>	0.829	0.821	0.797	0.768	0.747	0.722	0.691	0.697	0.680
SL	G	<b>0.578</b>	0.585	0.593	0.603	0.593	0.569	0.567	0.572	0.630	0.645
OL	H	<b>0.641</b>	0.637	0.635	0.639	0.638	0.633	0.629	0.618	0.616	0.617
Fidelity / Surety	K	<b>0.363</b>	0.366	0.394	0.384	0.399	0.417	0.430	0.464	0.462	0.473
Special Property	I	<b>0.550</b>	0.547	0.559	0.553	0.554	0.563	0.555	0.559	0.571	0.572
Auto Physical Damage	J	<b>0.727</b>	0.718	0.726	0.732	0.730	0.732	0.727	0.711	0.703	0.686
Other (Credit, A&H)	L	<b>0.702</b>	0.698	0.693	0.684	0.682	0.709	0.712	0.699	0.706	0.754
Financial / Mortgage Guaranty	S	<b>0.209</b>	0.203	0.252	0.513	0.811	1.099	1.175	1.293	1.096	1.242
Intl	M	<b>1.136</b>	1.166	0.762	0.758	0.795	0.584	0.565	0.607	1.150	1.131
Rein. Property & Financial Lines	NP	<b>0.578</b>	0.566	0.558	0.534	0.522	0.486	0.459	0.512	0.723	0.764
Rein. Liability	O	<b>0.743</b>	0.725	0.713	0.708	0.679	0.666	0.609	0.600	0.749	0.748
PL	R	<b>0.597</b>	0.601	0.617	0.645	0.656	0.671	0.670	0.684	0.715	0.716
Warranty	T	<b>0.652</b>	0.665	0.681	0.691	0.695	0.732	0.645	0.611	0.799	0.789

**NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

<p style="text-align: right;"><b>DATE:</b> <u>11/4/2022</u></p> <p><b>CONTACT PERSON:</b> <u>Debbie Doggett (MO DCI) &amp; Gavin Friedman (American Pet Ins Co; ZPIC Ins Co)</u></p> <p><b>TELEPHONE:</b> <u>Debbie (573) 526-2944 / Gavin (310) 254-5256</u></p> <p><b>EMAIL ADDRESS:</b> <u>debbie.doggett@insurance.mo.gov / gavin.friedman@trupanion.com</u></p> <p><b>ON BEHALF OF:</b> <u>Joint submission by (i) the MO Dept of Commerce and Insurance and (ii) American Pet Ins Co and ZPIC Ins Co</u></p> <p><b>NAME:</b> <u>Debbie Doggett</u></p> <p><b>TITLE:</b> <u>Chief Financial Analyst</u></p> <p><b>AFFILIATION:</b> <u>Missouri DCI</u></p> <p><b>ADDRESS:</b> <u>301 W Hight St. #530, Jefferson City, MO 65101</u></p>	<p style="text-align: center;"><b>FOR NAIC USE ONLY</b></p> <p>Agenda Item # <u>2023-01BWG</u></p> <p>Year <u>2024</u></p> <p>Changes to Existing Reporting [ X ]</p> <p>New Reporting Requirement [ ]</p> <hr/> <p style="text-align: center;"><b>REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</b></p> <p>No Impact [ X ]</p> <p>Modifies Required Disclosure [ ]</p> <p>Is there data being requested in this proposal which is available elsewhere in the Annual/Quarterly Statement? [ No ]</p> <p><i>***If Yes, complete question below***</i></p> <hr/> <p style="text-align: center;"><b>DISPOSITION</b></p> <p>[ ] Rejected For Public Comment</p> <p>[ ] Referred To Another NAIC Group</p> <p>[ ] Received For Public Comment</p> <p>[ ] Adopted Date _____</p> <p>[ ] Rejected Date _____</p> <p>[ ] Deferred Date _____</p> <p>[ ] Other (Specify) _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- |                                                            |                                                   |                                                 |
|------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------|
| <input checked="" type="checkbox"/> ANNUAL STATEMENT       | <input checked="" type="checkbox"/> INSTRUCTIONS  | <input checked="" type="checkbox"/> CROSSCHECKS |
| <input checked="" type="checkbox"/> QUARTERLY STATEMENT    | <input checked="" type="checkbox"/> BLANK         |                                                 |
| <input type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts        | <input type="checkbox"/> Title                  |
| <input checked="" type="checkbox"/> Property/Casualty      | <input type="checkbox"/> Protected Cell           | <input type="checkbox"/> Other _____            |
| <input type="checkbox"/> Health                            | <input type="checkbox"/> Health (Life Supplement) |                                                 |

Anticipated Effective Date: January 1, 2024

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Remove Pet Insurance from Inland Marine line of business and add a new line of business to Appendix – P/C Lines of Business. Add Pet Insurance line within the existing P/C Blank for the Underwriting and Investment Exhibits, Exhibit of Premiums and Losses (State Page), and Insurance Expense Exhibit. Add new Schedule P Parts 1 through 4 specific to Pet Insurance.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE\*\***

See Page 2 for detailed reason and justification for change.

**\*\*\*IF THE DATA IS AVAILABLE ELSEWHERE IN THE ANNUAL/QUARTERLY STATEMENT, PLEASE NOTE WHY IT IS REQUIRED FOR THIS PROPOSAL\*\*\***

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: \_\_\_\_\_

Other Comments:

\*\* This section must be completed on all forms.

Revised 11/17/2022

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

Pet insurance is reported today as an Inland Marine product. Separating Pet Insurance from Inland Marine for financial reporting purposes within the existing Blank is warranted for a number of reasons, including:

- There is no public or regulator visibility into the vast majority of the pet insurance industry's financial reporting. Other than for a monoline insurer that writes only pet insurance, the rest of the industry's pet insurance business financial reporting is included in Inland Marine, along with anything else in that broadly-defined line that the respective insurer has written. In short, regulators do not have clear visibility into even the most basic information about pet insurers and the pet insurance market, such as who is underwriting pet coverage, the volume being sold, losses, and who is selling it.
- The pet insurance industry has grown rapidly, and this high growth rate continues. The industry's self-reported data shows growth in annual gross written premium from \$836.5 M in 2016 to \$2.59 B in 2021, including more than 30% annual growth from 2020 to 2021. This growth rate makes the absence of visibility into each participating company's financial information more an acute challenge with each passing year.
- Relying on regulator data calls to gather basic information such as premium written and loss information is time-consuming for all involved, and prone to inconsistencies and errors.
- The NAIC's D Committee is proceeding with MCAS for pet insurance. It would be inapposite and have potential for inconsistent data, to require MCAS reporting while not requiring dedicated pet insurance financial reporting. In addition, separate financial reporting will be a useful complement to MCAS reporting, both to supplement the MCAS information and to validate it.
- Dedicated financial reporting of pet insurance will be helpful to state regulators' assessment of the appropriate amount of surplus insurers writing this business should hold. It is anticipated that once sufficient history is obtained, a separate RBC factor for pet insurance can be established.

ANNUAL STATEMENT INSTRUCTIONS – PROPERTY/CASUALTY

APPENDIX

PROPERTY AND CASUALTY LINES OF BUSINESS

These definitions should be applied when reporting all applicable amounts for the following schedules: Underwriting and Investment Exhibit Parts 1, 1A, 1B, 2, and 2A; Exhibit of Premiums and Losses (Statutory Page 14); and the Insurance Expense Exhibit. Policy fees, service charges or membership charges are to be included with the line of business or in Other Income, as determined by *SSAP No. 53—Property and Casualty Contracts – Premiums*.



**Detail Eliminated to Conserve Space**

Line 9.1 – Inland Marine

Coverage for property that may be in transit, held by a bailee, at a fixed location, a movable good that is often at different locations (e.g., off-road construction equipment) or scheduled property (e.g., Homeowners Personal Property Floater), including items such as live animals, property with antique or collector’s value, etc. This line also includes instrumentalities of transportation and communication, such as bridges, tunnels, piers, wharves, docks, pipelines, power and phone lines, and radio and television towers.

Animal Mortality

Coverage that provides a death benefit to the owner of a policy in the event of the death of the insured livestock.

EDP Policies

Coverage to protect against losses arising out of damage to or destruction of electronic data processing equipment and its software.

Communication Equipment (Cellular Telephones)

Provides insured subscribers of Communications Equipment Service Provider replacement coverage for loss of and damage, theft or mechanical breakdown to communications equipment. Communications equipment means wireless telephones and pagers, and any other devices incorporating wireless phone and pager capabilities, including but not limited to personal digital assistants (PDA) and wireless aircards.

Line 9.2 – Pet Insurance Plans

Veterinary care plan insurance policy providing care for a pet animal (e.g., dog or cat) of the insured owner in the event of its illness or accident.

**SCHEDULE P**

**SCHEDULE P – PART 1**

Part 1 – Summary is the total of the Schedule P lines. For the property lines, it is necessary to supplement the data in the individual sections of Schedule P in order to complete the Part 1 – Summary for all lines for all years. Non-proportional assumed reinsurance – Property, Liability and Financial Lines can be summed together as reported.

↓  
===== **Detail Eliminated to Conserve Space** =====  
↑

**Non-proportional assumed reinsurance –Property Reinsurance**

Includes all the following lines: Fire, Allied Lines, Ocean Marine, Inland Marine, Pet Insurance Plans, Earthquake, Group Accident and Health, Credit Accident and Health, Other Accident and Health, Auto Physical Damage, Boiler and Machinery, Burglary and Theft and International (of the foregoing).

↓  
===== **Detail Eliminated to Conserve Space** =====  
↑

**SCHEDULE P – PARTS 1A THROUGH 1U**

Reporting entities should complete Schedule P in thousands only but must report all claim counts in whole numbers.

↓  
===== **Detail Eliminated to Conserve Space** =====  
↑

ANNUAL STATEMENT BLANKS – PROPERTY/CASUALTY

UNDERWRITING AND INVESTMENT EXHIBIT  
PART 1 – PREMIUMS EARNED

Line of Business	1 Net Premiums Written per Column 6, Part 1B	2 Unearned Premiums Dec. 31 Prior Year- per Col. 3, Last Year's Part 1	3 Unearned Premiums Dec. 31 Current Year- per Col. 5 Part 1A	4 Premiums Earned During Year (Cols. 1 + 2 - 3)
1. Fire.....				
2.1 Allied lines.....				
2.2 Multiple peril crop.....				
2.3 Federal flood.....				
2.4 Private crop.....				
2.5 Private flood.....				
3. Farmowners multiple peril.....				
4. Homeowners multiple peril.....				
5.1 Commercial multiple peril (non-liability portion).....				
5.2 Commercial multiple peril (liability portion).....				
6. Mortgage guaranty.....				
8. Ocean marine.....				
9.1 Inland marine.....				
9.2. Pet Insurance Plans.....				
10. Financial guaranty.....				
11.1 Medical professional liability—occurrence.....				
11.2 Medical professional liability—claims-made.....				
12. Earthquake.....				
13.1 Comprehensive (hospital and medical) individual.....				
13.2 Comprehensive (hospital and medical) group				
14. Credit accident and health (group and individual).....				
15.1 Vision only.....				
15.2 Dental only.....				
15.3 Disability income.....				
15.4 Medicare supplement.....				
15.5 Medicaid Title XIX.....				
15.6 Medicare Title XVIII.....				
15.7 Long-term care.....				
15.8 Federal employees health benefits plan.....				
15.9 Other health.....				
16. Workers' compensation.....				
17.1 Other liability—occurrence.....				
17.2 Other liability—claims-made.....				
17.3 Excess workers' compensation.....				
18.1 Products liability—occurrence.....				
18.2 Products liability—claims-made.....				
19.1 Private passenger auto no-fault (personal injury protection).....				
19.2 Other private passenger auto liability.....				
19.3 Commercial auto no-fault (personal injury protection).....				
19.4 Other commercial auto liability.....				
21.1 Private passenger auto physical damage.....				
21.2 Commercial auto physical damage.....				
22. Aircraft (all perils).....				
23. Fidelity.....				
24. Surety.....				
26. Burglary and theft.....				
27. Boiler and machinery.....				
28. Credit.....				
29. International.....				
30. Warranty.....				
31. Reinsurance-nonproportional assumed property.....				
32. Reinsurance-nonproportional assumed liability.....				
33. Reinsurance-nonproportional assumed financial lines.....				
34. Aggregate write-ins for other lines of business.....				
35. TOTALS				
<b>DETAILS OF WRITE-INS</b>				
3401. ....				
3402. ....				
3403. ....				
3498. Sum. of remaining write-ins for Line 34 from overflow page.....				
3499. Totals (Lines 3401 through 3403 plus 3498) (Line 34 above)				



**UNDERWRITING AND INVESTMENT EXHIBIT**  
**PART 1A – RECAPITULATION OF ALL PREMIUMS**

Line of Business	1 Amount Unearned (Running One Year or Less from Date of Policy) (a)	2 Amount Unearned (Running More Than One Year from Date of Policy) (a)	3 Earned but Unbilled Premium	4 Reserve for Rate Credits and Retrospective Adjustments Based on Experience	5 Total Reserve for Unearned Premiums Cols. 1+2+3+4
1. Fire .....					
2.1 Allied lines .....					
2.2 Multiple peril crop .....					
2.3 Federal flood .....					
2.4 Private crop .....					
2.5 Private flood .....					
3. Farmowners multiple peril .....					
4. Homeowners multiple peril .....					
5.1 Commercial multiple peril (non-liability portion) .....					
5.2 Commercial multiple peril (liability portion) .....					
6. Mortgage guaranty .....					
8. Ocean marine .....					
9.1 Inland marine .....					
9.2 Pet Insurance Plans .....					
10. Financial guaranty .....					
11.1 Medical professional liability—occurrence .....					
11.2 Medical professional liability—claims-made .....					
12. Earthquake .....					
13.1 Comprehensive (hospital and medical) individual .....					
13.2 Comprehensive (hospital and medical) group .....					
14. Credit accident and health .....					
individual)					
15.1 Vision only .....					
15.2 Dental only .....					
15.3 Disability income .....					
15.4 Medicare supplement .....					
15.5 Medicaid title XIX .....					
15.6 Medicare title XVIII .....					
15.7 Long-term care .....					
15.8 Federal employees health benefits plan .....					
15.9 Other health .....					
16. Workers' compensation .....					
17.1 Other liability—occurrence .....					
17.2 Other liability—claims-made .....					
17.3 Excess workers' compensation .....					
18.1 Products liability—occurrence .....					
18.2 Products liability—claims-made .....					
19.1 Private passenger auto no-fault (personal injury protection) .....					
19.2 Other private passenger auto liability .....					
19.3 Commercial auto no-fault (personal injury protection) .....					
19.4 Other commercial auto liability .....					
21.1 Private passenger auto physical damage .....					
21.2 Commercial auto physical damage .....					
22. Aircraft (all perils) .....					
23. Fidelity .....					
24. Surety .....					
26. Burglary and theft .....					
27. Boiler and machinery .....					
28. Credit .....					
29. International .....					
30. Warranty .....					
31. Reinsurance-nonproportional assumed property .....					
32. Reinsurance-nonproportional assumed liability .....					
33. Reinsurance-nonproportional assumed financial lines .....					
34. Aggregate write-ins for other lines of business .....					
35. TOTALS					
36. Accrued retrospective premiums based on experience .....					
37. Earned but unbilled premiums .....					
38. Balance (Sum of Lines 35 through 37)					
<b>DETAILS OF WRITE-INS</b>					
3401. ....					
3402. ....					
3403. ....					
3498. Sum. of remaining write-ins for Line 34 from overflow page .....					
3499. Totals (Lines 3401 through 3403 plus 3498) (Line 34 above)					

(a) State here basis of computation used in each case .....

**UNDERWRITING AND INVESTMENT EXHIBIT**  
**PART 1B – PREMIUMS WRITTEN**

Line of Business	1 Direct Business (a)	Reinsurance Assumed		Reinsurance Ceded		6 Net Premiums Written Cols. 1+2+3- 4-5
		2 From Affiliates	3 From Non- Affiliates	4 To Affiliates	5 To Non- Affiliates	
1. Fire .....						
2.1 Allied lines .....						
2.2 Multiple peril crop.....						
2.3 Federal flood .....						
2.4 Private crop .....						
2.5 Private flood .....						
3. Farmowners multiple peril.....						
4. Homeowners multiple peril.....						
5.1 Commercial multiple peril (non-liability portion).....						
5.2 Commercial multiple peril (liability portion) ...						
6. Mortgage guaranty .....						
8. Ocean marine .....						
9.1 Inland marine .....						
9.2 Pet Insurance Plans .....						
10. Financial guaranty.....						
11.1 Medical professional liability—occurrence.....						
11.2 Medical professional liability—claims-made ...						
12. Earthquake.....						
13.1 Comprehensive (hospital and medical) individual.....						
13.2 Comprehensive (hospital and medical) group ...						
14. Credit accident and health (group and individual).....						
15.1 Vision only.....						
15.2 Dental only.....						
15.3 Disability income .....						
15.4 Medicare supplement .....						
15.5 Medicaid Title XIX.....						
15.6 Medicare Title XVIII .....						
15.7 Long-term care .....						
15.8 Federal employees health benefits plan .....						
15.9 Other Health .....						
16. Workers' compensation .....						
17.1 Other liability—occurrence.....						
17.2 Other liability—claims-made.....						
17.3 Excess workers' compensation .....						
18.1 Products liability—occurrence.....						
18.2 Products liability—claims-made .....						
19.1 Private passenger auto no-fault (personal injury protection).....						
19.2 Other private passenger auto liability .....						
19.3 Commercial auto no-fault (personal injury protection) .....						
19.4 Other commercial auto liability .....						
21.1 Private passenger auto physical damage.....						
21.2 Commercial auto physical damage .....						
22. Aircraft (all perils).....						
23. Fidelity .....						
24. Surety .....						
26. Burglary and theft .....						
27. Boiler and machinery .....						
28. Credit .....						
29. International .....						
30. Warranty.....						
31. Reinsurance-nonproportional assumed property .....	XXX					
32. Reinsurance-nonproportional assumed liability.....	XXX					
33. Reinsurance-nonproportional assumed financial lines .....	XXX					
34. Aggregate write-ins for other lines of business .						
35. TOTALS						
<b>DETAILS OF WRITE-INS</b>						
3401. ....						
3402. ....						
3403. ....						
3498.Sum. of remaining write-ins for Line 34 from overflow page.....						
3499.Totals (Lines 3401 through 3403 plus 3498) (Line 34 above)						

- (a) Does the company's direct premiums written include premiums recorded on an installment basis? Yes [ ] No [ ]  
 If yes: 1. The amount of such installment premiums \$.....  
 2. Amount at which such installment premiums would have been reported had they been recorded on an annualized basis \$.....

**UNDERWRITING AND INVESTMENT EXHIBIT**  
**PART 2 – LOSSES PAID AND INCURRED**

Line of Business	Losses Paid Less Salvage			5 Net Losses Unpaid Current Year (Part 2A, Col. 8)	6 Net Losses Unpaid Prior Year	7 Losses Incurred Current Year (Cols 4 + 5-6)	8 Percentage of Losses Incurred to Premiums Earned (Col. 4, Part 1)
	1 Direct Business	2 Reinsurance Assumed	3 Reinsurance Recovered				
1. Fire.....							
2.1 Allied lines.....							
2.2 Multiple peril crop.....							
2.3 Federal flood.....							
2.4 Private crop.....							
2.5 Private flood.....							
3. Homeowners multiple peril.....							
4. Homeowners multiple peril.....							
5. Commercial multiple peril (non-liability portion).....							
5.1 Commercial multiple peril (liability portion).....							
5.2 Commercial multiple peril (liability portion).....							
6. Mortgage guaranty.....							
8. Ocean marine.....							
9.1 Inland marine.....							
9.2 Pet Insurance Plans.....							
10. Financial guaranty.....							
11.1 Medical professional liability—occurrence.....							
11.2 Medical professional liability—claims-made.....							
12. Earthquake.....							
13.1 Comprehensive (hospital and medical) individual.....							
13.2 Comprehensive (hospital and medical) group.....							
14. Credit accident and health (group and individual).....							
15.1 Vision only.....							
15.2 Dental only.....							
15.3 Disability income.....							
15.4 Medicare supplement.....							
15.5 Medicare Title XIX.....							
15.6 Medicare Title XVIII.....							
15.7 Long-term care.....							
15.8 Federal employees health benefits plan.....							
15.9 Other health.....							
16. Workers' compensation.....							
17.1 Other liability—occurrence.....							
17.2 Other liability—claims-made.....							
17.3 Excess workers' compensation.....							
18.1 Products liability—occurrence.....							
18.2 Products liability—claims-made.....							
19.1 Private passenger auto no-fault (personal injury protection).....							
19.2 Other private passenger auto liability.....							
19.3 Commercial auto no-fault (personal injury protection).....							
19.4 Other commercial auto liability.....							
21.1 Private passenger auto physical damage.....							
21.2 Commercial auto physical damage.....							
22. Aircraft (all perils).....							
23. Fidelity.....							
24. Surety.....							
26. Burglary and theft.....							
28. Boiler and machinery.....							
28. Credit.....							
29. International.....							
30. Warranty.....							
31. Reinsurance—nonproportional assumed property.....							
32. Reinsurance—nonproportional assumed liability.....							
33. Reinsurance—nonproportional assumed financial lines.....							
34. Aggregate write-ins for other lines of business.....							
35. TOTALS.....							
DETAILS OF WRITE-INS.....							
3401.....							
3402.....							
3403. Sum of remaining write-ins for Line 34 from overflow page.....							
3499. Totals (Lines 3401 through 3403 + 3498) (Line 34 above).....							

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**UNDERWRITING AND INVESTMENT EXHIBIT  
PART 2A – UNPAID LOSSES AND LOSS ADJUSTMENT EXPENSES**

Line of Business	Repaired Losses			Incurred But Not Reported			8 Net Losses Unpaid (Cols. 4 + 5 + 6 - 7)	9 Net Unpaid Loss Adjustment Expenses
	1 Direct	2 Reinsurance Assumed	3 Deduct Reinsurance Recoverable	4 Net Losses Excl. Incurred But Not Reported (Cols. 1-2-3)	5 Direct	6 Reinsurance Assumed		
1. Fire.....								
2.1 Allied lines.....								
2.2 Multiple peril crop.....								
2.3 Federal flood.....								
2.4 Private crop.....								
2.5 Private flood.....								
3. Homeowners multiple peril.....								
4. Homeowners multiple peril (non-liability portion).....								
5.1 Commercial multiple peril (non-liability portion).....								
5.2 Commercial multiple peril (liability portion).....								
6. Mortgage guaranty.....								
8. Ocean marine.....								
9.1 Inland marine.....								
9.2 Pet insurance plans.....								
10. Financial guaranty.....								
11.1 Medical professional liability—claims-made.....								
11.2 Medical professional liability—occurrence.....								
12. Earthquake.....								
13.1 Comprehensive (hospital and medical) individual.....								
13.2 Comprehensive (hospital and medical) group.....								
14. Credit accident and health (group and individual).....								
15.1 Vision only.....								
15.2 Dental only.....								
15.3 Disability income.....								
15.4 Medicare supplement.....								
15.5 Medicare Title XIX.....								
15.6 Medicare Title XVIII.....								
15.7 Long-term care.....								
15.8 Federal employees health benefits plan.....								
15.9 Other health.....								
16. Workers' compensation.....								
17.1 Other liability—occurrence.....								
17.2 Other liability—claims-made.....								
17.3 Excess workers' compensation.....								
18.1 Products liability—occurrence.....								
18.2 Products liability—claims-made.....								
19.1 Private passenger auto no-fault (personal injury protection).....								
19.2 Other private passenger auto liability.....								
19.3 Commercial auto no-fault (personal injury protection).....								
19.4 Other commercial auto liability.....								
21.1 Private passenger auto physical damage.....								
21.2 Commercial auto physical damage.....								
22. Aircraft (all perils).....								
23. Fidelity.....								
24. Surety.....								
26. Burglary and theft.....								
27. Boiler and machinery.....								
28. Credit.....								
29. Commercial.....								
30. International.....								
31. Guaranty.....								
32. Reinsurance-nonproportional assumed property liability.....								
33. Reinsurance-nonproportional assumed liability.....								
34. Reinsurance-nonproportional assumed financial lines.....								
35. Aggregate write-ins for other lines of business.....								
TOTALS.....								
3401. DETAILS OF WRITE-INS.....								
3402. XXX								
3403. XXX								
3404. XXX								
3498. Sum. of remaining write-ins for Line 34 from overflow page.....								
3499. Totals (Lines 3401 through 3403 + 3498) (Line 34 above).....								

(a) Including \$.....for present value of life indemnity claims reported in Lines 13 and 15.

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EXHIBIT OF PREMIUMS AND LOSSES (Statutory Page 14)

NAIC Group Code	Line of Business	BUSINESS IN THE STATE OF _____ DURING THE YEAR _____												12 Taxes, Licenses and Fees		
		1 Direct Premiums Written	2 Direct Premiums Earned	3 Dividends or Credited to Policyholders on Direct Business	4 Direct Unearned Reserves	5 Direct Losses Paid (deducting salvage)	6 Direct Losses Incurred	7 Direct Losses Unpaid	8 Direct Defense and Cost Expense Paid	9 Direct Defense and Cost Expense Incurred	10 Direct Defense and Cost Expense Unpaid	11 Commissions and Expense				
	1. Fire.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	2.1 Allied Lines.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	2.2 Multiple Peril Crop.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	2.3 Federal Flood.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	2.5 Private Flood.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	3. Farmowners Multiple Peril.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	4. Homesteaders Multiple Peril.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	5.1 Commercial Multiple Peril (Non- Liability).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	5.2 Commercial Multiple Peril (Liability Portion).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	6. Mortgage Guaranty.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	8. Ocean Marine.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	9.1 Inland Marine.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	9.2 Pet Insurance Plans.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	10. Medical Professional Liability.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	11.1 Medical Professional Liability— Claims-Made.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	12. Earthquake.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	13.1 Comprehensive (hospital and medical) net (b).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	13.2 Comprehensive (hospital and medical) net group (b).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	14. Credit A&H Group and Individual.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	15.1 Vision Only (b).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	15.2 Dental Only (b).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	15.3 Disability Income (b).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	15.4 Long-Term Care (b).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	15.5 Medicare Part XVIII (b).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	15.6 Medicare Title XVIII (b).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	15.7 Long-Term Care (b).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	15.8 Federal Employees Health Benefits Plan (b).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	15.9 Other Health (b).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	16. Other Liability.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	17.1 Other Liability— Occurrence.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	17.2 Other Liability— Claims-Made.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	17.3 Excess Workers' Compensation.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	18.1 Products Liability— Occurrence.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	18.2 Products Liability— Claims-Made.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	19.1 Private Passenger Auto No-Fault (Personal Injury Protection).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	19.2 Other Private Passenger Auto Liability.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	19.3 Commercial Auto No-Fault (Personal Injury Protection).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	19.4 Commercial Auto Liability.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	21.1 Private Passenger Auto Physical Damage.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	21.2 Commercial Auto Physical Damage.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	22. Aircraft (toll perils).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	23. Fidelity.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	24. Boiler and Machinery.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	25. Boiler and Machinery.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	26. Boiler and Machinery.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	27. Boiler and Machinery.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	28. Credit.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	29. International.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	30. Reinsurance.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	31. Reins nonproportional assumed process.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	32. Reins nonproportional assumed process.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	33. Reins nonproportional assumed financial lines.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	34. Aggregate Write-Ins for Other Lines of Business.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	35. TOTAL (b)	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....

DETAILS OF WRITE-INS

3492.....  
 3493.....  
 3494.....  
 3498 Sum of remaining write-ins for Line 34 from overflow page.....  
 3499 TOTAL (Lines 3401 through 3493 plus 3498) (Line 34 above)

(b) Finance and service charges not included in Lines 1 to 35  
 (b) For health business on indicated lines report: Number of persons insured under PPO managed care products..... and number of persons insured under indemnity only products.....

**INSURANCE EXPENSE EXHIBIT**  
**PART II – ALLOCATION TO LINES OF BUSINESS NET OF REINSURANCE**  
**PREMIUMS, LOSSES, EXPENSES, RESERVES AND PROFITS AND PERCENTAGES TO PREMIUMS EARNED FOR BUSINESS NET OF REINSURANCE**  
**(\$'000 OMITTED)**

	Premiums Written (Pg. 8, Pt. 1B, Col. 6)		Premiums Earned (Pg. 6, Pt. 1, Col. 4)		Dividends to Policyholders (Pg. 4, Line 17)		Incurred Loss (Pg. 9, Pt. 2, Col. 7)		Loss Adjustment Expense Defense and Cost Containment Expenses Incurred		Loss Adjustment Expense Adjusting and Other Expenses Incurred		Unpaid Losses (Pg. 10, Pt. 2A, Col. 8)		Loss Adjustment Expense Defense and Cost Containment Expenses Unpaid		Loss Adjustment Expense Adjusting and Other Expenses Unpaid		Unearned Premium Reserves (Pg. 7, Pt. 1A, Col. 5)		Agents' Balances	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
1. Fire	XXX																					
2.1 Allied Lines	XXX		100.0																			
2.2 Multiple Peril Crp	XXX																					
2.3 Private Crop	XXX																					
2.4 Private Flood	XXX																					
2.5 Private Flood	XXX																					
3. Farmowners Multiple Peril	XXX																					
4. Homeowners Multiple Peril	XXX																					
5.1 Comm Multi Peril (Lab)	XXX																					
5.2 Comm Multi Peril (Lab)	XXX																					
6. Mortgage Guaranty	XXX																					
8. Ocean Marine	XXX																					
9. Inland Marine	XXX																					
10. Pet Insurance Plans	XXX																					
11.1 Med Prof Libs—Occurrence	XXX																					
11.2 Med Prof Libs—Claims-Made	XXX																					
12. Earthquakes	XXX																					
13.1 Comprehensive Individual	XXX																					
13.2 Comprehensive Group	XXX																					
14. Credit A&H	XXX																					
15.1 Vision Only	XXX																					
15.2 Dental Only	XXX																					
15.3 Disability Income	XXX																					
15.4 Medical Expense	XXX																					
15.5 Medicare Title XIX	XXX																					
15.6 Medicare Title XVIII	XXX																					
15.7 Long-Term Care	XXX																					
15.8 FEHBP	XXX																					
15.9 Other Health	XXX																					
16.1 Workers Comp	XXX																					
17.1 Other Liability—Occurrence	XXX																					
17.2 Other Liability—Claims-Made	XXX																					
17.3 Excess Workers' Compensation	XXX																					
18.1 Products Lib—Occurrence	XXX																					
18.2 Products Lib—Claims-Made	XXX																					
19.1 Priv Passenger Auto No-Fault	XXX																					
19.2 Other Priv Passenger Auto Lib	XXX																					
19.3 Commercial Auto No-Fault	XXX																					
19.4 Other Commercial Auto Liability	XXX																					
21.1 Priv Passenger Auto No-Fault	XXX																					
21.2 Commercial Auto No-Fault	XXX																					
22. Aircraft (all perils)	XXX																					
23. Fidelity	XXX																					
24. Surety	XXX																					
26. Burglary and Theft	XXX																					
27. Power and Machinery	XXX																					
28. Credit	XXX																					
29. International	XXX																					
30. Warranty	XXX																					
31. Reins-Nonproportional Assumed Property	XXX																					
32. Reins-Nonproportional Assumed Casualty	XXX																					
33. Reins-Nonproportional Assumed Fire/Lib	XXX																					
34. A&P White-Ins for Other Lines of Bus.	XXX																					
35. TOTAL (Lines 1 through 34)	XXX		100.0																			
<b>DETAILS OF WRITINGS</b>																						
3401.	XXX		100.0																			
3402.	XXX		100.0																			
3403.	XXX		100.0																			
3408.	XXX		100.0																			
3499.	XXX		100.0																			
3499.	XXX		100.0																			

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**INSURANCE EXPENSE EXHIBIT**  
**PART II—ALLOCATION TO LINES OF BUSINESS NET OF REINSURANCE (Continued)**  
**PREMIUMS, LOSSES, EXPENSES, RESERVES AND PROFITS AND PERCENTAGES TO PREMIUMS EARNED FOR BUSINESS NET OF REINSURANCE**  
**(\$'000 OMITTED)**

	Commission and Brokerage Expenses Incurred (IEE Pt. 1, Line 2.8, Col. 2)		Taxes, Licenses & Fees Incurred (IEE Pt. 1, Line 20.5, Col. 4)		Other Underwriting Expenses		General Expenses Incurred (IEE Pt. 1, Line 25, Col. 3)		Other Income Less Other Expenses (Pg. 4, Line 15 minus Line 5)		Pre-Tax Profit or Loss Excluding All Investment Gain		Investment Gain Attributable to Insurance Transactions		Profit or Loss Excluding Investment Gain Attributable to Capital and Surplus		Investment Gain Attributable to Capital and Surplus		Total Profit or Loss		
	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	
1. Fire																					
2.1 Allied Lines																					
2.2 Multiple Peril Cop																					
2.3 Auto																					
2.4 Private Flood																					
2.5 Private Flood																					
3. Farmowners Multiple Peril																					
4. Homeowners Multiple Peril																					
5.1 Comm Multi Peril (Non-Lab)																					
5.2 Comm Multi Peril (Lab)																					
6. Mortgage Guaranty																					
8. Ocean Marine																					
9.1 Inland Marine																					
9.2 Pet Insurance Plans																					
10.1 Multiple Peril - Occurrence																					
11.1 Med Prof Lib - Occurrence																					
11.2 Med Prof Lib - Claims-Made																					
12. Earthquake																					
13.1 Comprehensive Individual																					
14. Comprehensive Group																					
15.1 Vision Only																					
15.2 Dental Only																					
15.3 Disability Income																					
15.4 Medicare Supplement																					
15.5 Medicare Supplement																					
15.6 Medicare Title XVIII																					
15.7 Long Term Care																					
15.8 FEHBP																					
15.9 Other Health																					
16.1 Workers' Compensation																					
17.1 Other Liability - Occurrence																					
17.2 Other Liability - Claims-Made																					
17.3 Excess Workers' Compensation																					
18.1 Products Lib - Occurrence																					
18.2 Products Lib - Claims-Made																					
19.2 Other Priv Passenger Auto Lib																					
19.3 Commercial Auto No-Fault																					
19.4 Other Commercial Auto Lib																					
21.1 Priv Passenger Auto Phys Damage																					
21.2 Commercial Auto Phys Damage																					
22. Aircraft (all risks)																					
23. Fidelity																					
24. Surety																					
26. Burglary and Theft																					
27. Boiler and Machinery																					
29. International																					
30. Warranty																					
31. Reins-Nonproportional Assumed Property																					
32. Reins-Nonproportional Assumed Liab																					
33. Agr Write-ins for Other Lines of Bus																					
34. Agr Write-ins for Other Lines of Bus																					
35. TOTAL (Lines 1 through 34)																					
DEFICITS OF WRITE-INS																					
3401. ....																					
3402. ....																					
3403. ....																					
3404. ....																					
3405. Summary of remaining write-ins for Line 34 from overflow page																					
3498. ....																					
3499. TOTAL (Lines 3401 through 3405 plus 3498) (Line 34 above)																					

NOTE: THE ALLOCATION OF INVESTMENT INCOME FROM CAPITAL AND SURPLUS BY LINE OF BUSINESS MAY NOT ACCURATELY REFLECT THE PROFITABILITY OF A PARTICULAR LINE FOR USE IN THE RATE MAKING PROCESS.

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**INSURANCE EXPENSE EXHIBIT**  
**PART III – ALLOCATION TO LINES OF DIRECT BUSINESS WRITTEN**  
**PREMIUMS, LOSSES, EXPENSES, RESERVES AND PROFITS AND PERCENTAGES TO PREMIUMS EARNED FOR DIRECT BUSINESS WRITTEN**  
**(\$000 OMITTED)**

	Premiums Written (Pg. 8, Pt. 1B, Col. 1)		Premiums Earned (Sch. T, Line 59, Col. 3)		Dividends to Policyholders		Incurred Loss (Sch. T, Line 59, Col. 6)		Loss Adjustment Expense Defense and Cost Containment Expenses Incurred			Loss Adjustment Expense Adjusting and Other Expenses Incurred			Unpaid Losses (Sch. T, Line 59, Col. 7)			Loss Adjustment Expense Defense and Cost Containment Expenses Unpaid			Unpaid Premium Reserves			Agents' Balances				
	1 Amount	2 %	3 Amount	4 %	5 Amount	6 %	7 Amount	8 %	9 Amount	10 %	11 Amount	12 %	13 Amount	14 %	15 Amount	16 %	17 Amount	18 %	19 Amount	20 %	21 Amount	22 %						
1. Fire.....	XXX	100.0	XXX	100.0																								
2.1 Allied Lines.....	XXX	100.0	XXX	100.0																								
2.2 Multiple Peril Crop.....	XXX	100.0	XXX	100.0																								
2.3 Federal Flood.....	XXX	100.0	XXX	100.0																								
2.4 Private Flood.....	XXX	100.0	XXX	100.0																								
2.5 Earthquake.....	XXX	100.0	XXX	100.0																								
3. Farmowners Multiple Peril.....	XXX	100.0	XXX	100.0																								
4. Homeowners Multiple Peril.....	XXX	100.0	XXX	100.0																								
5.1 Comm Mutl Peril (Non-Liab).....	XXX	100.0	XXX	100.0																								
5.2 Comm Mutl Peril (Liab).....	XXX	100.0	XXX	100.0																								
6. Ocean Marine.....	XXX	100.0	XXX	100.0																								
7. Inland Marine.....	XXX	100.0	XXX	100.0																								
8. Pet Insurance Plans.....	XXX	100.0	XXX	100.0																								
9. Financial Guaranty.....	XXX	100.0	XXX	100.0																								
10. Life Insurance.....	XXX	100.0	XXX	100.0																								
11.2 Excess Workers' Compensation.....	XXX	100.0	XXX	100.0																								
12. Earthquake.....	XXX	100.0	XXX	100.0																								
13.1 Comprehensive Individual.....	XXX	100.0	XXX	100.0																								
13.2 Comprehensive Group.....	XXX	100.0	XXX	100.0																								
13.3 Credit &CH.....	XXX	100.0	XXX	100.0																								
14.1 Life Insurance.....	XXX	100.0	XXX	100.0																								
15.1 Dental Only.....	XXX	100.0	XXX	100.0																								
15.2 Disability Income.....	XXX	100.0	XXX	100.0																								
15.3 Medicare Supplement.....	XXX	100.0	XXX	100.0																								
15.4 Medicaid Title XXX.....	XXX	100.0	XXX	100.0																								
15.5 Medicare Title VIII.....	XXX	100.0	XXX	100.0																								
15.6 Long Term Care.....	XXX	100.0	XXX	100.0																								
15.7 FEHBP.....	XXX	100.0	XXX	100.0																								
15.8 Other Health.....	XXX	100.0	XXX	100.0																								
16. Workers' Compensation.....	XXX	100.0	XXX	100.0																								
17.1 Excess Workers' Compensation.....	XXX	100.0	XXX	100.0																								
17.2 Other Liability - Claims Made.....	XXX	100.0	XXX	100.0																								
17.3 Excess Workers' Compensation.....	XXX	100.0	XXX	100.0																								
18.1 Products Liab-Occurrence.....	XXX	100.0	XXX	100.0																								
18.2 Products Liab-Claims-Made.....	XXX	100.0	XXX	100.0																								
19.1 Priv Passenger Auto No-Fault.....	XXX	100.0	XXX	100.0																								
19.2 Commercial Auto No-Fault.....	XXX	100.0	XXX	100.0																								
19.3 Commercial Auto No-Fault.....	XXX	100.0	XXX	100.0																								
19.4 Other Commercial Auto Liability.....	XXX	100.0	XXX	100.0																								
21.1 Priv Passenger Auto Phys Damage.....	XXX	100.0	XXX	100.0																								
21.2 Commercial Auto Phys Damage.....	XXX	100.0	XXX	100.0																								
22.1 Commercial Auto Phys Damage.....	XXX	100.0	XXX	100.0																								
23. Fidelity.....	XXX	100.0	XXX	100.0																								
24. Surety.....	XXX	100.0	XXX	100.0																								
26. Burglary and Theft.....	XXX	100.0	XXX	100.0																								
27. Boiler and Machinery.....	XXX	100.0	XXX	100.0																								
28. Credit.....	XXX	100.0	XXX	100.0																								
29. Financial.....	XXX	100.0	XXX	100.0																								
30. Warranty.....	XXX	100.0	XXX	100.0																								
31. Reins-Nonproportional Assumed Property.....	XXX	100.0	XXX	100.0																								
32. Reins-Nonproportional Assumed Liab.....	XXX	100.0	XXX	100.0																								
33. Reins-Nonproportional Assumed Fin Lines.....	XXX	100.0	XXX	100.0																								
34. TOTAL (Lines 1 through 34).....	XXX	100.0	XXX	100.0																								
35. TOTAL (Lines 1 through 34).....	XXX	100.0	XXX	100.0																								
DEFINES OF WRITE-INS.....																												
3401. ....																												
3402. ....																												
3403. ....																												
3408. Summary of remaining write-ins for Line.....																												
3498. TOTAL (Lines 3401 through 3403) plus.....																												
3499. 3498) (Line 34 above).....																												

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**INSURANCE EXPENSE EXHIBIT**  
**PART III – ALLOCATION TO LINES OF DIRECT BUSINESS WRITTEN (Continued)**  
**PREMIUMS, LOSSES, EXPENSES, RESERVES AND PERCENTAGES TO PREMIUMS EARNED FOR DIRECT BUSINESS WRITTEN**  
**(\$000 OMITTED)**

	Commission and Brokerage Expenses				Taxes, Licenses & Fees Incurred				Other Underwriting Expenses				General Expenses Incurred		Other Income Less Other Expenses		Pre-Tax Profit or Loss Excluding All Investment	
	23 Amount	24 %	25 Amount	26 %	27 Amount	28 %	29 Amount	30 %	31 Amount	32 %	33 Amount	34 %						
1. Fire.....																		
2.1 Allied Lines.....																		
2.2 Multiple Peril Crop.....																		
2.3 Fidelity Bond.....																		
2.4 Private Flood.....																		
2.5 Private Flood.....																		
3. Farmowners Multiple Peril.....																		
4. Homeowners Multiple Peril.....																		
5.1 Comm Multi Peril (Non-Liab).....																		
6.1 Multi Peril (Liab).....																		
6.2 Mortgage Guaranty.....																		
8. Ocean Marine.....																		
9.1 Inland Marine.....																		
9.2 Pet Insurance Plans.....																		
10.1 Motor Vehicle Liability.....																		
11.1 Motor Vehicle Liability—Occurrence.....																		
11.2 Motor Vehicle Liability—Claims Made.....																		
12. Earthquake.....																		
13.1 Comprehensive Individual.....																		
13.2 Comprehensive Group.....																		
14.1 Vision Only.....																		
15.2 Dental Only.....																		
15.3 Disability Income.....																		
15.4 Medicare Supplement.....																		
15.5 Medicare Supplement.....																		
15.6 Medicare Supplement.....																		
15.7 Medicare Supplement.....																		
15.8 Long-Term Care.....																		
15.9 FEHBP.....																		
15.9 Other Health.....																		
16. Workers Compensation.....																		
17. Other Liability.....																		
17.2 Other Liability—Claims Made.....																		
17.3 Excess Workers' Compensation.....																		
18.1 Products Liability—Occurrence.....																		
18.2 Products Liability—Claims Made.....																		
18.3 Products Liability—Occurrence.....																		
19.2 Other Prio Passenger Auto Liab.....																		
19.3 Commercial Auto Non-Fault.....																		
19.4. Other Commercial Auto Liability.....																		
21.1 Prio Passenger Auto Phys Damage.....																		
21.2 Commercial Auto Phys Damage.....																		
22. Commercial Auto Phys Damage.....																		
23. Fidelity.....																		
24. Surety.....																		
26. Burglary and Theft.....																		
27. Boiler and Machinery.....																		
29. International.....																		
30. Warranty.....																		
31. Reins-Nonproportional Assumed Property.....																		
32. Reins-Nonproportional Assumed Liab.....																		
33. Reins-Nonproportional Assumed Liab.....																		
34. Assur Write-Ins for Other Lines.....																		
35. TOTAL (Lines 1 through 34).....																		
DETAILS OF WRITE-INS																		
3401.....																		
3402.....																		
3403.....																		
3408.....																		
3499.....																		
TOTAL (Lines 3401 through 3405 plus 3408) (Line 34 above).....																		

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**SCHEDULE P – PART 1U – PET INSURANCE PLANS**  
**(\$000 OMITTED)**

Years in Which Premiums Were Earned and Losses Were Incurred	Premiums Earned			Loss and Loss Expense Payments						10 Salvage and Subrogation Received	11 Total Net Paid (Cols. 4 - 5 + 6 - 7 + 8 - 9)	12 Number of Claims Reported Direct and Assumed
	1 Direct and Assumed	2 Ceded	3 Net (Cols. 1 - 2)	Loss Payments		Defense and Cost Containment Payments		Adjusting and Other Payments				
				4 Direct and Assumed	5 Ceded	6 Direct and Assumed	7 Ceded	8 Direct and Assumed	9 Ceded			
1. Prior .....	XXX	XXX	XXX	.....	.....	.....	.....	.....	.....	.....	.....	XXX
2. 2023 .....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	XXX
3. 2024 .....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	XXX
4. Totals	XXX	XXX	XXX									XXX

	Losses Unpaid				Defense and Cost Containment Unpaid				Adjusting and Other Unpaid		23 Salvage and Subrogation Anticipated	24 Total Net Losses and Expenses Unpaid	25 Number of Claims Outstanding Direct and Assumed
	Case Basis		Bulk + IBNR		Case Basis		Bulk + IBNR		21 Direct and Assumed	22 Ceded			
	13 Direct and Assumed	14 Ceded	15 Direct and Assumed	16 Ceded	17 Direct and Assumed	18 Ceded	19 Direct and Assumed	20 Ceded					
1. ....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
2. ....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
3. ....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
4. ....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....

	Total Losses and Loss Expenses Incurred			Loss and Loss Expense Percentage (Incurred/Premiums Earned)			Nontabular Discount		34 Inter-Company Pooling Participation Percentage	Net Balance Sheet Reserves After Discount	
	26 Direct and Assumed	27 Ceded	28 Net	29 Direct and Assumed	30 Ceded	31 Net	32 Loss	33 Loss Expense		35 Losses Unpaid	36 Loss Expenses Unpaid
1. ....	XXX	XXX	XXX	XXX	XXX	XXX	.....	.....	XXX	.....	.....
2. ....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
3. ....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
4. ....	XXX	XXX	XXX	XXX	XXX	XXX			XXX		



**Detail Eliminated to Conserve Space**


**SCHEDULE P – PART 2U – PET INSURANCE PLANS**

Years in Which Losses Were Incurred	INCURRED NET LOSSES AND DEFENSE AND COST CONTAINMENT EXPENSES REPORTED AT YEAR-END (\$000 OMITTED)										DEVELOPMENT	
	1 2015	2 2016	3 2017	4 2018	5 2019	6 2020	7 2021	8 2022	9 2023	10 2024	11 One Year	12 Two Year
1. Prior .....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	.....
2. 2023 .....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	XXX
3. 2024 .....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	XXX
4. Totals												

**SCHEDULE P – PART 3U – PET INSURANCE PLANS**

Years in Which Losses Were Incurred	CUMULATIVE PAID NET LOSSES AND DEFENSE AND COST CONTAINMENT EXPENSES REPORTED AT YEAR-END (\$000 OMITTED)										11 Number of Claims Closed With Loss Payment	12 Number of Claims Closed Without Loss Payment
	1 2015	2 2016	3 2017	4 2018	5 2019	6 2020	7 2021	8 2022	9 2023	10 2024		
1. Prior.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	000	.....	.....	XXX	XXX
2. 2023.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	.....	XXX	XXX
3. 2024.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	XXX	XXX


**Detail Eliminated to Conserve Space**


**SCHEDULE P – PART 4U – PET INSURANCE PLANS**

Years in Which Losses Were Incurred	BULK AND IBNR RESERVES ON NET LOSSES AND DEFENSE AND COST CONTAINMENT EXPENSES REPORTED AT YEAR-END (\$000 OMITTED)									
	1 2015	2 2016	3 2017	4 2018	5 2019	6 2020	7 2021	8 2022	9 2023	10 2024
1. Prior.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	.....	.....
2. 2023.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	.....
3. 2024.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....

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**NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

	DATE: <u>08/19/2022</u>	<b>FOR NAIC USE ONLY</b>
<b>CONTACT PERSON:</b> _____		Agenda Item # <u>2022-15BWG</u>
<b>TELEPHONE:</b> _____		Year <u>2023</u>
<b>EMAIL ADDRESS:</b> _____		Changes to Existing Reporting <input checked="" type="checkbox"/> [ X ]
<b>ON BEHALF OF:</b> _____		New Reporting Requirement <input type="checkbox"/> [ ]
<b>NAME:</b> <u>Debbie Doggett</u>		<b>REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</b>
<b>TITLE:</b> _____		No Impact <input checked="" type="checkbox"/> [ X ]
<b>AFFILIATION:</b> <u>Missouri Department of Insurance</u>		Modifies Required Disclosure <input type="checkbox"/> [ ]
<b>ADDRESS:</b> <u>301 W High St #630</u>		<b>DISPOSITION</b>
<u>Jefferson City, MO 65101</u>		<input type="checkbox"/> [ ] Rejected For Public Comment
		<input type="checkbox"/> [ ] Referred To Another NAIC Group
		<input checked="" type="checkbox"/> [ X ] Received For Public Comment
		<input type="checkbox"/> [ ] Adopted Date _____
		<input type="checkbox"/> [ ] Rejected Date _____
		<input type="checkbox"/> [ ] Deferred Date _____
		<input type="checkbox"/> [ ] Other (Specify) _____

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- |                                                                             |                                                        |                                                       |
|-----------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------|
| <input checked="" type="checkbox"/> [ X ] ANNUAL STATEMENT                  | <input checked="" type="checkbox"/> [ X ] INSTRUCTIONS | <input checked="" type="checkbox"/> [ X ] CROSSCHECKS |
| <input type="checkbox"/> [ ] QUARTERLY STATEMENT                            | <input type="checkbox"/> [ ] BLANK                     |                                                       |
| <input checked="" type="checkbox"/> [ X ] Life, Accident & Health/Fraternal | <input type="checkbox"/> [ ] Separate Accounts         | <input type="checkbox"/> [ ] Title                    |
| <input checked="" type="checkbox"/> [ X ] Property/Casualty                 | <input type="checkbox"/> [ ] Protected Cell            | <input type="checkbox"/> [ ] Other _____              |
| <input type="checkbox"/> [ ] Health                                         | <input type="checkbox"/> [ ] Health (Life Supplement)  |                                                       |

Anticipated Effective Date: Annual 2023

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Revise the language of the Schedule H, Part 5 to remove the 5% of premiums filing exemption (FE).

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE\*\***

The purpose of the proposal is to remove the 5% of premium filing exemption on the Schedule H, Part 5. Before Schedule H was updated for Annual 2022 to bring uniformity in the accident and health lines of business, the Property/Casualty instructions for Schedule H, Part 5 had the less than 5% filing exemption and the Life/Fraternal instructions did not have the 5% filing exemption. The removal of the 5% exemption would require both Property/Casualty and Life/Fraternal filers to file the Schedule H, Part 5.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: \_\_\_\_\_

Other Comments:



\*\* This section must be completed on all forms.

Revised 7/18/2018

ANNUAL STATEMENT INSTRUCTIONS – LIFE\FRATERNAL AND PROPERTY

SCHEDULE H

ACCIDENT AND HEALTH EXHIBIT



↓  
↑  **Detail Eliminated to Conserve Space**  ↓

PART 5 – HEALTH CLAIMS

A. DIRECT

Line 1 – Incurred Claims

Should agree with Line 3 plus Line 4 minus Line 2.

↓  
↑  **Detail Eliminated to Conserve Space**  ↓

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### Property and Casualty Risk-Based Capital Committee Recent Activities

Ronald Wilkins, MAAA, FCAS  
Vice Chairperson  
Property and Casualty Risk-Based Capital Committee

Discussion of Preliminary Results—For Discussion Only

March 22, 2023



### Agenda

1. Background
2. 2022 interest rate increases—need for new present value methodology
3. Investment income offset and adjustment for loss runoff risk horizon (preliminary figures)
4. Safety Level Options (preliminary figures)
5. Year-over-year capping approaches (preliminary figures)



### Background: Importance of R4 and R5

- The committee (“we”, within this presentation) has been working to recalibrate the R4 and R5 components of risk-based capital (RBC) with certain small exceptions (e.g., excessive premium growth charge). These are particularly important for companies with an RBC ratio of 3 or less (see highlighted figures).

RBC Charge	2021 Company Action Level Amounts (\$B)			
	P&C Industry		Cos. w/ RBC Ratio <= 3.0	
	Amount	%	Amount	%
R0 Subsidiary	84.1	6%	2.2	
R1 Asset - Fixed Income	19.5	6%	0.9	6%
R2 Asset - Equity	192.1	59%	1.4	9%
R3 Credit	11.4	4%	1.1	8%
R4 Reserve	145.5	46%	1.8	12%
R5 Premium	81.1	25%	1.8	12%
Rcat Catastrophe	54.5	17%	1.8	12%
Total	407.6		17.1	
Total ex. R0	323.5	100%	14.9	100%

**Notes:**  
Figures in this chart are aggregate company action level amounts for the industry and for companies with an RBC Ratio of 3 or less.  
The totals in the last two rows of the chart are before Basic Operational Risk. The totals are less than the sum of the preceding rows because they are the result of the covariance adjustment for each company (i.e., square root of sum of squares).  
For the companies with an RBC Ratio of 3 or less, the RBC Ratio for each company is calculated as Authorized Control Level RBC including Basic Operational Risk, divided by Total Adjusted Capital.



### Background: Calculation of Premium Risk and Reserve Risk

- For each line of business, premium risk and reserve risk are calculated as
  - Basic Risk Factor, excluding **Rcat overlap**
  - Adjustment for 10-Yr company experience in relation to industry
  - Adjustment for company expenses (premium risk only)
  - **Adjustment for investment income (IIA)**
  - Adjustment for loss sensitive discount
- Risk charges for each line are summed and a **diversification factor** is applied to calculate the all-lines risk charge.
- We provided indicated basic risk factors before the adjustment to remove the Rcat overlap to the working group in April 2021.
- We are working on updating the highlighted portions of R4 and R5.



### Background: Investment Income Adjustment (IIA)

- The IIA reduces the risk charge for anticipated investment income earned on losses prior to payout at the risk-free rate. This credit gets applied to both Reserve Risk and Premium Risk.
- Two elements go into the calculation of the IIA
  - Payment patterns—time between when ultimate losses are incurred and losses are paid out.
    - We used industry total paid loss triangles from Schedule P part 2 and RBC filings to calculate payment patterns.
    - Previous methodology was similar to IRS tax methodology and used a single point along the diagonal from Schedule P part 1.
    - Also new is a method to determine loss payouts beyond year ten. Previous method was similar to IRS and generally repeated last payout percent in each subsequent years (up to year 15) until losses were 100% paid.
    - New method exponentially decays unpaid losses (up to year 40). The decay rate gets selected from runoff in development years 8-10. Generally, the decay rate is the losses that get paid in the next development year as a percentage of unpaid losses at the beginning of the year.
  - Interest rates—these have varied extensively across the experience period used to calibrate risk charges (starting in 1987). See next slide.



### Historical Interest Rates



Observation:  
Interest rates have declined from above 8% in the late '80s to below 2% in 2012–17. In the past year, rates increased to about 4%.



### Investment Income Adjustment (IIA)

- Year-by-year variation in nominal risk charges (calculated from Schedule P and RBC data for this analysis) has generally followed the variation in US Treasury rates.
- 
- Hence, we utilize a new method, the present value method, that discounts individual company datapoints in the dataset based on historical interest rates and then chooses the 87.5 percentile.
  - This approach produces a more consistent measure of risk because it removes a systematic source of variation in results across the experience period. What remains is a better reflection of true risk inherent in the lines, at present values.
  - We will still calculate an investment income adjustment factor for use in the RBC formula. We will essentially divide this factor from the 87.5 percentile discounted datapoint so that the final risk charge is not affected.



### IIA—Risk Horizon for Loss Runoff

- The premium and reserve risk datapoints used in the analysis come from Schedule P or RBC filings, generally at 10 years development.
  - Premium risk factors have a development time horizon of ten years. We generally capture the loss ratio for the most mature accident year at age ten. Hence the development time horizon for premium risk is ten years.
  - Reserve risk factors have a development time horizon of nine years. We generally capture the most mature incurred losses at age ten and calculate the change from the initial reading at age 1. Hence, this reflects a development horizon of nine years.
- Payout patterns run off for up to 40 years. Premium and reserve risk still exist after age 10 and this is not captured in the analysis. Hence, we recommend adjusting the investment income discount to match the risk horizon. Specifically, we do not recommend providing credit for investment income beyond the time horizon period for which risk is captured.
- We accomplish this by adjusting the 87.5th percentile present value risk factors based on how much investment income can be earned in a period limited to 10 or nine years compared to how much can be earned over full runoff of the line of business.
  - We calculated these adjustments factors using current risk-free rates.
  - The adjustments increase with the level of interest rates.



### Impact of Adjustments to Loss Runoff Horizon – Preliminary Figures

LOB	Premium Risk Charge			Reserve Risk Charge		
	Unadj. Incr.	Adjus. Incr.	% Chg.	Unadj. Incr.	Adjus. Incr.	% Chg.
HO	0.213	0.213	0.1%	16.4%	16.6%	0.9%
PPA	0.137	0.138	0.3%	12.8%	12.8%	1.4%
CA	0.201	0.201	0.4%	25.7%	25.9%	0.9%
MC	0.095	0.121	27.0%	1.6%	4.9%	213.2%
CMP	0.173	0.176	1.5%	31.4%	32.6%	3.7%
MPL-O	0.345	0.363	5.2%	8.0%	9.5%	19.0%
MPL-C	0.230	0.244	2.1%	-1.5%	-0.8%	-45.8%
IL	0.200	0.204	1.7%	21.5%	24.0%	11.8%
DL	0.125	0.136	8.5%	27.4%	29.3%	7.0%
SP	0.094	0.095	0.1%	21.3%	21.3%	0.3%
APD	0.054	0.054	0.0%	11.2%	11.2%	-0.1%
Pd/Sur	0.105	0.106	0.9%	43.7%	44.0%	0.7%
Emer	0.143	0.143	0.2%	14.6%	14.7%	0.6%
Inf	0.934	0.944	1.0%	81.2%	83.3%	5.1%
Re-Prop	0.296	0.299	0.9%	19.6%	20.5%	4.7%
Re-Liab	0.196	0.231	18.0%	19.9%	26.7%	34.3%
PL	0.266	0.287	8.0%	97.7%	101.5%	3.9%
PC/MG	1.532	1.524	-0.1%	-5.1%	-5.0%	-1.9%
Wrtty	0.216	0.216	0.0%	30.2%	30.2%	0.0%

Negative changes are generally increases. Here, the negative risk charge decreases, hence the negative change.

### Development of Reserve Risk Ratio as Risk Horizon Expands from 1 to 9 Years

	87.5 percentile incurred loss change as a percentage of reserves at year 1								
	1 yr	2 yr	3 yr	4 yr	5 yr	6 yr	7 yr	8 yr	9 yr
HO	18.8%	22.2%	23.1%	23.8%	25.2%	25.8%	26.1%	26.8%	26.8%
change		3.5%	1.0%	-0.1%	1.7%	0.6%	0.0%	0.3%	0.5%
MPL	15.6%	22.0%	30.4%	34.5%	37.9%	38.2%	40.0%	40.0%	43.1%
change		6.0%	7.9%	4.1%	3.3%	0.4%	0.0%	-3.1%	3.1%
Re-Liab	25.3%	43.8%	65.4%	96.9%	110.8%	128.2%	152.6%	171.3%	187.3%
change		18.6%	21.7%	31.0%	14.4%	18.4%	20.4%	19.7%	16.1%

- Ultimate incurred losses at the 87.5th percentile increase as risk horizon increases from one to nine years.
- We conclude risk will continue to increase beyond year nine.
- We apply this conclusion to both reserve and premium risk factors. Both depend on how ultimate incurred losses can change over time.

### Statistical Safety Level in RBC—Preliminary Figures

- Part of the recent analysis we have completed is looking at the impacts of using various safety levels in RBC.
- The indicated company action level risk charges in the report are based on an 87.5th percentile safety level. We seek direction from working group members on what safety level to use.
- Considerations for not changing the safety level:
  - Capital required for a loss development runoff time horizon of nine years is more than that required by some regulatory solvency formulas which utilize a one-year development horizon.
  - Past analysis has shown that larger companies, who cover most policyholders, have lower indicated risk charges than smaller and mid-sized companies, implying a higher safety level for most policyholders.
- Considerations for increasing the safety level:
  - 87.5% is lower than the safety level in any other component of the RBC formula or, to our knowledge, in regulatory capital formulas in other countries (e.g., Rca=99%, Bond Factors=95%).
  - Risk charges have declined over time, concurrent with interest rates. But there is no reason to expect a continuation of the downward trend in risk.
  - Years prior to 1988, with poor experience, have been excluded from the analysis and deserve some consideration.
  - Captives and runoff companies may now rely on regulatory capital requirements more, making the setting of regulatory capital more important.
- Preliminary impacts of higher safety levels on indicated risk charges (compared to 87.5 percentile):
  - 90th percentile safety level increases premium risk charges about 25%, reserve risk charges about 42%.
  - 95th percentile safety level increases premium risk charges about 110% and reserve risk charges about 180%.

### Minimum Risk Charges/Year-Over-Year Capping Approaches

- We have considered a minimum risk charge of 5%, consistent with the current lowest risk charge.
- We looked at various capping approaches to limit changes in risk charge over one year to +/- 10%, 20%, or 35%, values which the committee has reviewed in the past.
- These risk charges limits are calculated line by line assuming a company with LOB expense ratio equal to the industry expense ratios and assuming no company loss experience adjustment.
- What capping level approach would working group members prefer?



### Academy P&C RBC Next Steps

- Obtain P&C RBC Working Group Feedback
  - On present value methodology
  - On adjustment to match loss runoff horizon to risk horizon
  - On statistical safety level
  - On minimum risk charge and year-over-year capping approaches
- Complete Revised Investment Income Report—Targeting May–June 2023.
- Report to working group on analysis of line of business diversification factors.

### Contact

- Matthew Sonduck—[sonduck@actuary.org](mailto:sonduck@actuary.org)

Draft: 4/4/23

Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group  
Virtual Meeting  
March 23, 2023

The RBC Investment Risk and Evaluation (E) Working Group of the Capital Adequacy (E) Task Force met March 23, 2023. The following Working Group members participated: Philip Barlow, Chair (DC); Thomas Reedy (CA); Wanchin Chou (CT); Virginia Christy (FL); Vincent Tsang (IL); Roy Eft (IN); Carrie Mears and Kevin Clark (IA); Debbie Doggett (MO); Lindsay Crawford (NE); Bob Kasinow (NY); Dale Bruggeman and Tom Botsko (OH); Rachel Hemphill (TX); Steve Drutz (WA); and Amy Malm (WI). Also participating was: Doug Stolte (VA).

1. Adopted its Feb. 27, 2023, and 2022 Fall National Meeting Minutes

The Working Group met Feb. 27, 2023, and took the following action: 1) discussed comments received on the American Academy of Actuaries' (Academy's) presentation on collateralized loan obligations (CLOs); 2) discussed comments received on the referral from the Valuation of Securities E) Task Force; and 3) discussed potential structure change to address residual tranches.

Eft made a motion, seconded by Chou, to adopt the Working Group's Feb. 27, 2023 (Attachment Five-A) and Dec. 14, 2022 (*see NAIC Proceedings – Fall 2022, Capital Adequacy (E) Task Force, Attachment Six*) minutes. The motion passed unanimously.

2. Received Updates from the Valuation of Securities (E) Task Force and the Statutory Accounting Principles (E) Working Group

Mears said a newly created ad hoc group of the Valuation of Securities (E) Task Force is looking for participation from a variety of stakeholders with technical expertise in this area to dig into some of the more granular areas of the modeling process. Ultimately, the group would have participation from the American Academy of Actuaries (Academy). She said the other item on the agenda of the Task Force is to review the structured equity or rated feeder fund type structures and have a proposal to ensure transparency into those types of structures.

Bruggeman said the Statutory Accounting Principles (E) Working Group is moving forward with the principle-based bond definition in their its reporting, which includes the new Schedule D1.1 and D1.2 and new reporting categories with the planned effective date of Jan. 1, 2025. He said the Working Group exposed limited revisions to bond classification and accounting in addition to detailed accounting and reporting guidance for debt securities that do not qualify as bonds. The Working Group also exposed proposed reporting changes to capture new Schedule BA reporting lines for non-bond debt securities. The bond reporting changes to Schedule D1 and other related schedules were exposed by the Blanks (E) Working Group. A referral is expected to the Capital Adequacy (E) Task Force and the risk-based capital (RBC) groups to assess whether the blanks reporting changes will necessitate RBC revisions. Bruggeman said the Working Group discussed negative interest maintenance reserve (IMR) amounts and directed NAIC staff to move forward with referrals and drafting language for possible exposure. He said one of the referrals will be to the Capital Adequacy (E) Task Force, requesting that it consider removing admitted negative IMR as a direct reduction to total adjusted capital in the RBC formula along with consideration of sensitivity testing. He said there are a number of other considerations, including a referral to the Life Actuarial (A) Task Force. He said the Working Group also adopted clarifying language on invested assets issued by an affiliated entity or that include the obligations of an affiliated entity.

### 3. Continued Discussion of CLOs

Stephen Smith (Academy), chair of the Academy's C1 Work Group, said the Academy is focused on a couple of main priorities that it is trying to understand better. He said one ongoing project is that the Academy is trying to come up with a hypothetical model specification document to model CLOs for RBC purposes or provide a blueprint to check any other proposed model against. He said the Academy is also doing more work on the concept of RBC arbitrage. He said the Academy has observed that regulators, interested parties, and the industry have differing definitions of RBC arbitrage. He said the Academy is working on a document that will more clearly lay out the different definitions, along with some views on definitions that would be useful in terms of driving RBC. Mears asked Smith about the time frame. Smith said the Academy is trying to get the RBC arbitrage document out as quickly as possible, perhaps in a couple of months, and model specifications will be on a longer time frame.

### 4. Discussed Residual Tranche Structural Change

Barlow said his understanding of the charge received from the Financial Condition (E) Committee is to look at residual tranches for all structured assets, not just CLOs, and that this is intended to be an interim solution. As work continues on CLOs, as Smith just discussed, Barlow said he hopes to get a structure and a methodology that can be applied to other types of assets as well as CLOs. While CLOs may no longer be included in this interim solution, it could be that it stays in place for some categories of assets that do not have enough volume to warrant developing a methodology specifically for them.

Clark said a key point in taking an interim step would be the magnitude of the population and whether it is a pressing enough issue that an interim step is needed. Until regulators hold a meeting to look at the data, he said he is not sure a decision can be made. Barlow said he believes the guidance received for the Working Group's charge is to develop an interim proposal. Although the 2022 year-end data might inform the necessity of an interim proposal, he said he does not believe the Working Group should be deciding if an interim proposal is needed. However, if that is the will of the Working Group after reviewing the 2022 year-end data in the upcoming April meeting, it can be taken back to the Financial Condition (E) Committee. Clark said he is fine with the structural change to accommodate the timeline, as it keeps the Working Group's options open as to whether a change in factors is needed at this time.

Stolte said Virginia is supportive of the interim solution on residuals. He expressed concern about being out of step with other financial service regulators in the U.S. and internationally. Bruggeman said he supports looking at the data and waiting for a decision on a charge but expressed concern about waiting for all the data to be available because of the number of different structures and the materiality to individual companies.

Clark said he shared these concerns but said there is currently some ambiguity in the accounting guidance regarding what constitutes a residual tranche, and there will be some continued inconsistency in reporting until the definition is further refined. Therefore, the Working Group may not be looking at the full population, and that may inform the RBC decision. He expressed concern about implementing an interim step that does not have the usual level of analysis unless there is a material concern. Barlow said these are the issues the Working Group is to address and why there is representation from the other groups—so there is coordination from start to finish. He said his goal is to make RBC a non-factor when companies make investment decisions.

Hemphill said she does not think it is appropriate to just think of materiality from an overall industry perspective since the concern is from a solvency perspective. She said the Working Group needs to be willing to make incremental changes and improvements, and it is appropriate to consider making the change even if there is a concern that the average materiality across companies may not be high.

## 5. Discussed Next Steps

In line with many of the comments received, Barlow said it seems that the Working Group is supportive of having one category and one factor for the interim proposal on residual tranches. He said there were also several comments supporting sensitivity tests. He said he does not believe this would be a substitute for what the Working Group was asked to do but had suggested that if a proposal for sensitivity tests was received, the Working Group could consider that as an additional item. He said the American Council of Life Insurers (ACLI) has submitted a proposed sensitivity test.

Steve Clayburn (ACLI) said the ACLI believes there should be some quantitative analysis before a final factor is determined and thinks the sensitivity testing could be an additional tool for the state insurance regulators. Barlow said the structural change was exposed by the end of January, but the sensitivity test change was not exposed. He said that work will be done to get it ready for exposure and that this would include a request for input from RBC vendors as to the possibility of having this included for yearend 2023. He said there will be a regulator-only meeting in April to look at the 2022 year-end data on residual tranches and then an open meeting to continue discussions on the interim proposal.

Having no further business, the RBC Investment Risk and Evaluation (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/E CMTE/CADTF/2023-1-Spring/RBCIREWG/RBC Investment Risk 03-23-23 Minutes.docx

Draft: 3/17/23

Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group  
Virtual Meeting  
February 27, 2023

The RBC Investment Risk and Evaluation (E) Working Group of the Capital Adequacy (E) Task Force met Feb. 27, 2023. The following Working Group members participated: Philip Barlow, Chair (DC); Thomas Reedy (CA); Wanchin Chou (CT); Ray Spudeck (FL); Carrie Mears and Kevin Clark (IA); Vincent Tsang (IL); Fred Andersen (MN); William Leung (MO); Lindsay Crawford (NE); Bob Kasinow and Bill Carmello (NY); Dale Bruggeman and Tom Botsko (OH); Rachel Hemphill (TX); Tim Hays (WA); and Amy Malm (WI).

1. Discussed the Academy Follow-Up to the Presentation on CLOs

Stephen Smith (American Academy of Actuaries—Academy), chair of the Academy's C1 Work Group, presented the Academy's letter (Attachment Five-A1). He said the intersection of collateralized loan obligations (CLOs) and RBC creates a unique challenge for the purpose of purely modeling credit risk. He said the Academy is looking for regulatory guidance on the statistical safety level in terms of how the risk should be measured. Historically, factors for bonds have been based on the 96th percentile of losses. The Academy suggested in its October report that a conditional tail expectation (CTE) type of measure would be more appropriate due to the cliff risk embedded in CLOs, and the Academy is seeking regulator input. Smith said the Academy is also seeking input on where to set the statistical safety level, as well as the concept of RBC arbitrage. As the Academy previously indicated, he said structuring does not eliminate risks, but it changes the nature of the risk, especially among the tranches, for several reasons.

Smith said the Academy's view is that the total C-1 requirement for adding up all the underlying loans inside of a CLO does not necessarily have to equal the sum of the capital charges on a vertical slicing of a CLO. The Academy is asking if state insurance regulators have a strong view on this; if so, the Academy is going to incorporate state insurance regulators' views into their work. Otherwise, the Academy would like to know what it can share to help inform these views. The Academy has expressed the view that the materiality is low enough that a short-term solution may not be needed, so more time can be given to a longer-term solution. If state insurance regulators' judgement is different, the Academy would like to know what they can do to be supportive. Barlow said the first question is whether there is an urgency in updating the C-1 factors for CLOs. He said the Working Group is working on two projects, and the first one is updating the C-1 factors for CLOs. He said he understands that the risk may not be sufficiently material overall right now, but there may be some companies for which it is material, so the Working Group wants to address that. He said the two projects are to get solutions for the CLOs and an interim solution to address residual tranches before a more long-term solution can be developed for structured assets. He said the Working Group would like the Academy's Work Group to do a diligent review of the CLOs and develop recommendations as quickly as it can, but this is separate from the short-term interim solution for the residual tranches.

Barlow said the Working Group is looking to the Academy to provide some recommendations on the statistical safety level. Because of the level of tail risk involved, he said he believes the Working Group would feel more comfortable with a CTE type measure. In terms of the time horizon, he said he believes the Working Group would benefit from the Academy's perspective. Carmello said he believes using CTE makes sense, but he expressed concern with just using historical information. He said he believes it is more appropriate for RBC to have some modeling of potential market situations that are worse than the historical experience. Mears agreed on using CTE as opposed to using percentile just because it was used for other types of investments, as long as it does not introduce too much complexity. Tsang questioned whether it would be confusing to change the C-1 factor from

the 96th percentile to the CTE measure. Barlow said RBC has percentile and CTE measures in various components, and there are ways to determine consistency. Smith said the Academy would work on a reconciliation between the CTE and percentile measures to make them comparable.

With respect to the Academy's question on RBC arbitrage, Barlow said he believes this is more of a topic for the Capital Adequacy (E) Task Force because it affects more than the asset side of the RBC. Mears and Botsko agreed. With respect to the C3 implications, Barlow said once the structure for C1 is in place, this could be addressed if it is material enough.

With respect to whether active management within the CLO structure should be considered in developing C-1 factors, Barlow said the Working Group would look to the Academy for a recommendation. He said he believes assuming an active management adds a lot of complexity, and no active management sounds more conservative. Smith said the first kind of active management is around credit selection, and it would be more conservative not to model active management for this kind. He said the other kind of active management is that the manager makes active decisions especially in terms of whether it is extending and refinancing debt tranches or shifting risks around among the tranches. He said this gets a lot more complicated to model. Mears said implications of not including the active management need to be understood. Chou said he would support the more complicated study on the active management. Tsang expressed concern, and he said he is not sure whether it adds any value. Barlow said it appears that there is agreement on being conservative on the first kind of active management, and there is an interest in identifying how material the second kind of active management could potentially be. Smith said the Academy will take this feedback and do some work on the risks shifting between tranches of the active management.

## 2. Discussed Comment Letters

Paul Graham (American Council of Life Insurers—ACLI) presented the ACLI's comment letter (Attachment Five-A2), and he said the ACLI would like to have some analysis supporting the interim solution while the ACLI is proposing one factor for now. He said the ACLI is proposing boundaries on the factor because it should not have more of an impact than completely non-admitting the assets. This is different for every company depending upon where their RBC level is. In addition, the ACLI is proposing sensitivity tests.

Debra Casey (Global Atlantic Financial Group), representing a group of companies, presented their comment letter (Attachment Five-A3). She said they commended the Working Group for engaging the Academy to prepare the report on CLOs and agreed with the summary observations from that study. She said they do not understand the sense of urgency with the need for the interim solution, but they need to do something for structured securities. She agreed with the ACLI on sensitivity analysis that would provide state insurance regulators with more transparency as to the holdings and the impact on the RBC of CLOs versus other types of asset-backed securities (ABS). She said the main point of their comment letter is that they believe there needs to be a data-driven solution, and they support the model used for the update of the bond factors with an expert engaged, as well as engaging the industry to perform field testing. At least for CLOs, she said they believe there can be a streamlined process that can produce new factors or a new methodology that could be implemented at the same time as the new bond standards.

Christopher Halldorson (Prudential), representing a group of companies, presented their comment letter (Attachment Five-A4). He said there have been several comments concerned about the arbitrary nature of an interim solution, and the arbitrary charge of 30% should have already been recognized, which is based on the analysis of public equity losses under stress, and there is no analysis to connect that to residual tranches of structured securities. He said the residual tranches of structured securities are highly leveraged to the underlying, typically high-yield collateral, and that is not the same risk as holding Standard & Poor's 500 index (S&P 500). He

said they support an interim charge of at least 45%, which is the highest current factor for high-beta equity holdings. He also said this is a fast-growing asset class, and there are some material concentrations. They think a single charge that has some analysis supporting it, which is more than what currently exists, is a good first step and can lead to more robust transparency.

Eric C. DuPont (Guardian Life) said he spoke for his company and partnered closely with MassMutual on its comment letter (Attachment Five-A5). He said they appreciate the thoughtful approach taken, and they would suggest continuing that and finding a data-driven solution. They think the sensitivity testing provides an opportunity to provide what-if scenarios. DuPont said there is some concern about individual companies that may have high concentrations of risk, and they believe what-if scenarios can identify those so state insurance regulators can address those companies rather than taking a broad brush that would apply to the entire market.

Barlow said he does not believe the charge from the Financial Condition (E) Committee can be addressed solely by sensitivity testing, but proposed approaches to sensitivity testing can be submitted. He said the original referral of three factors from the Valuation of Securities (E) Task Force can be simplified to one factor at least for the interim solution. Mears said it would be fine if the Working Group wants to move forward with a single factor for an interim solution.

Mears said 2022 reporting is the first time to have residuals reported separately, and the definition of what should go in that category may need to be more explicit. She suggested that the Working Group consider a referral to the Statutory Accounting Principles (E) Working Group to review that definition.

Having no further business, the RBC Investment Risk and Evaluation (E) Working Group adjourned.

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January 31, 2023

Mr. Philip Barlow  
Chair, Risk-Based Capital Investment Risk and Evaluation (E) Working Group (RBCIRE WG)  
National Association of Insurance Commissioners (NAIC)

Re: Follow-up to Academy Presentation on CLOs given to RBCIRE WG

Dear Mr. Barlow,

On behalf of the American Academy of Actuaries<sup>1</sup> C1 Work Group (C1WG), thank you for the opportunity to present early findings on collateralized loan obligations (CLOs) risk-based capital (RBC). As the work group continues to research the issue, it aims to produce analysis that is relevant for regulators. To that end, this letter seeks clarification on several issues raised in the [December CLO report](#) to the RBCIRE WG that needs regulatory judgment.

1. Given the exposure statistics that the C1WG shared with RBCIRE, what is the urgency of updating C-1 factors for CLOs? Is the risk sufficiently material to warrant a short-term solution before a long-term solution can be determined?
2. What information does the RBCIRE need to establish the statistical safety level (SSL)? The SSL specifies the statistical measure for the capital requirement, including the choice of risk measure (percentile vs. conditional tail expectation vs. other) and the level, and the time horizon. For reference, the C1 bond factors are set at the 96<sup>th</sup> percentile over a ten-year period.
3. Does RBCIRE believe that the “no RBC arbitrage” principle should be applied to the C-1 factor methodology?
4. Would RBCIRE like to follow up on exploring possible C-3 implications of the optionality embedded in CLOs (including callability, resets, or other choices available to the equity tranche vis-à-vis the debt tranches)?
5. Should active management within the CLO structure be considered when developing C-1 factors?

The C1WG appreciates your attention to the issues raised in this letter and looks forward to discussing them further with you. Should you have any questions or comments in response to

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<sup>1</sup> The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.



this letter, please contact Amanda Barry-Moilanen, life policy analyst  
([barrymoilanen@actuary.org](mailto:barrymoilanen@actuary.org)).

Sincerely,

Stephen Smith  
Chair, C1 Work Group  
American Academy of Actuaries



**Steve Clayburn, FSA, MAAA**  
Senior Actuary, Health Insurance & Reinsurance  
[steveclayburn@accli.com](mailto:steveclayburn@accli.com)

February 3, 2023

Mr. Philip Barlow, Chair  
RBC Investment Risk & Evaluation (E) Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

Via email: [dfleming@naic.org](mailto:dfleming@naic.org)

**Re: Residual Tranches - Interim Solution**

Dear Mr. Barlow:

ACLI appreciates the opportunity to provide comments on the exposure of the Valuation of Securities (E) Task Force (VoSTF) referral to RBC Investment Risk & Evaluation (E) Working Group (RBC IRE WG) on a proposed “interim solution” for additional RBC factor categories for securitized residuals.

**Executive Summary**

The ACLI supports the efforts to assess the potential need for determining capital charges associated with CLO investments that better reflects the actual risk of the various tranches. We also understand that the additional RBC factors (75% and 100%, in addition to the existing 30% factor) recommended by the SSG are intended to support an interim solution until structured finance securities can be studied and modeled more fully by the NAIC.

While we understand some regulators’ desire to develop an interim solution with some level of expediency, we do have concerns that these factors were recommended without the normal level of rigor provided when making RBC changes. As such, it is important to understand the impact that the recommended changes will have. If the NAIC finds it prudent to adopt an interim approach to RBC factors for residual tranches of structured securities reported through Schedule BA, we recommend that the interim approach be simple and in place for as short of a time as possible.

Thus, we urge the RBC IRE WG to transition quickly from the work on the interim solution to the development of factors based on actual loss experience of the securities in question. We also

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133

The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States.

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suggest for simplicity purposes that such tranches of structured securities be mapped to a single factor, as they are today. We have some suggested paths for the interim solution below.

### Comments on Exposure

Understanding that some regulators desire an interim solution, we have some observations, concerns, questions, and suggestions for your consideration as outlined further in our comments.

### **One Factor for Interim Solution**

The goal of an interim solution should be “do no harm” when compared to what the ultimate solution will be, especially given the “rough justice” nature of RBC. Neither the VoSTF referral nor the structural exhibit change proposal provides a rationale for setting temporary RBC factors at 30%, 75%, and 100%, nor how a reporting entity would distinguish among the three. In considering an interim solution, we recommend the use of only one factor for residual tranches reported on Schedule BA, as is the case currently. Because the factor may be chosen without the normal quantitative analysis that goes into RBC factor development, ACLI members have a variety of views on the selection of the single factor. Some companies believe that a higher factor is appropriate. Some companies recommend that the single factor continue to be 30%, augmented with a higher factor within the Sensitivity Testing exhibit on Pages LR038 and LR039. This sensitivity testing would allow regulators to determine whether any companies have a material risk from their residual tranches as well as be the basis for an analysis of other factors.

Since the factor does not need to be adopted until June 30, 2023, ACLI would like to see consideration by the NAIC to do additional quantitative analysis before the single factor is chosen. We believe that whatever factor is chosen, it should not be materially more conservative than complete non-admittance of the asset for the average industry participant, and likely a little less so, given the risk premium already contained in policy reserves. We recommend that the RBC IRE WG use information gathered from the year-end 2022 RBC reports to help identify a rational factor, and, if possible, review of any available experience data on CLO residual tranches to help check for reasonableness.

To prepare for the potential for a variety of solutions, ACLI recommends that the structural changes to the RBC forms accommodate a single factor and additional sensitivity testing. ACLI would be happy to support NAIC staff in developing these structural changes.

### **Scope of Application**

It is not clear from the VoSTF referral memorandum as well as the exposed RBC exhibit form whether the proposal is intended to apply to the residual tranches of collateralized loan obligations (CLOs) or a broader application to all residual tranches for the variety of structured finance securities. We recommend that any future exposure draft clarify specifically to what types of investments the interim solution is intended to apply.

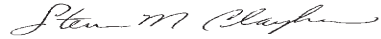
### **Define Timeframe of Use**

The VoSTF referral does not mention any proposed implementation timeframe. Reviewing an RBC structural change during the first quarter of the year implies the possibility of implementation for year-end 2023 financial statements. Is this the intent or expectation? Furthermore, will this be in conjunction with review of the recent updates to Schedule BA for residual tranches which are to have the 30% RBC factor? Will the proposed factor, if any, be exposed for comment? And finally, how long would the interim solution remain in place?

Conclusion

Thank you for the opportunity to continue to participate and comment on this issue. We understand some regulators feel the need to do something additional to the 30% charge that has been applied to residual tranches for year-end 2022; however, we believe that appropriate review and analysis to provide a basis for factor selection is necessary for the stability of the NAIC's RBC framework. We look forward to future discussions and continued collaboration with the NAIC on this important initiative.

Sincerely,



Steve Clayburn

cc: Mike Monahan, ACLI  
Paul Graham, ACLI

January 27, 2023

Mr. Philip Barlow, Chair  
Risk-Based Capital Investment Risk and Evaluation (E) Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

**Re: The American Academy of Actuaries C1 Work Group Presentation to the Risk-Based Capital Investment Risk and Evaluation Working Group (RBCIRE WG) on collateralized loan obligations (CLOs) (the “AAA Report”) and the Valuation of Securities Task Force (“VOSTF”) Referral on the Risk Assessment of Structured Securities- CLOs and Risk-based capital (RBC) structural proposal addressing residual tranches, together, the “Exposures”)**

Dear Mr. Barlow:

We are a group of insurance companies concerned about the proposal to adopt an interim solution for residual tranches of securitized assets that is not supported by the thoughtful analysis and field testing that the NAIC has implemented in the past. We believe such thoughtful analysis is the hallmark of any responsible regulatory regime. We appreciate the opportunity to provide comments on the Valuation of Securities Task Force (“VOSTF”) proposed interim solution as well as the American Academy of Actuaries’ (“the Academy”) presentation on CLOs.

Our group of companies agrees that the RBC treatment of the investments commonly referred to as “structured securities” is important and deserving of review and analysis. Our view is that:

- RBC factors for structured securities should be thoughtfully analyzed and developed following a similar process to the successful C-1 bond factor development project.
- Calculating RBC using factors developed without sufficient analysis and due diligence risks presenting a misleading assessment of a company’s financial position to users of a company’s statutory financial information, including the public.
- A rushed approach, without appropriate analytical rigor disincentivizes companies from investing in an important asset class, has the potential of causing market disruption, and negatively impacts the liquidity of these assets and the markets that rely on insurance company investments.
- The Academy’s report stating that CLOs are not a current risk to insurance industry solvency builds a strongly constructive case for having the NAIC perform thorough and thoughtful quantitative analysis and field testing.
- A more rational and less disruptive approach is to have companies provide RBC sensitivities to regulators that will enable regulators to risk assess company balance sheets along with the baseline RBC measurement. It should be understood that any such assessment would be measured against factors that were developed without sufficient analysis and due diligence, as discussed in this letter, and therefore should be viewed as indicative only and not meant to be a definitive quantification of the risk associated with the sensitivities.

RBC factors currently applicable to the senior tranches of structured securities are based on the review of default and loss experience of corporate bonds. Based on a long track record of available data, it is clear that corporate bonds have higher default and loss experience than equivalently rated structured securities, making comparable structured securities' RBC factors overly conservative as they currently stand. Further, the RBC factors currently applicable to residual tranches of structured securities were developed based on a study of unaffiliated common stock over a two-year time horizon and we are not aware of any analysis completed in connection with the Exposures that evaluates whether these RBC factors are conservative or aggressive. Given the current state of both conservative and untested RBC factors, we believe, and the Academy agrees, that an arbitrary interim charge is not appropriate and that any new factors should be developed using the proven, collaborative process that was used during the changes to the C-1 bond factors. We are confident that this could be done in an expedited manner to produce rational and predictable results that regulators and industry alike would support as long-term rather than interim solutions. Like the C-1 process, we propose that the plan should be to engage an expert consultant or consulting actuary with the relevant expertise and significant resources to perform the necessary quantitative analysis. That expert should also work with industry to propose changes, perform field testing, and then promulgate appropriate charges to ensure "equal capital for equal risk across different asset classes." We expect that a streamlined process to develop appropriate factors could be performed in time to be released concurrently with the principle-based bond definition currently being worked on by the Statutory Accounting Principles Working Group.

Additional specific comments on the two exposures recently released by the Risk-Based Capital Investment Risk and Evaluation (E) Working Group ("the Working Group") are provided in the balance of this document.

First, we commend you for engaging the Academy to prepare a report on CLOs. The Academy report is thoughtfully prepared and enlightening, and we agree with the Academy's summary observations. With respect to residual tranches, we found the Academy's observation about the lack of quantitative analysis to support the current 30% capital charge or the Investment Analysis Office's ("IAO") proposed sub-categories of NAIC 6 particularly insightful. We agree with the Academy that justification of a CLO residual tranche charge or new sub-categories of NAIC 6 will require substantial analysis.

The Academy report made the point that CLOs do not present a danger to the solvency of the insurance industry. In fact, the NAIC Capital Markets Bureau's special report, released on January 5, 2023, states: "Based on the NAIC's stress test results, U.S. insurer investments in CLOs remain an insignificant risk." Based on the work of the Academy and the NAIC Capital Markets Bureau, NAIC has ample time to conduct the necessary quantitative analysis to develop a solution that can be supported with data, is properly field tested, and would result in a capital charge that is based on sufficient analysis and due diligence so that it is not misleading to the public or other users of a company's financial information. An interim solution not grounded in quantitative analysis is unnecessary and potentially harmful because a temporary increase in the capital charge that is unrelated to the actual risk of the investment, and which may ultimately be reversed, could be difficult for a company to manage and for stakeholders to

understand. As we stated above, a more appropriate course of action would be to add sensitivity analysis information to the 2023 RBC submission designed to target the risks and populations important to regulators. This approach would have the added benefit of time to incorporate impact analysis required by the Capital Adequacy Task Force for any RBC factor changes. Industry partners would be willing to assist in the development of the information regulators are targeting, such as the impact of increased factors applied to CLO residual tranches.

We also note that given changes in blanks guidance for YE 2022 requiring residual tranches to be moved to schedule BA, regulators and other key stakeholders will have more transparency into the holdings related to this asset class.

Second, we strongly object to the proposal from VOSTF to use three new sub-categories of NAIC 6 as the interim solution for residual tranches of any structured finance security for the reasons stated above. To our knowledge, no proposed framework for sorting investments into these sub-categories currently exists, and no rationale has been offered as to why these respective proposed capital charges are appropriate, adding confusion to the implementation of this proposed treatment. Further detail as to the rationale behind the charges and clarity as to what would be required to differentiate the 3 sub-categories would be needed before they could be implemented by the industry. Without quantitative analysis and field testing, we risk misleading the public, policyholders, regulators, and other users of the financial statements as to the risk inherent in these structures. Additionally, if the charges are driven by inherent risk specific to CLO residuals rather than all structured finance residuals (which is not entirely clear based on the release), time should be taken to understand the differences in those structures and the potential that the “regulatory capital arbitrage” normalization might not be easily calculated.

Furthermore, we agree with the observation in the Academy report that CLO structures can transform the risk such that vertical ownership versus ownership of the underlying loans can have different RBC values. Factors such as active trading of loans, excess spread being used to cover principal losses and strict reinvestment criteria that ensures diversity, and reduced concentration risk can alter CLO risks as compared to underlying loans. We think it is appropriate to stress structured securities in an analytical way which includes both a fundamental analysis of the underlying asset risk as well as the way the structure will absorb those losses. As the Academy suggests, analyzing the tail risk embedded in any structure ensures that the structures themselves can absorb (or not) the losses that may occur under different scenarios. Ignoring the structural protections in a transaction is not a transparent method to stress these assets

Finally, we note that the IAO proposal states that the proposed interim solution is intended to be applied to all structured securities, but only CLOs have been the focus of recent discussions. Any interim rule must clearly state with specificity which securities are covered. If the scope includes other types of investments, then we believe a cohesive plan, including a similar analytical approach should be employed with respect to those other investments consistent with the work done on RMBS, CMBS and CLOs and must be exposed. If, against the best advice of this industry group, an interim solution is adopted, we request a concrete, definitive timeframe

for the interim solution so that industry has time to plan and ensure that a robust and transparent process is achieved.

We appreciate that the Working Group is focused on these issues with the goal of ensuring that RBC is appropriate for the risk that insurance companies are taking. We look forward to engaging with the Working Group in a transparent process to develop a new framework for residual tranches that incorporates appropriate quantitative analytics based on their historical performance of defaults and losses and aligns with other asset classes ensuring “equal capital for equal risk.”

Athene  
Delaware Life Insurance Company  
F&G Annuities and Life  
Nassau Financial Group

Clear Spring Life and Annuity Company  
Everlake Life Insurance Company  
Global Atlantic Financial Group  
Security Benefit Life Insurance Company

cc: Superintendent Elizabeth Dwyer, Chair, Financial Condition (E) Committee



February 3, 2023

Mr. Philip Barlow, Chair  
RBC Investment Risk & Evaluation (E) Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

Via email: [dfleming@naic.org](mailto:dfleming@naic.org)

RE: Referral on the Risk Assessment of Structured Securities - CLOs

Dear Mr. Barlow,

On behalf of the undersigned life insurance companies (“the companies”), we are writing to express our strong support for the steps the NAIC is taking to model collateralized loan obligations (CLO) for risk-based capital (RBC) purposes. The companies are also supportive of the Valuation of Securities Task Force (VOSTF) recommendation that the Risk-Based Capital and Investment Risk and Evaluation (RBC IRE) Working Group develop interim RBC factors for the NAIC 6 designation. Aligning RBC with the underlying investment risk of the residual tranches of structured securities is a critical component of minimizing RBC arbitrage in securitized assets, a regulatory objective that we also support.

Structured securities, including CLOs, are material to insurer solvency. Structured credit has become a core asset strategy in US Life General Accounts, similar in size to Commercial Mortgages. CLOs in particular are a fast-growing asset class that are highly correlated to other credit exposures within insurers’ asset management portfolios and have indirect implications for other insurer capital holdings under stress.

Structured securities are important financial products, but they also have unique “cliff risks” not present in most financial assets. While small levels of default will not translate into immediate losses within a transaction’s rated tranches, once the first loss protection is depleted small additional collateral losses will result in large losses within those tranches. Residual tranches are the first loss protection layer shielding the rest of the structure but are not themselves protected.

The companies recognize the significant progress made to date by the RBC IRE Working group and VOSTF to develop an appropriate modeling methodology and accompanying RBC framework. As this work progresses, we agree that it is critical for regulators to enact interim RBC factors for the residual tranches while NAIC fulsomely evaluates more permanent changes to its RBC framework for structured securities. The current capital factor of 30% was designed for more traditional equity holdings, not the highly levered residual tranches of structured securities. A practicable interim solution could address the risks of investing in residual tranches while providing regulators with additional information for that long-term solution.

The companies agree with ACLI that there is no need to pursue three new NAIC 6 designation categories (i.e., 6.A, 6.B, and 6.C) in the interim. Instead, the companies recommend use of a single interim RBC factor for structured securities tranches with an NAIC 6 designation. **We support an interim RBC factor for the residual tranches of at least 45%, which is the highest current factor for high beta equity holdings.**

There have also been industry discussions about maintaining the current 30% factor and using a higher factor in sensitivity testing to help regulators assess risk. While sensitivity testing or impact analysis can provide regulators with valuable information on materiality and solvency of the residual tranches, sensitivity testing alone will not provide data on what appropriate RBC factors should be nor will it meet the regulators' goals of reducing RBC arbitrage while more refined charges are developed. As such, should the regulators decide to employ sensitivity testing, the companies believe a higher factor for residual tranches is also needed.

\*\*\*\*\*

Thank you in advance for your consideration of our comments. We are committed to working with NAIC and regulators to enact reasonable RBC factors for structured securities that reflect the underlying risk for all tranches. The companies join ACLI in urging the RBC IRE Working Group to transition quickly from the work on the interim solution to the development of permanent RBC factors.

Respectfully Submitted,

Equitable  
MetLife  
New York Life  
Northwestern Mutual  
Pacific Life  
Prudential Financial, Inc.  
Western & Southern

February 6, 2023

Mr. Philip Barlow, Chair  
RBC Investment Risk and Evaluation (E) Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

Via email: [dfleming@naic.org](mailto:dfleming@naic.org)

**Re: Residual Tranches - Interim Solution**

Dear Mr. Barlow:

We, the undersigned companies, appreciate the opportunity to provide comments on the NAIC's exposure of the Valuation of Securities (E) Task Force (VoSTF) referral to Risk-Based Capital Investment Risk and Evaluation (E) Working Group (RBC IRE) on a proposed "interim solution" for additional RBC factor categories for securitized residuals.

Overall, we are supportive of the NAIC's efforts to further model and understand the complexities of structured securities and ensure that life insurers are holding the appropriate levels of capital to support the risk on their books. Some have raised concerns about the potential for capital arbitrage specific to collateralized loan obligations (CLOs). However, we believe this is premature. We are not aware of underlying facts which would call for an immediate modification to Risk-Based Capital (RBC) prior to completing a comprehensive analysis. We believe it would be unwise to set a precedent for disruptive intra-year changes to what is a stable long-term capital framework and ignore what has been a successful data-driven approach historically.

Accordingly, we do not believe the proposed interim factors should be applied to CLO holdings. Instead, an expeditious undertaking of information gathering through disclosures of the Residual Tranche portion of AVR (already in place for YE 2022 reporting) and adding structure to existing sensitivity testing would provide transparency regarding the scope and reach of individual company CLO or other residual tranche holdings. Such a process would avoid unnecessary and potentially uneconomic volatility in company reported financial strength while still addressing the Task Force's concerns in a timely manner.

**Recent Independent Experts State an Immediate RBC Correction is Not Needed or Necessarily Appropriate**

We support swift information gathering in advance of taking action to modify a company's reported RBC. Our view is based on recent reports from the American Academy of Actuaries (Academy) and the NAIC Capital Markets Bureau, which both state that on an aggregate basis, CLOs do not present a material solvency risk to our industry as noted in:

- 1) The January 2023, NAIC Capital Markets Bureau Special Report on Collateralized Loan Obligations (NAIC Report) states "Based on the NAIC's stress test results, U.S. insurer investments in CLOs *remain an insignificant risk.*" (Emphasis added)
- 2) The Academy's C1 Work Group's (C1WG) December 14, 2022, presentation to the NAIC's RBC IRE states on Slide 12: "In the C1WG's view, *CLOs do not present a material risk to the aggregate solvency of the life insurance industry currently.*" (Emphasis added)

Mr. Philip Barlow  
February 6, 2023  
Page 2

- 3) Slide 21 of the C1WG’s presentation states: “While a CLO’s total collateral and a vertical slice of its tranches have the same *risk* at a point in time, it does not follow that they must have the same total C-1 requirement.”
- Noting in support of this statement:
- a. Each of corporate bonds, bank loans, and CLOs have unique structures and risk profiles.
  - b. C-1 corporate bond factors are not appropriate for bank loans or for CLOs due to different assumptions and models (e.g., secured vs. unsecured, time horizon, etc.)
  - c. It would not be appropriate to force equivalence using the current C-1 corporate bond factors.

**Sensitivity Testing is More Appropriate than Applying an Interim Capital Charge to Residual Tranche Holdings**

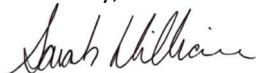
Following other recent examples of a non-urgent nature (such as RBC sensitivity tests or Group Capital Calculation calibration), we propose the sensitivity testing section of the Life RBC Exhibits (Pages LR038 and LR039) as the interim solution. Doing so, the NAIC could apply one or more sensitivity factors to residual results to get a sense of impact to each company, without modifying the reported result. This alternative interim solution will accomplish multiple goals:

- 1) It is expedient, without damaging the integrity of a company’s RBC calculation.
- 2) It allows regulators to see the impacts to their respective domestic companies in a “what if” scenario, helping to identify companies with potential material risk from residual tranches of CLOs.
- 3) It allows the RBC IRE WG time to undertake extensive analysis and testing of CLO experience, without having a hurried approach for YE 2023.
- 4) It allows regulators and industry to review the sensitivity testing results, to discuss the advantages and disadvantages of alternatives, and to understand the broad, long-term impacts to industry and reinsurance counterparties, and the impact to availability and pricing in the risk transfer marketplace.
- 5) It does not create the same potential for disruption in the structured securities market.
- 6) Disclosure, identification of material ownership, and sensitivity testing would dissuade material owners from significantly increasing exposure.

In conclusion, the proposal to collect sensitivity testing data rather than apply an interim RBC charge in 2023 is based on (i) recent independent reports that conclude CLOs do not present material risk to the life insurance industry and (ii) the Academy report which notes forcing the sum of capital charges for all CLO tranches to equal a C-1 bond charge is inappropriate. Moreover, sensitivity testing presents an expeditious information gathering opportunity to allow regulators to target needed adjustments while avoiding a threat of unneeded market disruptions.

We look forward to the opportunity to discuss our proposed solution and answer any questions you may have.

Sincerely,



Sarah Williams  
Chief Risk Officer  
The Guardian Life Insurance Company of America



Michael O'Connor  
General Counsel  
Massachusetts Mutual Life Insurance Company

**Capital Adequacy (E) Task Force**  
**RBC Proposal Form**

- |                                                                     |                                                           |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------|
| <input checked="" type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group     | <input type="checkbox"/> Life RBC (E) Working Group    |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup              | <input type="checkbox"/> Investment RBC (E) Working Group | <input type="checkbox"/> Operational Risk (E) Subgroup |
| <input type="checkbox"/> C3 Phase II/ AG43 (E/A) Subgroup           | <input type="checkbox"/> P/C RBC (E) Working Group        | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |

<b>DATE:</b> <u>8/11/22</u>	<b><u>FOR NAIC USE ONLY</u></b>
<b>CONTACT PERSON:</b> <u>Eva Yeung</u>	Agenda Item # <u>2022-09-CA</u>
<b>TELEPHONE:</b> <u>816-783-8407</u>	Year <u>2023</u>
<b>EMAIL ADDRESS:</b> <u>eyeung@naic.org</u>	<b><u>DISPOSITION</u></b>
<b>ON BEHALF OF:</b> <u>Capital Adequacy (E) Task Force</u>	<input checked="" type="checkbox"/> ADOPTED <u>3/23/23</u>
<b>NAME:</b> <u>Tom Botsko</u>	<input type="checkbox"/> REJECTED _____
<b>TITLE:</b> <u>Chair</u>	<input type="checkbox"/> DEFERRED TO _____
<b>AFFILIATION:</b> <u>Ohio Department of Insurance</u>	<input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____
<b>ADDRESS:</b> <u>50 West Town Street, Suite 300</u>	<input checked="" type="checkbox"/> EXPOSED <u>8/11/22</u>
<u>Columbus, OH 43215</u>	<input type="checkbox"/> OTHER (SPECIFY) _____

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

- Health RBC Blanks       Property/Casualty RBC Blanks       Life and Fraternal RBC Instructions  
 Health RBC Instructions       Property/Casualty RBC Instructions       Life and Fraternal RBC Blanks  
 OTHER \_\_\_\_\_

**DESCRIPTION OF CHANGE(S)**

The proposed change would revise the instructions and structure for the Affiliated Investments for all lines.

**REASON OR JUSTIFICATION FOR CHANGE \*\***

The proposed revisions will improve the risk-based capital formulas and provide consistency to the treatment of affiliates for all lines of business.

**Additional Staff Comments:**

8/11/22 - The Task Force exposed this proposal for a 60-day public comment period ending Oct, 10.  
 3/23/23 – The Task Force adopted the proposal on 3/23/23

\*\* This section must be completed on all forms.

**AFFILIATED/SUBSIDIARY STOCKS**  
**XR002 – XR004**

There are nine categories of affiliated/subsidiary investments that are subject to Risk-Based Capital requirements for common stock and preferred stock holdings. Those nine categories are:

1. Directly Owned U.S. Insurance Affiliates/Subsidiaries Subject to a Risk-Based Capital (RBC)-Look-Through Calculation
  - a. Health Insurance Company or Health Entity
  - b. Property and Casualty Insurance Company
  - c. Life Insurance Company
2. Indirectly Owned U.S. Insurance Affiliates/Subsidiaries Subject to RBC-Look-Through Calculation
  - a. Health Insurance Company or Health Entity
  - b. Property and Casualty Insurance Company
  - c. Life Insurance Company
3. Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries
4. Investment Subsidiaries
5. Directly Owned Alien Insurance Affiliates/Subsidiaries
  - a. Health Insurance Company or Health Entity
  - b. Property and Casualty Insurance Company
  - c. Life Insurance Company
6. Indirectly Owned Alien Insurance Affiliates/Subsidiaries
  - a. Health Insurance Company or Health Entity
  - b. Property and Casualty Insurance Company
  - c. Life Insurance Company
7. Investments in Upstream Affiliate (Parent)
8. Directly Owned U.S. Insurance Affiliates/Subsidiaries Not Subject to RBC
  - a. Health Insurance Companies and Health Entities Not Subject to RBC
  - b. Property and Casualty Insurance Companies Not Subject to RBC
  - c. Life Insurance Companies Not Subject to RBC
9. Non-Insurance Affiliates/Subsidiaries Not Subject to RBC
  - a. Entities with a capital requirement imposed by a regulatory body
  - b. Other Financial Entities without regulatory capital requirements
  - c. Other Non-financial entities

Enter applicable items for each affiliate/subsidiary in the Details for Affiliated/Subsidiary Stocks worksheet. The program will automatically calculate the risk-based capital charge for each affiliate/subsidiary. When the data is uploaded to the NAIC database, it will be crosschecked, and the company will be required to correct any discrepancies and refile a corrected version with the NAIC and/or any state that requires the company to file RBC with its department. The RBC report will display the number of affiliates/subsidiaries. These numbers should be reviewed to ensure that all affiliates/subsidiaries are appropriately reported.

Line 10 of XR003 – Fair Value Excess Subsidiary Common Stock equals the total of type codes 1.a. through 2.c., Column 13 of the Subsidiary Companies Risk – Details Page. The program will automatically calculate this figure.

The total of all reported affiliate/subsidiary stock should equal the amounts reported on Schedule D, Part 2, Section 1, Line 4409999999 plus Schedule D, Part 2, Section 2, Line 5979999999 and 93999999 and should also equal Schedule D, Part 6, Section 1, Line 09999999 plus Line 18999999.

Affiliated/Subsidiary investments fall primarily into two broad categories: (a) Insurance Affiliates/Subsidiaries that are Subject to risk-based capital; and (b) Affiliates/Subsidiaries that are Not Subject to risk-based capital. The risk-based capital for these two broad groups differs. A third category of Affiliates/Subsidiaries, publicly traded insurance affiliates/subsidiaries held at market value, has characteristics of both broader categories. As a result, it has a two-part RBC calculation. The general treatment for each is explained below.

Directly owned insurance and health entity affiliates/subsidiaries are affiliates/subsidiaries in which the reporting company owns the stock of the affiliate/subsidiary. Indirectly owned insurance affiliate/subsidiaries and health entities are those where the reporting company owns stock in a holding company, which in turn owns the stock of the insurance affiliate/subsidiary or health entity. Note that there could be multiple holding companies that control the downstream insurance company.

Enter the book/adjusted carrying value of: the common stock in Column (5), the preferred stock in Column (9), the total outstanding common stock in Column (7) and the total outstanding preferred stock of that affiliate/subsidiary in Column (10) of the appropriate worksheet. The percentage of ownership is calculated by summing the book/adjusted carrying values of the owned preferred and common stock and dividing that amount by the sum of all outstanding preferred and common stock.

Insurance Affiliates/Subsidiaries that are Subject to RBC

1. Directly Owned U.S. Affiliates/Subsidiaries:

The risk-based capital requirement for the reporting company for those insurance affiliates/subsidiaries that are subject to a risk-based capital requirement is based on the Total Risk-Based Capital After Covariance of the subsidiary, prorated for the percent of ownership of that affiliate/subsidiary.

For purposes of Affiliate/Subsidiary Risk all references to Total Risk-Based Capital After Covariance of the affiliate/subsidiary means:

- a. For a Health affiliate/subsidiary RBC filing, Total Risk-Based Capital After Covariance before Basic Operational Risk (XR025, Line (37)).
- b. For a P/C affiliate/subsidiary RBC filing, Total Risk-Based Capital After Covariance before Basic Operational Risk (PR032, Line (68)).
- c. For a Life affiliate/subsidiary RBC filing, the sum of
  - i. Total Risk-Based Capital After Covariance before Basic Operational Risk (LR031, Line (67)); and
  - ii. Primary Security shortfalls for all cessions covered by Actuarial Guideline XLVIII (AG 48) multiplied by two (LR031, Line (71)).

For RBC purposes, the reporting insurer must determine the carrying value and the RBC requirement of a directly owned RBC filing affiliate/subsidiary company, even if the RBC filing affiliate/subsidiary is non-admitted for financial reporting purposes. The value reported in annual statement Schedule D, Part 6, Section 1 will be used for RBC purposes. In addition to RBC, the carrying value of the RBC filer must be reported in total adjusted capital for RBC purposes, in order to appropriately balance the numerator with the addition to the denominator value. Enter the carrying value of the insurer on **Line XXX** of the Calculation of Total Adjusted Capital page to satisfy these instructions.



**Equity method Insurance Affiliates/Subsidiaries:** Equity method is defined in SSAP 97, Paragraph 8b, as the underlying audited statutory equity of the respective entity's financial statements, adjusted for any unamortized goodwill as provided for in SSAP No. 68—Business Combinations and Goodwill. For those insurance Affiliates/Subsidiaries of the reporting company that are reported under the equity method, the  $H_0$  charge of the ownership of the common and preferred stock in these Affiliates/Subsidiaries is limited to the lesser of:

- (a) the Total RBC After Covariance of the affiliate/subsidiary times the percentage of ownership, which is the total of common stock and preferred stock; or
- (b) the common and preferred stock book/adjusted carrying value at which the affiliate/subsidiary is carried

**Market Value (including discounted market value) Insurance Affiliates/Subsidiaries (See SSAP No. 97, Paragraph 8a.):** If the affiliate/subsidiary's common stock is publicly traded and the reporting company carries the affiliate/subsidiary at market value, after any "discount," there are generally two components to the reporting company's RBC generated by the affiliate/subsidiary. The prorated portion is the percentage of ownership of total common and preferred stock. The smaller of the prorated portion of the affiliate/subsidiary's own statutory surplus or the prorated portion of its RBC after covariance is added to the  $H_0$  component of the reporting company. In the normal case, the common and preferred stock book/adjusted carrying value of the affiliate/subsidiary exceeds the prorated portion of the larger of its statutory surplus and its RBC after covariance. In this case, the addition to the  $H_1$  component is the larger of a) 22.5 percent of the affiliate/subsidiary's common and preferred stock book/adjusted carrying value in excess of the prorated portion of the affiliate's/subsidiary's statutory surplus or b) the prorated portion of the affiliate's/subsidiary's RBC after covariance in excess of the prorated portion of its statutory surplus. If the affiliate/subsidiary's common and preferred stock book/adjusted carrying value is less than the prorated portion of its RBC after covariance, but greater than the prorated portion of its statutory surplus, 100 percent of the common and preferred stock book/adjusted carrying value in excess of the prorated portion of the affiliate/subsidiary's statutory surplus is added to the reporting company's  $H_1$  component. If the affiliate/subsidiary's common and preferred stock book/adjusted carrying value is less than the prorated portion of the affiliate/subsidiary statutory surplus, there is no addition to the  $H_1$  component.

## 2. Indirectly Owned U.S. Insurance Affiliates/Subsidiaries

For Indirectly Owned U.S. Insurance Affiliates/Subsidiaries, the carrying value and RBC is calculated in the same manner as for directly owned U.S. Insurance Affiliates/Subsidiaries. The RBC for the indirect affiliates/subsidiaries must be calculated prior to completing this RBC report.

SSAP No. 97 provides guidance for the reporting and admittance requirements of SCAs. Accordingly, there may be cases where an indirectly owned RBC filer may not be separately reported in the statutory financial statements (e.g., they are captured within the carrying value of an intermediate holding company). The SSAP No. 97 guidance permits reporting SCAs at the directly owned holding company level or via look-through to the downstream entity (including where the downstream entity is an RBC filer), but an audit of the entity is required for admittance (i.e. if reporting is at the directly owned holding company level, the holding company must be audited, if the reporting is on a look-through basis then the downstream entity must be audited). Regardless of whether there is a look-through applied pursuant to Statutory Accounting Principles (SAP) for annual financial statement reporting, for RBC purposes the reporting insurer must "look-through" all intermediate holding and subsidiary companies to determine the carrying value and the RBC requirement of indirectly owned RBC filing affiliate/subsidiary companies. This involves drilling down to the first RBC filing insurance subsidiary and adjusting for percentage ownership of the intermediate entity directly owning the RBC filing affiliate/subsidiary. Both RBC and carrying value of the RBC filer must be reported for RBC purposes, in order to appropriately balance the numerator with the addition to the denominator value. Enter the carrying value of the insurer on **Line XXX** of the Calculation of Total Adjusted Capital page to satisfy these instructions.

The carrying value for each indirect insurance affiliate/subsidiary is established based on company records using the statutory value of the insurer as reported in the NAIC annual financial statement blank submitted by the affiliate/subsidiary or market value when applicable, and the RBC requirement as determined in its



RBC Report adjusted for the ownership percentages (both the percentage of the indirectly owned RBC filing affiliate/subsidiary that is owned by the directly held downstream holding company and the reporting insurer's ownership percentage in that downstream entity). The value reported by the downstream holding company for the U.S. RBC filing insurer is the same as the statutory value established for the insurer on a look-through basis.

3. Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries

The carrying value of a U.S. Insurance Affiliate/Subsidiary that is subject to RBC is deducted from the value of the directly held holding company or other entity that in turn directly owns the U.S. Insurance Affiliate/Subsidiary that is subject to RBC, based on the value reported for each insurance subsidiary on the downstream immediate holding company or non-insurance owner's balance sheet. That value is prescribed by the NAIC Accounting Practices and Procedures Manual (SSAP No. 97, paragraph 22.a.). A similar exercise is required for each RBC filing insurer and each non-U.S. insurer in order to determine the remaining excess value of the holding company.

The remaining value of the directly held holding company is then subject to a charge that is calculated in accordance with the instructions for Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries as specified in the RBC formula. If the holding company is not admitted, report the excess carrying value as zero and the corresponding RBC charge will also be zero. If a negative excess value for the downstream holding company results from removing the value of U.S. RBC filing insurers from the downstream holding company's reported value, then the value of that holding company will be floored at zero and the corresponding RBC charge will also be zero.

The following hypothetical Balance Sheet indicates the view of a Holding Company - Holder, Inc. which is 100% owned by MEGA Health Insurance Company (it assumes that the value reported by the downstream holding company for the U.S. RBC filing insurer is the same as the statutory value established for the insurer on a look-through basis):

		Balance Sheet		
		Holder, Inc.		
		12/31/XXXX		
Cm Stk:	ABC Life Company	10,000,000	Long Term Debt	5,000,000
	XYZ Casualty Company	15,000,000	Other Liabilities	2,000,000
	ANH Health Company	3,000,000		
	Other Common Stock	17,000,000	Total Liabilities	7,000,000
	Cash	7,000,000	Equity	50,000,000
	Other Assets	5,000,000		
	Total Assets	57,000,000	Total Liabilities & Equity	57,000,000

The RBC calculation for Holder, Inc.'s value in excess of the indirectly owned insurance affiliates/subsidiaries is as follows:

<u>Company</u>	<u>Stat. Book value</u>	<u>Source:</u>
Holder, Inc.	50,000,000	MEGA Health Sch D - Part 6, Section 1
<i>Holder, Inc. aff/subs subject to RBC</i>		
ABC Life Company	10,000,000	Holder, Inc. Stat. balance sheet
XYZ Casualty Company	15,000,000	Holder, Inc. Stat. balance sheet
ANH Health Company	<u>3,000,000</u>	Holder, Inc. Stat. balance sheet
Subtotal	28,000,000	
Holder, Inc. excl. RBC aff/subs	22,000,000	
		<i>(amount subject to the 30.0% factor for Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries)</i>

The following table shows the XR002 entries that MEGA Health Insurance Company (which owns 100% of Holder, Inc.) would report for the indirectly owned insurance affiliates/subsidiaries under Holder, Inc. This table assumes that Holder, Inc. owns 40%, 50% and 25% of ABC Life, XYZ Casualty, and ANH Health, respectively. The table also assumes that the RBC values shown for these affiliates/subsidiaries at the 100% level are the correct RBC After Covariance but Before Operational Risk.

		XR002 Column					
Affiliates/Subsidiaries	Affiliates/Subsidiaries Type	4 100% RBC	5 Book Adjusted Carrying Value	7 Total Value of Affiliates/Subsidiaries	8 Statutory Surplus of Affiliates/Subsidiaries	11 % Owned	12 RBC Required
ABC Life Company	Indirect U.S. Life Aff/Sub	5,000,000	10,000,000	25,000,000	25,000,000	40%	2,000,000
XYZ Casualty Company	Indirect U.S. P&C Aff/Sub	12,000,000	15,000,000	30,000,000	30,000,000	50%	6,000,000
ANH Health Company	Indirect U.S. Health Aff/Sub	6,000,000	3,000,000	12,000,000	12,000,000	25%	1,500,000

The risk-based capital charge for the parent insurer preparing the calculation is a 30 percent charge against the holding company value in excess of the indirectly owned insurance affiliates/subsidiaries as calculated in the prior example. Enter information in the appropriate columns of the worksheet, omitting those columns that do not apply (Column (3) – NAIC Company Code or Alien ID Number and Column (4) Affiliate's RBC After Covariance).

Affiliates/Subsidiaries that are Not Subject to RBC

4. Investment Subsidiaries

An investment subsidiary is a subsidiary that exists only to invest the funds of the parent company. The term investment subsidiary is defined in the annual statement instructions as any subsidiary, other than a holding company, engaged or organized primarily to engage in the ownership and management of investments for the insurer. An investment subsidiary shall not include any broker-dealer or a money management fund managing funds other than those of the parent company. The risk-based capital for an investment in an investment subsidiary is 30 percent of the carrying value of the common and preferred stock.

5. Directly Owned Alien Insurance Affiliates/Subsidiaries

For purposes of this formula, the Risk-Based Capital (RBC) of each directly owned alien insurance affiliate/subsidiary is the annual statement book adjusted carrying value of the reporting company's interest in the affiliate multiplied by 1.000. Enter information for any non-U.S. insurance affiliate/subsidiary: life, property and casualty, and health insurers.

For each affiliate/subsidiary, enter the following information:

- Company Name,
- Alien Insurer Identification Number,
- Book Adjusted carrying value of common and preferred stock,
- Total Outstanding value of common and preferred stock,
- Book/adjusted carrying value of the common and preferred stock from Schedule D, Part 6, Section 1, Line 1499999. If no value is reported in the Total Value of Affiliate's common and preferred stock columns (7) and (10), the program will assume 100 percent ownership.

6. Indirectly Owned Alien Insurance Affiliates/Subsidiaries

For Indirectly Owned Alien Insurance Affiliates/Subsidiaries, the carrying value and RBC charge is calculated in a similar manner as for directly owned Alien Insurance Affiliates/Subsidiaries.

SSAP No. 97 provides guidance for the reporting and admittance requirements of SCAs. Accordingly, there may be cases where an indirectly owned Alien insurer may not be separately reported in the statutory financial statements (e.g., they are captured within the carrying value of an intermediate holding company). The SSAP No. 97 guidance permits reporting SCAs at the directly owned holding company level or via look-through to the downstream entity (including where the downstream entity is an Alien insurer), but an audit of the entity is required for admittance (i.e. if reporting is at the directly owned holding company level, the holding company must be audited, if the reporting is on a look-through basis then the downstream entity must be audited). Regardless of whether there is a look-through applied pursuant to Statutory Accounting Principles (SAP) for annual financial statement reporting, for RBC purposes the reporting insurer must "look-through" all intermediate holding and subsidiary companies to determine the carrying value and the RBC charge that would be imposed had the Alien insurance affiliate/subsidiary companies been directly held by the reporting insurer. This involves looking down to the first alien insurer affiliate/subsidiary, unless there is an RBC filer in between, and adjusting for percentage ownership of the intermediate entity directly owning the RBC filing affiliate/subsidiary. Both the RBC charge and carrying value of the alien insurer must be reported for RBC purposes, in order to appropriately balance the numerator with the addition to the denominator value. Enter the carrying value of the insurer on Line **XXX** of the Calculation of Total Adjusted Capital page to satisfy these instructions.

The carrying value of an alien insurance affiliate/subsidiary is deducted from the value of the directly held holding company or other entity that in turn directly owns the U.S. Insurance Affiliate/Subsidiary that is subject to RBC, based on the value reported for each insurance subsidiary on the downstream immediate holding company or non-insurance owner's balance sheet. That value is prescribed by the NAIC Accounting Practices and Procedures Manual (SSAP No. 97, paragraph 22.a.). A similar exercise is required for each RBC filing insurer and each non-U.S. insurer in order to determine the remaining excess value of the holding company.

The RBC charge to be applied to each indirectly owned alien insurance affiliate/subsidiary is the annual statement book adjusted carrying value of the reporting company's interest in the affiliate/subsidiary multiplied by 1.0 and adjusted to reflect the reporting company's ownership on the holding company. For example, assume NEWBIE Insurance Company acquired 100 percent shares of Holder (a holding company), and Holder owns an Alien Insurance Company, which represents 50 percent of the book adjusted carrying value of Holder. If Holder has a book adjusted carrying value of \$20,000,000, NEWBIE Insurance Company would enter \$10,000,000 (1/2 of \$20,000,000) as the carrying value of the Alien Insurance Company and the RBC charge for the indirect ownership of the alien insurance affiliate/subsidiary would be \$5,000,000 (0.500 times \$10,000,000). The risk-based capital charge for the parent insurer preparing the calculation is a 30 percent charge against the holding company value in excess of the indirectly owned insurance affiliates/subsidiaries.

If NEWBIE Insurance Company only acquired 50 percent shares of Holder, NEWBIE Insurance Company would enter \$5,000,000 (50 percent of 1/2 of \$20,000,000) as the carrying value of the Alien Insurance Company and the RBC charge for the indirect ownership of the Alien insurance affiliate/subsidiary would be \$5,000,000 (1.0 times \$5,000,000). Enter information for any indirectly owned alien insurance subsidiaries.

		XR002 Column				
Affiliate/Subsidiary	Affiliate/Subsidiary Type	4 100% RBC	5 Book Adjusted Carrying Value	7 Total Value of Affiliate/Subsidiary	11 % Owned	12 RBC Required
Alien Insurance Company	Indirect Alien Life Affiliate/Subsidiary	5,000,000	10,000,000	20,000,000	50%	5,000,000

For each affiliate/subsidiary enter the following information:

- Company Name,
- Alien Insurer Identification Number,
- Book Adjusted carrying value of common and preferred stock,
- Total Outstanding value of common and preferred stock,
- Book/adjusted carrying value of the common and preferred stock from Schedule D, Part 6, Section 1, Line 1499999. If no value is reported in the Total Value of Affiliate's Common and preferred stock column.

7. Investment in Upstream Affiliate (Parent)  
The risk-based capital (RBC) for an investment in an upstream parent is 30.0 percent of the book/adjusted carrying value of the common and preferred stock, regardless of whether that upstream parent is subject to RBC. Report the appropriate information from Schedule D, Part 6, Section 1, Lines 0199999 and 1099999 in Columns (1) through (10).
- For each affiliate, enter the following information:
- Company Name,
  - Affiliate Type Code,
  - NAIC Company Code,
  - Book Adjusted carrying value of common stock
  - Book Adjusted carrying value of preferred stock,
  - Total Outstanding value of common and preferred stock.
8. Directly Owned U.S. Insurance Affiliates/Subsidiaries Not Subject to RBC
- a. Health Insurance Companies and Health Entities Not Subject to RBC
  - b. Property and Casualty Insurance Companies Not Subject to RBC, such as title insurers, monoline financial guaranty insurers, and monoline mortgage guarantee insurers
  - c. Life Insurance Companies Not Subject to RBC, such as life insurance subsidiary exempted from RBC
- The risk-based capital for insurers not subject to RBC is based on the underlying statute, regulation, or rule governing capital requirements for such entities. If not otherwise specified by statute regulation or rule, the risk-based capital for an investment in a U.S. insurer that is not required to file an RBC formula is 30 percent of the book/adjusted carrying value of the common and preferred stock.
9. Non-Insurance Affiliates/Subsidiaries Not Subject to RBC
- a. Financial entities with a capital requirement imposed by a regulatory body (e.g., a bank)
  - b. Other financial entities without regulatory capital requirements
  - c. Other non-financial entities
- The risk-based capital for entity types a, b, and c is 30 percent of the book/adjusted carrying value of the common and preferred stock. The affiliate/subsidiary code for Non-Insurer Affiliates/Subsidiaries Not Subject to RBC is "9". Reported amounts use Schedule D, Part 6, Section 1, Line 0899999, and Line 1799999 as the basis of reporting.

**APPENDIX 3 – EXAMPLE USED FOR AFFILIATED/SUBSIDIARY STOCKS**

To determine the value of total outstanding common stock or total outstanding preferred stock, divide the book/adjusted carrying value of the investment (found in Schedule D - Part 6 Section 1, Column 9) by the percentage of ownership (found in Schedule D – Part 6 – Section 1, Column 12). For example:

<u>Subsidiary Insurance Company</u>	<u>Owner's Book / Adjusted Carrying Value</u>	<u>Percentage Ownership</u>	<u>Total Stock Outstanding</u>
Subsidiary #1	\$1,000,000	100%	\$1,000,000
Subsidiary #2	\$1,000,000	75%	\$1,333,333
Subsidiary #3	\$1,000,000	50%	\$2,000,000
Subsidiary #4	\$1,000,000	25%	\$4,000,000
Subsidiary #5	\$1,000,000	10%	\$10,000,000

**AFFILIATED COMPANIES RISK - DETAILS  
DETAILS FOR AFFILIATED STOCKS**

(1) Name of Affiliate	(2) Affiliate Code	(3) NAIC Company Code or Alien ID Number	(4) Affiliate's RBC after Coverage Before Basic Operational Risk (7) p032 Line (67) L001 Line (67) + (71)	(5) Book/Adjusted Carrying Value (statement value) of Affiliate's Common Stock	(6) Valuation Basis of Col (5) M - Market Value after any "discount" A - All Other	(7) Total Value of Affiliate's Outstanding Common Stock	(8) Statutory Surplus of Affiliate Subject to RBC (Adjusted for % Owned)	(9) Book/Adjusted Carrying Value (statement value) of Affiliate's Preferred Stock	(10) Total Value of Affiliate's Outstanding Preferred Stock	(11) Percent Owned (Cols 5 + 9) /(Cols 7 + 10)	(12) RBC Required (H0 Component)	(13) Market Value Excess Component Affiliated Common Stock RBC Required (H1 Component)
(01)										100.0000%		
(02)										100.0000%		
(03)										100.0000%		
(04)										100.0000%		
(05)										100.0000%		
(06)										100.0000%		
(07)										100.0000%		
(08)										100.0000%		
(09)										100.0000%		
(10)										100.0000%		
(11)										100.0000%		
(12)										100.0000%		
(13)										100.0000%		
(14)										100.0000%		
(15)										100.0000%		
(16)										100.0000%		
(17)										100.0000%		
(18)										100.0000%		
(19)										100.0000%		
(20)										100.0000%		
(21)										100.0000%		
(22)										100.0000%		
(23)										100.0000%		
(24)										100.0000%		
(25)										100.0000%		
(26)										100.0000%		
(27)										100.0000%		
(28)										100.0000%		
(29)										100.0000%		
(30)										100.0000%		
(31)										100.0000%		
(32)										100.0000%		
(33)										100.0000%		
(34)										100.0000%		
(35)										100.0000%		
(36)										100.0000%		
(37)										100.0000%		
(38)										100.0000%		
(39)										100.0000%		
(40)										100.0000%		
(41)										100.0000%		
(42)										100.0000%		
(43)										100.0000%		
(44)										100.0000%		
(45)										100.0000%		
(46)										100.0000%		
(47)										100.0000%		
(48)										100.0000%		
(49)										100.0000%		
(50)										100.0000%		
(9999999)										100.0000%		
Total										XXX	0	0

Remark: Subcategory 8a, 8b, and 8c are referring to the directly owned insurance affiliates not subject to RBC look-through

Indirectly owned insurance affiliate not subject to RBC will be included Category 4

If Col (2) < 5 and Col (6) = F, Do Calculation

**Calculation**

Col (12) = Min (Col (4) \* Col (11), Col (8) \* Col (11))

If Col (5) > Col (9) → Max (Col (4) \* Col (11), Col (8) \* Col (11)) then

Col (12) → Max (Col (5) + Col (9) - Col (8) \* Col (11), (Col (4) - Col (8)) \* Col (11))

If Col (4) \* Col (11) > Col (5) + Col (9) - Col (8) \* Col (11) then

Col (12) = Col (5) + Col (9) - Col (8) \* Col (11)

Otherwise

Col (12) = 0

Col (12) and (13) cannot be less than 0



**SUBSIDIARY, CONTROLLED AND AFFILIATED INVESTMENTS  
AFFILIATED COMPANIES RISK**

	Type of Affiliate/ Affiliate Type	Type Code	Basis	(1) Number of Companies	(2) Total RBC Required
(1)	Directly Owned Health Insurance Companies or Health Entities	1a	Affiliate's RBC ÷ Sub's RBC After Covariance	0	\$0
(2)	Directly Owned Property and Casualty Insurance Affiliates	1b	Affiliate's RBC ÷ Sub's RBC After Covariance	0	\$0
(3)	Directly Owned Life Insurance Affiliates	1c	Affiliate's RBC ÷ Sub's RBC After Covariance	0	\$0
(4)	Indirectly Owned Health Insurance Companies or Health Entities	2a	Affiliate's RBC ÷ Sub's RBC After Covariance	0	\$0
(5)	Indirectly Owned Property and Casualty Insurance Affiliates	2b	Sub's RBC After Covariance	0	\$0
(6)	Indirectly Owned Life Insurance Affiliates	2c	Sub's RBC After Covariance	0	\$0
(7)	Holding Company in Excess of Indirect Subs	3	0.300	0	\$0
(8)	Investment Subsidiary	4	0.300	0	\$0
(9)	Directly Owned Alien Health Insurance Companies or Health Entities	5a	1.000	0	\$0
(10)	Directly Owned Alien Property and Casualty Insurance Affiliates	5b	1.000	0	\$0
(11)	Directly Owned Alien Life Insurance Affiliates	5c	1.000	0	\$0
(12)	Indirectly Owned Alien Health Insurance Companies or Health Entities	6a	1.000	0	\$0
(13)	Indirectly Owned Alien Property and Casualty Insurance Affiliates	6b	1.000	0	\$0
(14)	Indirectly Owned Alien Life Insurance Affiliates	6c	1.000	0	\$0
(15)	Investment in Upstream Affiliate (Parent)	7	0.300	0	\$0
(16)	Directly Owned Health Insurance Companies or Health Entities Not Subject to RBC	8a	0.300	0	\$0
(17)	Directly Owned Property and Casualty Insurance Companies Not Subject to RBC	8b	0.300	0	\$0
(18)	Directly Owned Life Insurance Companies Not Subject to RBC	8c	0.300	0	\$0
(19)	Non-Insurance Entities with a Capital Requirement Imposed by a Regulatory Body	9a	0.300	0	\$0
(20)	Non-Insurance Other Financial Entities without Regulatory Capital Requirements	9b	0.300	0	\$0
(21)	Other Non-financial Entities	9c	0.300	0	\$0
(22)	Total			0	\$0

**CROSS-CHECKING FOR AFFILIATED INVESTMENTS**  
**SUMMARY FOR SUBSIDIARY, CONTROLLED AND AFFILIATED INVESTMENTS FOR CROSS-CHECKING STATEMENT VALUES**

	Annual Statement Line Number	(1) Total Preferred Stock	(2) Total From RBC Report	(3) Difference
Affiliated Preferred Stock				
Schedule D Part 6 Section 1 C 7				
(1) Parent	0199999	0	0	0
(2) U.S. P&C Insurer	0299999	0	0	0
(3) U.S. Life Insurer	0399999	0	0	0
(4) U.S. Health Insurer	0499999	0	0	0
(5) Alien Insurer	0599999	0	0	0
(6) Non-Insurer Which Controls Insurer	0699999	0	0	0
(7) Investment Subsidiary	0799999	0	0	0
(8) Other Affiliates	0899999	0	0	0
(9) Subtotal	0999999	0	0	0

	Annual Statement Line Number	(1) Total Common Stock	(2) Total From RBC Report	(3) Difference
Affiliated Common Stock				
Schedule D Part 6 Section 1 C 7				
(10) Parent	1099999	0	0	0
(11) U.S. P&C Insurer	1199999	0	0	0
(12) U.S. Life Insurer	1299999	0	0	0
(13) U.S. Health Insurer	1399999	0	0	0
(14) Alien Insurer	1499999	0	0	0
(15) Non-Insurer Which Controls Insurer	1599999	0	0	0
(16) Investment Subsidiary	1699999	0	0	0
(17) Other Affiliates	1799999	0	0	0
(18) Subtotal	1899999	0	0	0

EQUITY ASSETS

PREFERRED STOCK - UNAFFILIATED

	Annual Statement Source	(1) Bk/Adj Carrying Value	Factor	(2) RBC Requirement
(1) NAIC 01 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.003	\$0
(2) NAIC 02 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.010	\$0
(3) NAIC 03 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.020	\$0
(4) NAIC 04 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.045	\$0
(5) NAIC 05 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.100	\$0
(6) NAIC 06 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.300	\$0
(7) Total - Unaffiliated Preferred Stock	Sum of Lines (1) through (6)	\$0		\$0

(Should equal Page 2, Column 3, Line 2.1 less Sch D Sum, Column 1, Line 18)

COMMON STOCK - UNAFFILIATED

(8) Federal Home Loan Bank Stock	Company Records		0.023	\$0
(9) Total Common Stock	Schedule D, Summary, Column 1, Line 25			
(10) Affiliated Common Stock	Schedule D, Summary, Column 1, Line 24			
(11) Other Unaffiliated Common Stock	Lines (9) - (8) - (10)	\$0	0.150	\$0
(12) Market Value Excess Affiliated Common Stock	XR002 C(13) L(9999999)			\$0
(13) Total Unaffiliated Common Stock	Lines (8) + (11) + (12)	\$0		\$0

**CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE**

	(1) RBC Amount
<b>H0 - INSURANCE AFFILIATES AND MISC. OTHER AMOUNTS</b>	
(1) Off-Balance Sheet Items	\$0
(2) Directly Owned Health Insurance Companies or Health Entities	\$0
(3) Directly Owned Property and Casualty Insurance Affiliates	\$0
(4) Directly Owned Life Insurance Affiliates	\$0
(5) Indirectly Owned Health Insurance Companies or Health Entities	\$0
(6) Indirectly Owned Property and Casualty Insurance Affiliates	\$0
(7) Indirectly Owned Life Insurance Affiliates	\$0
(8) Affiliated Alien Insurers - Directly Owned	\$0
(9) Affiliated Alien Insurers - Indirectly Owned	\$0
(10) Total H0	\$0
<b>H1 - ASSET RISK - OTHER</b>	
(11) Investment-Affiliates	\$0
(12) Holding Company Excess of Subsidiaries	\$0
(13) Investment-in-Parent	\$0
(14) Other-Affiliates	\$0
(15) Fair-Value Excess-Affiliate-Common-Stock	\$0
(16) Holding Company in Excess of Indirect Subs	\$0
(17) Investment Subsidiary	\$0
(18) Investment in Upstream Affiliate (Parent)	\$0
(19) Directly Owned Health Insurance Companies or Health Entities	\$0
(20) Directly Owned Property and Casualty Insurance Companies Not Subject to RBC	\$0
(21) Directly Owned Life Insurance Companies Not Subject to RBC	\$0
(22) Affiliated Non-Insurer	\$0
(23) Fixed Income Assets	\$0
(24) Replication & Mandatory Convertible Securities	\$0
(25) Unaffiliated Preferred Stock	\$0
(26) Unaffiliated Common Stock	\$0
(27) Property & Equipment	\$0
(28) Asset Concentration	\$0
(29) Total H1	\$0
<b>H2 - UNDERWRITING RISK</b>	
(30) Net Underwriting Risk	\$0
(31) Other Underwriting Risk	\$0
(32) Disability Income	\$0
(33) Long-Term Care	\$0
(34) Limited Benefit Plans	\$0
(35) Premium Stabilization Reserve	\$0
(36) Total H2	\$0
<b>Sum Lines (1) through (9)</b>	\$0
<b>XR003, Affiliates Page, Line (5)</b>	\$0
<b>XR003, Affiliates Page, Line (6)</b>	\$0
<b>XR003, Affiliates Page, Line (9)</b>	\$0
<b>XR003, Affiliates Page, Line (14)</b>	\$0
<b>XR003, Affiliates Page, Line (15)</b>	\$0
<b>XR003, Affiliates Page, Line (16)</b>	\$0
<b>XR003, Affiliates Page, Line (17)</b>	\$0
<b>XR003, Affiliates Page, Line (18)</b>	\$0
<b>XR003, Affiliates Page, Column 2, Line (19) + (20) + (21)</b>	\$0
<b>XR006, Off-Balance Sheet Collateral, Lines (27) + (37) + (38) + (39) + XR008, Fixed Income Assets Page Line (51)</b>	\$0
<b>XR009, Replication/MCS Page, Line (9999999)</b>	\$0
<b>XR006, Off-Balance Sheet Collateral, Line (34) + XR010, Equity Assets Page, Line (7)</b>	\$0
<b>XR006, Off-Balance Sheet Collateral, Line (35) + XR010, Equity Assets Page, Line (13)</b>	\$0
<b>XR006, Off-Balance Sheet Collateral, Line (36) + XR011, Prop/Equip Assets Page, Line (9)</b>	\$0
<b>XR012, Grand Total Asset Concentration Page, Line (27)</b>	\$0
<b>Sum Lines (11) through (23)</b>	\$0
<b>XR013, Underwriting Risk Page, Line (21)</b>	\$0
<b>XR015, Underwriting Risk Page, Line (25.3)</b>	\$0
<b>XR015, Underwriting Risk Page, Lines (26.3) + (27.3) + (28.3) + (29.3) + (30.6) + (31.3) + (32.3)</b>	\$0
<b>XR016, Underwriting Risk Page, Line (41)</b>	\$0
<b>XR017, Underwriting Risk Page, Lines (42.2) + (43.6) + (44)</b>	\$0
<b>XR017, Underwriting Risk Page, Line (45)</b>	\$0
<b>Sum Lines (25) through (30)</b>	\$0



**CALCULATION OF TOTAL ADJUSTED CAPITAL**

	Annual Statement Source	(1) Amount	Factor	(2) Adjusted Capital
<b>Company Amounts</b>				
(1) Capital and Surplus	Page 3, Column 3, Line 33		1.000	\$0
<b>Subsidiary Adjustments</b>				
(2) AVR - Life Subs	Affiliate's Statement §		1.000	\$0
(3) Dividend Liability - Life Subsidiaries	Affiliate's Statement		0.500	\$0
(4) Tabular Discounts - P&C Subsidiaries	Affiliate's Statement		-1.000	\$0
(5) Non-Tabular Discounts - P&C Subsidiaries	Affiliate's Statement		-1.000	\$0
(6) <b>Carrying Value of Non-Admitted Insurance Affiliates</b>	<b>Included in XR002 Column 5 and Column 9</b>	<b>0</b>	<b>1.000</b>	<b>\$0</b>
(7) Total Adjusted Capital, Post-Deferred Tax				\$0
<b>SENSITIVITY TEST:</b>				
(8) DTA Value for Company	Page 2, Column 3, Line 18.2		1.000	\$0
(9) DTL Value for Company	Page 3, Column 3, Line 10.2		1.000	\$0
(10) DTA Value for Insurance Subsidiaries	Company Records		1.000	\$0
(11) DTL Value for Insurance Subsidiaries	Company Records		1.000	\$0
(12) Total Adjusted Capital, Pre-Deferred Tax (Sensitivity)	<b>Lines (7) - (8) + (9) - (10) + (11)</b>			\$0
<b>Ex DTA ACL RBC Ratio Sensitivity Test</b>				
(13) Deferred Tax Asset	Page 2 Column 3, Line 18.2		1.000	\$0
(14) Total Adjusted Capital Less Deferred Tax Asset	<b>Lines (7) less (13)</b>			\$0
(15) Authorized Control Level RBC	XR027 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)			\$0
(16) Ex DTA ACL RBC Ratio	<b>Line (14)/(15)</b>			0.000%

§ The portion of the AVR that can be counted as capital is limited to the amount not utilized in asset adequacy testing in support of the Actuarial Opinion for reserves.

**AFFILIATED/SUBSIDIARY STOCKS**  
**LR042 – LR044**

There are ten categories of affiliated/subsidiary investments that are subject to Risk-Based Capital requirements for common stock and preferred stock holdings. Those ten categories are:

1. Directly Owned U.S. Insurance Affiliates/Subsidiaries Subject to a Risk-Based Capital (RBC)-Look-Through Calculation
  - a. Health Insurance Company or Health Entity
  - b. Property and Casualty Insurance Company
  - c. Life Insurance Company
2. Indirectly Owned U.S. Insurance Affiliates/Subsidiaries Subject to RBC-Look-Through Calculation
  - a. Health Insurance Company or Health Entity
  - b. Property and Casualty Insurance Company
  - c. Life Insurance Company
3. Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries
4. Investment Subsidiaries
5. Directly Owned Alien Insurance Affiliates/Subsidiaries
  - a. Health Insurance Company or Health Entity
  - b. Property and Casualty Insurance Company
  - c. Life Insurance Company
6. Indirectly Owned Alien Insurance Affiliates/Subsidiaries
  - a. Health Insurance Company or Health Entity
  - b. Property and Casualty Insurance Company
  - c. Life Insurance Company
7. Investments in Upstream Affiliate (Parent)
8. Directly Owned U.S. Insurance Affiliates/Subsidiaries Not Subject to RBC
  - a. Health Insurance Companies and Health Entities Not Subject to RBC
  - b. Property and Casualty Insurance Companies Not Subject to RBC
  - c. Life Insurance Companies Not Subject to RBC
9. Non-Insurance Affiliates/Subsidiaries Not Subject to RBC
  - a. Entities with a capital requirement imposed by a regulatory body
  - b. Other Financial Entities without regulatory capital requirements
  - c. Non-financial entities
10. Publicly Traded Insurance Affiliates/Subsidiaries Held at Market Value

Enter applicable items for each affiliate/subsidiary in the Details for Affiliated/Subsidiary Stocks worksheet. The program will automatically calculate the risk-based capital charge for each affiliate/subsidiary. When the data is uploaded to the NAIC database, it will be cross-checked and the company will be required to correct any discrepancies and refile a corrected version with the NAIC and/or any state that requires the company to file RBC with its department. The RBC report will display the number of affiliates/subsidiaries. These numbers should be reviewed to ensure that all affiliates/subsidiaries are appropriately reported.

The total of all reported affiliate/subsidiary stock should equal the amounts reported on Schedule D, Part 2, Section 1, Line 4409999999 plus Schedule D, Part 2, Section 2, Line 5979999999 and should also equal Schedule D, Part 6, Section 1, Line 09999999 plus Line 18999999.

Affiliated/Subsidiary investments fall into two broad categories: (A) Insurance Affiliates/Subsidiaries that are Subject to risk-based capital; and (B) Affiliates/Subsidiaries that are Not Subject to risk-based capital. The risk-based capital for these two broad groups differs. Investment subsidiaries are a subset of category A in that they are subject to a risk-based capital charge that includes the life RBC risk factors applied only to the investments held by the investment subsidiary for its parent insurer. Publicly traded insurance affiliates/subsidiaries held at market value have characteristics of both broader categories. As a result, there is a two-part RBC calculation. The general treatment for each is explained below.

Directly owned insurance and health entity affiliates/subsidiaries are affiliates/subsidiaries in which the reporting company owns the stock of the affiliate/subsidiary. Indirectly owned insurance affiliates/subsidiaries and health entities are those where the reporting company owns stock in a holding company, which in turn owns the stock of the insurance affiliate/subsidiary or health entity. Note that there could be multiple holding companies that control the downstream insurance company.

Enter the book/adjusted carrying value of: the common stock in Column (5), the preferred stock in Column (7), the total outstanding common stock in Column (6) and the total outstanding preferred stock of that affiliate/subsidiary in Column (10) of the appropriate worksheet. The percentage of ownership is calculated by summing the book/adjusted carrying values of the owned preferred stock and common stock and dividing that amount by the sum of all outstanding preferred and common stock.

Insurance Affiliate/Subsidiaries that are Subject to RBC

1. Directly Owned U.S. Affiliates/Subsidiaries:

The risk-based capital requirement for the reporting company for those insurance affiliates/subsidiaries that are subject to a risk-based capital requirement is based on the Total Risk-Based Capital After Covariance of the affiliate/subsidiary, prorated for the percent of ownership of that affiliate/subsidiary.

For purposes of Subsidiary Risk all references to Total Risk-Based Capital After Covariance of the affiliate/subsidiary means:

- a. For a Health affiliate/subsidiary RBC filing, Total Risk-Based Capital After Covariance before Basic Operational Risk (XR024, Line (37));
- b. For a P/C affiliate/subsidiary RBC filing, Total Risk-Based Capital After Covariance before Basic Operational Risk (PR032, Line (68)); and
- c. For a Life affiliate/subsidiary RBC filing, the sum of
  - (a) Total Risk-Based Capital After Covariance before Basic Operational Risk (LR031, Line (67)); and
  - (b) Primary Security shortfall for all cessions covered by Actuarial Guideline XLVIII (AG 48) multiplied by two (LR031, Line (71)).

For RBC purposes, the reporting insurer must determine the carrying value and the RBC requirement of directly owned RBC filing affiliate/subsidiary company, even if the RBC filing affiliate/subsidiary is non-admitted. The value reported in annual statement Schedule D, Part 6, Section 1 should be used for RBC purposes. In addition to RBC, the carrying value of the RBC filer must be reported in total adjusted carrying value for RBC purposes, in order to appropriately balance the numerator with the addition of the denominator value. Enter the carrying value of the insurer on **Line XXXX** of the Calculation of Total Adjusted Capital page to satisfy these instructions.



**Equity method Insurance Affiliates/Subsidiaries:** Equity method is defined in SSAP No. 97, Paragraph 8b. as the underlying audited statutory equity of the respective entity's financial statements, adjusted for any unamortized goodwill as provided for in SSAP No. 68—Business Combinations and Goodwill. For those insurance Affiliates/Subsidiaries of the reporting company that are reported under the equity method, the C<sub>0</sub> charge of the ownership of the common and preferred stock in these Affiliates/Subsidiaries is limited to the lesser of:

- (a) the Total RBC After Covariance of the affiliate/subsidiary times the percentage of ownership, which is the total of common stock and preferred stock; or
- (b) the common and preferred stock book/adjusted carrying value at which the affiliate/subsidiary is carried.

**Market Value (including discounted market value) Insurance Affiliates/Subsidiaries (See SSAP No. 97, Paragraph 8a.):** See 10 below.

2. Indirectly Owned U.S. Insurance Affiliates/Subsidiaries

For Indirectly Owned U.S. Insurance Affiliates/Subsidiaries, the carrying value and RBC is calculated in the same manner as for directly owned U.S. Insurance Affiliates/Subsidiaries. The RBC for the indirect affiliates/subsidiaries must be calculated prior to completing this RBC report.

SSAP No. 97 provides guidance for the reporting and admittance requirements of SCAs. Accordingly, there may be cases where an indirectly owned RBC filer may not be separately reported in the statutory financial statements (e.g., they are captured within the carrying value of an intermediate holding company). The SSAP No. 97 guidance permits reporting SCAs at the directly owned holding company level or via look-through to the downstream entity (including where the downstream entity is an RBC filer), but an audit of the entity is required for admittance (i.e. if reporting is at the directly owned holding company level, the holding company must be audited, if the reporting is on a look-through basis then the downstream entity must be audited). Regardless of whether there is a look-through applied pursuant to Statutory Accounting Principles (SAP) for annual financial statement reporting, for RBC purposes the reporting insurer must “look-through” all intermediate holding and subsidiary companies to determine the carrying value and the RBC requirement of indirectly owned RBC filing affiliate/subsidiary company. This involves drilling down to the first RBC filing insurance affiliate/subsidiary and adjusting for percentage ownership of the intermediate entity directly owning the RBC filing affiliate/subsidiary. Both RBC and carrying value of the RBC filer must be reported for RBC purposes, in order to appropriately balance the numerator with the addition to the denominator value. Enter the carrying value of the insurer on Line XXX of the Calculation of Total Adjusted Capital page to satisfy these instructions.

The carrying value for each indirect insurance affiliate/subsidiary is established based on company records using the statutory value of the insurer as reported in the NAIC annual financial statement blank submitted by the affiliate/subsidiary or market value when applicable, and the RBC requirement as determined in its RBC Report adjusted for the ownership percentages (both the percentage of the indirectly owned RBC filing affiliate/subsidiary that is owned by the directly held downstream holding company and the reporting insurer's ownership percentage in that downstream entity). The value reported by the downstream holding company for the U.S. RBC filing insurer is the same as the statutory value established for the insurer on a look-through basis.

3. Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries :

The carrying value of a U.S. Insurance Affiliate/Subsidiary that is subject to RBC is deducted from the value of the directly held holding company or other entity that in turn directly owns the U.S. Insurance Affiliate/Subsidiary that is subject to RBC, based on the value reported for each insurance affiliate/subsidiary on the downstream immediate holding company or non-insurance owner's balance sheet. That value is prescribed by the NAIC Accounting Practices and Procedures Manual (SSAP No. 97, paragraph 22.a.). A similar exercise is required for each RBC filing insurer and each non-U.S. insurer in order to determine the remaining excess value of the holding company.

The remaining value of the directly held holding company is then subject to a charge that is calculated in accordance with the instructions for Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries as specified in the RBC formula. If the holding company is not admitted, report the excess carrying value as zero and the

corresponding RBC charge will also be zero. If a negative excess value for the downstream holding company results from removing the value of U.S. RBC filing insurers from the downstream holding company's reported value, then the value of that holding company will be floored at zero and the corresponding RBC charge will also be zero.

The following hypothetical Balance Sheet indicates the view of a Holding Company - Holder, Inc. which is 100% owned by MEGA Life Insurance Company (it assumes that the value reported by the downstream holding company for the U.S. RBC filing insurer is the same as the statutory value established for the insurer on a look-through basis):

	Balance Sheet Holder, Inc. 12/31/XXXX	
Cm Slt:		
ABC Life Company	10,000,000	Long Term Debt
XYZ Casualty Company	15,000,000	Other Liabilities
ANH Health Company	3,000,000	
Other Common Stock	17,000,000	Total Liabilities
Cash	7,000,000	
Other Assets	5,000,000	Equity
Total Assets	57,000,000	Total Liabilities & Equity
		57,000,000

The RBC calculation for Holder, Inc.'s value in excess of the indirectly owned insurance affiliates is as follows:

Company	Stat. Book	
	value	Source:
Holder, Inc.	50,000,000	MEGA Life Sch D - Part 6, Section 1
Holder, Inc. aff/subs subject to RBC		
ABC Life Company	10,000,000	Holder, Inc. Stat. balance sheet
XYZ Casualty Company	15,000,000	Holder, Inc. Stat. balance sheet
ANH Health Company	3,000,000	Holder, Inc. Stat. balance sheet
Subtotal	28,000,000	
Holder, Inc. excl. RBC aff/subs	22,000,000	(amount subject to the 30.0% factor for Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries)

The following table shows the LR044 entries that MEGA Life Insurance Company (which owns 100% owns of Holder, Inc.) would report for the indirectly owned insurance subsidiaries under Holder, Inc. This table assumes that Holder, Inc. owns 40%, 50% and 25% of ABC Life, XYZ Casualty, and ANH Health, respectively. The table also assumes that the RBC values shown for these subsidiaries at the 100% level are the correct RBC After Covariance but Before Operational Risk.

Affiliates/Subsidiaries	Affiliates/Subsidiaries Type	LR044 Column				
		4 100% RBC	5 Book Adjusted Carrying Value	6 Total Value of Affiliates/Subsidiaries	9 % Owned	10 RBC Required
ABC Life Company	Indirect U.S. Life Aff/Sub	5,000,000	10,000,000	25,000,000	40%	2,000,000
XYZ Casualty Company	Indirect U.S. P&C Aff/Sub	12,000,000	15,000,000	30,000,000	50%	6,000,000
ANH Health Company	Indirect U.S. Health Aff/Sub	6,000,000	3,000,000	12,000,000	25%	1,500,000

The risk-based capital charge for the parent insurer preparing the calculation is a 30.0 percent charge against the holding company value in excess of the indirectly owned insurance affiliates/subsidiaries as calculated in the prior example. Enter information in the appropriate columns of the worksheet, omitting those columns that do not apply (Column (3) – NAIC Company Code or Alien ID Number and Column (4) Affiliate’s RBC After Covariance).

4. Investment Subsidiaries

An investment subsidiary is a subsidiary that exists only to invest the funds of the parent company. The term “investment subsidiary” is defined in the NAIC’s *Annual Statement Instructions* as any subsidiary, other than a holding company, engaged or organized primarily to engage in the ownership and management of investments for the insurer. An investment subsidiary shall not include any broker-dealer or a money management fund managing funds other than those of the parent company. The risk-based capital charge for the ownership of an investment subsidiary is based on the risk-based capital of the underlying assets, pro-rated for the degree of ownership. The basis for this calculation is the assumption that the charge should be the same as it would be if the life insurer held the assets directly.

Report information regarding any investment subsidiaries. Subsidiaries reported in this section will be assigned an affiliate code of “4” for investment subsidiaries. The amount of reported common stock should be the same as Schedule D, Part 6, Section 1, Line 1699999. Preferred stock information should be the same as Schedule D, Part 6, Section 1, Line 0799999.

Affiliates/Subsidiaries that are Not Subject to RBC

5. Directly Owned Alien Insurance Affiliates/Subsidiaries

For purposes of this formula, the risk-based capital of each alien insurance affiliate/subsidiary is zero. Report information for any non-U.S. insurance affiliate/subsidiary, both life and property and casualty.

For each affiliate/subsidiary, report the name and alien insurer identification number. For purposes of this formula, the statement value of common and preferred stock and the total outstanding value of common and preferred stock for alien insurance affiliates/subsidiaries should be entered as zero. Companies reported in this section will be assigned an affiliate/subsidiary code of “5” for alien insurers.

For each affiliate/subsidiary, enter the following information:

- Company Name,
- Alien Insurer Identification Number,

- Book Adjusted carrying value of common and preferred stock,
- Total Outstanding value of common and preferred stock,
- Book/adjusted carrying value of the common and preferred stock from Schedule D, Part 6, Section 1, Line 1499999. If no value is reported in the Total Value of Affiliate's/Subsidiary's common and preferred stock columns (6) and (8), the program will assume 100 percent ownership.

6. Indirectly Owned Alien Insurance Affiliates/Subsidiaries  
 Consistent with the treatment of Directly Owned Alien Insurance Subsidiaries / Affiliates, for purposes of this formula, the carrying value and risk-based capital charge of each alien insurance affiliate is zero.

For each affiliate/Subsidiary enter the following information:

- Company Name,
- Alien Insurer Identification Number,
- Book Adjusted carrying value of common and preferred stock,
- Total Outstanding value of common and preferred stock,
- Book/adjusted carrying value of the common and preferred stock from Schedule D, Part 6, Section 1, Lines 1499999 and 0599999. If no value is reported in the Total Value of Affiliate's/Subsidiary's Common and preferred stock columns (6) and (8), the program will assume 100 percent ownership.

7. Investment in Upstream Affiliate (Parent)

The pre-tax Risk-Based Capital (RBC) for an investment in an upstream parent is 30.0 percent of the book/adjusted carrying value of the common and preferred stock, regardless of whether that upstream parent is subject to RBC. Report the appropriate information from Schedule D, Part 6, Section 1, Lines 0199999 and 1099999 in Columns (1) through (6).

For each affiliate, enter the following information:

- Company Name,
- Affiliate Type,
- NAIC Company Code,
- Book Adjusted carrying value of common and preferred stock,
- Total Outstanding value of common and preferred stock.

8. Directly Owned U.S. Insurance Affiliates/Subsidiaries Not Subject to RBC

- a. Health Insurance Companies and Health Entities Not Subject to RBC
- b. Property and Casualty Insurance Companies Not Subject to RBC, such as title insurers, monoline financial guaranty insurers, and monoline mortgage guarantee insurers
- c. Life Insurance Companies Not Subject to RBC, such as life insurance affiliate/subsidiary exempted from RBC

The risk-based capital for insurers not subject to RBC is based on the underlying statute, regulation, or rule governing capital requirements for such entities. If not otherwise specified by statute, regulation or rule, the risk-based capital for an investment in a U.S. insurer that is not required to file an RBC formula Investment is 0.300 times the book/adjusted carrying value of the common and preferred stock.

9. Non-Insurance Affiliates/Subsidiaries Not Subject to RBC

- a. Financial entities with a capital requirement imposed by a regulatory body (e.g. a bank)
- b. Other financial entities without regulatory capital requirements
- c. Other Non-financial entities

The risk-based capital for entity types a, b, and c. is 0.300 times the book/adjusted carrying value of the common and preferred stock. The affiliate/subsidiary code for Non-Insurance Affiliates/Subsidiaries Not Subject to RBC is "g." Reported amounts use Schedule D, part 6, Schedule 1, Line 0899999, and Line 1799999 as the basis of reporting.

10. Publicly Traded Insurance Affiliates/Subsidiaries Held at Market Value

The risk-based capital for a publicly traded insurance affiliate/subsidiary held at market value after any "discount," is calculated in two parts. First, calculate and report the risk-based capital of the affiliate/subsidiary according to the relevant instructions above for Insurance Affiliates/Subsidiaries that are Subject to a RBC-look-through Calculation. Second, calculate the additional risk-based capital charge as 34.6 percent pre-tax of any excess of the market (statement) value over the book value of the affiliate/subsidiary. The result of the second calculation will be added to the C-1a component.

Report information regarding any publicly traded insurance affiliate/subsidiary held at market value. The reported market value of common stock should be the same as shown in Schedule D, Part 2, Section 2, Column 8, Line 5919999999 plus Line 5929999999. The market value of preferred stock should be the same as shown in Schedule D, Part 2, Section 1, Column 10, line 4319999999 plus 4329999999. The reported book value of common stock should be the same as shown in Schedule D, Part 2, Section 2, Column 6, Line 5919999999 plus Line 5929999999. The reported book value of preferred stock should be the same as Schedule D, Part 2, Section 1, Column 8, Line 4319999999 plus 4329999999.

**APPENDIX 3 – EXAMPLE USED FOR AFFILIATED/SUBSIDIARY STOCKS**

To determine the value of total outstanding common stock or total outstanding preferred stock, divide the book/adjusted carrying value of the investment (found in Schedule D - Part 6 Section 1, Column 9) by the percentage of ownership (found in Schedule D – Part 6 – Section 1, Column 12). For example:

Subsidiary Insurance Company	Owner's Book / Adjusted Carrying Value	Percentage Ownership	Total Stock Outstanding
Subsidiary #1	\$1,000,000	100%	\$1,000,000
Subsidiary #2	\$1,000,000	75%	\$1,333,333
Subsidiary #3	\$1,000,000	50%	\$2,000,000
Subsidiary #4	\$1,000,000	25%	\$4,000,000
Subsidiary #5	\$1,000,000	10%	\$10,000,000

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Company Name

CALCULATION OF TAX EFFECT FOR LIFE AND PATERNAL RISK-BASED CAPITAL

ASSET RISKS

	Source	RFC Amount	Tax Factor	RFC Tax Effect
(001) Long-term Bonds – NAIC 1	LR002 Bonds Column (2) Line (2.8) + LR018 OFE-Balance Sheet Collateral Column (3) Line (2.8)	X	0.1680	=
(002) Long-term Bonds – NAIC 2	LR002 Bonds Column (2) Line (3.4) + LR018 OFE-Balance Sheet Collateral Column (3) Line (3.4)	X	0.1680	=
(003) Long-term Bonds – NAIC 3	LR002 Bonds Column (2) Line (4.4) + LR018 OFE-Balance Sheet Collateral Column (3) Line (4.4)	X	0.1680	=
(004) Long-term Bonds – NAIC 4	LR002 Bonds Column (2) Line (5.4) + LR018 OFE-Balance Sheet Collateral Column (3) Line (5.4)	X	0.1680	=
(005) Long-term Bonds – NAIC 5	LR002 Bonds Column (2) Line (6.4) + LR018 OFE-Balance Sheet Collateral Column (3) Line (6.4)	X	0.1680	=
(006) Long-term Bonds – NAIC 6	LR002 Bonds Column (2) Line (7) + LR018 OFE-Balance Sheet Collateral Column (3) Line (7)	X	0.2100	=
(007) Short-term Bonds – NAIC 1	LR002 Bonds Column (2) Line (10.8)	X	0.1680	=
(008) Short-term Bonds – NAIC 2	LR002 Bonds Column (2) Line (11.4)	X	0.1680	=
(009) Short-term Bonds – NAIC 3	LR002 Bonds Column (2) Line (12.4)	X	0.1680	=
(010) Short-term Bonds – NAIC 4	LR002 Bonds Column (2) Line (13.4)	X	0.1680	=
(011) Short-term Bonds – NAIC 5	LR002 Bonds Column (2) Line (14.4)	X	0.1680	=
(012) Short-term Bonds – NAIC 6	LR002 Bonds Column (2) Line (15)	X	0.2100	=
(013) Credit for Hedging – NAIC 1 Through 5 Bonds	LR014 Hedged Asset Bond Schedule Column (13) Line (0199999)	X	0.1680	†
(014) Credit for Hedging – NAIC 6 Bonds	LR014 Hedged Asset Bond Schedule Column (13) Line (0299999)	X	0.2100	†
(015) Bond Reduction - Reinsurance	LR002 Bonds Column (2) Line (19)	X	0.2100	=
(016) Bond Increase - Reinsurance	LR002 Bonds Column (2) Line (20)	X	0.2100	=
(017) Non-Exempt NAIC 1 U.S. Government Agency	LR002 Bonds Column (2) Line (22)	X	0.1680	=
(018) Bonds Size Factor	LR002 Bonds Column (2) Line (26) - LR002 Bonds Column (2) Line (21)	X	0.1680	=
<b>Mortgages</b>				
(019) Residential Mortgages - Insured	LR004 Mortgages Column (6) Line (1)	X	0.1575	=
(020) Residential Mortgages - Other	LR004 Mortgages Column (6) Line (2)	X	0.1575	=
(021) Commercial Mortgages - Insured	LR004 Mortgages Column (6) Line (3)	X	0.1575	=
(022) Total Commercial Mortgages - All Other	LR004 Mortgages Column (6) Line (9)	X	0.1575	=
(023) Total Farm Mortgages	LR004 Mortgages Column (6) Line (15)	X	0.1575	=
<b>All Days Overdue</b>				
(024) Residential Mortgages - Insured	LR004 Mortgages Column (6) Line (16)	X	0.1575	=
(025) Residential Mortgages - Other	LR004 Mortgages Column (6) Line (17)	X	0.1575	=
(026) Commercial Mortgages - Insured	LR004 Mortgages Column (6) Line (18)	X	0.1575	=
(027) Commercial Mortgages - Other	LR004 Mortgages Column (6) Line (19)	X	0.1575	=
(028) All Passives of Enclosed	LR004 Mortgages Column (6) Line (20)	X	0.1575	=
(029) Farm Mortgages	LR004 Mortgages Column (6) Line (21)	X	0.1575	=

† Denotes lines that are deducted from the total rather than added.  
Denotes items that must be manually entered on the filing software.

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NAIC Company Code

CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

	Source	REC Amount	Tax Factor	REC Tax Effect
(030) Residential Mortgages - Insured	LR004 Mortgages Column (6) Line (22)	X	0.1575	=
(031) Residential Mortgages - Other	LR004 Mortgages Column (6) Line (23)	X	0.1575	=
(032) Commercial Mortgages - Insured	LR004 Mortgages Column (6) Line (24)	X	0.1575	=
(033) Commercial Mortgages - Other	LR004 Mortgages Column (6) Line (25)	X	0.1575	=
(034) Due & Unpaid Taxes Mortgages	LR004 Mortgages Column (6) Line (26)	X	0.1575	=
(035) Due & Unpaid Taxes - Foreclosures	LR004 Mortgages Column (6) Line (27)	X	0.1575	=
(036) Mortgage Reduction - Reinsurance	LR004 Mortgages Column (6) Line (29)	X	0.2100	=
(037) Mortgage Increase - Reinsurance	LR004 Mortgages Column (6) Line (30)	X	0.2100	=
(038) Unaffiliated Preferred Stock NAIC 1	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (1)	X	0.1575	=
(039) Unaffiliated Preferred Stock NAIC 2	- LR018 OPE Balance Sheet Collateral Column (3) Line (9)	X	0.1575	=
(040) Unaffiliated Preferred Stock NAIC 3	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (2)	X	0.1575	=
(041) Unaffiliated Preferred Stock NAIC 4	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (3)	X	0.1575	=
(042) Unaffiliated Preferred Stock NAIC 5	- LR018 OPE Balance Sheet Collateral Column (3) Line (11)	X	0.1575	=
(043) Unaffiliated Preferred Stock NAIC 6	- LR018 OPE Balance Sheet Collateral Column (3) Line (12)	X	0.1575	=
(044) Preferred Stock - Reduction-Reinsurance	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (5)	X	0.1575	=
(045) Preferred Stock - Increase-Reinsurance	- LR018 OPE Balance Sheet Collateral Column (3) Line (13)	X	0.2100	=
(046) Guaranteed Index	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (6)	X	0.2100	=
(047) Nonindex-Book Reserve	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (8)	X	0.2100	=
(048) Separate Accounts Nonindex-Market Reserve	LR006 Separate Accounts Column (3) Line (1)	X	0.1575	=
(049) Separate Accounts Reduction-Reinsurance	LR006 Separate Accounts Column (3) Line (2)	X	0.1575	=
(050) Separate Accounts Increase-Reinsurance	LR006 Separate Accounts Column (3) Line (3)	X	0.2100	=
(051) Synthetic GICs	LR006 Separate Accounts Column (3) Line (4)	X	0.1575	=
(052) Separate Account Surplus	LR006 Separate Accounts Column (3) Line (5)	X	0.1575	=
(053) Commercial Mortgages Real Estate	LR007 Real Estate Column (3) Line (1)	X	0.2100	=
(054) Commercial Mortgages Real Estate	LR007 Real Estate Column (3) Line (2)	X	0.2100	=
(055) Investment Real Estate	LR007 Real Estate Column (3) Line (3)	X	0.2100	=
(056) Real Estate Reduction - Reinsurance	LR007 Real Estate Column (3) Line (11)	X	0.2100	=
(057) Real Estate Increase - Reinsurance	LR007 Real Estate Column (3) Line (12)	X	0.2100	=
(058) Sch BA Real Estate Excluding Low Income Housing Tax Credits	LR007 Real Estate Column (3) Line (16)	X	0.2100	=
(059) Guaranteed Low Income Housing Tax Credits	LR007 Real Estate Column (3) Line (17) - Line (19)	X	0.0000	=
(060) Non-Guaranteed and All Other Low Income Housing Tax Credits	LR007 Real Estate Column (3) Line (18) - Line (20) - Line (21)	X	0.0000	=
(061) Sch BA Real Estate Reduction - Reinsurance	LR007 Real Estate Column (3) Line (23)	X	0.2100	=
(062) Sch BA Real Estate Increase - Reinsurance	LR007 Real Estate Column (3) Line (24)	X	0.2100	=

† Denotes lines that are deducted from the total rather than added.  
‡ Denotes items that must be manually entered on the filing software.

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CALCULATION OF TAX EFFECT FOR LIFE AND PATERNAL RISK-BASED CAPITAL (CONTINUED)

(1)	RBC Amount	Tax Factor	(2)	RBC Tax Effect
(063)	Sch BA Bond NAIC 1	X	0.1575	=
(064)	Sch BA Bond NAIC 2	X	0.1575	=
(065)	Sch BA Bond NAIC 3	X	0.1575	=
(066)	Sch BA Bond NAIC 4	X	0.1575	=
(067)	Sch BA Bond NAIC 5	X	0.1575	=
(068)	Sch BA Bond NAIC 6	X	0.1575	=
(069)	BA Bond - Reinsurance	X	0.2100	=
(070)	BA Bond Increase - Reinsurance	X	0.2100	=
(071)	BA Preferred Stock NAIC 1	X	0.1575	=
(072)	BA Preferred Stock NAIC 2	X	0.1575	=
(073)	BA Preferred Stock NAIC 3	X	0.1575	=
(074)	BA Preferred Stock NAIC 4	X	0.1575	=
(075)	BA Preferred Stock NAIC 5	X	0.1575	=
(076)	BA Preferred Stock NAIC 6	X	0.2100	=
(077)	BA Preferred Stock Reduction-Reinsurance	X	0.2100	=
(078)	BA Preferred Stock Increase - Reinsurance	X	0.1575	=
(079)	BA Preferred Stock - Reinsurance	X	0.1575	=
(080)	BA Common Stock - Reinsurance	X	0.1575	=
(081)	BA Common Stock - Reinsurance	X	0.1575	=
(082)	BA Common Stock - Reinsurance	X	0.1575	=
(083)	Other BA Assets	X	0.2100	=
(084)	Other BA Assets Reduction-Reinsurance	X	0.2100	=
(085)	Other BA Assets Increase - Reinsurance	X	0.2100	=
(086)	BA Mortgages - In Good Standing	X	0.1575	=
(087)	BA Mortgages - 90 Days Overdue	X	0.1575	=
(088)	BA Mortgages - 90 Days Overdue - Reinsurance	X	0.1575	=
(089)	Rebate - Reinsurance	X	0.2100	=
(090)	Increase - Reinsurance	X	0.2100	=
(091)	Miscellaneous	X	0.1575	=
(092)	Asset Concentration Factor	X	0.1575	=
(093)	Miscellaneous Assets	X	0.1575	=
(094)	Derivatives - Collateral and Exchange Traded	X	0.1575	=
(095)	Derivatives NAIC 1	X	0.1575	=
(096)	Derivatives NAIC 2	X	0.1575	=
(097)	Derivatives NAIC 3	X	0.1575	=
(098)	Derivatives NAIC 4	X	0.1575	=
(099)	Derivatives NAIC 5	X	0.1575	=
(100)	Miscellaneous Assets Reduction-Reinsurance	X	0.2100	=
(101)	Miscellaneous Assets Increase-Reinsurance	X	0.2100	=
<p>‡ Denotes lines that are deducted from the total rather than added.            † Denotes items that must be manually entered on the filing software.</p>				



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CALCULATION OF TAX EFFECT FOR LIFE AND PATERNAL RISK-BASED CAPITAL (CONTINUED)

	(1) REC Amount	Tax Factor 0.1575	(2) REC Tax Effect
(102) Replacements	X	0.1575	=
(103) Reinsurance	X	0.2100	=
(104) Investment Affiliates	X	0.2100	=
(105) Common Stock	X	0.2100	=
(106) Directly Owned Health Insurance Companies or Health Entities Not Subject to RBC	X	0.2100	=
(107) Directly Owned Property and Casualty Insurance Companies Not Subject to RBC	X	0.2100	=
(108) Directly Owned Life Insurance Companies Not Subject to RBC	X	0.2100	=
(109) Publicly Traded Insurance Affiliates	X	0.2100	=
(110) Subtotal for C-to Assets	X	0.2100	=
C-to Affiliated Common Stock			
(111) OPE-Balance Sheet and Other Items	X	0.1575	=
(112) OPE-Balance Sheet Items Reduction - Reinsurance	X	0.2100	=
(113) OPE-Balance Sheet Items Increase - Reinsurance	X	0.2100	=
(114) OPE-Balance Sheet Items Increase - Health Entities	X	0.2100	=
(115) OPE-Balance Sheet Items Increase - Property and Casualty Insurance Affiliates	X	0.2100	=
(116) Directly Owned Life Insurance Companies	X	0.2100	=
(117) Indirectly Owned Health Insurance Companies or Health Entities	X	0.2100	=
(118) Indirectly Owned Property and Casualty Insurance Affiliates	X	0.2100	=
(119) Indirectly Owned Life Insurance Companies	X	0.2100	=
(120) Affiliated Alien Insurers - Directly Owned	X	0.0000	=
(121) Affiliated Alien Insurers - Indirectly Owned	X	0.0000	=
(122) Subtotal for C-to Affiliated Common Stock	X	0.0000	=
Common Stock			
(123) Unaffiliated Common Stock	X	0.2100	=
(124) Credit for Holding - Common Stock	X	0.2100	=
(125) Stock Reduction - Reinsurance	X	0.2100	=
(126) Stock Increase - Reinsurance	X	0.2100	=
(127) BA Common Stock Unaffiliated	X	0.2100	=
(128) BA Common Stock Affiliated - C-Les	X	0.2100	=
(129) Common Stock Concentration Factor	X	0.2100	=
(130) NAIC 01 Working Capital Finance Notes	X	0.1575	=
(131) NAIC 02 Working Capital Finance Notes	X	0.1575	=
(132) Indirectly Owned Excess of Indirect Subs	X	0.2100	=
(133) Affiliated Non-Insurers	X	0.2100	=
(134) Total for C-Les Assets	X	0.2100	=
Insurance Risk			
(135) Disability Income Premium	X	0.2100	=

LR013 Replication (Synthetic Asset) Transactions and Mandatory Convertible Securities Column (7) Line (9999999)

LR016 Reinsurance Column (4) Line (17)

LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (8)

LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (15)

LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (16)

LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (17)

LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (18)

LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (22)

Sum of Lines (001) through (109), Recognizing the Deduction of Lines (013), (014), (015), (036), (044), (049), (056), (061), (069), (077), (084), (089) and (100)

LR017 OPE-Balance Sheet and Other Items Column (5) Line (27)

LR017 OPE-Balance Sheet and Other Items Column (5) Line (28)

LR017 OPE-Balance Sheet and Other Items Column (5) Line (29)

LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (1)

LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (2)

LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (3)

LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (4)

LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (5)

LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (6)

LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (9) + (10) + (11) + (12) + (13) + (14) + (15) + (16) + (17) + (18) + (19) + (20) + (21)

LR005 Unaffiliated Preferred and Common Stock Column (5) Line (17) +

LR018 OPE-Balance Sheet Collateral Column (3) Line (16)

LR015 Hedged Asset Common Stock Subtable Column (10) Line (0299999)

LR005 Unaffiliated Preferred and Common Stock Column (5) Line (19)

LR005 Unaffiliated Preferred and Common Stock Column (5) Line (20)

LR008 Other Long-Term Assets Column (5) Line (47)

LR008 Other Long-Term Assets Column (5) Line (49.2)

LR001 Common Stock Concentration Factor Column (6) Line (6)

LR008 Other Long-Term Assets Column (5) Line (51.1)

LR008 Other Long-Term Assets Column (5) Line (51.2)

LR008 Other Long-Term Assets Column (5) Line (51.3)

LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (7)

LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (9) + (20) + (21) + (23) + (24) + (25) + (26) + (27) + (28) + (29) + (30) + (31) + (32) + (33)

LR019 Health Premiums Column (2) Lines (21) through (27)

† Denotes lines that are deducted from the total rather than added.  
 Denotes items that must be manually entered on the filing software.

Company Name

Confidential when Completed

NAIC Company Code

CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

	(1) REC.Amount	Tax Factor	(2) REC.Tax Effect
(136) Long-Term Care		X 0.2100	=
(137) Life Insurance-C-2 Risk		X 0.2100	=
(138) Life Insurance-C-2 Risk		X 0.2100	=
(138b) Longevity-C-2 Risk		X 0.2100	=
(139) Disability and Long-Term Care Health		X 0.2100	=
(140) Claim Reserves		X 0.0000	=
(141) Premium Stabilization Credit			
(142) Interest Rate Risk		X 0.2100	=
(143) Health Credit Risk		X 0.0000	=
(144) Medical Expense Risk		X 0.2100	=
(144b) Business Risk		X 0.0000	=
(144c) Health Administrative Expenses			
(147) Total Tax Effect			

LR019 Health Premiums Column (2) Line (28) + LR021 Long-Term Care Column (4) Line (7)  
 LR025 Life Insurance Column (2) Line (8)  
 LR025 Life Insurance Column (2) Lines (20) and (21)  
 LR025-A Longevity Risk Column (2) Line (5)  
 LR024 Health Claim Reserves Column (4) Line (9) + Line (15)  
 LR026 Premium Stabilization Reserves Column (2) Line (10)  
 $L(135) + L(136) + L(137) + L(140) + \text{Greater of (Guardrail Factor} * (L(137)+L(138)), \text{Guardrail Factor} * L(138b), \text{Square Root of } (L(137) + L(138))^2 + L(138b)^2 + 2 * (\text{Correlation Factor} * (L(137) + L(138)) * L(138b)))$   
 LR027 Interest Rate Risk Column (3) Line (36)  
 LR028 Health Credit Risk Column (2) Line (7)  
 LR029 Medical Expense Risk Column (2) Line (37)  
 LR029 Business Risk Column (2) Line (40)  
 LR029 Business Risk Column (2) Line (57)  
**Lines (110) + (122) + (134) + (41) + (42) + (43) + (144) + (145) + (146)**

† Denotes lines that are deducted from the total rather than added.  
 ‡ Denotes items that must be manually entered on the filing software.

CALCULATION OF CAPITAL AND RISK CONTROL LEVEL RISK-BASED CAPITAL

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NAIC Company Code

(1)  
RBC  
Requirement

Source

(1)	Insurance Affiliates and Misc. Other Amounts (C-0)	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (1)
(2)	Directly Owned Health Insurance Companies or Health Entities	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (2)
(3)	Directly Owned Property and Casualty Insurance Affiliates	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (3)
(4)	Directly Owned Life Insurance Affiliates	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (4)
(5)	Indirectly Owned Health Insurance Companies or Health Entities	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (5)
(6)	Indirectly Owned Property and Casualty Insurance Affiliates	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (6)
(7)	Indirectly Owned Life Insurance Affiliates	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Lines (9) + (10) + (11)
(8)	Affiliated Alien Insurers - Directly Owned	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Lines (12) + (13) + (14)
(9)	Affiliated Alien Insurers - Indirectly Owned	LR017 Off-Balance Sheet and Other Items Column (5) Line (34)
(10)	Off-Balance Sheet and Other Items	Sum of Lines (1) through (9)
(11)	Total (C-0) - Pre-Tax	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (122)
(12)	(C-0) Tax Effect	Line (10) - Line (11)
(13)	Net (C-0) - Post-Tax	
(14)	Asset Risk - Unaffiliated Common Stock, and Affiliated Non-Insurance Stock (C-1a)	
(15)	Schedule BA Unaffiliated Common Stock	LR005 Unaffiliated Common Stock Column (5) Line (21) + LR018 Off-Balance Sheet Collateral Column (3) Line (16)
(16)	Schedule BA Affiliated Common Stock - C-1s	LR008 Other Long-Term Assets Column (5) Line (47)
(17)	Common Stock Concentration Factor	LR008 Other Long-Term Assets Column (5) Line (49.2)
(18)	Holding Company in Excess of Indirect Subs	LR011 Common Stock Concentration Factor Column (6) Line (6)
(19)	Affiliated Non-Insurers	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (7)
(20)	Total (C-1s) - Pre-Tax	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Lines (19) + (20) + (21)
(21)	(C-1s) Tax Effect	Sum of Lines (15) through (18)
(22)	Net (C-1s) - Post-Tax	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (134)
(23)	Asset Risk - All Other (C-1a)	
(24)	Bonds after Size Factor	LR002 Bonds Column (2) Line (27) + LR018 Off-Balance Sheet Collateral Column (3) Line (8)
(25)	Mortgages (including past due and unpaid taxes)	LR004 Mortgages Column (6) Line (31)
(26)	Unaffiliated Preferred Stock	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (10) + LR018 Off-Balance Sheet Collateral Column (3) Line (15)
(27)	Investment Affiliates	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (8)
(28)	Investment in Upstream Affiliate (Parent)	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (15)
(29)	Directly Owned Health Insurance Companies or Health Entities Not Subject to RBC	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (16)
(30)	Directly Owned Property and Casualty Insurance Companies Not Subject to RBC	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (17)
(31)	Directly Owned Life Insurance Companies Not Subject to RBC	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (18)
(32)	Publicly Traded Insurance Affiliates	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (22)
(33)	Separate Accounts with Guarantees	LR006 Separate Accounts Column (3) Line (7)

Denotes items that must be manually entered on the filing software.

CALCULATION OF THE CONTROL LEVEL RISK-BASED CAPITAL (CONTINUED)

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NAIC Company Code

(1)  
RBC  
Requirement

	Source	
(32) Synthetic GICs (C-1o)	LR006 Separate Accounts Column (3) Line (8)	
(33) Surplus in Non-Guaranteed Separate Accounts	LR006 Separate Accounts Column (3) Line (13)	
(34) Real Estate (gross of encumbrances)	LR007 Real Estate Column (3) Line (13)	
(35) Schedule BA Real Estate (gross of encumbrances)	LR007 Real Estate Column (3) Line (25)	
(36) Other Long-Term Assets	LR008 Other Long-Term Assets Column (5) Line (56) + LR018 Off-Balance Sheet Collateral Column (3) Line (17) + Line (18)	
(37) Schedule BA Mortgages	LR009 Schedule BA Mortgages Column (6) Line (23)	
(38) Concentration Factor	LR010 Asset Concentration Factor Column (6) Line (62) Grand Total Page	
(39) Miscellaneous	LR012 Miscellaneous Assets Column (2) Line (21)	
(40) Replication Transactions and Mandatory Convertible Securities	LR013 Replication (Synthetic Asset) Transactions and Mandatory Convertible Securities Column (7) Line (9999999)	
(41) Reinsurance	LR016 Reinsurance Column (4) Line (17)	
(42) Total (C-1o) - Pre-Tax	Sum of Lines (22) through (41)	
(43) (C-1o) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (110) Line (42) - Line (43)	
(44) Net (C-1o) - Post-Tax		
<b>Insurance Risk (C-2)</b>		
(45) Individual and Industrial Life Insurance	LR025 Life Insurance Column (2) Line (8)	
(46) Group and Credit Life Insurance and FEGISGLI	LR025 Life Insurance Column (2) Lines (20) and (21)	
(46b) Longevity Risk	LR025-A Longevity Risk Column (2) Line (5)	
(47) Total Health Insurance	LR024 Health Claim Reserves Column (4) Line (18)	
(48) Premium Stabilization Reserve Credit	LR026 Premium Stabilization Reserves Column (2) Line (10)	
(49) Total (C-2) - Pre-Tax	$L(47) + L(48) + \text{Greatest of [Guardrail Factor} * L(45) + L(46)], \text{Guardrail Factor} * L(46b), \text{Square Root of } [(L(45) + L(46b))^2 + 2 * (\text{Correlation Factor} * L(45) + L(46)) * L(46b)]$	
(50) (C-2) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (141) Line (49) - Line (50)	
(51) Net (C-2) - Post-Tax		
<b>Interest Rate Risk (C-3a)</b>		
(52) Total Interest Rate Risk - Pre-Tax	LR027 Interest Rate Risk Column (3) Line (36)	
(53) (C-3a) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (142) Line (52) - Line (53)	
(54) Net (C-3a) - Post-Tax		
<b>Health/Credit Risk (C-3b)</b>		
(55) Total Health/Credit Risk - Pre-Tax	LR028 Health/Credit Risk Column (2) Line (7)	
(56) (C-3b) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (143) Line (55) - Line (56)	
(57) Net (C-3b) - Post-Tax		
<b>Market Risk (C-3c)</b>		
(58) Total Market Risk - Pre-Tax	LR027 Interest Rate Risk Column (3) Line (37)	
(59) (C-3c) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (144) Line (58) - Line (59)	
(60) Net (C-3c) - Post-Tax		

Denotes items that must be manually entered on the filing software.

NAIC Company Code	(1) RBC Requirement	Source	Confidential when Completed
			CALCULATION OF AUTHORITY CONTROL LEVEL RISK-BASED CAPITAL (CONTINUED)
			Business Risk (C-4a)
(61)		LR029 Business Risk Column (2) Lines (12) + (24) + (36)	Premium Component
(62)		LR029 Business Risk Column (2) Line (39)	Liability Component
(63)		Lines (61) + (62)	Subtotal Business Risk (C-4a) - Pre-Tax
(64)		LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (145)	(C-4a) Tax Effect
(65)		Line (63) - Line (64)	Net (C-4a) - Post-Tax
			Business Risk (C-4b)
(66)		LR029 Business Risk Column (2) Line (57)	Health Administrative Expense Component of Business Risk (C-4b) - Pre-Tax
(67)		LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (146)	(C-4b) Tax Effect
(68)		Line (66) - Line (67)	Net (C-4b) - Post-Tax
			Total Risk-Based Capital After Covariance Before Basic Operational Risk
(69)		REPORT AMOUNT ON PARENT COMPANY'S RBC IF APPLICABLE $L(12)+L(65) + \text{Square Root of } [(L(44) + L(54))^2 + (L(21) + L(60))^2 + L(51) + L(57) + L(68)^2]$	$C-0 + C-4a + \text{Square Root of } [(C-1a + C-3a)^2 + (C-1c + C-3c)^2 + (C-2)^2 + (C-3b)^2 + (C-4b)^2]$
(70)		$0.03 \times L(69)$	Gross Basic Operational Risk
(71)		Company Records	C-4a of U.S. Life Insurance Subsidiaries
(72)		Line (70) - Line (65) + Line (71) (Not less than zero)	Net Basic Operational Risk
(73)		LR036 XXX/XXX Rensurance Primary Security Shortfall by Cession Column (7) Line (9999999) Multiplied by 2	Primary Security Shortfall Calculated in Accordance With Actuarial Guideline XLVIII Multiplied by 2
(74)		Line (69) + Line (72) + Line (73)	Total Risk-Based Capital After Covariance (Including Basic Operational Risk and Primary Security Shortfall multiplied by 2)
(75)		Line (74) x 0.50	Authorized Control Level Risk-Based Capital (After Covariance Adjustment and Shortfall) Total Risk-Based Capital After Covariance Times Fifty Percent
(76)		$L(10)+L(63) + \text{Square Root of } [(L(42) + L(52))^2 + (L(19) + L(58))^2 + L(49)^2 + L(55)^2 + L(66)^2]$	Tax Sensitivity Test Tax Sensitivity Test: Total Risk-Based Capital After Covariance
(77)		Line (76) x 0.50	Tax Sensitivity Test: Authorized Control Level Risk-Based Capital

Denotes items that must be manually entered on the filing software.

Company Name

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NAIC Company Code

SUMMARY FOR AFFILIATED/SUBSIDIARY INVESTMENTS STOCKS

	Affiliate Type	Affiliate Code	Book / Adjusted Carrying Value	Book Value †	Difference Col. (1) - (2)	RBC Basis	RBC Requirement	Number of Companies
(1)	Directly Owned Health Insurance Companies or Health Entities	1a	XXX	XXX	XXX	Subsidiaries' Total Risk-Based Capital After Covariance / 0.79		
(2)	Directly Owned Property and Casualty Insurance Affiliates	1b	XXX	XXX	XXX	Subsidiaries' Total Risk-Based Capital After Covariance / 0.79		
(3)	Directly Owned Life Insurance Affiliates	1c	XXX	XXX	XXX	Subsidiaries' Total Risk-Based Capital After Covariance / 0.79		
(4)	Indirectly Owned Health Insurance Companies or Health Entities	2a	XXX	XXX	XXX	Subsidiaries' Total Risk-Based Capital After Covariance / 0.79		
(5)	Indirectly Owned Property and Casualty Insurance Affiliates	2b	XXX	XXX	XXX	Subsidiaries' Total Risk-Based Capital After Covariance / 0.79		
(6)	Indirectly Owned Life Insurance Affiliates	2c	XXX	XXX	XXX	Subsidiaries' Total Risk-Based Capital After Covariance / 0.79		
(7)	Holding Company in Excess of Indirect Subs	3	XXX	XXX	XXX	X 0.300		
(8)	Investment Subsidiary	4	XXX	XXX	XXX	Subsidiaries' Total Risk-Based Capital After Covariance / 0.79		
(9)	Directly Owned Health Insurance Companies or Health Entities	5a	XXX	XXX	XXX	X 1.000		
(10)	Directly Owned Alien Property and Casualty Insurance Affiliates	5b	XXX	XXX	XXX	X 1.000		
(11)	Directly Owned Alien Life Insurance Affiliates	5c	XXX	XXX	XXX	X 1.000		
(12)	Indirectly Owned Health Insurance Companies or Health Entities	6a	XXX	XXX	XXX	X 1.000		
(13)	Indirectly Owned Alien Property and Casualty Insurance Affiliates	6b	XXX	XXX	XXX	X 1.000		
(14)	Indirectly Owned Alien Life Insurance Affiliates	6c	XXX	XXX	XXX	X 1.000		
(15)	Investment in Upstream Affiliate (Parent)	7	XXX	XXX	XXX	X 0.300		
(16)	Directly Owned Health Insurance Companies or Health Entities Not Subject to RBC	8a	XXX	XXX	XXX	X 0.300		
(17)	Directly Owned Property and Casualty Insurance Companies Not Subject to RBC	8b	XXX	XXX	XXX	X 0.300		
(18)	Directly Owned Life Insurance Companies Not Subject to RBC	8c	XXX	XXX	XXX	X 0.300		
(19)	Non-Insurance Entities with a Capital Requirement Imposed by a Regulatory Body	9a	XXX	XXX	XXX	X 0.300		
(20)	Non-Insurance Other Financial Entities without Regulatory Capital Requirements	9b	XXX	XXX	XXX	X 0.300		
(21)	Other Non-financial Entities	9c	XXX	XXX	XXX	X 0.300		
(22)	Publicly Traded Insurance Affiliates	10	XXX	XXX	XXX	X 0.346		
(23)	Total (Sum of Lines (1) through (22))	XXX	XXX	XXX	XXX	XXX		

† If different than book / adjusted carrying value.

Denotes items that must be manually entered on the filing software.

Company Name

Confidential when Completed

NAIC Company Code

**CROSSCHECKING FOR AFFILIATED/SUBSIDIARY INVESTMENTS STOCKS**

Affiliated Preferred Stock

	(1)	(2)	(3)
Schedule D Part 6 Section 1 Type	Annual Statement Line Number	Annual Statement Total Preferred Stock†	Total from Life and Fraternal Risk-Based Capital Report‡
(1) Parent	01999999		Difference
(2) U.S. Property and Casualty Insurer	02999999		
(3) U.S. Life Insurer	03999999		
(4) U.S. Health Entity	04999999		
(5) Alien Insurer	05999999		
(6) Non-Insurer Which Controls Insurer	06999999		
(7) Investment Subsidiary	07999999		
(8) Other Affiliates	08999999		
(9) Total (Sum of Lines (1) through (8))			

Affiliated Common Stock

	(1)	(2)	(3)
Schedule D Part 6 Section 1 Type	Annual Statement Line Number	Annual Statement Total Common Stock†	Total from Life and Fraternal Risk-Based Capital Report‡
(10) Parent	10999999		Difference
(11) U.S. Property and Casualty Insurer	11999999		
(12) U.S. Life Insurer	12999999		
(13) U.S. Health Entity	13999999		
(14) Alien Insurer	14999999		
(15) Non-Insurer Which Controls Insurer	15999999		
(16) Investment Subsidiary	16999999		
(17) Other Affiliates	17999999		
(18) Total (Sum of Lines (10) through (17))			

† Column (1) Lines (1) through (8) and (10) through (17) come from Schedule D Part 6 Section 1 Column 7 of the annual statement.

‡ Column (2) Lines (1) through (8) come from LR044 Details for Affiliated Investments Column (7).

§ Column (2) Lines (10) through (17) come from LR044 Details for Affiliated Investments Column (5).

Denotes items that must be manually entered on the filing software.

Company Name

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NAIC Company Code

DETAILS FOR AFFILIATED/SUBSIDIARY INVESTMENTS STOCKS

Affiliate-Code for Column (2)		RBC-Basis		Affiliate-Type		RBC-Basis		Affiliate-Code for Column (2)	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Direct U.S. Property and Casualty Subsidiaries	1	Subs. RBC-After Covariance / 0.79	Subs. RBC-After Covariance / 0.79	Alien Insurance Subsidiaries - Canadian Life	8	Subsidiaries - MCCSR / 0.79	8	1.000 x Book/Adj. Carrying Value	
Direct U.S. Life Subsidiaries	2	Subs. RBC-After Covariance / 0.79	Subs. RBC-After Covariance / 0.79	Alien Insurance Subsidiaries - Other	9	Investment in Parents	9	0.300 x Book/Adj. Carrying Value	
Direct and Indirect U.S. Health Subsidiaries	3	Subs. RBC-After Covariance / 0.79	Subs. RBC-After Covariance / 0.79	Other - Affiliate - P&C Insurers not subject to RBC	10	Other - Affiliate - All Other	10	0.300 x Book/Adj. Carrying Value	
Indirect U.S. Property and Casualty Subsidiaries	4	Subs. RBC-After Covariance / 0.79	Subs. RBC-After Covariance / 0.79	Other - Affiliate - Life Insurers not subject to RBC	11		11	0.300 x Book/Adj. Carrying Value	
Indirect U.S. Life Subsidiaries	5	Subs. RBC-After Covariance / 0.79	Subs. RBC-After Covariance / 0.79		12		12	0.300 x Book/Adj. Carrying Value	
Investment Subsidiaries	6	Subs. RBC-After Covariance / 0.79	Subs. RBC-After Covariance / 0.79		13		13	0.300 x Book/Adj. Carrying Value	
Holding Company in Excess of Indirect Subsidiaries	7	0.300 x Book/Adj. Carrying Value	0.300 x Book/Adj. Carrying Value						

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Name of Affiliate	Affiliate Code (1 to 21)	NAIC Company Code or Alien ID Number†	Affiliate's RBC After Covariance‡ LR031, Lines (67)-(71), PR032, Line (67), XR025, Line (37)	Book / Adjusted Carrying Value of Affiliate's	Total Value of Affiliate's Outstanding	Book / Adjusted Carrying Value of Affiliate's	Total Value of Affiliate's Outstanding	Percent Owned	RBC Requirement*
	(00000001)			Common Stock	Common Stock	Preferred Stock	Preferred Stock		
	(00000002)								
	(00000003)								
	(00000004)								
	(00000005)								
	(00000006)								
	(00000007)								
	(00000008)								
	(00000009)								
	(00000010)								
	(00000011)								
	(00000012)								
	(00000013)								
	(00000014)								
	(00000015)								
	(00000016)								
	(00000017)								
	(00000018)								
	(00000019)								
	(00000020)								
(99999999) Total	XXXXX	XXXXX		XXXXX	XXXXX	XXXXX	XXXXX	XXXXX	

† If applicable.  
‡ If applicable. For Canadian life subsidiaries, the Minimum Continuing Capital and Surplus Requirement (MCCSR) should be used.  
\* The RBC Requirement column is calculated on a pre-tax basis.

Denotes items that must be manually entered on the filing software.

#REF!



**AFFILIATED/SUBSIDIARY STOCKS**  
**PR003 – PR005**

There are nine categories of affiliated/subsidiary investments that are subject to Risk-Based Capital requirement for common stock and preferred stock holdings. Those nine categories are:

1. Directly Owned U.S. Insurance Affiliates/Subsidiaries Subject to a Risk-Based Capital (RBC)-Look-Through Calculation
  - a. Health Insurance Company or Health Entity
  - b. Property and Casualty Insurance Company
  - c. Life Insurance Company
2. Indirectly Owned U.S. Insurance Affiliates/Subsidiaries Subject to RBC-Look-Through Calculation
  - a. Health Insurance Company or Health Entity
  - b. Property and Casualty Insurance Company
  - c. Life Insurance Company
3. Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries
4. Investment Subsidiaries
5. Directly Owned Alien Insurance Affiliates/Subsidiaries
  - a. Health Insurance Company or Health Entity
  - b. Property and Casualty Insurance Company
  - c. Life Insurance Company
6. Indirectly Owned Alien Insurance Affiliates/Subsidiaries
  - a. Health Insurance Company or Health Entity
  - b. Property and Casualty Insurance Company
  - c. Life Insurance Company
7. Investments in Upstream Affiliate (Parent)
8. Directly Owned U.S. Insurance Affiliates/Subsidiaries Not Subject to RBC
  - a. Health Insurance Companies or Health Entities Not Subject to RBC
  - b. Property and Casualty Insurance Companies Not Subject to RBC
  - c. Life Insurance Companies Not Subject to RBC
9. Non-Insurance Affiliates/Subsidiaries Not Subject to RBC
  - a. Entities with a capital requirement imposed by a regulatory body
  - b. Other Financial Entities without regulatory capital requirements
  - c. Other Non-financial entities

Enter applicable items for each affiliate/subsidiary in the Details for Affiliated/Subsidiary Stocks worksheet. The program will automatically calculate the risk-based capital charge for each affiliate/subsidiary. When the data is uploaded to the NAIC database, it will be cross-checked and the company will be required to correct any discrepancies and refile a corrected version with the NAIC and/or any state that requires the company to file RBC with its department. The RBC report will display the number of affiliates/subsidiaries. These numbers should be reviewed to ensure that all affiliates/subsidiaries are appropriately reported.

The total of all reported affiliate/subsidiary stock should equal the amounts reported on Schedule D, Part 2, Section 1, Line 4409999999 plus Schedule D, Part 2, Section 2, Line 5979999999 and should also equal Schedule D, Part 6, Section 1, Line 09999999 plus Line 18999999.

Affiliated/Subsidiary investments fall primarily into two broad categories: (a) Insurance Affiliates/Subsidiaries that are Subject to risk-based capital; and (b) Affiliates/Subsidiaries that are Not Subject to risk-based capital. The risk-based capital for these two broad groups differs. A third category of Affiliates/Subsidiaries, publicly traded insurance affiliates/subsidiaries held at market value, has characteristics of both broader categories. As a result, it has a two-part RBC calculation. The general treatment for each is explained below.

Directly owned insurance and health entity affiliates/subsidiaries are affiliates/subsidiaries in which the reporting company owns the stock of the affiliate/subsidiary. Indirectly owned insurance affiliates/subsidiaries and health entities are those where the reporting company owns stock in a holding company, which in turn owns the stock of the insurance affiliate/subsidiary or health entity. Note that there could be multiple holding companies that control the downstream insurance company.

Enter the book/adjusted carrying value of: the common stock in Column (5), the preferred stock in Column (9), the total outstanding common stock in Column (7) and the total outstanding preferred stock of that affiliate/subsidiary in Column (10) of the appropriate worksheet. The percentage of ownership is calculated by summing the book/adjusted carrying values of the owned preferred and common stock and dividing that amount by the sum of all outstanding preferred and common stock.

Insurance Affiliates/Subsidiaries that are Subject to RBC

1. Directly Owned U.S. Affiliates/Subsidiaries:

The risk-based capital requirement for the reporting company for those insurance affiliates/subsidiaries that are subject to a risk-based capital requirement is based on the Total Risk-Based Capital After Covariance of the subsidiary, prorated for the percent of ownership of that affiliate/subsidiary.

For purposes of Affiliate/Subsidiary Risk all references to Total Risk-Based Capital After Covariance of the affiliate/subsidiary means:

- a. For a Health affiliate/subsidiary RBC filing, Total Risk-Based Capital After Covariance before Basic Operational Risk (XR025, Line (37).
- b. For a P/C affiliate/subsidiary RBC filing, Total Risk-Based Capital After Covariance before Basic Operational Risk (PR032, Line (68).
- c. For a Life affiliate/subsidiary RBC filing, the sum of
  - i. Total Risk-Based Capital After Covariance before Basic Operational Risk (LR031, Line (67)); and
  - ii. Primary Security shortfalls for all cessions covered by Actuarial Guideline XLVIII (AG 48) multiplied by two (LR031, Line (71)).

For RBC purposes, the reporting insurer must determine the carrying value and the RBC requirement of a directly owned RBC filing affiliate/subsidiary company, even if the RBC filing affiliate/subsidiary is non-admitted for financial reporting purposes. The value reported in annual statement Schedule D, Part 6, Section 1 will be used for RBC purposes. In addition to RBC, the carrying value of the RBC filer must be reported in total adjusted capital for RBC purposes, in order to appropriately balance the numerator with the addition to the denominator value. Enter the carrying value of the insurer on **Line XXX** of the Calculation of Total Adjusted Capital page to satisfy these instructions.

**Equity method Insurance Affiliates/Subsidiaries:** Equity method is defined in SSAP 97, Paragraph 8b, as the underlying audited statutory equity of the respective entity's financial statements, adjusted for any unamortized goodwill as provided for in SSAP No. 68—Business Combinations and Goodwill. For those insurance

Affiliates/Subsidiaries of the reporting company that are reported under the equity method, the  $R_0$  charge of the ownership of the common and preferred stock in these Affiliates/Subsidiaries is limited to the lesser of:

- (a) the Total RBC After Covariance of the affiliate/subsidiary times the percentage of ownership, which is the total of common stock and preferred stock; or
- (b) the common and preferred stock book/adjusted carrying value at which the affiliate/subsidiary is carried

**Market Value (including discounted market value) Insurance Affiliates/Subsidiaries (See SSAP No. 97, Paragraph 8a):** If the affiliate/subsidiary's common stock is publicly traded and the reporting company carries the affiliate/subsidiary at market value, after any "discount," there are generally two components to the reporting company's RBC generated by the affiliate/subsidiary. The prorated portion is the percentage of ownership of the total common and preferred stock. The smaller of the prorated portion of the affiliate/subsidiary's own statutory surplus or the prorated portion of its RBC after covariance is added to the  $R_0$  component of the reporting company. In the normal case, the common and preferred stock book/adjusted carrying value of the affiliate/subsidiary exceeds the prorated portion of the larger of its statutory surplus and its RBC after covariance. In this case, the addition to the  $R_2$  component is the larger of a) 22.5 percent of the affiliate/subsidiary's common and preferred stock book/adjusted carrying value in excess of the prorated portion of the affiliate/subsidiary's statutory surplus or b) the prorated portion of the affiliate/subsidiary's RBC after covariance in excess of the prorated portion of its statutory surplus. If the affiliate/subsidiary's common and preferred stock book/adjusted carrying value is less than the prorated portion of its RBC after covariance, but greater than the prorated portion of its statutory surplus, 100 percent of the common and preferred stock book/adjusted carrying value in excess of the prorated portion of the affiliate/subsidiary's statutory surplus is added to the reporting company's  $R_2$  component. If the affiliate/subsidiary's common and preferred stock book/adjusted carrying value is less than the prorated portion of the affiliate/subsidiary's statutory surplus, there is no addition to the  $R_2$  component.

## 2. Indirectly Owned U.S. Insurance Affiliates/Subsidiaries

For Indirectly Owned U.S. Insurance Affiliates/Subsidiaries, the carrying value and RBC is calculated in the same manner as for directly owned U.S. Insurance Affiliates/Subsidiaries. The RBC for the indirect affiliates/subsidiaries must be calculated prior to completing this RBC report.

SSAP No. 97 provides guidance for the reporting and admittance requirements of SCAs. Accordingly, there may be cases where an indirectly owned RBC filer may not be separately reported in the statutory financial statements (e.g., they are captured within the carrying value of an intermediate holding company). The SSAP No. 97 guidance permits reporting SCAs at the directly owned holding company level or via look-through to the downstream entity (including where the downstream entity is an RBC filer), but an audit of the entity is required for admittance (i.e. if reporting is at the directly owned holding company level, the holding company must be audited, if the reporting is on a look-through basis then the downstream entity must be audited). Regardless of whether there is a look-through applied pursuant to Statutory Accounting Principles (SAP) for annual financial statement reporting, for RBC purposes the reporting insurer must "look-through" all intermediate holding and subsidiary companies to determine the carrying value and the RBC requirement of indirectly owned RBC filing affiliate/subsidiary companies. This involves drilling down to the first RBC filing insurance affiliate/subsidiary and adjusting for percentage ownership of the intermediate entity directly owning the RBC filing affiliate/subsidiary. Both RBC and carrying value of the RBC filer must be reported for RBC purposes, in order to appropriately balance the numerator with the addition to the denominator value. Enter the carrying value of the insurer on Line XXX of the Calculation of Total Adjusted Capital page to satisfy these instructions.

The carrying value for each indirect insurance affiliate/subsidiary is established based on company records using the statutory value of the insurer as reported in the NAIC annual financial statement blank submitted by the affiliate/subsidiary or market value when applicable, and the RBC requirement as determined in its RBC Report adjusted for the ownership percentages (both the percentage of the indirectly owned RBC filing affiliate/subsidiary that is owned by the directly held

downstream holding company and the reporting insurer's ownership percentage in that downstream entity). The value reported by the downstream holding company for the U.S. RBC filing insurer is the same as the statutory value established for the insurer on a look-through basis.

**3. Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries**

The carrying value of a U.S. Insurance Affiliate/Subsidiary that is subject to RBC is deducted from the value of the directly held holding company or other entity that in turn directly owns the U.S. Insurance Affiliate/Subsidiary that is subject to RBC, based on the value reported for each insurance subsidiary on the downstream immediate holding company or non-insurance owner's balance sheet. That value is prescribed by the NAIC Accounting Practices and Procedures Manual (SSAP No. 97, paragraph 22.a.). A similar exercise is required for each RBC filing insurer and each non-U.S. insurer in order to determine the remaining excess value of the holding company.

The remaining value of the directly held holding company is then subject to a charge that is calculated in accordance with the instructions for Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries as specified in the RBC formula. If the holding company is not admitted, report the excess carrying value as zero and the corresponding RBC charge will also be zero. If a negative excess value for the downstream holding company results from removing the value of U.S. RBC filing insurers from the downstream holding company's reported value, then the value of that holding company will be floored at zero and the corresponding RBC charge will also be zero.

The following hypothetical Balance Sheet indicates the view of a Holding Company - Holder, Inc. which is 100% owned by MEGA P&C Insurance Company (it assumes that the value reported by the downstream holding company for the U.S. RBC filing insurer is the same as the statutory value established for the insurer on a look-through basis):

	Balance Sheet	
	Holder, Inc.	
	12/31/XXXX	
Cm Stk:		
ABC Life Company	10,000,000	Long Term Debt
XYZ Casualty Company	15,000,000	Other Liabilities
ANH Health Company	3,000,000	
Other Common Stock	17,000,000	Total Liabilities
Cash	7,000,000	
Other Assets	5,000,000	Equity
Total Assets	57,000,000	Total Liabilities & Equity
		57,000,000

The RBC calculation for Holder, Inc.'s value in excess of the indirectly owned insurance affiliates/subsidiaries is as follows:

<u>Company</u>	<u>Stat. Book value</u>	<u>Source:</u>
Holder, Inc.	50,000,000	MEGA P&C Sch D - Part 6, Section 1
<i>Holder, Inc. Aff/subs subject to RBC</i>		
ABC Life Company	10,000,000	Holder, Inc. Stat. balance sheet
XYZ Casualty Company	15,000,000	Holder, Inc. Stat. balance sheet
ANH Health Company	<u>3,000,000</u>	Holder, Inc. Stat. balance sheet
subtotal	28,000,000	
Holder, Inc. excl. RBC aff/subs	22,000,000	<i>(amount subject to the 22.5% factor for Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries)</i>

The following table shows the PR003 entries that MEGA P&C Insurance Company (which owns 100% of Holder, Inc.) would report for the indirectly owned insurance Affiliates/subsidiaries under Holder, Inc. This table assumes that Holder, Inc. owns 40%, 50% and 25% of ABC Life, XYZ Casualty, and ANH Health, respectively. The table also assumes that the RBC values shown for these affiliates/subsidiaries at the 100% level are the correct RBC After Covariance but Before Operational Risk.

Affiliates/Subsidiaries	Affiliates/Subsidiaries Type	PR003 Column					
		4	5	7	8	9	13
		100% RBC	Book Adjusted Carrying Value	Total Value of Affiliates/Subsidiaries	Statutory Surplus of Affiliates/Subsidiaries	% Owned	RBC Required
ABC Life Company	Indirect U.S. Life Aff/Sub	5,000,000	10,000,000	25,000,000	25,000,000	40%	2,000,000
XYZ Casualty Company	Indirect U.S. P&C Aff/Sub	12,000,000	15,000,000	30,000,000	30,000,000	50%	6,000,000
ANH Health Company	Indirect U.S. Health Aff/Sub	6,000,000	3,000,000	12,000,000	12,000,000	25%	1,500,000

The risk-based capital charge for the parent insurer preparing the calculation is a 22.5 percent charge against the holding company value in excess of the indirectly owned insurance affiliates/subsidiaries as calculated in the prior example. Enter information in the appropriate columns of the worksheet, omitting those columns that do not apply (Column (3) – NAIC Company Code or Alien ID Number and Column (4) Affiliate's RBC After Covariance).



Affiliates/Subsidiaries that are Not Subject to RBC

4. Investment Subsidiaries

An investment subsidiary is a subsidiary that exists only to invest the funds of the parent company. The term investment subsidiary is defined in the annual statement instructions as any subsidiary, other than a holding company, engaged or organized primarily to engage in the ownership and management of investments for the insurer. An investment subsidiary shall not include any broker-dealer or a money management fund managing funds other than those of the parent company. The risk-based capital for an investment in an investment subsidiary is 22.5 percent of the carrying value of the common and preferred stock.

5. Directly Owned Alien Insurance Affiliates/Subsidiaries

For purposes of this formula, the Risk-Based Capital (RBC) of each directly owned alien insurance affiliate/subsidiary is the annual statement book adjusted carrying value of the reporting company's interest in the affiliate multiplied by 0.500. Enter information for any non-U.S. insurance affiliate/subsidiary: life, property and casualty, and health insurers.

For each affiliate/subsidiary, enter the following information:

- Company Name,
- Alien Insurer Identification Number,
- Book Adjusted carrying value of common and preferred stock,
- Total Outstanding value of common and preferred stock,
- Book/adjusted carrying value of the common and preferred stock from Schedule D, Part 6, Section 1, Line 1499999. If no value is reported in the Total Value of Affiliate's common and preferred stock columns (7) and (11), the program will assume 100 percent ownership.

6. Indirectly Owned Alien Insurance Affiliates/Subsidiaries

For Indirectly Owned Alien Insurance Affiliates/Subsidiaries, the carrying value and RBC charge is calculated in a similar manner as for directly owned Alien Insurance Affiliates/Subsidiaries.

SSAP No. 97 provides guidance for the reporting and admittance requirements of SCAs. Accordingly, there may be cases where an indirectly owned Alien insurers may not be separately reported in the statutory financial statements (e.g., they are captured within the carrying value of an intermediate holding company). The SSAP No. 97 guidance permits reporting SCAs at the directly owned holding company level or via look-through to the downstream entity (including where the downstream entity is an Alien insurer), but an audit of the entity is required for admittance (i.e. if reporting is at the directly owned holding company level, the holding company must be audited, if the reporting is on a look-through basis then the downstream entity must be audited). Regardless of whether there is a look-through applied pursuant to Statutory Accounting Principles (SAP) for annual financial statement reporting, for RBC purposes the reporting insurer must "look-through" all intermediate holding and subsidiary companies to determine the carrying value and the RBC charge that would be imposed had the alien insurance affiliate/subsidiary companies been directly held by the reporting insurer. This involves looking down to the first alien insurer affiliate/subsidiary, unless there is an RBC filer in between and adjusting for percentage ownership of the intermediate entity directly owning the RBC filing affiliate/subsidiary. Both the RBC charge and carrying value of the alien insurer must be reported for RBC purposes, in order to appropriately balance the numerator with the addition to the denominator value. Enter the carrying value of the insurer on Line XXXX of the Calculation of Total Adjusted Capital page to satisfy these instructions.

The carrying value of an alien insurance Affiliate/Subsidiary is deducted from the value of the directly held holding company or other entity that in turn directly owns the U.S. Insurance Affiliate/Subsidiary that is subject to RBC, based on the value reported for each insurance subsidiary on the downstream immediate holding company or non-insurance owner's balance sheet. That value is prescribed by the NAIC Accounting Practices and Procedures Manual (SSAP No. 97, paragraph 22.a.). A similar exercise is required for each non-U.S. insurer in order to determine the remaining excess value of the holding company.

The RBC charge to be applied to each indirectly owned alien insurance affiliate/subsidiary is the annual statement book adjusted carrying value of the reporting company's interest in the affiliate/subsidiary multiplied by 0.500 and adjusted to reflect the reporting company's ownership on the holding company. For example, assume NEWBIE Insurance Company acquired 100 percent shares of Holder (a holding company), and Holder owns an Alien Insurance Company, which represents 50 percent of the book adjusted carrying value of Holder. If Holder has a book adjusted carrying value of \$20,000,000, NEWBIE Insurance Company would enter \$10,000,000 (1/2 of \$20,000,000) as the carrying value of the Alien Insurance Company and the RBC charge for the indirect ownership of the Alien insurance affiliate/subsidiary would be \$5,000,000 (0.500 times \$10,000,000). The risk-based capital charge for the parent insurer preparing the calculation is a 22.5 percent charge against the holding company value in excess of the indirectly owned insurance affiliates/subsidiaries.

If NEWBIE Insurance Company only acquired 50 percent shares of Holder, NEWBIE Insurance Company would enter \$5,000,000 (50 percent of 1/2 of \$20,000,000) as the carrying value of the Alien Insurance Company and the RBC charge for the indirect ownership of the Alien insurance affiliate/subsidiary would be \$2,500,000 (0.500 times \$5,000,000). Enter information for any indirectly owned alien insurance subsidiaries.

Affiliates/Subsidiaries	Affiliates/Subsidiaries Type	PR003 Column			RBC Required
		4 100% RBC	5 Book Adjusted Carrying Value	7 Total Value of Affiliates/Subsidiaries	
Alien Insurance Company	Indirect Alien Life Aff/Sub	5,000,000	10,000,000	20,000,000	50%
					2,500,000

For each affiliate/subsidiary enter the following information:

- Company Name,
- Alien Insurer Identification Number,
- Book Adjusted carrying value of common and preferred stock,
- Total Outstanding value of common and preferred stock,
- Book/adjusted carrying value of the common and preferred stock from Schedule D, Part 6, Section 1, Line 1499999. If no value is reported in the Total Value of Affiliate's Common and preferred stock column.

7. Investment in Upstream Affiliate (Parent)

The Risk-Based Capital (RBC) for an investment in an upstream parent is 22.5 percent of the book/adjusted carrying value of the common and preferred stock, regardless of whether that upstream parent is subject to RBC. Report the appropriate information from Schedule D, Part 6, Section 1, Lines 0199999 and 1099999 in Columns (1) through (10).

For each affiliate, enter the following information:

- Company Name,
  - Affiliate Type Code,
  - NAIC Company Code,
  - Book Adjusted carrying value of common stock
  - Book Adjusted carrying value of preferred stock,
  - Total Outstanding value of common and preferred stock.
8. Directly Owned U.S. Insurance Affiliates/Subsidiaries Not Subject to RBC
- a. Health Insurance Companies and Health Entities Not Subject to RBC
  - b. Property and Casualty Insurance Companies Not Subject to RBC, such as title insurers, monoline financial guaranty insurers, and monoline mortgage guaratee insurers
  - c. Life Insurance Companies Not Subject to RBC, such as life insurance subsidiary exempted from RBC

The risk-based capital for insurers not subject to RBC is based on the underlying statute, regulation, or rule governing capital requirements for such entities. If not otherwise specified by statute regulation or rule, the risk-based capital for an investment in a U.S. insurer that is not required to file an RBC formula is 22.5 percent of the book/adjusted carrying value of the common and preferred stock.

9. Non-Insurance Affiliates/Subsidiaries Not Subject to RBC
- a. Financial entities with a capital requirement imposed by a regulatory body (e.g., a bank)
  - b. Other financial entities without regulatory capital requirements
  - c. Other Non-financial entities

The risk-based capital for entity types a, b, and c is 22.5 percent of the book/adjusted carrying value of the common and preferred stock. The affiliate/subsidiary code for Non-Insurance Affiliates/Subsidiaries Not Subject to RBC is “9”. Reported amounts use Schedule D, part 6, Schedule I, Line 0899999, and Line 1799999 as the basis of reporting.



**APPENDIX 3 – EXAMPLE USED FOR AFFILIATED/SUBSIDIARY STOCKS**

To determine the value of total outstanding common stock or total outstanding preferred stock, divide the book/adjusted carrying value of the investment (found in Schedule D - Part 6 Section 1, Column 9) by the percentage of ownership (found in Schedule D – Part 6 – Section 1, Column 12). For example:

<u>Subsidiary Insurance Company</u>	<u>Owner's Book / Adjusted Carrying Value</u>	<u>Percentage Ownership</u>	<u>Total Stock Outstanding</u>
Subsidiary #1	\$1,000,000	100%	\$1,000,000
Subsidiary #2	\$1,000,000	75%	\$1,333,333
Subsidiary #3	\$1,000,000	50%	\$2,000,000
Subsidiary #4	\$1,000,000	25%	\$4,000,000
Subsidiary #5	\$1,000,000	10%	\$10,000,000

DETAILS FOR AFFILIATED STOCKS PR003

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
Name of Affiliate	Affil Type	NAIC Company Code or Alien ID Number	Affiliate's RBC After Covariance before Basic Operational Risk* LR031 L67 + L71 PR032 L67 XR025 L37	Book/Adjusted Carrying Value (statement value) of Affiliate's Common Stock**	Valuation Basis of Column (5) M - Market Value after any "discount" A - All Other	Total Value of Affiliate's Outstanding Common Stock	Statutory Surplus of Affiliate Subject to RBC (Adjusted for % Owned)	Book/Adjusted Carrying Value (statement value) of Affiliate's Preferred Stock	Total Value of Affiliate's Outstanding Preferred Stock	Percent Owned	RBC Required (R0 Component)	Market Value Excess Component/Affiliate Common Stock RBC Required (R2 Component)
0000001										100.000%	0	0
0000002										100.000%	0	0
0000003										100.000%	0	0
0000004										100.000%	0	0
0000005										100.000%	0	0
0000006										100.000%	0	0
0000007										100.000%	0	0
0000008										100.000%	0	0
0000009										100.000%	0	0
0000010										100.000%	0	0
0000011										100.000%	0	0
0000012										100.000%	0	0
0000013										100.000%	0	0
0000014										100.000%	0	0
0000015										100.000%	0	0
0000016										100.000%	0	0
0000017										100.000%	0	0
0000018										100.000%	0	0
0000019										100.000%	0	0
0000020										100.000%	0	0
0000021										100.000%	0	0
0000022										100.000%	0	0
0000023										100.000%	0	0
0000024										100.000%	0	0
0000025										100.000%	0	0
0000026										100.000%	0	0
0000027										100.000%	0	0
0000028										100.000%	0	0
0000029										100.000%	0	0
0000030										100.000%	0	0
0000031										100.000%	0	0
0000032										100.000%	0	0
0000033										100.000%	0	0
0000034										100.000%	0	0
0000035										100.000%	0	0
0000036										100.000%	0	0
0000037										100.000%	0	0
0000038										100.000%	0	0
0000039										100.000%	0	0
0000040										100.000%	0	0
0000041										100.000%	0	0
0000042										100.000%	0	0
0000043										100.000%	0	0
0000044										100.000%	0	0
0000045										100.000%	0	0
0000046										100.000%	0	0
0000047										100.000%	0	0
0000048										100.000%	0	0
0000049										100.000%	0	0
0000050										100.000%	0	0
(9999999)										100.000%	0	0
Total		XXX	0	0	XXX	XXX	XXX	0	XXX		0	0

Remark: Subcategory 8a, 8b, and 8c are referring to the directly owned insurance affiliates not subject to RBC look-through. Indirectly owned insurance affiliate not subject to RBC will be included Category 4

Note: PR007 L12 should now refers to PR003 C(13) L9999999

**#REF!**  
**SUBSIDIARY, CONTROLLED AND AFFILIATED INVESTMENTS PR004**

	Affiliate Types	Affil Code	RBC Basis	(1) Number of Companies	(2) Total RBC Required
(1)	Directly Owned Health Insurance Companies or Health Entities	1a	Sub's RBC After Covariance	0	0
(2)	Directly Owned Property and Casualty Insurance Affiliates	1b	Sub's RBC After Covariance	0	0
(3)	Directly Owned Life Insurance Affiliates	1c	Sub's RBC After Covariance	0	0
(4)	Indirectly Owned Health Insurance Companies or Health Entities	2a	Sub's RBC After Covariance	0	0
(5)	Indirectly Owned Property and Casualty Insurance Affiliates	2b	Sub's RBC After Covariance	0	0
(6)	Indirectly Owned Life Insurance Affiliates	2c	Sub's RBC After Covariance	0	0
(7)	Holding Company in Excess of Indirect Subs	3	0.225	0	0
(8)	Investment Subsidiary	4	0.225	0	0
(9)	Directly Owned Alien Health Insurance Companies or Health Entities	5a	0.5	0	0
(10)	Directly Owned Alien Property and Casualty Insurance Affiliates	5b	0.5	0	0
(11)	Directly Owned Alien Life Insurance Affiliates	5c	0.5	0	0
(12)	Indirectly Owned Alien Health Insurance Companies or Health Entities	6a	0.5	0	0
(13)	Indirectly Owned Alien Property and Casualty Insurance Affiliates	6b	0.5	0	0
(14)	Indirectly Owned Alien Life Insurance Affiliates	6c	0.5	0	0
(15)	Investment in Upstream Affiliate (Parent)	7	0.225	0	0
(16)	Directly Owned Health Insurance Companies or Health Entities Not Subject to RBC	8a	0.225	0	0
(17)	Directly Owned Property and Casualty Insurance Companies Not Subject to RBC	8b	0.225	0	0
(18)	Directly Owned Life Insurance Companies Not Subject to RBC	8c	0.225	0	0
(19)	Non-Insurance Entities with a Capital Requirement Imposed by a Regulatory Body	9a	0.225	0	0
(20)	Non-Insurance Other Financial Entities without Regulatory Capital Requirements	9b	0.225	0	0
(21)	Other Non-financial Entities	9c	0.225	0	0
(22)	Total			0	0

**SUMMARY FOR SUBSIDIARY, CONTROLLED AND AFFILIATED INVESTMENTS FOR CROSS-CHECKING STATEMENT VALUES PR005**

Affiliated Preferred Stock	Annual Statement Line Number	(1) Annual Statement Total Preferred Stock	(2) Total From RBC Report	(3) Difference
Schedule D Part 6 Section 1 C7				
(1) Parent	0199999	0	0	0
(2) U.S. P&C Insurer	0299999	0	0	0
(3) U.S. Life Insurer	0399999	0	0	0
(4) U.S. Health Insurer	0499999	0	0	0
(5) Alien Insurer	0599999	0	0	0
(6) Non-Insurer Which Controls Insurer	0699999	0	0	0
(7) Investment Subsidiary	0799999	0	0	0
(8) Other Affiliates	0899999	0	0	0
(9) Subtotal	0999999	0	0	0

Affiliated Common Stock	Annual Statement Line Number	(1) Annual Statement Total Common Stock	(2) Total From RBC Report	(3) Difference
Schedule D Part 6 Section 1 C7				
(10) Parent	1099999	0	0	0
(11) U.S. P&C Insurer	1199999	0	0	0
(12) U.S. Life Insurer	1299999	0	0	0
(13) U.S. Health Insurer	1399999	0	0	0
(14) Alien Insurer	1499999	0	0	0
(15) Non-Insurer Which Controls Insurer	1599999	0	0	0
(16) Investment Subsidiary	1699999	0	0	0
(17) Other Affiliates	1799999	0	0	0
(18) Subtotal	1899999	0	0	0

**UNAFFILIATED PREFERRED AND COMMON STOCK PR007**

	Annual Statement Source	(1) Book/Adjusted Carrying Value	Factor	(2) RBC Requirement
(1) Unaffiliated Preferred Stock				
(1) NAIC 01 Preferred Stock	Sch D Pt.2 Sn 1	0	0.003	0
(2) NAIC 02 Preferred Stock	Sch D Pt.2 Sn 1	0	0.010	0
(3) NAIC 03 Preferred Stock	Sch D Pt.2 Sn 1	0	0.020	0
(4) NAIC 04 Preferred Stock	Sch D Pt.2 Sn 1	0	0.045	0
(5) NAIC 05 Preferred Stock	Sch D Pt.2 Sn 1	0	0.100	0
(6) NAIC 06 Preferred Stock	Sch D Pt.2 Sn 1	0	0.300	0
(7) <b>TOTAL - UNAFFILIATED PREFERRED STOCK</b> (should equal P2 L2.1 C3 less Sch D-Sum C1 L18)	Sum of Ls (1) through (6)	0		0
(8) Unaffiliated Common Stock				
(8) Total Common Stock	Sch D - Summary C1 L25	0		0
(9) Affiliated Common Stock	Sch D - Summary C1 L24	0		0
(10) Non-Admitted Unaffiliated Common Stock	P2 C2 L2.2 - Sch D Pt6 Sn1 C9 L1899999	0		0
(11) Admitted Unaffiliated Common Stock	L(8) - L(9) - L(10)	0	0.150	0
(12) <b>Market</b> Value Excess Affiliated Common Stock	PR003 C(13) L(9999999)	0		0
(13) Total Unaffiliated Common Stock	L(11) + L(12)	0		0

Denotes items that must be manually entered on the filing software.

#####  
CALCULATION OF TOTAL ADJUSTED CAPITAL PR029

	Annual Statement Reference	(1) Statement Value*	Factor	(2) Adjusted Capital
(1)	Capital and Surplus	0	1,000	0
(2)	Non-Tabular Discount - Losses	0	1,000	0
(3)	Non-Tabular Discount - Expense	0	1,000	0
(4)	Discount on Medical Loss Reserves Reported as Tabular in Schedule P	0	1,000	0
(5)	Discount on Medical Expense Reserves Reported as Tabular in Schedule P	0	1,000	0
(6)	P&C Subs Non-Tabular Discount - Losses	0	1,000	0
(7)	P&C Subs Non-Tabular Discount - Expense	0	1,000	0
(8)	P&C Subs Discount on Medical Loss Reserves Reported as Tabular in Schedule P	0	1,000	0
(9)	P&C Subs Discount on Medical Expense Reserves Reported as Tabular in Schedule P	0	1,000	0
(10)	AVR - Life Subs §	0	1,000	0
(11)	Dividend Liability - Life Subs	0	0.500	0
(12)	Carrying Value of Non-Admitted Insurance Affiliates	0	1,000	0
(13)	Total Adjusted Capital Before Capital Notes	0		0
	<b>Credit for Capital Notes</b>			
(14.1)	Surplus Notes	0		
(14.2)	Limitation on Capital Notes	0		
(14.3)	Capital Notes Before Limitation	#REF!		#REF!
(14.4)	Credit for Capital Notes			
(15)	Total Adjusted Capital (Post-Deferred Tax)			
	<b>Sensitivity Test:</b>			
(16)	Deferred Tax Assets	0	1,000	0
(16.1)	Deferred Tax Liabilities	0	1,000	0
(17)	Deferred Tax Assets for Subsidiary	0	1,000	0
(17.1)	Deferred Tax Liabilities for Subsidiary	0	1,000	0
(18)	Total Adjusted Capital For Sensitivity Test			
	<b>Ex DTA ACL RBC Ratio Sensitivity Test</b>			
(19)	Deferred Tax Asset	0		0
(20)	Total Adjusted Capital Less Deferred Tax Asset	0		0
(21)	Authorized Control Level RBC			#REF!
(22)	Ex DTA ACL RBC Ratio			#REF!

\* Report amounts in this column as whole dollars.  
 † Denotes items that must be manually entered on the filing software.  
 § The portion of the AVR that can be counted as capital is limited to the amount not utilized in asset adequacy testing in support of the Actuarial Opinion for reserves.

CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE PRO30 R0-RI

RO-Subsidiary Insurance Companies and Misc. Other Amounts	PRBC O&I Reference	RBC Amount
(1) Affiliated US P&C Insurers - Directly Owned	PR004.L(2)C(2)	0
(2) Affiliated US P&C Insurers - Indirectly Owned	PR004.L(5)C(2)	0
(3) Affiliated US Life Insurers - Directly Owned	PR004.L(3)C(2)	0
(4) Affiliated US Life Insurers - Indirectly Owned	PR004.L(6)C(2)	0
(5) Affiliated US Health Insurer - Directly Owned	PR004.L(1)C(2)	0
(6) Affiliated US Health Insurer - Indirectly Owned	PR004.L(4)C(2)	0
(7) Affiliated Alien Insurers - Directly Owned	PR004.L(9)+L(10)+L(11)C(2)	0
(8) Affiliated Alien Insurers - Indirectly Owned	PR004.L(12)+L(13)+L(14)C(2)	0
(9) Misc. OIF-Balance Sheet - Non-Controlled Assets	PR014.L(15)C(3)	0
(10) Misc. OIF-Balance Sheet - Guarantees for Affiliates	PR014.L(16)C(3)	0
(11) Misc. OIF-Balance Sheet - Contingent Liabilities	PR014.L(17)C(3)	0
(12) Misc. OIF-Balance Sheet - SSAP No.101 Par. 11A DTA	PR014.L(19)C(3)	0
(13) Misc. OIF-Balance Sheet - SSAP No.101 Par. 11B DTA	PR014.L(20)C(3)	0
(14) Total R0	L(1)+L(2)+L(3)+L(4)+L(5)+L(6)+L(7)+L(8)+L(9)+L(10)+L(11)+L(12)+L(13)	0
RI - Asset Risk - Fixed Income		
(15) Bonds Subject to Size Factor	PR006.L(27)C(5)	0
(16) Bond Size Factor RBC	PR006.L(30)C(5)	0
(17) OIF-balance Sheet Collateral & Sch DL, PT1 - Total Bonds	PR015.L(27)C(4)	0
(18) OIF-balance Sheet Collateral & Sch DL, PT1 - Cash, & Short-Term Investments and Mort Loans on Real Est.	PR015.L(38)+39C(4)	0
(19) Other Long-Term Assets - Mortgage Loans, LHTC & WCFI	PR008.L(10)+L(13)+L(14)+L(15)+L(16)+L(17)+L(20)+L(21)C(2)	0
(20) Misc Assets - Collateral Loans	PR009.L(3)C(2)	0
(21) Misc Assets - Cash	PR009.L(5)C(2)	0
(22) Misc Assets - Cash Equivalents	PR009.L(7)C(2)	0
(23) Misc Assets - Other Short-Term Investments	PR009.L(10)C(2)	0
(24) Replication - Synthetic Asset: One Half	PR010.L(999999)C(7)	0
(25) Asset Concentration RBC - Fixed Income	PR011.L(21)C(3) Grand Total Page	0
(26) Total RI	L(15)+L(16)+L(17)+L(18)+L(19)+L(20)+L(21)+L(22)+L(23)+L(24)+L(25)	0

#REF!

CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE PR031 R2-R3

R2 - Asset Risk - Equity	PRBC O&I Reference	RBC Amount
(27) Common & Preferred- Affiliate Investment Subsidiary	PR004 L(8)C(2)	0
(28) Common & Preferred- Affiliate Hold. Company. in excess of Ins. Subs.	PR004 L(7)C(2)	0
(29) Common & Preferred- Investment in Parent	PR004 L(15)C(2)	0
(30) Common & Preferred- Aff'd US P&C Not Subj to RBC	PR004 L(17)C(2)	0
(31) Common & Preferred- Affil US Life Not Subj to RBC	PR004 L(18)C(2)	0
(32) Common & Preferred- Affil US Health Insurer Not Subj to RBC	PR004 L(16)C(2)	0
(33) Common & Preferred- Aff'd Non-insurer	PR004 L(19)+L(20)+L(21)C(2)	0
(34) Preferred - Aff'd Invest Sub	PR004 L(7)C(3)	0
(35) Preferred - Aff'd Hold. Co. in excess of Ins. Sub-	PR004 L(10)C(3)	0
(36) Preferred - Investment in Parent	PR004 L(11)C(3)	0
(37) Preferred - Affil US P&C Not Subj to RBC	PR004 L(12)C(3)	0
(38) Preferred - Affil US Life Not Subj to RBC	PR004 L(13)C(3)	0
(39) Preferred - Affil US Health Insurer Not Subj to RBC	PR004 L(14)C(3)	0
(40) Preferred - Affil Non-insurer	PR004 L(15)C(3)	0
(34) Unaffiliated Preferred Stock	PR007 L(7)C(2)+PR015 L(34)C(4)	0
(35) Unaffiliated Common Stock	PR007 L(13)C(2)+PR015 L(35)C(4)	0
(36) Other Long -Term Assets - Real Estate	PR008 L(7)C(2)	0
(37) Other Long-Term Assets - Schedule BA Assets	PR008 L(19)C(2)+PR015 L(36)+L(37)C(4)	0
(38) Misc Assets - Receivable for Securities	PR009 L(1)C(2)	0
(39) Misc Assets - Aggregate Write-ins for Invested Assets	PR009 L(2)C(2)	0
(40) Misc Assets - Derivatives	PR009 L(14)C(2)	0
(41) Replication - Synthetic Asset: One Half	PR010 L(9999999)(7)	0
(42) Asset Concentration RBC - Equity	PR011 L(33)C(3) Grand Total Page	0
(43) Total R2	L(27)+L(28)+L(29)+L(30)+L(31)+L(32)+L(33)+L(34)+L(35)+L(36)+L(37)+L(38)+L(39)+L(40)+L(41)+L(42)+L(43)+L(44)+L(45)+L(46)+L(47)+L(48)+L(49)	0
R3 - Asset Risk - Credit		
(44) Other Credit RBC	PR012 L(8)-L(1)-L(2)C(2)	0
(45) One half of Rein Recoverables	0.5 x (PR012 L(1)+L(2)C(2))	0
(46) Other half of Rein Recoverables	If R4 L(51)>(R3 L(45) + R3 L(46)), 0, otherwise, R3 L(46)	0
(47) Health Credit Risk	PR013 L(12)C(2)	0
(48) Total R3	L(45) + L(46) + L(47) + L(48)	0



**CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE PR032 R4-Reat**

		PRBC O&I Reference	RBC Amount
<b>R4 - Underwriting Risk - Reserves</b>			(1)
(49)	One half of Reinsurance RBC	$(R4 L(61) > (R3 L(45) + R3 L(46)), R3 L(46), \text{otherwise}, 0)$	0
(50)	Total Adjusted Unpaid Loss/Expense Reserve RBC	PR0017 L(15)C(20)	0
(51)	Excessive Premium Growth - Loss/Expense Reserve	PR016 L(13)C(8)	0
(52)	A&H Claims Reserves Adjusted for LCF	PR024 L(5) C(2) + PR023 L(6) C(4)	0
(53)	Total R4	$L(50)+L(51)+L(52)+L(53)$	0
<b>R5 - Underwriting Risk - Net Written Premium</b>			
(54)	Total Adjusted NWP RBC	PR018 L(15)C(20)	0
(55)	Excessive Premium Growth - Written Premiums Charge	PR016 L(14)C(8)	0
(56)	Total Net Health Premium RBC	PR022 L(21)C(2)	0
(57)	Health Stabilization Reserves	PR025 L(8)C(2) + PR023 L(3) C(2)	0
(58)	Total R5	$L(55)+L(56)+L(57)+L(58)$	0
<b>Reat- Catastrophe Risk</b>			
(59)	Total Reat	PR027 L(3) C(1)	0
(60)	Total RBC After Covariance Before Basic Operational Risk = $R0+SQRT(R1^2+R2^2+R3^2+R4^2+R5^2+Reat^2)$		0
(61)	Basic Operational Risk = $0.030 \times L(61)$		0
(62)	C-4a of U.S. Life Insurance Subsidiaries (from Company records)		0
(63)	Net Basic Operational Risk = Line (62) - Line (63) (Not less than zero)		0
(64)	Total RBC After Covariance including Basic Operational Risk = $L(61) + L(64)$		0
(65)	Authorized Control Level RBC including Basic Operational Risk = $.5 \times L(65)$		0

**Capital Adequacy (E) Task Force**  
**RBC Proposal Form**

- |                                                                     |                                                           |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------|
| <input checked="" type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group     | <input type="checkbox"/> Life RBC (E) Working Group    |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup              | <input type="checkbox"/> Investment RBC (E) Working Group | <input type="checkbox"/> Operational Risk (E) Subgroup |
| <input type="checkbox"/> C3 Phase II/ AG43 (E/A) Subgroup           | <input type="checkbox"/> P/C RBC (E) Working Group        | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |

<b>DATE:</b> <u>11/10/22</u>	<b><u>FOR NAIC USE ONLY</u></b>
<b>CONTACT PERSON:</b> <u>Eva Yeung</u>	Agenda Item # <u>2022-13-CA</u>
<b>TELEPHONE:</b> <u>816-783-8407</u>	Year <u>2023</u>
<b>EMAIL ADDRESS:</b> <u>eyeung@naic.org</u>	<b><u>DISPOSITION</u></b>
<b>ON BEHALF OF:</b> <u>Capital Adequacy (E) Task Force</u>	<input checked="" type="checkbox"/> ADOPTED <u>3-23-23</u>
<b>NAME:</b> <u>Tom Botsko</u>	<input type="checkbox"/> REJECTED _____
<b>TITLE:</b> <u>Chair</u>	<input type="checkbox"/> DEFERRED TO _____
<b>AFFILIATION:</b> <u>Ohio Department of Insurance</u>	<input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____
<b>ADDRESS:</b> <u>50 West Town Street, Suite 300</u>	<input checked="" type="checkbox"/> EXPOSED <u>12/14/22</u>
<u>Columbus, OH 43215</u>	<input type="checkbox"/> OTHER (SPECIFY) _____

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

- |                                                  |                                                                  |                                                                   |
|--------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Health RBC Blanks       | <input checked="" type="checkbox"/> Property/Casualty RBC Blanks | <input type="checkbox"/> Life and Fraternal RBC Instructions      |
| <input type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions      | <input checked="" type="checkbox"/> Life and Fraternal RBC Blanks |
| <input type="checkbox"/> OTHER _____             |                                                                  |                                                                   |

**DESCRIPTION OF CHANGE(S)**

The proposed changes would modify the line references in LR019, 020, PR019 and 020.

**REASON OR JUSTIFICATION FOR CHANGE \*\***

The proposed changes in Health Premiums and Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision pages would update the references to provide consistency categories used in the Annual Statement, Schedule H, Part 1.

**Additional Staff Comments:**

- 12/14/22 – The CADTF exposed this proposal for a 45/day public comment period ending Jan. 28, 2023.  
 12/20/22 – Updated to include LR019, the page was inadvertently excluded from the proposal package.  
 12/22/22 – Updated A/S Source Column to reference Col. 5 for Line 7 on page PR019 and Line 10 on page LR019.  
 3/23/23 – The TF adopted the proposal on 3/23/23

\*\* This section must be completed on all forms.

Revised 2-2019

A	B	C	D	E	F	G	H	I	J	K	
3	HEALTH PREMIUMS PR019				(1)	Factor		(2)			
6				Annual Statement Source	Statement Value	Factor		RBC Requirement			
7				Earned Premium (Schedule H Part 1 Column 3 Line 2 <del>in part</del> )	0	†		XXX			
8	Medical Insurance Premium - Individual <del>Morbidity</del>			Earned Premium (Schedule H Part 1 Column 7 Line 2 in part)	0	†		XXX			
9	<del>Health and Customary-Major Comprehensive</del> (Medical and Hospital)			Earned Premium (Schedule H Part 1 Column 9 + 11 Line 2 in part)	0	†		XXX			
10	Dental & Vision			Earned Premium (Schedule H Part 1 Line 2 in part)	0	†		XXX			
11	Medicare Supplement			Company Records	0	0.500				0	
12	Stand-Alone Medicare Part D Coverage			Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.020				0	
13	Supplemental Benefits within Stand-Alone Part D Coverage (Claims Incurred)			Company Records	0	0.035	*			0	
14	Medicaid Pass-Through Payments Reported as Premium			Earned Premium (Schedule H Part 1 Line 2 in part)	0	†				0	
15	Hospital Indemnity and Specified Disease			Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.050				0	
16	AD&D (Maximum Retained Risk Per Life			Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.050				0	
17	Other Accident				0					0	
18	Medical Insurance Premium - Group and Credit <del>Morbidity</del>			Earned Premium (Schedule H Part 1 Column 5 Line 2 <del>in part</del> )	0	†		XXX			
19	<del>Health and Customary-Major Comprehensive</del> (Medical and Hospital)			Earned Premium (Schedule H Part 1 Column 9 + 11 Line 2 in part)	0	†		XXX			
20	Dental & Vision			Earned Premium (Schedule H Part 1 Line 2 in part)	0	†		XXX			
21	Stop Loss and Minimum Premium			Earned Premium (Schedule H Part 1 Line 2 in part)	0	†		XXX		0	
22	Medicare Supplement			Earned Premium (Schedule H Part 1 Line 2 in part)	0	†		XXX		0	
23	Stand-Alone Medicare Part D Coverage (see instructions for limits)			Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.500				0	
24	Supplemental benefits within Stand-Alone Part D Coverage (Claims Incurred)			Company Records	0	0.020				0	
25	Medicaid Pass-Through Payments Reported as Premium			Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.035	*			0	
26	Hospital Indemnity and Specified Disease			Company Records	0	†				0	
27	AD&D (Maximum Retained Risk Per Life			Earned Premium (Schedule H Part 1 Line 2 in part)	0	†				0	
28	Other Accident			Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.050				0	
29	Federal Employee Health Benefit Plan			Earned Premium (Schedule H Part 1 <del>Line 2 in part</del> Column 13, Line 2)	0	0.000				0	
30					0					0	
31	Disability Income Premium			Earned Premium (Schedule H Part 1 Column 21 Line 2 in part)	0	†				0	
32	Noncancelable Disability Income - Individual Morbidity			Earned Premium (Schedule H Part 1 Column 21 Line 2 in part)	0	†				0	
33	Other Disability Income - Individual Morbidity			Earned Premium (Schedule H Part 1 Column 21 Line 2 in part)	0	†				0	
34	Disability Income - Credit Monthly Balance Plans			Earned Premium (Schedule H Part 1 Column 21 Line 2 in part)	0	†				0	
35	Disability Income - Group Long-Term			Earned Premium (Schedule H Part 1 Column 21 Line 2 in part)	0	†				0	
36	Disability Income - Credit Single Premium with Additional Reserve			Earned Premium (Schedule H Part 1 Column 21 Line 2 in part)	0	†				0	
37	Disability Income - Credit Single Premium without Additional Reserve			Earned Premium (Schedule H Part 1 Column 21 Line 2 in part)	0	†				0	
38	Disability Income - Group Short-Term			Earned Premium (Schedule H Part 1 Column 21 Line 2 in part)	0	†				0	
39					0					0	
40	Long-Term Care			Earned Premium (Schedule H Part 1 Column 23 Line 2 in part)	0	0.100				0	
41	Noncancelable Long-Term Care Premium - Rate Risk**			Earned Premium (Schedule H Part 1 Column 23 Line 2 in part)	0	0.000				0	
42	Other Long-Term Care Premium † †				0					0	
43					0					0	
44	Health Premium with Limited Underwriting Risk			Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.000				0	
45	ASC Business with Premium Reserve				0					0	
46	Other Health			Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.120				0	
47	Other Health				0					0	
48					0					0	
49					0					0	
50	Total Earned Premiums			Sum of Lines (1) through (25)	0					0	
51	C(1), L(26) should equal Schedule H Part 1 Column 1 Line 2			Company records	0	§				0	
52	Additional Reserves for Credit Disability Plans			Company records	0	§				0	
53	Additional Reserves for Credit Disability Plans, prior year				0					0	
54					0					0	
55	†			The premium amounts in these lines are transferred to PR020 Underwriting Risk - Premium Risk for Comprehensive Medical, Medicare Supplement, Dental & Vision and Stand-Alone Medicare Part D Coverage Lines (1.1) and (1.2) for the calculation of risk-based capital. The premium amounts are included here to assist in the balancing of total health premium. If managed care arrangements have been entered into, the company may also complete PR021 Underwriting Risk - Managed Care Credit. In which case, the company will also need to complete PR012 Health Credit Risk in the formula. If there are amounts in any of lines (1), (2), (3), (7), (8) or (10) on page PR019 Health Premiums, the company will also be directed to complete the Health Administrative Expense portion of PR023.							
56	‡			The two tiered calculation is illustrated in the risk-based capital instructions for PR019 Health Premiums.							
57	‡ ‡			The balance of the RBC requirement for Long Term Care - Morbidity Risk is calculated on Page PR023. The premium is shown to allow totals to check to Schedule H.							
58	‡ ‡ ‡			If there is premium included on either or both of these lines, the RBC value in Column (2) will include 3.5% of such premium and \$50,000 (included in the line with the larger premium).							
59	**			The factor applies to all Noncancelable premium.							
60	**			These amounts are used to adjust the premium base for single premium credit disability plans that carry additional tabular reserves.							
61	**			A factor of .350 will be applied to the first \$25,000,000 in Column (1), Line (9) and a factor of .250 will be applied to the remaining premium in excess of \$25,000,000.							
62	**			Denotes items that must be manually entered on the filing software.							
63	**			Vendor Links							
64	**										
65	**										
66	**										
67	**										
68	**										

**UNDERWRITING RISK – PREMIUM RISK FOR COMPREHENSIVE MEDICAL, MEDICARE SUPPLEMENT AND DENTAL & VISION PR020**  
(Experience Fluctuation Risk in Life RBC Formula)

	(1)	(2)	(3)	(4)	(5)
	Comprehensive Medical	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	TOTAL
(1.1) Premium – Individual	=PR019'F8	=PR019'F9	=PR019'F10	=PR019'F11	0
(1.2) Premium – Group	=PR019'F9	=PR019'F22	=PR019'F20	=PR019'F23	0
(1.3) Premium – Total = Line (1.1) + Line (1.2)	=schpt1C3+5L2	=schpt1C7L2	=schpt1C9+11L2	0	0
(2) Title XVII-Medicare†	=schpt1C15L2	XXX	XXX	XXX	0
(3) Title XIX-Medicad†	=schpt1C17L3	XXX	XXX	XXX	0
(4) Other Health Risk Revenue‡	0	0	0	0	0
(5) Underwriting Risk Revenue = Lines (1.3) + (2) + (3) + (4)	0	0	0	0	0
(6) Net Incurred Claims	=schptSC4+2+7+8L D1	=schptSC3L D1	=schptSC4+5L D1	0	0
(7) Fee-for-Service Offset‡	0	0	0	0	0
(8) Underwriting Risk Incurred Claims = Line (6) – Line (7)	0.0000	0.0000	0.0000	0.000	XXX
(9) Underwriting Risk Claims Ratio = Line (8) / Line (5)	0.1493	0.1043	0.1195	0.251	XXX
(10.1) Underwriting Risk Factor for Initial Amounts Of Premium‡	0.0893	0.0663	0.0755	0.151	XXX
(10.2) Underwriting Risk Factor for Excess of Initial Amount‡	0.0000	0.0000	0.0000	0.000	XXX
(10.3) Composite Underwriting Risk Factor	0	0	0	Uncle	0
(11) Base Underwriting Risk RBC = Line (5) x Line (9) x Line (10.3)	0.0000	0.0000	0.0000	0.000	XXX
(12) Managed Care Discount Factor = PR021 Line (12)	0	0	0	0	0
(13) Base RBC After Managed Care Discount = Line (11) x Line (12)	0	0	0	0	0
(14) RBC Adjustment For Individual =					
	[Line(1.1) x 1.2 + Line (1.2)] / Line (1.3) x Line (13)§				
(15) Maximum Per-Individual Risk After Reinsurance†	0	0	0	0	0
(16) Alternate Risk Charge*	0	0	0	0	0
(17) Net Alternate Risk Charge‡	0	0	0	0	0
(18) Net Underwriting Risk RBC (Maximum of Line (14) or Line (17) )	0	0	0	0	0

† Source is company records unless already included in premiums.  
‡ For Comprehensive Medical the Initial Premium Amount is \$25,000,000 or the amount in Line (1.3) if smaller. For Medicare Supplement and Dental & Vision the Initial Premium Amount is \$3,000,000 or the amount in Line (1.3) if smaller. For Stand-Alone Medicare Part D the Initial Premium Amount is \$25,000,000 or the amount in Line (1.3) if smaller.  
§ Formula applies only to Column (1), for all other columns Line (14) should equal Line (13).  
\* The Line (16) Alternate Risk Charge is calculated as follows:

LESSER OF:	\$1,500,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$150,000 or 6 x Maximum Individual Risk	Maximum of Columns (1), (2) (3) and (4)

£ Applicable only if Line (16) for a column equals Line (16) for Column (5), otherwise zero.  
Denotes items that must be manually entered on the filing software.

Company Name

Confidential when Completed

NAIC Company Code

A	B	C	D	E	F	G	H	I	J	K
2	HEALTH PREMIUMS			Annual Statement Source	(1) Statement Value		Factor		(2) RBC Requirement	#REF!
3										
4										
5										
6										
7	Medical Insurance Premiums - Individual, <del>Morbidity</del>			Earned Premium (Schedule H Part 1 <b>Column 3</b> Line 2 <del>in part</del> )			†		XXX	
8	<del>Loss and Custody- Major Comprehensive</del> (Medical and Hospital)			Earned Premium (Schedule H Part 1 <b>Column 7</b> Line 2 in part)			†		XXX	
9	Dental and Vision			Earned Premium (Schedule H Part 1 <b>Column 9 + 11</b> Line 2 in part)			†		XXX	
10	Stand-Alone Medicare Part D Coverage			Company Records						
11	Supplemental benefits within Stand-Alone Part D Coverage (Claims Incurred)			Company Records						
12	Medical Pass-Through Payments Reported as Premium			Earned Premium (Schedule H Part 1 Line 2 in part)			X	0.500		
13	Medical Indemnity and Specified Disease			Earned Premium (Schedule H Part 1 Line 2 in part)			X	0.020		
14	AD&D (Maximum Retained Risk Per Life)			Earned Premium (Schedule H Part 1 Line 2 in part)			X	*		
15	Other Accident			Earned Premium (Schedule H Part 1 Line 2 in part)			X	†		
16	Medical Insurance Premiums - Group and Credit <del>Morbidity</del>			Earned Premium (Schedule H Part 1 <b>Column 5</b> Line 2 <del>in part</del> )			†		XXX	
17	<del>Loss and Custody- Major Comprehensive</del> (Medical and Hospital)			Earned Premium (Schedule H Part 1 <b>Column 9 + 11</b> Line 2 in part)			†		XXX	
18	Dental and Vision			Earned Premium (Schedule H Part 1 Line 2 in part)			†			
19	Stop Loss and Minimum Premium			Earned Premium (Schedule H Part 1 <b>Column 7</b> Line 2 in part)			†			
20	Medicare Supplement			Earned Premium (Schedule H Part 1 Line 2 in part)			†			
21	Stand-Alone Medicare Part D Coverage (see instructions for limits)			Company Records						
22	Supplemental benefits within Stand-Alone Part D Coverage (Claims Incurred)			Company Records						
23	Medical Pass-Through Payments Reported as Premium			Earned Premium (Schedule H Part 1 Line 2 in part)			X	0.500		
24	Medical Indemnity and Specified Disease			Earned Premium (Schedule H Part 1 Line 2 in part)			X	0.020		
25	AD&D (Maximum Retained Risk Per Life)			Earned Premium (Schedule H Part 1 Line 2 in part)			X	*		
26	Other Accident			Earned Premium (Schedule H Part 1 Line 2 in part)			X	†		
27	Federal Employee Health Benefit Plan			Earned Premium (Schedule H Part 1 <del>Line 2 in part</del> <b>Column 13, Line 2</b> )			X	0.050		
28	Disability Income Premium			Earned Premium (Schedule H Part 1 Line 2 in part)			X	0.000		
29	Noncancelable Disability Income - Individual Morbidity			Earned Premium (Schedule H Part 1 <b>Column 21</b> Line 2 in part)			X	†		
30	Other Disability Income - Individual Morbidity			Earned Premium (Schedule H Part 1 <b>Column 21</b> Line 2 in part)			X	†		
31	Disability Income - Credit Monthly Balance Plans			Earned Premium (Schedule H Part 1 <b>Column 21</b> Line 2 in part)			X	†		
32	Disability Income - Group Long-Term			Earned Premium (Schedule H Part 1 <b>Column 21</b> Line 2 in part)			X	†		
33	Disability Income-Credit Single Premium with Additional Reserves			Earned Premium (Schedule H Part 1 <b>Column 21</b> Line 2 in part)			X	†		
34	Disability Income-Credit Single Premium without Additional Reserves			Earned Premium (Schedule H Part 1 <b>Column 21</b> Line 2 in part)			X	†		
35	Disability Income - Group Short-Term			Earned Premium (Schedule H Part 1 <b>Column 21</b> Line 2 in part)			X	†		
36	Long-Term Care									
37	Noncancelable Long-Term Care Premium - Rate Risk**			Earned Premium (Schedule H Part 1 <b>Column 23</b> Line 2 in part)			X	0.127**		
38	Other Long-Term Care Premium ††			Earned Premium (Schedule H Part 1 <b>Column 23</b> Line 2 in part)			X	0.000		
39	Health Premium With Limited Underwriting Risk									
40	ASC Business Reported as Revenue Premium			Earned Premium (Schedule H Part 1 Line 2 in part)			X	0.000		
41	Other Health									
42	Workers Compensation Curve-Out			Earned Premium (Schedule H Part 1 <b>Column 25</b> Line 2 in part)			X	0.000		
43	Other Health			Earned Premium (Schedule H Part 1 <b>Column 25</b> Line 2 in part)			X	0.120		
44	Total Earned Premiums			Sum of Lines (1) through (32)						
45	(Column (1) should equal Schedule H Part 1 Column 1 Line 2)			Exhibit 6, Column 10, Line 2						
46	Additional Reserves for Credit Disability Plans			Exhibit 6, Column 3, Line 2, prior year						
47	Additional Reserves for Credit Disability Plans, prior year									
48										
49	†			† The premium amounts in these lines are transferred to LR020 Underwriting Risk - Experience Fluctuation Risk Lines (1.1) and (1.2) for the calculation of risk-based capital. The premium amounts are included here to assist in the balancing of total health premium. If managed care arrangements have been entered into, the company may also complete LR027 Underwriting Risk - Managed Care Credit. In which case, the company will also need to complete LR028 Health Credit Risk in the (C-3) portion of the formula. If there are amounts in any of lines (1), (2), (3), (10), (11) or (13) on page LR019 Health Premiums, the company will also be directed to complete the Health Administrative Expense portion of LR029 Business Risk in the (C-4) portion of the formula.						
50	‡			‡ The two tiered calculation is illustrated in the risk-based capital instructions for LR019 Health Premiums.						
51	††			†† The balance of the RBC requirement for Long Term Care - Morbidity Risk is calculated on Column (2) will include 3.5 percent of such premium and \$50,000 (included in the line with the larger premium).						
52	*			* If there is premium included on either or both of these lines, the RBC requirement in Column (2) will include 3.5 percent of such premium and \$50,000 (included in the line with the larger premium).						
53	**			** The factor applies to all Noncancelable premium.						
54	†††			††† These amounts are used to adjust the premium base for single premium credit disability plans that carry additional tabular reserves.						
55	§			§ A factor of .350 will be applied to the first \$25,000,000 in Column (1), Line (12) and a factor of .250 will be applied to the remaining premium in excess of \$25,000,000.						
56	¶			¶ Denotes items that must be manually entered on the filing software.						
57										
58										
59										
60										#REF!

Company Name

Confidential when Completed

NAIC Company Code

#REF!

**UNDERWRITING RISK**

**Experience Fluctuation Risk**

	(1) Comprehensive Medical	(2) Medicare Supplement	(3) Dental & Vision	(4) Stand-Alone Medicare Part D Coverage	(5) Total
Line of Business					
(1.1) Premium – Individual	=LR019!F7	=LR019!F8	=LR019!F9	=LR019!F10	
(1.2) Premium – Group	=LR019!F17	=LR019!F20	=LR019!F18	=LR019!F21	
(1.3) Premium – Total = Line (1.1) + Line (1.2)	=schartC3+5L2	=schartC7L2	=schartC9+11L2		
(2) Title XVIII-Medicare†	XXX	XXX			=schartC15L2
(3) Title XIX-Medicaid†	XXX	XXX			=schartC17L3
(4) Other Health Risk Revenue†					
(5) Underwriting Risk Revenue = Lines (1.3) + (2) + (3) + (4)					
(6) Net Incurred Claims	=schart5C1+2+7+8LD1	=schart5C3LD1	=schart5C4+5LD1		
(7) Fee-for-Service Offset†		XXX			
(8) Underwriting Risk Incurred Claims = Line (6) – Line (7)					
(9) Underwriting Risk Claims Ratio = Line (8) / Line (5)					XXX
(10.1) Underwriting Risk Factor for Initial Amounts Of Premium‡	0.1493	0.1043	0.1195	0.251	XXX
(10.2) Underwriting Risk Factor for Excess of Initial Amount‡	0.0893	0.0663	0.0755	0.151	XXX
(10.3) Composite Underwriting Risk Factor					XXX
(11) Base Underwriting Risk RBC = Line (5) x Line (9) x Line (10.3)					
(12) Managed Care Discount Factor = LR022 Line (17)					XXX
(13) Base RBC After Managed Care Discount = Line (11) x Line (12)					
(14) RBC Adjustment For Individual = [(Line(1.1) x 1.2 + Line (1.2)) / Line (1.3)] x Line (13)§					
(15) Maximum Per-Individual Risk After Reinsurance†					XXX
(16) Alternate Risk Charge*					
(17) Net Alternate Risk Charge‡					
(18) Net Underwriting Risk RBC (Maximum of Line (14) or Line (17))					

† Source is company records unless already included in premiums.

‡ For Comprehensive Medical, the Initial Premium Amount is \$25,000,000 or the amount in Line (1.3) if smaller. For Medicare Supplement and Dental & Vision, the Initial Premium Amount is \$3,000,000 or the amount in Line (1.3) if smaller. For Stand-Alone Medicare Part D, the Initial Premium Amount is \$25,000,000 or the amount in Line (1.3) if smaller.

§ Formula applies only to Column (1), for all other columns Line (14) should equal Line (13).

\* The Line (16) Alternate Risk Charge is calculated as follows:

LESSER OF:	\$1,500,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$150,000 or 6 x Maximum Individual Risk	Maximum of Columns (1), (2), (3) and (4)
------------	-----------------------------------------------------	--------------------------------------------------	--------------------------------------------------	---------------------------------------------------	---------------------------------------------------

‡ Applicable only if Line (16) for a column equals Line (16) for Column (5), otherwise zero.

‡ Denotes items that must be manually entered on the filing software.

#REF!

LRBC FORMULA APPLICATION FOR P&C COMPANY'S A&H BUSINESS  
PR019 – PR026



**Detail Eliminated to Conserve Space**

Line (1)  
Health premiums for ~~usual and customary major comprehensive (medical and hospital), which (including comprehensive major medical and expense reimbursement hospital/medical coverage)~~ written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (1) Line (1.1). Medicaid Pass-Through Payments reported as premium in the annual statement filing should be excluded from the premium amounts reported in Line 1 and reported in Line (3.3) and (10.3), respectively.

Line (2)  
Health premiums for Medicare supplement written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (2) Line (1.1).

Line (3)  
Health premiums for dental or vision coverage written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (3) Line (1.1).

Line (3.1)  
~~Health premium for~~ Health premium for Stand-Alone Medicare Part D coverage written on individual contracts - includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D Payment Demonstration amounts and risk corridor payment adjustments. See Appendix 2 for definition of these terms. This does not include Medicare-Advantage prescription drug coverage (MA-PD) premiums which are to be included in Line (1). No RBC requirement is calculated in Column (2). The premium is carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (4) Line (1.1).



**Detail Eliminated to Conserve Space**

Line (7)  
Health premiums for ~~usual and customary major comprehensive (medical and hospital), which (including comprehensive major medical and expense reimbursement hospital/medical coverage)~~ written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (1) Line (1.2).



**Detail Eliminated to Conserve Space**

Line (10.3) Medicaid pass-through payments reported as premium and excluded from Line (4.7) should be reported in Line (10.3).



**Detail Eliminated to Conserve Space**

Lines (15) through (24)

Disability income premiums are to be separately entered depending on category (Individual and Group). For Individual, a further split is between noncancellable (NC) or other (GR, etc.) For Group, the further splits are between Credit Monthly Balance, Credit Single Premium (with additional reserves), Credit Single Premium (without additional reserves), Group Long-Term (benefit periods of two years or longer) and Group Short-Term (benefit periods less than two years). For long-term care insurance, premiums are reported separately for Individual noncancellable, Individual (other than NC) and Group LTCL. The RBC factors vary by the amount of premium reported such that a higher factor is applied to amounts below \$50,000,000 for similar types. Starting in 2001, in determining the premiums subject to the higher factors, individual disability income noncancellable and other is combined. All types of Group and Credit are combined in a different category from Individual. For long-term care, all types (Individual and Group) are combined.

The following table describes the calculation process used to assign RBC charges to disability income business. The reference to line numbers (e.g., Line 15) represent the actual line numbers used in the formula page, but the subdivisions of those lines [e.g., a), b), etc.] do not exist in the formula page. The total RBC Requirement shown in the last (Total) subdivision of each line will be included in Column (2) for that line in the formula page.

<u>Line</u>	<u>Disability Income Premium</u>	<u>Annual Statement Source</u>	<u>Statement Value</u>	<u>Factor</u>	<u>RBC Requirement</u>
<u>Line (15)</u>	<u>Noncancellable Disability Income - Individual Morbidity</u>	Earned Premium included in Schedule H, Part 1, <u>Column 2</u> , Line 2, in part			
a)	First \$50 Million Earned Premium of Line (15)	Company Records		X 0.350 =	
b)	Over \$50 Million Earned Premium of Line (15)	Company Records		X 0.150 =	
c)	Total Noncancellable Disability Income - Individual Morbidity	a) of Line (15) + b) of Line (15), Column (2)			
<u>Line (16)</u>	<u>Other Disability Income - Individual Morbidity</u>	Earned Premium included in Schedule H, Part 1, <u>Column 2</u> , Line 2, in part			
a)	Earned Premium in Line (16) [up to \$50 million less premium in a) of Line (15)]	Company Records		X 0.250 =	
b)	Earned Premium in Line (16) not included in a) of Line (16)	Company Records		X 0.070 =	
c)	Total Other Disability Income - Individual Morbidity	a) of Line (16) + b) of Line (16), Column (2)			



<u>Line</u>	<u>Disability Income Premium</u>	<u>Annual Statement Source</u>	<u>Statement Value</u>	<u>Factor</u>	<u>RBC Requirement</u>
<u>Line (17)</u>	<u>Disability Income - Credit Monthly Balance</u>	Earned Premium included in Schedule H, Part 1, <a href="#">Column 21</a> , Line 2, in part		X 0.200 =	
a)	First \$50 Million Earned Premium of Line (17)	Company Records		X 0.030 =	
b)	Over \$50 Million Earned Premium of Line (17)	Company Records			
c)	Total Disability Income - Credit Monthly Balance	a) of Line (17) + b) of Line (17), Column (2)			
<u>Line (18)</u>	<u>Disability Income – Group Long Term</u>	Earned Premium included in Schedule H, Part 1, <a href="#">Column 21</a> , Line 2, in part			
a)	Earned Premium in Line (18) [up to \$50 million less premium in a) of Line (17)]	Company Records		X 0.150 =	
b)	Earned Premium in Line (18) not included in a) of Line (18)	Company Records		X 0.030 =	
c)	Total Disability Income – Group Long Term	a) of Line (18) + b) of Line (18), Column (2)			
<u>Line (19)</u>	<u>Disability Income – Credit Single Premium with Additional Reserves</u>	Earned Premium included in Schedule H, Part 1, <a href="#">Column 21</a> , Line 2, in part. This amount to be reported on Health Premiums, Line (19)			
a)	Additional Reserves for Credit Disability Plans	PR019 Health Premiums Column (1) Line (27)			
b)	Additional Reserves for Credit Disability Plans, Prior Year	PR019 Health Premiums Column (1) Line (28)			
c)	Subtotal Disability Income - Credit Single Premium with Additional Reserves	Line (19) - a) of Line (19) + b) of Line (19)			
d)	Earned Premium in c) [up to \$50 million less premium in a) of Line (17) + a) of Line (18)]	Company Records		X 0.100 =	
e)	Earned Premium in c) of Line (19) not included in d) of Line (19)	Company Records		X 0.030 =	
f)	Total Disability Income - Credit Single Premium with Additional Reserves	d) of Line (19) + e) of Line (19), Column (2)			
<u>Line (20)</u>	<u>Disability Income – Credit Single Premium without Additional Reserves</u>	Earned Premium included in Schedule H, Part 1, <a href="#">Column 21</a> , Line 2, in part			
a)	Earned Premium in Line (20) [up to \$50 million less premium in a) of Line (17) + a) of Line (18) + d) of Line (19)]	Company Records		X 0.150 =	
b)	Earned Premium in Line (20) not included in a) of Line (20)	Company Records		X 0.030 =	

	<u>Disability Income Premium</u>	<u>Annual Statement Source</u>	<u>Statement Value</u>	<u>Factor</u>	<u>RBC Requirement</u>
c)	Total Disability Income – Credit Single Premium without Additional Reserves	a) of Line (20) + b) of Line (20), Column (2)			
<u>Line (21)</u>	Disability Income – Group Short Term	Earned Premium included in Schedule H, Part 1, <a href="#">Column 21</a> , Line 2, in part Company Records			
a)	Earned Premium in Line (21) [up to \$50 million less premium in a) of Line (17) + a) of Line (18) + d) of Line (19) + a) of Line (20)]	Company Records		X 0.050 =	
b)	Earned Premium in Line (21) not included in a) of Line (21)	Company Records		X 0.030 =	
c)	Total Disability Income – Group Short Term	a) of Line (21) + b) of Line (21), Column (2)			
<u>Line (22)</u>	Noncancellable Long-Term Care Premium – Rate risk	Earned Premium (Schedule H, Part 1, <a href="#">Column 23</a> , Line 2, in part)		X 0.100 =	

Line (25)

Most Health Premium will have been included in one of the prior lines. In the event that some coverage does not fit into any of these categories, “Other Health” category is applied with a 12% factor, which is from 1998 formula for Other Limited Benefits Anticipating Rate Increases.

 **Detail Eliminated to Conserve Space** 

PR020 - Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental and Vision

 **Detail Eliminated to Conserve Space** 

Line (6) Net Incurred Claims

Claims incurred (paid claims + change in unpaid claims) during the reporting year (net of reinsurance) that are arranged for or provided by the insurer. Paid claims include capitation and all other payments to providers for services to covered lives, as well as reimbursement directly to insureds (or their providers) for covered services. Paid claims also include salaries paid to company employees that provide medical services to covered lives and related expenses. This line does not include ASC payments or Federal Employees Health Benefit Program (FEHBP) claims.

Column (1) claims come from Annual Statement, Schedule H, Part 5 Column 1+2+7+8 Line D13, less the amounts reported as incurred claims for Administrative Services Contracts (ASC) in Line (8) of PR013 and Federal Employee Health Benefit Plan (FEHBP) in Line (3) of PR022. ~~(Note that Medicare supplement claims could be double-counted if included in Column 1 of Schedule H, Part 5 rather than Column (3)).~~ Column (2) claims come from [General Interrogatories Part 2, Line 1.5](#), [Schedule H, Part 5, Column 3, Line D1](#). Column (3) dental and vision claims come from Schedule H, Part 5, Columns 4+52, Line D113.

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in Appendix 2). Where there has been prepayment under the reinsurance coverage, paid claims should be offset from the cumulative deposits. Unpaid claim liabilities should reflect expected recoveries from the reinsurance coverage – for claims unpaid by the PDP or for amounts covered under the reinsurance coverage that exceed the cumulative deposits. Where there has not been any prepayment under the reinsurance coverage, unpaid claim liabilities should reflect expected amounts still due from CMS.



**Detail Eliminated to Conserve Space**



PR021 – Underwriting Risk – Managed Care Credit

Line (10.6)

Total Paid Claims – The total of Column (1) paid claims should equal the total claims paid for the year as reported in Schedule H, Part 5, Columns 1+2+3+4+5+~~6+7~~, Line D16 D4 of the annual statement.



**Detail Eliminated to Conserve Space**



**HEALTH PREMIUMS and HEALTH CLAIMS RESERVES**

LR019, LR023 and LR024



**Detail Eliminated to Conserve Space**



Line (1)

Health premiums for ~~self and customary major comprehensive~~ (medical and hospital) ~~which, including comprehensive major medical and expense reimbursement hospital/medical coverage~~ written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (1), Line (1.1).



**Detail Eliminated to Conserve Space**



Line (10)

Health premiums for ~~self and customary major comprehensive~~ (medical and hospital) ~~which, including comprehensive major medical and expense reimbursement hospital/medical coverage~~ written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (1), Line (1.2).



**Detail Eliminated to Conserve Space**



Lines (21) through (27)

Disability income premiums are to be separately entered depending upon category (individual and group). For Individual, a further split is between noncancellable (NC) or other (GR, etc.). For group, the further splits are between Credit Monthly Balance, Credit Single Premium (with additional reserves), Credit Single Premium (without additional reserves), Group Long-Term (benefit periods of two years or longer) and Group Short-Term (benefit periods less than two years). The RBC factors vary by the amount of premium reported such that a higher factor is applied to amounts below \$50,000,000 for similar types. Starting in 2001, in determining the premiums subject to the higher factors, individual disability income noncancellable and other is combined. All types of group and credit are combined in a different category from individual.

The following table describes the calculation process used to assign RBC charges to disability income business. The reference to line numbers (e.g., Line 19) represent the actual line numbers used in the formula page, but the subdivisions of those lines [e.g., a), b) etc.] do not exist in the formula page. The total RBC Requirement shown in the last (Total) subdivision of each line will be included in Column (2) for that line in the formula page.

	<u>Disability Income Premium</u>	<u>Annual Statement Source</u>	<u>(1) Statement Value</u>	<u>Factor</u>	<u>(2) RBC Requirement</u>
<u>Line (21)</u>	Noncancellable Disability Income - Individual Morbidity	Earned Premium included in Schedule H, Part 1, <a href="#">Column 21</a> , Line 2, in part			
a)	First \$50 Million Earned Premium of Line (21)	Company Records			



e) premium in a) of Line (23) + a) of Line (24)] Earned Premium in c) of Line (25) not included in d) of Line (25)	Company Records	X 0.1901 =	_____
f) Total Disability Income - Credit Single Premium with Additional Reserves	d) of Line (25) + e) of Line (25), Column (2)	X 0.0378 =	_____
<u>Line (26)</u> Disability Income – Credit Single Premium without Additional Reserves	Earned Premium included in Schedule H, Part 1, <a href="#">Column 21</a> , Line 2, in part		_____
a) Earned Premium in Line (26) [up to \$50 million less premium in a) of Line (23) + a) of Line (24) + d) of Line (25)]	Company Records	X 0.1267 =	_____
b) Earned Premium in Line (26) not included in a) of Line (26)	Company Records	X 0.0378 =	_____
c) Total Disability Income – Credit Single Premium without Additional Reserves	a) of Line (26) + b) of Line (26), Column (2)		_____
<u>Line (27)</u> Disability Income – Group Short-Term	Earned Premium included in Schedule H, Part 1, <a href="#">Column 21</a> , Line 2, in part		_____
a) Earned Premium in Line (27) [up to \$50 million less premium in a) of Line (23) + a) of Line (24) + d) of Line (25) + a) of Line (26)]	Company Records	X 0.0634 =	_____
b) Earned Premium in Line (27) not included in a) of Line (27)	Company Records	X 0.0378 =	_____
c) Total Disability Income – Group Short-Term	a) of Line (27) + b) of Line (27), Column (2)		_____

**Detail Eliminated to Conserve Space**

**UNDERWRITING RISK – EXPERIENCE FLUCTUATION RISK**  
LR020

**Detail Eliminated to Conserve Space**

Line (6) Net Incurred Claims  
Claims incurred (paid claims + change in unpaid claims) during the reporting year (net of reinsurance) that are arranged for or provided by the insurer. Paid claims includes capitation and all other payments to providers for services to covered lives, as well as reimbursement directly to insureds (or their providers) for covered services. Paid claims also include salaries paid to company employees that provide medical services to covered lives and related expenses. Line (6) does not include ASC payments or Federal Employees Health Benefit Program (FEHBP) claims.

Column (1) claims come from Schedule H, Part 5, Columns ~~1-4~~1-2+7+8 Line ~~4+5~~4+5 less the amounts reported as incurred claims for administrative services contracts (ASC) in Line (54) of LR029 Business Risk and Federal Employee Health Benefit Program (FEHBP) in Line (3) of LR021 Underwriting Risk – Other. Column (2) for Medicare supplement should be net of reinsurance, the same as the other columns. Column (2) for Medicare supplement ~~should use the direct claims from General Interrogatories Part 2, Line 1-5 after adjusting them for reinsurance~~ comes from Schedule H, Part 5, Column 3, Line D1. Column (3) dental and vision claims come from Schedule H, Part 5, Columns ~~4+5~~, Line ~~4+5~~.

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in Appendix 3). Where there has been prepayment under the reinsurance coverage, paid claims should be offset from the cumulative deposits. Unpaid claim liabilities should reflect expected recoveries from the reinsurance coverage – for claims unpaid by the PDP or for amounts covered under the reinsurance coverage that exceed the cumulative deposits. Where there has not been any prepayment under the reinsurance coverage, unpaid claim liabilities should reflect expected amounts still due from CMS.



**Detail Eliminated to Conserve Space**

**UNDERWRITING RISK - MANAGED CARE CREDIT**

LR022



**Detail Eliminated to Conserve Space**

Line (9)  
Subtotal Paid Claims – The total of Column (2) paid claims should equal the total claims paid for the year as reported in Schedule H, Part 5, Columns 1, ~~2, 3, 4~~ and 5, Line ~~D-4~~ of the annual statement.

**Capital Adequacy (E) Task Force**

**RBC Proposal Form**

- |                                                                               |                                                                  |                                                                             |
|-------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Capital Adequacy (E) Task Force                      | <input checked="" type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group                         |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup                        | <input type="checkbox"/> Investment RBC (E) Working Group        | <input type="checkbox"/> Longevity Risk (A/E) Subgroup                      |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group               | <input type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

<b>DATE:</b> <u>11-4-22</u>	<b><u>FOR NAIC USE ONLY</u></b>
<b>CONTACT PERSON:</b> <u>Crystal Brown</u>	Agenda Item # <u>2022-14-H</u>
<b>TELEPHONE:</b> <u>816-783-8146</u>	Year <u>2023</u>
<b>EMAIL ADDRESS:</b> <u>cbrown@naic.org</u>	<b><u>DISPOSITION</u></b>
<b>ON BEHALF OF:</b> <u>Health Risk-Based Capital (E) Working Grp</u>	<input checked="" type="checkbox"/> ADOPTED <u>HRBC 2/7/23, TF 3/23/23</u>
<b>NAME:</b> <u>Steve Drutz</u>	<input type="checkbox"/> REJECTED _____
<b>TITLE:</b> <u>Chief Financial Analyst/Chair</u>	<input type="checkbox"/> DEFERRED TO _____
<b>AFFILIATION:</b> <u>WA Office of Insurance Commissioner</u>	<input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____
<b>ADDRESS:</b> <u>5000 Capitol Blvd SE</u>	<input checked="" type="checkbox"/> EXPOSED <u>11-7-22</u>
<u>Tumwater, WA 98501</u>	<input type="checkbox"/> OTHER (SPECIFY) _____

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

- |                                                             |                                                             |                                                              |
|-------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Health RBC Blanks                  | <input type="checkbox"/> Property/Casualty RBC Blanks       | <input type="checkbox"/> Life and Fraternal RBC Instructions |
| <input checked="" type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions | <input type="checkbox"/> Life and Fraternal RBC Blanks       |
| <input type="checkbox"/> OTHER _____                        |                                                             |                                                              |

**DESCRIPTION OF CHANGE(S)**

Remove the trend test for information only instructions.

**REASON OR JUSTIFICATION FOR CHANGE \*\***

All states are in compliance with the Health Trend Test. This is part of the Accreditation Standards.

**Additional Staff Comments:**

11-7-22 cgb Exposed for 30-day comment period  
 12-7-22 cgb No comments received  
 2-7-23 cgb Health Risk-Based Capital Working Group adopted  
 3-23-23 cgb The Task Force adopted the proposal on 3/23/23

\*\* This section must be completed on all forms.

Revised 7-2022



**COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL**  
XR027



Detail Eliminated to Conserve Space

**Trend Test**

A company whose RBC ratio is between 200 percent and 300 percent and combined ratio is greater than 105 percent could trigger a Company Action Level RBC regulatory action per the Trend Test. ~~The calculation is informational only until state statutes are implemented so that the trend test would trigger a Company Action Level RBC regulatory action per the statute.~~

**Capital Adequacy (E) Task Force**  
**RBC Proposal Form**

- |                                                                               |                                                                  |                                                                             |
|-------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Capital Adequacy (E) Task Force                      | <input checked="" type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group                         |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup                        | <input type="checkbox"/> Investment RBC (E) Working Group        | <input type="checkbox"/> Longevity Risk (A/E) Subgroup                      |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group               | <input type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

<b>DATE:</b> <u>01-27-23</u>	<b><u>FOR NAIC USE ONLY</u></b>
<b>CONTACT PERSON:</b> <u>Crystal Brown</u>	Agenda Item # <u>2022-15-H</u>
<b>TELEPHONE:</b> <u>816-783-8146</u>	Year <u>2023</u>
<b>EMAIL ADDRESS:</b> <u>cbrown@naic.org</u>	<b><u>DISPOSITION</u></b>
<b>ON BEHALF OF:</b> <u>Health Risk-Based Capital (E) Working Grp</u>	<input checked="" type="checkbox"/> ADOPTED <u>HRBC 3/21/23 TF 3/23/23</u>
<b>NAME:</b> <u>Steve Drutz</u>	<input type="checkbox"/> REJECTED _____
<b>TITLE:</b> <u>Chief Financial Analyst/Chair</u>	<input type="checkbox"/> DEFERRED TO _____
<b>AFFILIATION:</b> <u>WA Office of Insurance Commissioner</u>	<input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____
<b>ADDRESS:</b> <u>5000 Capitol Blvd SE</u>	<input checked="" type="checkbox"/> EXPOSED <u>1-30-23</u>
<u>Tumwater, WA 98501</u>	<input type="checkbox"/> OTHER (SPECIFY) _____

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

- Health RBC Blanks     Property/Casualty RBC Blanks     Life and Fraternal RBC Instructions  
 Health RBC Instructions     Property/Casualty RBC Instructions     Life and Fraternal RBC Blanks  
 OTHER \_\_\_\_\_

**DESCRIPTION OF CHANGE(S)**

Renumber the lines on page XR008.

**REASON OR JUSTIFICATION FOR CHANGE \*\***

Renumber all the lines on page XR008. The line numbers carry over from the bond page, renumbering the lines will allow for easier updated in the future for adjustments to the bonds.

**Additional Staff Comments:**

1-30-23 cgb Proposal 2022-15-H was exposed for a 30-day comment period ending on Feb. 28.  
 2-28-23 cgb No comments received during comment period.  
 3-21-23 cgb HRBCWG adopted at their 3/21/23 meeting  
 3/23/23 cgb Task Force adopted at their 3/23/23 meeting

\*\* This section must be completed on all forms.

Revised 7-2022

**Overview of the NAIC Health Risk-Based Capital Report**



Negative values can sometimes appear in the value column or RBC Subtotal column of this report. These negative values are retained to facilitate crosschecking of amounts reported in the annual statement against amounts reported in the RBC filing. However, when a negative number appears in the value column, that value will be converted to zero before determining the RBC Requirement. For example, a negative \$10,000 for cash [XR008, Col (1), Line ~~(28)~~] will produce a zero (\$0 times 0.003) in Column (2), RBC Requirement, rather than a negative \$30 (-\$10,000 times 0.003).



**Fixed Income Assets  
 XR007 AND XR008**

The RBC requirement for fixed income assets is largely driven by the default risk on those assets. There are two major subcategories: Bonds and Miscellaneous. Bonds include items that meet the definition of a bond, regardless if the bond is long-term (reported on Schedule D-1), short-term (reported on Schedule DA), or a cash equivalent (reported on Schedule E-2). Miscellaneous fixed income assets include non-bond items reported on the cash equivalent and short-term schedules, derivatives, mortgage loans, collateral loans, and other items reported on Schedule BA: Other Long-Term Invested Assets.

**Bonds (XR007)**

The bond factors for investment grade bonds (NAIC Designation (1.A-2.C) are based on cash flow modeling. Each bond of a portfolio was annually tested for default (based on a “roll of the dice”) where the default probability varies by NAIC Designation Category and that year’s economic environment. The default probabilities were based on historical data intended to reflect a complete business cycle of favorable or unfavorable credit environments. The risk of default was measured over a five-year time horizon, based on the duration of assets held for health companies.

The factors for NAIC Designation Category 3.A to 6 recognize that these non-investment grade bonds are reported at the lower of amortized cost or fair value. These bond risk factors are based on the market value fluctuation for each of the NAIC Designation Category compared to the market value fluctuation of stocks during the 2008-2009 financial crisis.

While the life and property/casualty formulas have a separate calculation for the bond size factor (based on the number of issuers in the RBC filer’s portfolio), the health formula does not include a separate calculation, instead a bond size component was incorporated into the bond factors. A representative portfolio of 382 issuers was used in calculating the bond risk factors.

There is no RBC requirement for bonds guaranteed by the full faith and credit of the United States, Other U.S. Government Obligations, and securities on the NAIC U.S. Government Money Market Fund List because it is assumed that there is no default risk associated with U.S. Government issued securities.

The book/adjusted carrying value of all bonds should be reported in Columns (1), (2) or (3). The bonds are split into twenty-one different risk classifications. These risk classifications are based on the NAIC Designation Category as defined and permitted in the *Purposes and Procedures Manual of the Investment Analysis Office*. The subtotal of Columns (1), (2), and (3) will be calculated in Column (4). The RBC requirement will be automatically calculated in Column (5).

### Miscellaneous Fixed Income Assets (XR008)

The factor for cash is 0.3 percent. It is recognized that there is a small risk related to possible insolvency of the bank where cash deposits are held. This factor was based on the original unaffiliated NAIC 01 bond risk factor prior to the increased granularity of the NAIC Designation Categories in 2021 and reflects the short-term nature of this risk. The required risk-based capital for cash will not be less than zero, even if the company's cash position is negative.

The Short-Term Investments to be included in this section are those short-term investments not reflected elsewhere in the formula. The 0.3 percent factor is equal to the factor for cash. The amount reported in Line ~~(835)~~ reflects the total from Schedule DA: Short-Term Investments (Line ~~(633)~~), less the short-term bonds (Line ~~(734)~~). (The short-term bonds reported in Line ~~(734)~~ should equal Schedule DA, Part 1, Column 7, Line 2509999999.)

Mortgage loans (reported on Schedule B) and Derivatives (reported on Schedule DB) receive a factor of 5 percent, consistent with other risk-based capital formulas studied by the Working Group.

The following investment types are captured on Schedule BA: Other Long-Term Invested Assets. Specific factors have been established for certain Schedule BA assets based on the nature of the investment. Those Schedule BA assets not specifically identified below receive a 20 percent factor (Line ~~(1643)~~).

- Collateral Loans reported on Line ~~(1340)~~ receive a factor of 5 percent, consistent with other risk-based capital formulas studied by the Working Group.
- Working Capital Finance Investments: The book adjusted carrying value of NAIC 01 and 02 Working Capital Finance Investments, Lines ~~(1444)~~ and ~~(1549)~~, should equal the Notes to Financial Statement, Lines 5M(01a) and 5M(01b), Column 3 of the annual statement.
- Low-income housing tax credit investment are reported on Column (1) in accordance with *SSAP No. 93—Low Income Housing Tax Credit Property Investments*.
  - Federal Guaranteed Low-Income Housing Tax Credit (LIHTC) investments are to be included in Line ~~(1744)~~. There must be an all-inclusive guarantee from an ARO-rated entity that guarantees the yield on the investment.
  - Federal Non-Guaranteed LIHTC investments with the following risk mitigation factors are to be included in Line ~~(1845)~~:
    - a) A level of leverage below 50 percent. For a LIHTC Fund, the level of leverage is measured at the fund level.
    - b) There is a tax credit guarantee agreement from general partner or managing member. This agreement requires the general partner or managing member to reimburse investors for any shortfalls in tax credits due to errors of compliance, for the life of the partnership. For an LIHTC fund, a tax credit guarantee is required from the developers of the lower-tier LIHTC properties to the upper-tier partnership.
  - State Guaranteed LIHTC investments that at a minimum meet the federal requirements for guaranteed LIHTC investments are to be included in Line ~~(1946)~~.
  - State Non-Guaranteed LIHTC investments that at a minimum meet the federal requirements for non-guaranteed LIHTC investments are to be included on Line ~~(2047)~~.
  - All Other LIHTC investments, state and federal LIHTC investments that do not meet the requirements of Lines (44) through (47) would be reported on Line ~~(2148)~~.

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**FIXED INCOME ASSETS - BONDS**

	(1) Long-Term Bonds Schedule D, Part 1 Book/Adjusted Carrying Value $LC(1) thru LC(26) = Sch. D Pt. 1F$	(2) Short-Term Investments Schedule DA, Part 1 Book/Adjusted Carrying Value $LC(1) thru LC(26) = Sch. DA Pt. 1F$	(3) Cash Equivalents Schedule E, Part 2 Book/Adjusted Carrying Value $LC(1) thru LC(26) = Sch. E Pt. 2F$	(4) Subtotal $LC(1) + LC(2) + LC(3)$	(5) RBC Requirement Factor
<b>BONDS</b>					
(1) NAIC 1.A - U.S. Government - Full Faith and Credit, Other U.S. Government Obligations, and NAIC U.S. Government Money Market Fund List (Refer to AS Instructions)	Annual Statement Source				
(2) NAIC Designation Category 1.A Bonds	LC(1) = Sch. D, Pt. 1, C11, L0109999999 LC(2) = Sch. DA, Pt. 1, C7, L0109999999 LC(3) = Sch. E, Pt. 2, C7, L0109999999 + L8209999999				
(3) NAIC Designation Category 1.B Bonds	C1) = Footnote Amt 1 L000001A - L(1)				
(4) NAIC Designation Category 1.C Bonds	C2) = Footnote Amt 1 L000001A - L(1)				
(5) NAIC Designation Category 1.D Bonds	C3) = Footnote Amt 1 L000001A - SCE, Pt. 2, C7				
(6) NAIC Designation Category 1.E Bonds	L0109999999				
(7) NAIC Designation Category 1.F Bonds	Footnote Amt 2 L000001A				
(8) NAIC Designation Category 1.G Bonds	Footnote Amt 3 L000001A				
(9) Total NAIC 01 Bonds	Footnote Amt 4 L000001A				
(10) NAIC Designation Category 2.A Bonds	Footnote Amt 5 L000001A				
(11) NAIC Designation Category 2.B Bonds	Footnote Amt 6 L000001A				
(12) NAIC Designation Category 2.C Bonds	Footnote Amt 7 L000001A				
(13) Total NAIC 02 Bonds	Sum of Lines (1) through (8)				
(14) NAIC Designation Category 3.A Bonds	Footnote Amt 1 L000001B				
(15) NAIC Designation Category 3.B Bonds	Footnote Amt 2 L000001B				
(16) NAIC Designation Category 3.C Bonds	Footnote Amt 3 L000001B				
(17) Total NAIC 03 Bonds	Sum of Lines (10) through (12)				
(18) NAIC Designation Category 4.A Bonds	Footnote Amt 1 L000001C				
(19) NAIC Designation Category 4.B Bonds	Footnote Amt 2 L000001C				
(20) NAIC Designation Category 4.C Bonds	Footnote Amt 3 L000001C				
(21) Total NAIC 04 Bonds	Sum of Lines (14) through (16)				
(22) NAIC Designation Category 5.A Bonds	Footnote Amt 1 L000001D				
(23) NAIC Designation Category 5.B Bonds	Footnote Amt 2 L000001D				
(24) NAIC Designation Category 5.C Bonds	Footnote Amt 3 L000001D				
(25) Total NAIC 05 Bonds	Sum of Lines (18) through (20)				
(26) Total NAIC 06 Bonds	Footnote Amt 1 L000001E				
(27) Total Bonds RBC	Footnote Amt 2 L000001E				
	Footnote Amt 3 L000001E				
	Sum of Lines (22) through (24)				
	Footnote Amt 1 L000001F				
	Lines (9) + (13) + (17) + (21) + (25) + (26)				

FIXED INCOME ASSETS - MISCELLANEOUS

	(1) Bk/Adj Carrying Value	Factor	(2) RBC Requirement
(1) Cash		0.0030	
(2) Cash Equivalents			
(3) Less: Cash Equivalents, Total Bonds			
(4) Less: Exempt Money Market Mutual Funds as Identified by SVO			
(5) Net Cash Equivalents			
(6) Short-Term Investments			
(7) Short-Term Bonds			
(8) Total Other Short-Term Investments			
(9) Mortgage Loans - First Liens			
(10) Mortgage Loans - Other Than First Liens			
(11) Receivable for Securities			
(12) Aggregate Write-Ins for Invested Assets			
(13) Collateral Loans			
(14) NAIC 01 Working Capital Finance Investments			
(15) NAIC 02 Working Capital Finance Investments			
(16) Other Long-Term Invested Assets Excluding Collateral Loans and Working Capital Finance Investments			
(17) Federal Guaranteed Low Income Housing Tax Credits			
(18) Federal Non-Guaranteed Low Income Housing Tax Credits			
(19) State Guaranteed Low Income Housing Tax Credits			
(20) State Non-Guaranteed Low Income Housing Tax Credits			
(21) All Other Low Income Housing Tax Credits			
(22) Total Other Long-Term Invested Assets (Page 2, Column 3, Line 8)			
(23) Derivatives			
(24) Total <b>Miscellaneous</b> Fixed Income Assets RBC			

Annual Statement Source  
 Page 2, Line 5, inside amount 1  
 Page 2, Line 5, inside amount 2  
 Schedule E, Part 2, Column 7, Line 2509999999  
 Schedule E, Part 2, Column 7, Line 8209999999  
**Line (2) - (3) - (4)**  
 Page 2, Line 5, inside amount 3  
 Schedule DA, Part 1, Column 7, Line 2509999999  
**Lines (6) - (7)**  
 Page 2, Column 3, Line 3.1  
 Page 2, Column 3, Line 3.2  
 Page 2, Column 3, Line 9  
 Page 2, Column 3, Line 11  
 Included in Page 2, Column 3, Line 8  
 Notes to Financial Statement 5M(01a), Column 3  
 Notes to Financial Statement 5M(01b), Column 3  
 Included in Page 2, Column 3, Line 8  
 Schedule BA Part 1, Column 12 Lines 3599999 + 3699999  
 Schedule BA Part 1, Column 12 Lines 3799999 + 3899999  
 Schedule BA Part 1, Column 12 Lines 3999999 + 4099999  
 Schedule BA Part 1, Column 12 Lines 4199999 + 4299999  
 Schedule BA Part 1, Column 12 Lines 4399999 + 4499999  
**Lines (13) + (14) + (15) + (16) + (17) + (18) + (19) + (20) + (21)**  
 Page 2, Column 3, Line 7  
**Lines ~~(27)~~ (1) + (5) + (8) + (9) + (10) + (11) + (12) + (22) + (23)**

Denotes items that must be manually entered on filing software.

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**CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE**

	(1) <u>RBC Amount</u>
<b>H0 - INSURANCE AFFILIATES AND MISC. OTHER AMOUNTS</b>	
(1) Off-Balance Sheet Items	
(2) Directly Owned Insurer Subject to RBC	
(3) Indirectly Owned Insurer Subject to RBC	
(4) Directly Owned Health Entity Subject to RBC	
(5) Indirectly Owned Health Entity Subject to RBC	
(6) Directly Owned Alien Insurer	
(7) Indirectly Owned Alien Insurers	
(8) Total H0	
<b>H1 - ASSET RISK - OTHER</b>	
(9) Investment Affiliates	
(10) Holding Company Excess of Subsidiaries	
(11) Investment in Parent	
(12) Other Affiliates	
(13) Fair Value Excess Affiliate Common Stock	
(14) Fixed Income Assets	
(15) Replication & Mandatory Convertible Securities	
(16) Unaffiliated Preferred Stock	
(17) Unaffiliated Common Stock	
(18) Property & Equipment	
(19) Asset Concentration	
(20) Total H1	
<b>H2 - UNDERWRITING RISK</b>	
(21) Net Underwriting Risk	
(22) Other Underwriting Risk	
(23) Disability Income	
(24) Long-Term Care	
(25) Limited Benefit Plans	
(26) Premium Stabilization Reserve	
(27) Total H2	

#REF!

Denotes items that must be manually entered on filing software.

**CAPITAL ADEQUACY (E) TASK FORCE  
WORKING AGENDA ITEMS FOR CALENDAR YEAR 2023**

Priority 1 – High Priority  
Priority 2 – Medium Priority  
Priority 3 – Low Priority

2023 #	Owner	2023 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
<b>Ongoing Items – Life RBC</b>							
L1	Life RBC WG	Ongoing	Ongoing	Make technical corrections to Life RBC instructions, blank and /or methods to provide for consistent treatment among asset types and among the various components of the RBC calculations for a single asset type.			
L2	Life RBC WG	1	2022 or later	1. Monitor the impact of the changes to the variable annuities reserve framework and risk-based capital (RBC) calculation and determine if additional revisions need to be made. 2. Develop and recommend appropriate changes including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements. Provide recommendations for the appropriate treatment of longevity risk transfers by the new longevity factors.	CADTF	Being addressed by the Variable Annuities Capital and Reserve (E/A) Subgroup	
L3	Life RBC WG	1	2022 or later		New Jersey	Being addressed by the Longevity (E/A) Subgroup	
<b>Carryover Items Currently being Addressed – Life RBC</b>							
L4	Life RBC WG	1	2022 or later	Update the current C-3 Phase I or C-3 Phase II methodology to include indexed annuities with consideration of contingent deferred annuities as well	AAA		
L5	Life RBC WG	1	2022 or later	Work with the Life Actuarial (A) Task Force and Conning to develop the economic scenario generator for implementation.			
L6	Life RBC WG	1	2022	Review companies at action levels, including previous years, to determine what drivers of the events are and consider whether changes to the RBC statistics are warranted.			
L7	Life RBC WG	1	2022	Work with the Academy on creating guidance for the adopted C-2 mortality treatment for 2022 and next steps for 2023.			
<b>Working Agenda Item</b>							
<b>Ongoing Items – RBC IR &amp; E</b>							
<b>Carryover Items Currently being Addressed – RBC IR &amp; E</b>							
IR1	RBC IRE	2	2022 or later	Supplementary Investment Interrogatories (SIRI)	Referred from CADTF Referral from Blackrock and IL DOI	The Task Force received the referral on Oct. 27. This referral will be tabled until the bond factors have been adopted and the TF will conduct a holistic review all investment referrals.	1/12/2022 11/19/2020

Revised ~~1203/4423~~/20223



IR2	RBC IRE	2	2022 or later	NAIC Designation for Schedule D, Part 2 Section 2 - Common Stocks Equity investments that have an underlying bond characteristic should have a lower RBC charge. Similar to existing guidance for SVO-identified ETFs reported on Schedule D-1, are treated as bonds.	Referred from CADTF Referral from SAPWG 8/13/2018	10/8/19 - Exposed for a 30-day Comment period ending 11/8/2019 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.	1/12/2022 10/11/2018
IR3	RBC IRE	2	2022 or later	Structured Notes - defined as an investment that is structured to resemble a debt instrument, where the contractual amount of the instrument to be paid at maturity is at risk for other than the failure of the borrower to pay the contractual amount due. Structured notes reflect derivative instruments (i.e. put option or forward contract) that are wrapped by a debt structure.	Referred from CADTF Referral from SAPWG April 16, 2019	10/8/19 - Exposed for a 30-day Comment period ending 11/8/2019 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.	1/12/2022 8/4/2019
IR4	RBC IRE	2	2022 or later	Comprehensive Fund Review for investments reported on Schedule D Pt 2 Sn2	Referred from CADTF Referral from VOSTF 9/21/2018	Discussed during Spring Mtg. NAIC staff to do analysis. 10/8/19 - Exposed for a 30-day comment period ending 11/8/19 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.	1/12/2022 11/16/2018
<b>New Items – RBC IR &amp; E</b>							
IR5			2023 or later	Evaluate the appropriate RBC treatment of Asset-Backed Securities (ABS), including Collateralized Loan Obligations (CLO), collateralized fund obligations (CFOs), or other similar securities carrying similar types of tail risk (Complex Assets).	Request from E Committee, SAPWG, VOSTF	Per the request of E Committee comments were solicited asking if these types of assets should be considered a part of the RBC framework.	1/12/2022
IR6			2023 or later	Evaluate the appropriate RBC treatment of Residual Tranches.	Request from E Committee, SAPWG, VOSTF	Per the request of E Committee comments were solicited asking if these types of assets should be considered a part of the RBC framework.	1/12/2022
IR7			2025 or later	Phase 2 Bond analysis - evaluate and develop an approach to map other ABS to current bond factors following the established principles from Phase 1 where the collateral has an assigned RBC. This project will likely require an outside consultant and the timeline could exceed 2-3 years.	Request from E Committee	Per the request of E Committee comments were solicited requesting the need for outside review.	1/12/2022
IR8	RBC IRE		2023 or later	Address the tail risk concerns no captured by reserves for privately structured securities.	Referral from the Macprudential (E) Working Group		8/11/2022
2023 #	Owner	2023 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
<b>Ongoing Items – P&amp;C RBC</b>							

Revised 4/23/2023

P1	Cat Risk SG	1	<p>Continue development of RBC formula revisions to include a risk charge based on catastrophe model output;</p> <p>a) Evaluate other catastrophe risks for possible inclusion in the charge - determine whether to recommend developing charges for any additional perils, and which perils or perils those should be.</p>	<p>Referral from the Climate and Resiliency Task Force, March 2021</p>	4/26/2021
				<p>4/26/21 - The SG exposed the referral for a 30-day period. 6/1/21 - The SG forwarded the response to the Climate and Resiliency Task Force. 2/22/22 - The SG adopted proposal 2021-17-CR (adding the wildfire peril for informational purposes only). The SG continues reviewing other perils for possible inclusion in the Rcat. 8/11/22 - The TF adopted Proposal 2022-04-CR (2013-2021 Wildfire Event Lists) 9/26/22 - The SG formed an ad hoc group to conduct review on different convective storm models.</p>	
P1	Cat Risk SG	1	<p>Carryover items currently being Addressed – P&amp;C RBC</p> <p>Continue development of RBC formula revisions to include a risk charge based on catastrophe model output;</p> <p>a) Evaluate other catastrophe risks for possible inclusion in the charge - determine whether to recommend developing charges for any additional perils, and which perils or perils those should be.</p>	<p>Referral from the Climate and Resiliency Task Force, March 2021</p>	4/26/2021
				<p>4/26/21 - The SG exposed the referral for a 30-day period. 6/1/21 - The SG forwarded the response to the Climate and Resiliency Task Force. 2/22/22 - The SG adopted proposal 2021-17-CR (adding the wildfire peril for informational purposes only). The SG continues reviewing other perils for possible inclusion in the Rcat. 8/11/22 - The TF adopted Proposal 2022-04-CR (2013-2021 Wildfire Event Lists) 9/26/22 - The SG formed an ad hoc group to conduct review on different convective storm models.</p>	

Revised 12/03/4423/20223

P2	P&C RBC WG	1	Year-end 2020 or later	Evaluate a) the current growth risk methodology whether it is adequately reflects both operational risk and underwriting risk; b) the premium and reserve based growth risk factors either as a stand-alone task or in conjunction with the ongoing underwriting risk factor review with consideration of the operational risk component of excessive growth; c) whether the application of the growth factors to NET proxies adequately accounts for growth risk that is ceded to reinsures that do not trigger growth risk in their own right.	Refer from Operational Risk Subgroup	1) Sent a referral to the Academy on 6/14/18 conference call.	1/25/2018
P3	P&C RBC WG	1	2023 Summer Meeting or later	Continue working with the Academy to review the methodology and revise the underwriting (Investment Income Adjustment, Loss Concentration, LOB UW risk) charges in the PRBC formula as appropriate.			6/10/2019
P4	Cat Risk SG	1	<del>Year-end 2023 or later</del>	<del>Evaluate the possibility of allowing additional third-party models or adjustments to the vendor models to calculate the cat model losses</del>	-	<del>7/15/21 - The SG is continue evaluating this item. 10/27/21 - The SG exposed the KCC model. 12/16/21 - The SG adopted the proposal 2021-15-CR. 3/23/22 - The WG adopted this proposal.</del>	<del>12/6/2019</del>
P5	P&C RBC WG	1	2023 Summer Meeting or later	Evaluate the Underwriting Risk Line 1 Factors in the P/C formula.			7/30/2020
P6	Cat Risk SG	2	<del>2023 Spring Meeting or later</del>	<del>Evaluate the possibility of enhancing the Independent Model Instructions.</del>	-	<del>8/9/22 - The SG and WG exposed proposal 2022-07-P for a 30-day public comment period. 9/26/22 - The SG adopted proposal 2022-08-CR.</del>	<del>3/22/2022</del>
P7	PCRBCWG	1	2023 Spring Meeting	Changing the RBC PR035 Line of Business categories to match the Lines of Business categories in the Annual Statement, Underwriting and Investment Exhibit, Part 1B.		8/9/22 - The WG exposed proposal 2022-07-P for a 30-day comment period. <u>12/14/22 - The TF adopted the proposal</u>	7/7/2022
P6	PCRBCWG	1	Ongoing	<b>New Items – P&amp;C RBC</b> Review and analyze the P/C RBC charges that have not been reviewed since developed.			3/23/2023
P7	Cat Risk SG	1	2024 Spring Meeting	Quantify the R5 Ex-cat Factors for wildfire peril (for informational purposes only) - Evaluate the possibility of adding PR018A to determine the R5 including the wildfire peril			3/21/2023
P8	Cat Risk SG	2	2025 Spring Meeting	Evaluate the impact of flood peril to the insurance market			3/21/2023

Revised ~~1203/4423~~/20223

2023 #	Owner	2023 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
<b>Ongoing Items – Health RBC</b>							
X1	Health RBC WG	Yearly	Yearly	Evaluate the yield of the 6-month U.S. Treasury Bond as of Jan. 1 each year to determine if further modification to the <del>0.5% adjustment</del> to the Comprehensive Medical, Medicare Supplement and Dental and Vision underwriting risk factors is required. Any adjustments will be rounded up to the nearest 0.5%.	HRBCWG	<a href="#">Exposed 2022-16-CA (YE-2023)</a>	11/4/2021
X2	Health RBC WG	3	Ongoing	Continue to monitor the Federal Health Care Law or any other development of federal level programs and actions (e.g., state reinsurance programs, association health plans, mandated benefits, and cross-border) for future changes that may have an impact on the Health RBC Formula.	4/13/2010 CATF Call	Adopted 2014-01H Adopted 2014-02H Adopted 2014-05H Adopted 2014-06H Adopted 2014-24H Adopted 2014-25H Adopted 2016-01-H Adopted 2017-09-CA Adopted 2017-10-H The Working Group will continually evaluate any changes to the health formula <u>because of</u> ongoing federal discussions and legislation.  Discuss and monitor the development of federal level programs and the potential impact on the HRBC formula.	1/11/2018
<b>Carryover Items Currently being Addressed – Health RBC</b>							
X3	Health RBC WG	2	Year-End 2024 RBC or Later	Consider changes for stop-loss insurance or reinsurance.	AAA Report at Dec. 2006 Meeting	(Based on Academy report expected to be received at YE-2016) 2016-17-CA	
X4	Health RBC WG	2	Year-end <del>2023</del> <u>2024</u> RBC or later	Review the individual factors for each health care receivables line within the Credit Risk H3 component of the RBC formula.	HRBC WG	Adopted 2016-06-H Rejected 2019-04-H Annual Statement Guidance (Year-End 2020) and Annual Statement Blanks Proposal (Year-End 2021) referred to the Blanks (E) Working Group	
X5	Health RBC WG	1	Year-end 2023 or later	Continue to review the: premium and reserve ratio in the Health Test Ad Hoc Group in the Health Test <del>and review possible annual statement changes for reporting health business in the Life and P/C Blanks.</del>	HRBCWG	Evaluate the applicability of the current Health Test in the Annual Statement instructions in today's health insurance market. Discuss	8/4/2018

Revised ~~1203/4423~~ 2023

X6	Health RBC WG	1	Year-end <del>2023</del> 2024 or later	Work with the Academy to perform a comprehensive review of the H2 - Underwriting Risk component of the health RBC formula including the Managed Care Credit review (Item 18 above)  Review the Managed Care Credit calculation in the <del>Health</del> health RBC formula - specifically Category 2a and 2b.  Review Managed Care Credit across formulas.  As part of the H2 - Underwriting Risk review, determine if other lines of business should include investment income and how investment income would be incorporated into the existing lines if there are changes to the structure.  Review referral letter from the Operational Risk (E) Subgroup on the excessive growth charge and the development of an Ad Hoc group to charge.	HRBCWG	ways to gather additional information for health business reported in other blanks.  Referred Proposal 2022-06BWG to Blanks Working Group for exposure and consideration.	2/25/2022
X7	Health RBC WG	1	Year-end <del>2023</del> 2024 or later		HRBCWG	Review if changes are required to the Health RBC Formula	4/7/2019
X8	Health RBC WG	2	Year-End <del>2023</del> 2024 or later	Consider the impact of COVID-19 and pandemic risk in the health RBC formula.	HRBCWG		7/30/2020
X9	Health RBC WG	3	Year-End <del>2023</del> 2025 or later	Discuss and determine the re-evaluation of the bond factors for the 20 designations.	Referral from Investment RBC July, 2020	Working Group will use two- and five-year time horizon factors in 2020 impact analysis. Proposal 2021-09-H - Adopted 5/25/21 by the WG	9/11/2020
X10	Health RBC WG	1	Year-End 2023 or later	Review and respond to the request from the Capital Adequacy (E) Task Force on the referral from the Restructuring Mechanisms (E) Subgroup for input regarding health runoff companies.	Capital Adequacy (E) Task Force	Response letter sent to Capital Adequacy 3/21/23	8/11/2022
X10	Health RBC WG	1	Year-End 2023 or later	<b>New Items – Health RBC</b> Review and respond to the request from the Capital Adequacy (E) Task Force on the referral from the Restructuring Mechanisms (E) Subgroup for input regarding health runoff companies.	Capital Adequacy (E) Task Force		8/11/2022
2023 #	Owner	2023 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
<b>Ongoing Items – Task Force</b>							
CA1	CADTF	2	2023	Affiliated Investment Subsidiaries Referral Ad Hoc group formed Sept. 2016	Ad Hoc Group	Structural and instructions changes will be exposed by each	Revised <del>12/03</del> 4/23/2023





## MEMORANDUM

TO: Tom Botsko, Chair, and Members of the Capital Adequacy (E) Task Force

FROM: Steve Drutz, Chair, and Members of the Health Risk-Based Capital (E) Working Group

DATE: Dec. 12, 2022

RE: Request for Response for Input Regarding Runoff Companies

At the Summer National Meeting, the Capital Adequacy (E) Task Force requested that the Health Risk-Based Capital (E) Working Group review and discuss the request from the Restructuring Mechanisms (E) Subgroup for input regarding runoff companies. The request was originally sent to the Property and Casualty Risk-Based Capital (E) Working Group. In its response, it suggested that the best course of action is to monitor these companies through state analysis and exam functions.

The Health Risk-Based Capital (E) Working Group discussed both the Restructuring Mechanisms (E) Subgroup and Property and Casualty Risk-Based Capital (E) Working Group letters on its Sept. 9 call. The Health Risk-Based Capital (E) Working Group drafted and requested comments on the following questions from its members, interested state insurance regulators, and interested parties. The Working Group received no comments.

- 1) What is the process for running off a health company? Are there any specific considerations to address for health companies?
- 2) Are there concerns with the functionality of the current health risk-based capital (RBC) formula for a health company in run-off? Are changes needed to the health RBC formula for a runoff company?
- 3) Could a company in run-off trigger the trend test or an excessive growth charge? If so, should the instructions be modified to include an exemption of these calculations if a company is in run-off?
- 4) Are there concerns with handling this process for health companies in the same manner as outlined by the Property and Casualty Risk-Based Capital (E) Working Group?
- 5) The Property and Casualty Risk-Based Capital (E) Working Group defined a runoff company as one that, "voluntary or involuntary, should include the following characteristics: 1) no renewing of policies for at least 12 months; 2) no new direct or new assumed business; and 3) no additional runoff blocks of business. In addition, the amount of renewal premium to reserves has also been identified as a characteristic of these types of companies when this ratio is de minimis."

For health companies, a similar definition could be considered with some modification due to differences in the type of business and distinguish a runoff company from a start-up company or shell. A health runoff company, voluntary or involuntary, should include the following characteristics: 1) no renewing of policies for at least 12 months; 2) no plans or intentions to write new direct or new assumed business; 3) no

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additional runoff blocks of business; and 4) reserves reported for the remaining runoff business.

The health RBC formula sufficiently addresses runoff companies through the underwriting risk component when the RBC charge of a runoff company is reduced as premiums are reduced. The company would still have to maintain a minimum amount of surplus as it continues its run-off. However, as the premiums are reduced, the RBC requirement within the authorized control level (ACL) would also be reduced.

The Working Group agrees with the suggested recommendations of the Property and Casualty Risk-Based Capital (E) Working Group that monitoring these companies would be best accomplished through the state analysis and exam functions.

If a definition of a health runoff company is necessary, the Working Group recommends that it would be defined as one that, “voluntary or involuntarily, should include the following characteristics: 1) no renewing of policies for at least 12 months; 2) no plans or intentions to write new direct or new assumed business; 3) no additional runoff blocks of business; and 4) reserves reported for the remaining runoff business.”

Please contact Crystal Brown, NAIC staff support for the Health Risk-Based Capital (E) Working Group, at [cbrown@naic.org](mailto:cbrown@naic.org) with any questions.





TO: Thomas Botsko, Chair, Capital Adequacy (E) Task Force  
 Rachel Hemphill, Chair, Life Actuarial (A) Task Force  
 Philip Barlow, Chair, Risk-Based Capital Investment Risk and Evaluation (E) Working Group

FROM: Carrie Mears, Chair, Valuation of Securities (E) Task Force

CC: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)  
 Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)  
 Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau  
 Dave Fleming, Sr. Life RBC Analyst, NAIC Financial Regulatory Affairs  
 Jennifer Frasier, Life Examination Actuary, NAIC Financial Regulatory Affairs  
 Scott O’Neal, Life Actuary, NAIC Financial Regulatory Affairs  
 Eva Yeung, Sr. P/C RBC Analyst/Technical Lead, NAIC Financial Regulatory Affairs

RE: Referral regarding a Proposed Purposes and Procedures Manual (P&P Manual) Amendment to Define and Add Guidance for Structured Equity and Funds

DATE: February 3, 2023

**Summary** – The SVO has processed several private letter rating (PLR) filings for investments in notes issued by special purpose vehicles or other legal entities that operate as feeder funds which themselves then invest, directly or indirectly, in one or more funds or other equity investments. The SVO proposes defining these investments as Structured Equity and Fund investments.<sup>1</sup> The SVO proposed at the 2022 Fall National Meeting the removal of Structured Equity and Fund investments from Filing Exemption, the reliance upon a credit rating provider (CRP) ratings for the assignment of NAIC Designations. The SVO is concerned about this general structure for the following reasons:

<sup>1</sup> Proposed Definition: A Structured Equity and Fund investment is a note issued by, or equity or limited partnership interest in, a special purpose vehicle, trust, limited liability company, limited partnership, or other legal entity type, as issuer, the contractually promised payments of which are wholly dependent, directly or indirectly, upon payments or distributions from one or more underlying equity or fund investments. The inclusion of an intervening legal entity or entities between the Structured Equity and Fund investment issuer and the underlying equity or fund(s), does not change the risk that the insurer investment is ultimately dependent, in whole or in part, upon an investment in equity or one or more funds and its underlying investments. Any design that circumvents this definition, and related examples, through technical means but which in substance achieves the same ends or poses the same risk, shall be deemed a Structured Equity and Fund.

- 1) Circumvent Regulatory Guidance - The introduction of an intervening entity as debt issuer, when the underlying investment is in substance an equity investment, circumvents regulatory guidance established by the Valuation of Securities (E) Task Force, the Statutory Accounting Principles (E) Working Group and the Capital Adequacy (E) Task Force for the reporting of equity investments because, according to the P&P Manual (i) equity and fund investments are ineligible to use credit rating provider (CRP) ratings in the assignment of an NAIC Designation and (ii), in the case of funds, only the SVO is tasked with determining whether a fund produces fixed-income like cash flows and is therefore eligible for specific classification.

**All non-SEC registered funds are required to be reported on Schedule BA. Life insurance entities are permitted to file investments in non-SEC registered private equity funds, partnerships, limited liability companies and joint ventures with the SVO for specific classification on Schedule BA;**

- 2) Reliance on Ratings - These investments are being reported as bonds and receiving bond risk-based capital (RBC) factors based upon the mechanical assignment of NAIC Designations that rely upon CRP ratings through the filing exempt process. The use of CRP ratings would not be permitted for the fund or equity investments which underly these notes if the equity or fund investments were held directly;
- 3) RBC / Investment Limit Arbitrage - The structure may permit in-substance equity and fund investments to obtain better RBC treatment than would otherwise be received if the investments had been directly reported. In addition to improved RBC treatment, the structures could permit entities to hold more underlying equity / fund investments than would be permitted under state investment law; and
- 4) Transparency - The structures typically use two or more interconnected private entities through which the privately rated “bond” securities are issued that are backed by investments in non-public assets. The many non-public layers deny regulators, and possibly insurer investors, transparency into the true underlying risks, credit exposure and nature of the investment. The notes issued are described generically as a “senior note” or “term loan” further obscuring their actual structure and complexity. These structures can invest in any asset including affiliate investments, non-fixed income investments, derivatives, borrowings for the purpose of leverage and non-admitted assets.

It is possible that many of the transactions the SVO has processed would not qualify as bonds eligible for Schedule D-1 reporting according to the principles-based bond definition currently being drafted by the Statutory Accounting Principles (E) Working Group, while others likely will qualify. The bond definition requires a review of the substance of the investment to determine whether it has the substance of a bond; significantly, that the ultimate underlying collateral has fixed income cash flows. In either case, however, the use of a fund intermediary has the potential to be abused and requires significant judgment to understand the substance and nature of the ultimate underlying risk. This has already been recognized by the establishment of processes for the SVO to provide NAIC Designations for fixed-income-like funds. It would then follow that debt instruments backed by the types of funds that would ordinarily be required to be filed with the SVO, should follow the same process.

**Informational Referral** – Given the magnitude of the multiple regulatory arbitrage opportunities, the judgment involved in assessing the nature of the ultimate risk, the lack of transparency, circumvention of regulatory guidance and the reliance on CRP ratings to accomplish these ends, the SVO proposed amending the P&P Manual to include a definition for Structured Equity and Fund and to exclude such investments from Filing Exemption eligibility. The proposed amendment would not change how the investment is classified for reporting by the insurer but it would ensure that the NAIC Designation and Category assigned are appropriate for the risk. This is an informational referral and no direct action is required by the Capital Adequacy (E) Task Force, Life Actuarial (A) Task Force or Risk-based Capital Investment Risk and Evaluation (E) Working Group unless those groups wish to comment on the proposal.

Please contact Charles Therriault or Marc Perlman with any questions.

<https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2023/Referrals/To CATF LATF RBCIRE/VOSTF Referral to CATF LATF RBCIRE - Structured Equity and Funds 2022-02-03.docx>



TO: Elizabeth Kelleher Dwyer, Chair, Financial Conditions (E) Committee  
 Marlene Caride, Chair, Financial Stability (E) Task Force  
 Bob Kasinow, Chair, Macroprudential (E) Working Group  
 Thomas Botsko, Chair, Capital Adequacy (E) Task Force  
 Phillip Barlow, Chair, Risk-Based Capital Investment Risk and Evaluation (E) Working Group  
 Cassie Brown, Chair, Life Actuarial (A) Task Force  
 Judy Weaver, Chair, Financial Analysis (E) Working Group  
 Dale Bruggeman, Chair, Statutory Accounting Principles (E) Working Group  
 Fred Andersen, Chair, Valuation Analysis (E) Working Group

FROM: Carrie Mears, Chair, Valuation of Securities (E) Task Force

CC: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)  
 Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau  
 Dan Daveline, Director, NAIC Financial Regulatory Services  
 Todd Sells, Director, NAIC Financial Regulatory Policy & Data  
 Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)  
 Julie Gann, Assistant Director, NAIC Solvency Policy  
 Bruce Jenson, Assistant Director, NAIC Solvency Monitoring  
 Pat Allison, Managing Life Actuary, NAIC Financial Regulatory Affairs  
 Jane Koenigsman, Sr. Manager II, NAIC L/H Financial Analysis  
 Andy Daleo, Sr. Manager I, NAIC P/C Domestic and International Analysis  
 Dave Fleming, Sr. Life RBC Analyst, NAIC Financial Regulatory Affairs  
 Jennifer Frasier, Life Examination Actuary, NAIC Financial Regulatory Affairs  
 Scott O'Neal, Life Actuary, NAIC Financial Regulatory Affairs  
 Eva Yeung, Sr. P/C RBC Analyst/Technical Lead, NAIC Financial Regulatory Affairs

RE: Referral on Additional Market and Analytical Information for Bond Investments

DATE: February 13, 2023

**Summary** – The Investment Analysis Office (IAO) staff recommended in its Feb. 25, 2022, memorandum to the Valuation of Securities (E) Task Force (VOSTF) (attached hereto, Blanks Market Data Disclosure v2.pdf) that it would like additional market-data fields added to the annual statement instructions for bond investments. This was, in part, based upon the NAIC's adoption in 2010 of the recommendations of

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the Rating Agency (E) Working Group (RAWG), which was formed following the Great Financial Crisis of 2007-2008 to study the NAIC's reliance on rating agencies, and the IAO staff's recent findings in its Nov. 2021 memo regarding disparities between rating agencies. RAWG recommended that: 1) regulators explore how reliance on rating agencies can be reduced when evaluating new, structured, or alternative asset classes, particularly by introducing additional or alternative ways to measure risk; and 2) consider alternatives for regulators' assessment of insurers' investment risk, including expanding the role of the NAIC Securities Valuation Office ("SVO"); and 3) VOSTF should continue to develop independent analytical processes to assess investment risks. These mechanisms can be tailored to address unique regulatory concerns and should be developed for use either as supplements or alternatives to ratings, depending on the specific regulatory process under consideration.

The NAIC's need for alternative measures of investment risk has only increased since RAWG made its recommendations, as privately issued and rated complex structured finance transactions have become commonplace without adequate ways of identifying them. The SVO recommended the following market data fields to be added to the annual statement instructions: Market Yield, Market Price, Purchase Yield, Weighted Average Life, Spread to Average Life UST, Option Adjusted Spread, Effective Duration, Convexity and VISION Issue ID. Please refer to the attached memo for more detail on each data field.

In comments received from industry there were question as to how the SVO, VOSTF and/or other regulators who would receive the analytic data included in the proposal would utilize that information and why it is of value to them. The SVO was also asked to consider industry's recommendation that the NAIC be responsible for calculating this analytical information by utilizing commercially available data sources and investment models instead of having each individual insurance company incur the costs to implement system changes. The SVO shared their thoughts on the alternatives in the Jul. 14, 2022, memorandum to the VOSTF (attached, Blanks\_Market\_Data\_Options\_v3.pdf).

Capabilities like this within the SVO would permit it to calculate for regulators all the analytic values previously mentioned for any Schedule D investment along with additional measures such as key rate duration (a measure of interest rate sensitivity to maturity points along the yield curve), sensitivity to interest rate volatility, principal and interest cash flow projections for any security or portfolio for any given interest rate projection, loss estimates for any security for any given scenario and many others measures.

**Referral** – VOSTF refers this matter to the above referenced Committees, Task Forces and Working Groups for consideration and requests a response from you by May 15<sup>th</sup> outlining:

1. Indicate if your group is supportive of creating this capability within the SVO.
2. List the investment analytical measures and projections that would be most helpful to support the work performed by your respective group.
3. Describe how your group would utilize the data and why it would be of value.
4. Are there other investment data or projection capabilities that would be useful to your group that could be provided by commercially available data sources or investment models? And if so, please list them.
5. Any other thoughts you may have on this initiative.

Please contact Charles Therriault or Marc Perlman with any questions.

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

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

**FINANCIAL STABILITY (E) TASK FORCE**

Financial Stability (E) Task Force March 22, 2023, Minutes.....	9-507
Plan for the List of 13 Considerations – Private Equity (PE) Related and Other (Attachment One) .....	9-513
Macroprudential (E) Working Group Referral to the Reinsurance (E) Task Force (Attachment Two) .....	9-522
NAIC – Reinsurance Comparison Worksheet, Dec. 5, 2022 (Attachment Three).....	9-524
Valuation Analysis (E) Working Group Memorandum to the Financial Stability (E) Task Force (Attachment Four) .....	9-528

Draft: 4/3/23

Financial Stability (E) Task Force  
and the Macroprudential (E) Working Group  
Louisville, Kentucky  
March 22, 2023

The Financial Stability (E) Task Force met in Louisville, KY, March 22, 2023, in joint session with the Macroprudential (E) Working Group. The following Task Force members participated: Marlene Caride, Chair (NJ); Nathan Houdek, Vice Chair (WI); Alan McClain represented by Leo Liu (AR); Ricardo Lara represented by Susan Bernard (CA); Andrew N. Mais represented by Michael Shanahan (CT); Karima M. Woods represented by Philip Barlow (DC); Michael Yaworsky represented by Carolyn Morgan (FL); Amy L. Beard represented by Roy Eft (IN); Doug Ommen represented by Carrie Mears (IA); Vicki Schmidt represented by Tish Becker (KS); Gary D. Anderson represented by Debra Kaplan (MA); Kathleen A. Birrane represented by Lynn Beckner (MD); Timothy N. Schott (ME); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by John Rehagen (MO); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Lindsay Crawford (NE); Adrienne A. Harris represented by Bob Kasinow (NY); Judith L. French represented by Dale Bruggeman (OH); Glen Mulready represented by Eli Snowbarger (OK); Andrew R. Stolfi represented by Doug Hartz (OR); Michael Humphreys represented by Diana Sherman (PA); Elizabeth Kelleher Dwyer represented by Ted Hurley (RI); Michael Wise represented by Tom Baldwin (SC); Cassie Brown represented by Jamie Walker (TX); and Scott A. White (VA). The following Working Group members participated: Bob Kasinow, Chair (NY); Carrie Mears, Vice Chair (IA); Susan Bernard (CA); Michael Shanahan (CT); Philip Barlow (DC); Tom Hudson (DE); Ray Spudeck (FL); Roy Eft (IN); Timothy N. Schott (ME); Lynn Beckner (MD); John Turchi (MA); Steve Mayhew (MI); Fred Andersen (MN); John Rehagen (MO); David Wolf (NJ); Doug Hartz (OR); Diana Sherman (PA); Ted Hurley (RI); Jamie Walker (TX); Greg Chew (VA); and Amy Malm (WI). Also participating was: Mark Fowler (AL).

1. Heard Opening Remarks

Commissioner Caride said materials for consideration and discussion for this meeting are available on the NAIC website in the Committees section under the Financial Condition (E) Committee.

2. Adopted the Task Force’s Fall National Meeting Minutes

Eft made a motion, seconded by Obusek, to adopt the Task Force’s Dec. 13, 2022, minutes (*see NAIC Proceedings – Fall 2022, Financial Stability (E) Task Force*). The motion passed unanimously.

3. Heard an Update on FSOC Developments

Commissioner Caride reported on a few Financial Stability Oversight Council (FSOC) discussions identified publicly that are most directly related to the NAIC’s work because Superintendent Dwyer was unable to attend:

- The FSOC continues to be focused on climate risk, the digital asset space, hedge funds, Treasury market resilience, and cloud service providers (CSPs).
- The FSOC formed a new staff-level committee, called the Climate-Related Financial Risk Committee (CFRC), with representation from all 15 FSOC members. The CFRC began meeting regularly in February 2022, and it serves as an active forum for interagency information-sharing, coordination, and capacity-building. The NAIC, as one of the 15 members, continues its leading role in assessing climate-related risks in the insurance sector and weighing in on any discussion or effort that might affect state insurance regulators, insurers, or policyholders.



- The FSOC established the Climate-Related Financial Risk Advisory Committee (CFRAC) on Oct. 3, 2022, which includes stakeholders from a wide range of backgrounds such as the financial services industry, non-governmental research institutions, climate-related data and analytics providers, non-profit organizations, and academia.
- The CFRAC’s goal is to leverage members’ climate data and analytical expertise to support the CFRC’s efforts to translate climate-related risks into economic and financial impacts. The CFRAC is up and running; it held its first meeting on March 7, and it is now in the process of prioritizing its charges.
- President Joe Biden’s Executive Order on climate-related financial risks also directed the Office of Financial Research (OFR) to assist the U.S. Secretary of the Treasury and the FSOC to identify and assess climate-related financial stability risk. The OFR is setting up a climate data and analytics hub with climate data most likely being obtained through federal governmental agencies.
- The OFR hub will also provide tools to access and analyze the datasets included. The rollout of this data hub is in the process of beginning with user acceptance testing with the goal of providing access to all FSOC members, including the NAIC, later this year.
- In February, the FSOC also received a briefing on a Treasury report assessing the benefits and challenges of CSP’s use in the financial sector. The Treasury report includes a number of recommendations for financial institutions and financial regulators to consider closing data gaps to better understand regulated entities’ linkages to CSPs. As more processes are moved to the cloud, and with a relatively small number of CSPs dominating the market, understanding how an outage or disruption at a particular provider could affect customers should be a priority for state insurance regulators.
- The FSOC also discussed the existing process and guidance for designating non-bank financial companies for enhanced supervision, which is of great interest to the NAIC, given the prior use of the authority to designate American International Group Inc. (AIG), MetLife, and Prudential.
- The FSOC also convened over the weekend of March 12 to discuss the rapid collapse of Silicon Valley Bank and Signature Bank and actions taken to restore confidence in the banking sector. The insurance sector experienced only a minimal impact from the two banks’ failures, with less than \$2 billion in investments and deposits across both banks. Total insurer deposits at both banks amounted to roughly \$200 million, and the bridge banks created to assume the obligations of Silicon Valley Bank and Signature Bank will continue to meet insurer, and by extension, policyholder commitments.

#### 4. Received a Working Group Update

Kasinow said the Working Group revitalized its Counterparty Exposure Initiative, which is the identification and aggregation of interconnected exposures that will help state insurance regulators identify risk both to and from other financial sectors. He added that the Counterparty Exposure Initiative was one of the original four macroprudential initiatives started in 2017 to assess the NAIC’s reporting structure, aggregate data and analysis, and determine if any reporting and/or disclosure gaps exist. He said NAIC staff are working on identifying and aggregating all counterparty exposure data within the current investment schedules and annual statements, as well as conducting a thorough academic literature review on the topic of counterparty risk assessment to assist methodology development and better understand the uniqueness of counterparty credit risk in the insurance market. He concluded that the Counterparty Exposure Initiative dovetails nicely with the Risk Assessment framework, and it will assist state insurance regulators in assessing interconnectedness risk and credit risk.

Kasinow reported that with respect to the liquidity stress test (LST), Working Group members agreed to ask lead states to follow up with their insurers subject to the LST regarding the impact on liquidity from the significant increase in interest rates in 2022. He added that the primary objective was to determine if interest rate increase assumptions used in the insurer’s LST scenarios in last year’s June 30 filings were large enough compared to actual increases in 2022, and for that purpose:

- NAIC staff developed a back-testing questionnaire that was used by the states to collect data from their LST eligible insurers, and responses were then submitted by the states to the NAIC and summarized by NAIC staff.
- One key objective was to understand if potential asset sales that were reported in the LST scenarios materialized or differed from actual experience in 2022.
- Overall, the actual asset sales in 2022 from back-testing questionnaire respondents were comparable to their June 30, 2022, LST submissions.
- Insurers were also asked to determine how the rise in interest rates may have affected the value and availability of assets for sale, as well as collateral calls on derivative contracts.
- Insurers reported a decrease in market values and an increase in unrealized losses in their bond portfolios due to a large increase in interest rates, but not to a degree to materially affect their liquidity profile.
- Insurers reported little to no impact on their liquidity profile due to collateral posting on derivative contracts.
- While some insurers reported additional collateral requirements for interest rate hedges, most respondents had other derivative hedges, whereby they were on the receiving end of additional collateral (e.g., equity and foreign exchange hedges). Therefore, due to collateral netting agreements, net collateral pledged, if any, was minimal.

Kasinow reported that the 2022 Liquidity Stress Testing Framework (LST Framework) with lead state guidance has been finalized and posted to the Task Force's web page, which was later due to Moody's Investors Service's (Moody's) delayed publishing of its default tables, which is included in the Annexes of the LST Framework.

Kasinow referred to an update on the referrals of the Working Group's list of 13 private equity (PE) and related considerations (Attachment One), and he only summarized reinsurance that remained with the Working Group:

- The Working Group met Jan. 18, Feb. 23, and Feb. 27 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings.
- On Jan. 18, the Working Group met with the Cayman Islands Monetary Authority (CIMA) to discuss its regulatory regime.
- On Feb. 23, the Working Group met with the Bermuda Monetary Authority (BMA) to hear an overview of its recently released public consultation on proposed enhancements to its regulatory regime, with comments by interested parties due April 30.
- On Feb. 27, the Working Group discussed a reinsurance comparison worksheet designed for state insurance regulators to assess cross-border reinsurance treaties where there are different regulatory systems involved, which will enhance state insurance regulators' ability to monitor these transactions.

Kasinow concluded that the Working Group would appreciate any feedback from interested parties, and he requested that the Task Force expose the cross-border reinsurance worksheet. Rehagen requested that the Working Group keep the Reinsurance (E) Task Force informed with respect to its work. Mears suggested that the worksheet be sent as a referral to the Reinsurance (E) Task Force.

Rehagen made a motion, seconded by Mears, to send a referral (Attachment Two) to the Reinsurance (E) Task Force and expose the cross-border reinsurance worksheet (Attachment Three) for a 30-day public comment period. The motion passed unanimously.

##### 5. Received a Valuation Analysis (E) Working Group Update

Andersen reported that starting in 2019, the Valuation Analysis (E) Working Group began a continued effort to address a request from the Task Force to assess a potential concern that the American Academy of Actuaries'

(Academy's) economic scenario generator (ESG) may not adequately consider a very low or negative interest rate environment, which raises a material risk at the macroprudential level in the U.S., particularly for variable annuities. He added that during the interim period, until a new ESG is in place, the Working Group was asked to assess this concern and provide assurance that any issues have either been addressed or will be able to be addressed.

Andersen said the Working Group's most recent effort to address this request was a stress test to assess the impact of persistently low interest rates on variable annuity reserves and risk-based capital (RBC), which used a modified set of scenarios, including many interest rate scenarios that sustained low rates for much of the projection period. He added that the stress test scenarios were used to calculate reserves and RBC as of year-end 2021, and the results were compared to a baseline of reported reserves and RBC.

Andersen summarized the results:

- Twenty-four companies completed the stress test. In total, the guaranteed benefit reserves on a pre-reinsurance basis increased by 6%, and RBC increased by 24%.
- To address the risk of prolonged low interest rates, the Working Group found that many companies have already taken action and are also considering future actions for the near term, including performing testing, additional analysis, implementing product changes, or adjusting hedging.

Andersen reported that the implementation of a new ESG is in progress:

- The Life Actuarial (A) Task Force has conducted an industry field test, and the results are being reviewed. There is an expectation of recalibrating the ESG for a second field test, and implementation is anticipated to be no sooner than 2025.
- In the interim, the Working Group can look to those field tests as a way to monitor the impacts of negative and prolonged low interest rates.
- The change in the guaranteed benefit reserve on a pre-reinsurance basis ranged from approximately a 75% decrease to a 500% increase, for an overall average of a 6% increase.
- The change in RBC ranged from approximately a 100% decrease to a 250% increase, for an overall average of a 24% increase.

Andersen reported that insurers provided comments to explain their results:

- Most companies used the Academy's ESG for their baseline, so the stress test scenarios generally had lower interest rates, leading to an increase in the reserves and RBC.
- Some companies used a proprietary ESG for their baseline and noted that the stress test scenarios were less conservative than their baseline scenarios.
- More scenario reserves exceeded the cash surrender value (CSV) floor.
- There were equity scenarios in the stress test that offset some of the lower interest rate effects.
- Hedging generally improved results.

Andersen reported that to address low interest rates in 2021, many insurers took at least one of the following actions for their variable annuity block of business:

- Performed additional testing and analysis.
- Made efforts to adjust the sales mix.
- Redesigned the products for new business.
- Repriced for new business.

- Discontinued products.
- Adjusted hedging.
- Added or amended reinsurance.

Becker made a motion, seconded by Obusek, to receive the Valuation Analysis (E) Working Group update (Attachment Four). The motion passed unanimously.

#### 6. Heard an International Update

Tim Nauheimer (NAIC) reported that the International Association of Insurance Supervisors (IAIS) has launched the Global Monitoring Exercise (GME), which involves:

- Data calls in connection with the individual insurer monitoring (IIM) and the sector-wide monitoring (SWM) exercises.
- The deadline for insurers to submit IIM data to the IAIS in coordination with the Federal Insurance Office (FIO) is May 10.
- Lead state regulators may wish to request a copy of the insurer's submission to the IAIS.
- This year's IIM and SWM include an additional request for data on reinsurance and climate.
- Climate data was added to the IIM, because of a lack of SWM data outside the U.S.

Nauheimer stressed that the NAIC continues to highlight to the IAIS the need to strike a balance with respect to the burden for insurers and supervisors by removing data items that do not provide sufficient value and limiting additional data requests that are more closely tied to specific objectives. He added that the IAIS has started the work on potential revisions of the IIM systemic risk assessment methodology, which will be completed this year as part of a three-year cycle.

Nauheimer reported that the Climate Risk Steering Group (CRSG) has completed its research and recommendations on data and scenario analysis to be considered this year as part of the GME:

- The IAIS continues to attempt to gauge transition risk in insurers' investment portfolios by requesting investment data in six climate categories, as outlined in the 2021 Global Insurance Market Report (GIMAR) Special Topic Edition on investments.
- The NAIC has the ability to apply the six-category classification system to corporate bonds and stocks, and is in the process of applying it to other asset classes, such as municipal bonds, U.S. Treasuries and Government agency bonds, real estate, and mortgages.
- Last year, the IAIS requested the six-category split as part of the SWM, and it is being requested for the first time this year as part of the IIM.
- The CRSG will also be drafting an Application Paper providing guidance for applying scenario analysis within the context of the Insurance Core Principle (ICP) 16 on enterprise risk management (ERM) and ICP 24 on macroprudential supervision.

Nauheimer said the IAIS has completed the GIMAR Special Topic on Cyber, which includes both resilience and underwriting data from both the IIM and SWM. He added that the Macroprudential Supervision Working Group (MSWG) has organized into three separate working groups that cover the following topics: cross-border reinsurance, allocation of alternative assets, as well as interest rates and inflation. The MSWG made recommendations for additional data requests for the GME that include Level 3 assets and cross-border reinsurance activity and will analyze these topics going forward.

## 7. Discussed Other Matters

Commissioner Caride said the NAIC and state insurance regulators are closely monitoring developments in the banking sector subsequent to the takeover of Silicon Valley Bank and Signature Bank:

- U.S. insurance industry investment and deposit exposure to Silicon Valley Bank and Signature Bank is relatively small, and the NAIC does not expect an adverse impact on policyholders.
- The U.S. insurance sector remains well capitalized, but state insurance regulators and companies must remain vigilant as the situation develops, including any contagion effects in the banking sector.
- The IAIS monitors overall exposure to the banking sector as part of its SWM and the NAIC as part of its macroprudential risk assessment process.
- The Counterparty Exposure Initiative, which was already underway prior to these events, will also enhance the NAIC's supervisory oversight of financial sector-related exposure.
- The impact of rising interest rates, which led to the problems at Silicon Valley Bank, is being closely monitored through the NAIC's regulatory reporting system and actuarial analysis requirements.
- The Federal Reserve Board enacted a quarter percentage point interest rate increase today.
- The LST Framework is one example of how state insurance regulators assess liquidity scenarios similar to the scenario that played out with Silicon Valley Bank.

Commissioner Caride noted that state insurance regulators have a few other tools and requirements, such as cash flow testing, asset adequacy analysis, and actuarial guidelines to assess the adequacy of life reserves. She said state insurance regulators expect companies to continually assess their risks and proactively raise concerns with their domestic regulator. She stressed that state insurance regulators must carefully monitor any vulnerabilities of the insurance market and insurers.

Having no further business, the Financial Stability (E) Task Force and Macroprudential (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/2023 Spring National Meeting/

## Plan for the List of MWG Considerations – PE Related and Other

Some of these Working Group projects will continue for several years. The status of the 13 MWG Considerations is as follows as of **March 22, 2023**:

1. Holding Company Structures:

Sent a referral for new work to the Group Solvency Issues (E) Working Group.

**GSIWG Update:** *The GSIWG plans to discuss this issue at its Dec. 14 meeting to determine next steps in addressing the referral.*

2. Ownership and Control:

Sent a referral for new work to the Group Solvency Issues (E) Working Group.

**GSIWG Update:** *The GSIWG plans to discuss this issue at its Dec. 14 meeting to determine next steps in addressing the referral.*

3. Investment Management Agreements (IMAs):

Sent a referral to the Risk-Focused Surveillance (E) Working Group to add this consideration to existing work involving affiliated agreements and Form D filings. Also sent a referral to the Valuation of Securities (E) Task Force (VOSTF) to highlight the regulatory discussion involving topics it administers.

**RFSWG Update:** *The RFSWG received and discussed this referral during its Nov. 1 interim meeting. During the meeting, the RFSWG agreed to defer further work on this issue until its ongoing project to update general guidance in NAIC handbooks related to affiliated service agreements is completed in early 2023.*

4. Owners of Insurers with Short-Term Focus and/or Unwilling to Support a Troubled Insurer:

Sent a referral to the Risk-Focused Surveillance (E) Working Group to add this consideration to existing work involving affiliated agreements and fees. Also sent a referral to the Life Actuarial (A) Task Force recognizing its existing work to ensure the long-term life liabilities (reserves) and future fees to be paid out of the insurer are supported by appropriately modeled assets.

**RFSWG Update:** *The RFSWG received and discussed this referral during its Nov. 1 interim meeting. During the meeting, the RFSWG agreed to defer further work on this issue until its ongoing project to update general guidance in NAIC handbooks related to affiliated service agreements is completed in early 2023.*

**LATF Update:** *Asset adequacy analysis requirements in NAIC Model #820 and VM-30 require that company Appointed Actuaries perform testing to ensure that the reserves held for the company's liabilities are adequate in light of the assets supporting the business. Regulators review associated company Statements of Actuarial Opinion periodically.*

5. Operational, Governance and Market Conduct Practices:

The MWG will keep developing more specific suggestions before likely referring this consideration to the Risk-Focused Surveillance (E) Working Group.

**MWG Update:** *No new action has occurred for this consideration as the regulators have focused on the reinsurance consideration.*

6. Definition of Private Equity (PE):

No action was deemed necessary for this consideration.

**No update.**

7. Identifying Related Party-Originated Investments (Including Structured Securities):

Sent a referral to the Statutory Accounting Principles (E) Working (SAPWG) Group recognizing its existing work regarding disclosures for related-party issuance/acquisition. Once MWG regulators work with these SAPWG disclosures and regulatory enhancements from referrals to other groups, further regulatory guidance may be considered as needed.

**SAPWG Completed Actions:**

- *Ref #2021-21 included revisions that clarified guidance for related parties and developed a blanks proposal which provided new investment schedule column with reporting codes to identify investments that involve related parties. (Adopted May 2022)*

- *Ref #2021-22BWG added six related party reporting codes effective for year-end 2022. The investment schedule disclosures include codes that identify the role of the related party in the investment, e.g., a code to identify direct credit exposure as well as codes for relationships in securitizations or similar investments. (Adopted May 2022)*



8. Identifying Underlying Affiliated/Related Party Investments and/or Collateral in Structured Securities:

Sent a referral to the Statutory Accounting Principles (E) Working Group in recognition of existing work to develop disclosures to identify the role of the related party in the investment and codes for relationships in securitizations or similar investment. Also sent a referral for new work to the Examination Oversight (E) Task Force for the CLO/structured security considerations.

**SAPWG Completed Actions:**

- *See above descriptions (Ref # 2021-21 and Ref #2021-22 BWG) on investment reporting codes for year end 2022 reporting.*
- *Ref #2019-34 included revisions that clarify: 1) identification of related parties; 2) a non-controlling ownership over 10% results in a related party classification regardless of any disclaimer of control or affiliation; 3) a disclaimer of control or affiliation does not eliminate the classification as a “related party” and the disclosure of material transactions. This agenda item also resulted in the creation of a new Schedule Y Part 3, which was effective for year-end 2021. This schedule identifies all entities with greater than 10% ownership – regardless of any disclaimer of affiliation - and whether there is a disclaimer of control/disclaimer of affiliation and identifies the ultimate controlling party. (Ref #2019-34 and Ref #2020-37BWG, both adopted March 2021)*

**EOTF Update:** *The EOTF delegated work on this referral to its Financial Analysis Solvency Tools (E) Working Group and its Financial Examiners Handbook (E) Technical Group. Both groups developed new guidance for inclusion in 2023 NAIC handbooks related to the new related party investment disclosures developed by SAPWG and the AG 53 standards developed by LATF that will be in place for 12/31/22 reporting. The groups may develop additional guidance for NAIC handbooks, as well as supporting regulatory reports and tools, as work proceeds in this area.*

9. Asset Manager Affiliates and Disclaimers of Affiliation:

MWG regulators are comfortable waiting to realize the benefits of the recently implemented Schedule Y, Part 3, along with the changes other NAIC committee groups will make for several of the previously listed referrals, before determining if additional work is needed. Also, a referral was sent to the Statutory Accounting Principles (E) Working Group recognizing its existing work to

revamp Schedule D reporting along with the previously mentioned code disclosures will assist with this consideration.

**SAPWG Completed Actions:**

- See above descriptions of Schedule Y Part 3. (Ref #2019-34 and Ref #2020-37BWG).

**SAPWG Ongoing Work:**

- Ref #2022-15, which clarifies affiliated investment reporting, is planned for adoption consideration at the Spring National Meeting . It adds guidance on reporting of affiliated investments.
- As part of a project known as the bond project, the SAPWG is developing a proposal to revise Schedule D reporting, which intends to determine what is considered a qualifying bond and to identify different types of investments more clearly. For example, the current bond proposal would divide Schedule D-1 into a Schedule D-1-1 for issuer credit obligations and a Schedule D-1-2 for asset-backed securities. The proposal includes more detailed reporting lines to provide more granularity on the actual types of investments held. The effective date of the bond proposal, and the reporting changes, is anticipated for January 1, 2025. Reporting changes to reflect the Schedule D-1 proposed changes were exposed by the Blanks (E) Working Group on March 7, 2023. Updated revisions to the statutory accounting guidance are planned for exposure by the Statutory Accounting Principles (E) Working Group at the 2023 Spring National Meeting.
- Ref #2022-17, which clarifies interest income disclosures, is planned for adoption consideration at the Spring National Meeting.

10. Privately Structured Securities:

Sent a referral to the Life Actuarial (A) Task Force recognizing its existing work on an Actuarial Guideline including disclosure requirements for the risks of privately structured securities and how the insurer is modeling the risks. Sent a referral to the VOSTF highlighting the MWG regulators' support for the blanks proposal to add market data fields for private securities being considered by the Valuation of Securities (E) Task Force (VOSTF). MWG regulators will wait on any further work or referrals until they have an opportunity to work with the results of the VOSTF proposal and the SAPWG Schedule D revamp project. Sent a referral for new work to the RBC

Investment Risk and Evaluation (E) Working Group to address the tail risk concerns not captured by reserves.

**LATF Update:** *Actuarial Guideline 53 (AG 53) has been adopted by the NAIC’s Executive (EX) Committee and Plenary and was effective for year-end 2022 reporting. Starting in Spring 2023, regulators on the Valuation Analysis (E) Working Group will be conducting AG 53 reviews. This will involve a targeted review of asset adequacy analysis related to modeling of business supported with projected high net yield assets.*

**VOSTF Update:** The VOSTF sent referrals to the Financial Condition (E) Committee, Financial Stability (E) Task Force, Macroprudential (E) Working Group, Capital Adequacy (E) Task Force, Risk-Based Capital Investment Risk and Evaluation (E) Working Group, Life Actuarial (A) Task Force, Financial Analysis (E) Working Group, Statutory Accounting Principles (E) Working Group and Valuation Analysis (E) Working Group requesting feedback on a proposal to have the NAIC’s SVO develop the analytical capability to produce risk metrics for bond investments, and model measures of interest rate sensitivity and project investment cash flows and estimated losses for any given interest rate or economic scenario for regulator use. These groups were asked if they support the proposal and to describe different ways they envision being able to take advantage of such a capability within the NAIC.

**SAPWG Ongoing Work:**

- *As discussed above, the Schedule D bond proposal is planned for 2025 reporting.*

**RBCIREWG Update:** *The Risk-Based Capital Investment Risk and Evaluation (E) Working Group added this item to its working agenda. While not specifically addressing privately structured securities, the Working Group’s current work on collateralized loan obligations may contribute to addressing this item.*

11. Reliance on Rating Agencies:

Sent a referral to the VOSTF indicating the MWG regulators’ agreement to monitor the work of its ad hoc group addressing various rating agency considerations.

**VOSTF Update:**

- The Task Force adopted an amendment at its Feb. 21 meeting that effective Jan. 1, 2024, financially modeled collateralized loan obligations (CLO) will not be eligible to use credit rating provider ratings to determine an NAIC Designation.
- The Task Force has drafted a list of questions to discuss with each rating agency in future regulatory-only meetings. The questions are in the materials for the Spring National Meeting and will likely be exposed for public comment.
- The Securities Valuation Office (SVO) has proposed an amendment to remove Structured Equity and Funds transactions from being eligible to use credit rating provider (CRP) ratings to assign an NAIC Designation. The SVO has proposed defining Structured Equity and Funds investments as investments which, through the insertion of an intervening entity such as a special purpose vehicle (SPV) or limited partnership, enable underlying assets that may not qualify as ‘bonds’ or be eligible to receive an NAIC Designation under the current regulatory guidance, to be reported as ‘bonds’ because the intervening entity issues notes and those notes receive a credit rating provider rating. The SVO identified multiple regulatory reporting arbitrage opportunities with these investments that circumvent regulatory guidance using a CRP rating to accomplish that result.
- The Task Force adopted a new charge for 2023 to establish criteria to permit staff’s discretion over the assignment of NAIC designations for securities subject to the FE process (the use of CRP ratings to determine an NAIC designation) to ensure greater consistency, uniformity, and appropriateness to achieve the NAIC’s financial solvency objectives. The criteria have not yet been proposed.

12. Pension Risk Transfer (PRT) Business Supported by Complex Investments.a. LATF’s Actuarial Guideline:

Sent a referral to the LATF recognizing its work on an Actuarial Guideline which should address the reserve considerations of pension risk transfer (PRT) business. Sent a referral to the SAPWG to address the related disclosure considerations as the goal was to have them in the Notes to Financial Statements.

**LATF Update:** *The PRT Drafting Group of the VM-22 SG is considering the development of PRT/longevity risk mortality factors. The DG hopes to share data with the Longevity Risk*

*Subgroup of LATF that the Subgroup could consider for C-2 RBC for PRT products and longevity risk transactions.*

**SAPWG Completed Actions:**

- *Ref #2020-37: Separate Account – Product Identifiers and Ref #2020-38: Pension Risk Transfer - Separate Account Disclosure, which did not result in statutory accounting revisions but instead resulted in modifications to the reporting of PRT transactions in the annual financial statements, was adopted by the SAPWG May 2021. Ref #2021-03BWG was adopted by Blanks (E) Working Group in 2021.*

**Comment** – *The 2022 review of the initial 2021 disclosures noted that although the instructions were clarified to require by product reporting including the use of a distinct disaggregated product identifier for each product represented; most entities are still broadly grouping PRT activity in the disclosures. Review of 2022 data is planned to be completed in the first half of 2023.*

b. Department of Labor Protections:

**MWG Update:** *NAIC staff are continuing to hold discussions with Department of Labor representatives.*

c. State Guaranty Funds Compared to PBGC Protection – NOLHGA 2016 Study:

No further action was deemed necessary.

**MWG Update:** *However, NAIC staff have contacted PBGC representatives to inquire if they have any items they wish to address with the MWG.*

d. RBC Treatment of PRT Business:

Sent a referral to the Longevity Risk (E/A) Subgroup recognizing its work will also address PRT business and indicating the MWG regulators will monitor this work.

**LATF Update:** *The Longevity Risk (E/A) Subgroup will review the currently exposed VM-22 PBR methodology once it is finalized and adopted. The Subgroup will consider whether to develop and recommend longevity risk factor(s) for the product(s) that were excluded from the application of the current longevity risk factors.*

13. Offshore/Complex Reinsurance:

**MWG Update:** *MWG regulators are wrapping up the confidential discussions with industry participants and other jurisdictions regarding the use of offshore reinsurers and complex affiliated reinsurance vehicles. They are continuing discussions to identify the best mechanism to ensure reviewing/approving regulators can identify the true economic impacts of the reinsurance transaction. MWG regulators will consider further work and/or referrals once they have concluded these discussions.*



**To:** Chlora Lindley-Myers, Chair of the NAIC Reinsurance (E) Task Force and  
Adrienne A. Harris, Vice Chair of the NAIC Reinsurance (E) Task Force

**From:** Marlene Caride, Commissioner, Financial Stability (E) Task Force Chair and  
Bob Kasinow, Macroprudential (E) Working Group Chair

**CC:** NAIC Support Staff: Jake Stultz/Dan Schelp

**Date:** March 31, 2023

**Re:** Referral to review the Reinsurance Worksheet

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The NAIC Macroprudential (E) Working Group (MWG) of the Financial Stability (E) Task Force (FSTF) requests comments and feedback from the Reinsurance (E) Task Force on the Reinsurance Worksheet.

The MWG was charged with coordinating the various NAIC activities related to private equity (PE) owned insurers. As an initial step, the MWG developed a list of 13 regulatory considerations. These considerations are frequently referenced as private equity (PE) concerns, but the Working Group developed the list with an activities-based frame of mind, recognizing that any ownership type and/or corporate structure could participate in these activities, including but not limited to PE owned insurers. The MWG and FSTF adopted a final plan for addressing each of the 13 considerations, including many referrals to other NAIC committee groups.

The Financial Condition (E) Committee adopted this plan with no changes during its virtual meeting on July 21, 2022. NAIC staff support drafted this referral letter to accomplish the actions captured in the adopted plan.

The Reinsurance Worksheet was created to address reinsurance activities in item 13 of the list of considerations. Please see a brief timeline of relevant discussions below.

NAIC staff support for the MWG will follow the work your group performs and summarize your activities for reporting up to the FSTF. If you have any questions or need further direction, please contact Tim Nauheimer (tnauheimer@naic.org).

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Background:

The MWG itself has been tasked with addressing item 13 on the list of PE considerations (whereas most of the other items have been referred to other WG's). In its research efforts, MWG regulators have been engaged in confidential discussions with industry participants and other jurisdictions regarding the use of cross-border reinsurers and complex affiliated reinsurance vehicles. The MWG identified the reinsurance worksheet as a mechanism to assist regulators in reviewing reinsurance transactions.

Key points for the proposed reinsurance worksheet:

- Use by regulators is **optional**, it is **not required**,
- The worksheet originated from states currently using a similar form,
- May be used however a state sees fit-for any type of transaction or not at all,
- Is **not** being incorporated into the Financial Analysis Handbook,
- Is separate and apart from any other analysis, i.e., asset adequacy analysis, AG 53, cash flow testing, covered agreement impact, etc.

**MWG Regulator discussion recap:**

- The MWG met Jan. 18, Feb. 23, and Feb. 27 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings.
- On Jan. 18, the MWG met with the Cayman Islands Monetary Authority (CIMA) to discuss its regulatory regime.
- On Feb. 23, the MWG met with the Bermuda Monetary Authority (BMA) to hear an overview of its recently released public consultation on proposed enhancements to its regulatory regime, with comments by interested parties due April 30.
- On Feb. 27, the MWG discussed the attached reinsurance comparison worksheet designed for state insurance regulators to assess cross-border reinsurance treaties where there are different regulatory systems involved, which will enhance state insurance regulators' ability to monitor these transactions.
- On Mar. 22, the FSTF exposed the cross-border reinsurance worksheet for a 30-day public comment period.
- On Mar. 22, the FSTF made a motion to refer the Reinsurance Worksheet to the Reinsurance Task Force.



**The worksheet is an option for regulators to require.** The regulator will inform the insurer if it is needed and provide the insurer the version of the worksheet to be completed.

**As such, the initial Worksheet's categories are listed generically to allow for variations.** For example, regulators may wish to use more than 3 Asset Categories to get more detailed data for specific risk characteristics, liquidity characteristics, etc. Similarly, different/more granular liability categories may wish to be used (e.g., one for annuities and another for life insurance). For the capital categories, if there is no rating agency involved, then the categories would be reduced to one line for "required capital" and another line for "additional capital." Similarly, the worksheet includes an "Other Jurisdiction" column as well as an "Alternate Method" column to allow for jurisdictions with optionality (e.g., Bermuda); if the jurisdiction has no optionality, only the single column is needed.

**When should regulators use this worksheet?** It is probably most valuable to new treaties when regulators are considering approvals, but it could be helpful for treaties already in place where there are significant and material questions/concerns. The worksheet is meant to be a tool to help the regulator understand the impacts of the reinsurance transaction; so if the regulator fully understands these impacts, a completed worksheet would not be necessary.

**For which product types?** Again, the worksheet is generic and can be used for whichever product(s) for which the regulator needs clarity. The "Total Asset Requirement" is more explicit/understood for annuities through C-3 Phases 1 and 2, so the concept might need to be clarified for life insurance.

**This worksheet should be completed at the individual block of business level.**

**Cross-border or U.S. to U.S. as well?** The worksheet was designed for cross-border reinsurance treaties where there are regulatory differences involved.

However, if a regulator would find this information useful for a U.S. to U.S. transaction, there is no reason for the regulator to not pursue its completion.

**Who should provide the responses in this worksheet?** It is expected the insurer will complete the worksheet initially. However, in situations where a consultant is engaged and/or there are concerns with information being provided by the insurer, it may be appropriate for the consultant to generate the completed worksheet.

<b>DRAFT: Cross-border Affiliated Reinsurance Comparison Worksheet - by Treaty</b>					
Category	US Stat. Pre-Transaction	Impacts of Transaction (Col's B-D)	US Stat. Post-Transaction	Other Jurisdiction	(Alternate Method) - Other Jurisdiction
<b>BALANCE SHEET COMPARISON:</b>					
Asset Grouping 1 (e.g., Cash/Investments)					
Asset Grouping 2 (e.g., Policy Loans)					
Asset Grouping3 (e.g., Separate Accounts)					
Other Assets					
<b>TOTAL ASSETS *</b>					
Liab. Grouping1 (e.g., Gen. Acct. Reserves)					
Liab. Grouping2 (e.g., Gen. Acct. Policy Loan Reserves)					
Liab. Grouping3 (e.g., Separate Accounts)					
Unauthorized Reinsurance Liability					
Other Liabilities (See NOTES SECTION)					
<b>TOTAL LIABILITIES</b>					
<b>TOTAL ASSET REQUIREMENT COMPARTISON:</b>					
Reserve Grouping1 (e.g., Separate Account Reserves)					
Reserve Grouping2 (e.g., GA Policy Loan Reserves)					
Reserve Grouping3 (e.g., GA Policy Reserves)					
<b>TOTAL RESERVES</b>					
Capital Grouping1 (e.g., Required Capital)					
Capital Grouping2 (e.g., Add'l Capital for Rating Agency)					
Capital Grouping3 (e.g., in Excess of Rating Agency Cap.)					
<b>TOTAL CAPITAL</b>					
<b>TOTAL ASSET REQUIREMENT</b>					
<b>CHANGE IN CAPITAL AND SURPLUS:</b>					
Capital and Surplus					
Net Income					
Change in Liability for Unauthorized Reinsurance					
Aggregate Write Ins for gains and losses in surplus					
Capital Contribution/(Dividends)					
Other Changes in surplus					
<b>TOTAL LIABILITIES &amp; CAPITAL</b>					
<b>SOLVENCY RATIO</b>					
* Supported by listings of asset categories and amounts to highlight differences in supporting assets after the transaction.					
<b>NOTES SECTION:</b>					
(e.g., explain product line, describe transaction and any unique aspects)					
(If Asset Adequacy Testing is included in "Other Liabilities," additional regulatory guidance may be needed, e.g., on counterparty asset assumptions where access is limited.)					

Transaction Details	Contract 1 (if needed)	Contract 2 (if needed)	Contract 3 (if needed)	Contract 4 (if needed)
<b>Please identify the following transaction details if applicable:</b> Which party of the contract are you assuming or (retroceding)?				
Description risk category covered (mortality, longevity, Cat Risk, etc.)				
Start date				
End date				
Currency				
Sum insured / Gross Notional amount / PML				
Capital at risk				
Line of Business (e.g. annuities, term, participating guarantee, etc.)				
Risks covered (e.g. longevity, mortality, etc.)				
Type of reinsurance treaty (XoL, Quota share – proportionate, etc.)				
Collateral value				
Value of guarantee				
Name(s) of the reinsurer(s) (please only include top 3 by premium share if more than one)				
Rating of reinsurer(s)				
Countries of reinsurer(s)				
Assets pledged by reinsurer				
Initial premium				
Initial fees				
Value of reserves				
Ceding commission structure				
If yes, provide description of these derivatives				
Any experience refund or loss carryforward features				
If yes, provide description of these derivatives				
Do you use or plan to use any form of derivatives for reinsurance purposes (e.g. longevity or mortality swaps)?				
If yes, provide description of these derivatives				
<b>Please identify and describe if any of the following types of arrangements are associated with this transaction:</b>	Exit mechanism			
Trust				
Funds Withheld				
Coinsurance				
Modified Coinsurance				
Sidecars				
Any other Joint Venture or SPV				
Third-party capital				
<b>Ceded and Retroceded Details</b>	<b>Reinsurer Name</b>	<b>Jurisdiction</b>		
If ceding to an offshore affiliate please identify the assuming affiliated reinsurer(s) and their regulatory jurisdiction				
If ceding to an offshore affiliate and that affiliate is going to retrocede to another reinsurer, please identify the ultimate assuming reinsurer(s) and their regulatory jurisdiction				





**To:** Commissioner Marlene Caride, Chair of the Financial Stability (E) Task Force  
**From:** Fred Andersen, Chair of the Valuation Analysis (E) Working Group  
**Date:** December 12, 2022  
**Re:** Response to Request from the Financial Stability (E) Task Force

## I. Executive Summary

In 2019, the Financial Stability (E) Task Force (FSTF) made a request to the Valuation Analysis (E) Working Group (VAWG) to assess a potential concern related to Economic Scenario Generators (ESGs) developed by the American Academy of Actuaries (Academy). It was suggested that there is a deficiency in the current ESG in that it doesn't adequately consider a very low or negative interest rate environment, and more specifically that this raises a material risk at the macro prudential level in the U.S., particularly for variable annuities. To allay any concerns during the interim period until a new ESG is in place, the FSTF asked the VAWG to assess this concern and provide assurance that any issues either have been addressed, or will be able to be addressed.

VAWG previously responded to the FSTF in 2019 and 2021 and has continued to assess the materiality of variable annuity interest rate risk and the approaches companies have taken to measure and manage it. The current report involves a request to 24 companies to perform a stress test for disclosure as of year-end 2021 (2021 VA Stress Test). The purpose of the 2021 VA Stress Test was to assess, at an industry level, the impact of a continuation of persistently low interest rates on VA reserves and risk-based capital (RBC). This report provides details and key findings from the 2021 VA Stress Test as well as an update on the development of the new ESG.

For the 2021 VA Stress Test, companies were asked to repeat the calculations for reserves and RBC as of 12/31/2021, after replacing the economic scenarios used for year-end reporting with a modified set of scenarios. The modified set included many interest rate scenarios that sustained low rates for much of the projection period.

Results from the 2021 VA Stress Test were compared against the baseline of actual 12/31/21 reported reserves and RBC. For the 24 companies combined:

- Pre-reinsurance ceded guaranteed benefit reserves increased \$1.8 billion (6%) from \$30.0 billion to \$31.8 billion
- RBC increased \$1.5 billion (24%) from \$6.4 billion to \$7.9 billion

The VAWG has found that, to address the risk of prolonged low interest rates, many companies took actions in 2021 as well as in one or more prior years. Many companies are also considering potential future actions for the near term. These are similar to past actions, such as performing testing and additional analysis, implementing product changes, or adjusting hedging.

The implementation of a new ESG is in progress. The results of an industry field test are currently under review. A recalibration of the ESG is expected, followed by a second field test. Ultimately, *Valuation Manual* amendments and RBC instruction changes will be necessary to incorporate prescription of the new ESG, which is now anticipated to be no sooner than 1/1/25.

Additional VA stress tests will be considered as needed prior to adoption of the new ESG. However, the ESG field tests enable VAWG to monitor the impacts of negative and prolonged low interest rates. Thirty-one VA writers participated in the ESG field test, representing a high percentage of the industry. Participants include most of the 24 companies that performed the 2021 VA stress test.

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## II. 2021 VA Stress Test

### A. Background

Twenty-four VA writers, representing a majority of U.S. VA business inforce, were contacted in February 2022 and asked to perform a stress test for disclosure by 4/30/2022 and to respond to a series of related questions. The purpose of the test was for VAWG to assess, at an industry level, the impact of a continuation of persistently low interest rates on VA reserves and RBC.

### B. Instructions

Companies were asked to perform the 2021 VA Stress Test according to the following instructions:

After calculating 12/31/21 variable annuity reserves and capital as normal, repeat the calculations, replacing the economic scenarios with a modified set of scenarios which will be emailed to you [separately]. These scenarios were developed by modifying the Academy ESG to better reflect the risk of low for long scenarios. This was done by changing the mean reversion parameter (MRP) in the Academy ESG to 1.5% and lowering the soft floor on long-term rates from 1.15% to 0.01%. Additionally, the Academy’s Scenario Picking Tool was used to select a representative subset of 1,000 scenarios, and this subset should be used for the Stress Test (whether or not the company used 1,000 scenarios for 12/31/21 annual statement reporting). If the company used scenarios as of a date prior to 12/31/21 for annual statement reporting, the company should use the Stress Test scenarios as of that date.

For the Stress Test, all components of the modeling other than the ESG-generated economic scenarios and scenario selection should remain the same (e.g., the same investment strategy, CDHS modeling, etc. should be used for the stress test).

### C. Summary of Results

Results for the 2021 VA Stress Test were calculated in comparison to a baseline of actual 12/31/21 reported reserves and RBC. Shown below, for the 24 companies combined, is the increase in total reserves for guaranteed benefits (which excludes the cash surrender value) plus RBC over the baseline.

	Baseline	Increase over Baseline	% Increase over Baseline
Pre-Reinsurance Ceded Reserve for Guaranteed Benefits	\$30.0 B	\$1.8 B	6%
Risk-Based Capital	\$6.4 B	\$1.5 B	24%
Total	\$36.4 B	\$3.3 B	9%

At the company level, changes to the pre-reinsurance ceded reserve for guaranteed benefits ranged from approximately a 75% decrease to a 500% increase. Changes to RBC ranged from approximately a 100% decrease to a 250% increase. Additional details about the distribution of results are shown below.

	Approximate % of Companies that showed:		
	More than a 20% increase over baseline	An increase over baseline of 0% to 20%	A decrease from the baseline
Pre-Reinsurance Ceded Reserve for Guaranteed Benefits	35%	25%	40%
Risk-Based Capital	20%	35%	45%

Companies explained their stress test results. Many noted offsetting effects of different calculation elements. The scenarios used for the 2021 VA Stress Test (Stress Test Scenarios) and the scenarios used for the baseline (Baseline Scenarios) were often compared to provide additional insight. The following general observations were made:

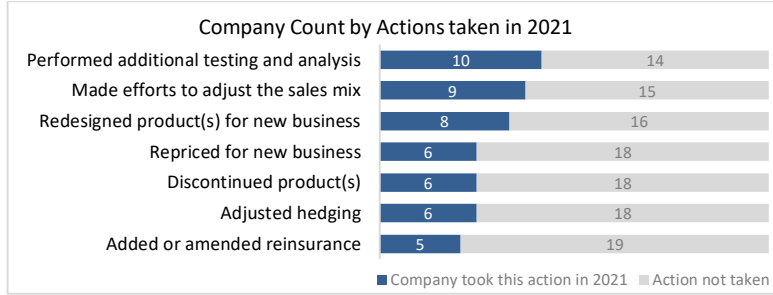
- For most companies, the interest rates in the Stress Test Scenarios were generally lower than those in the Baseline Scenarios, and had the effect of raising reserves and RBC.
- In contrast, the equity returns in the Stress Test Scenarios were generally more favorable than those in the Baseline Scenarios, which improved results significantly for many companies. The favorable equity scenarios reflect a limitation of the methodology currently used to select scenario subsets (out of a total of 10,000 scenarios). A 1,000 scenario subset was selected for the stress test since this is what VA writers typically use to calculate reserves and RBC. The current scenario selection process relies on the 20-year UST and therefore may not be effective at selecting subsets for products sensitive to equity performance (i.e., they may not be representative of the full set of 10,000 equity scenarios produced by the ESG). A newly formed VM-20/VM-21 ESG Drafting Group will be reviewing the existing methodology used to select scenario subsets.
- Hedging generally improved results. Some companies noted an increase in hedging gains or a decrease in hedging losses due to lower or less volatile interest rates in the Stress Test Scenarios.
- Some of the companies used a proprietary ESG for their baseline results. A subset of these companies noted that the Stress Test Scenarios were less conservative than their Baseline Scenarios.
- Some companies noted that the stress test resulted in more scenario reserves exceeding the cash surrender value floor.

#### D. Summary of Responses to Questions

Companies were asked to respond to a series of questions, summarized below.

1. **View of moderately adverse:** Many companies viewed the Stress Test Scenarios as beyond moderately adverse. However, given the low interest rate environment as of 12/31/2021, some companies commented that the Stress Test Scenarios were in the range of being moderately adverse.
2. **Other stress tests:** Many companies have conducted their own stress test using low interest rates for a prolonged period of at least 10 years. Some companies have been using a stress test focused on a shorter period of low interest rates or with an immediate shock scenario.
3. **Negative interest rates:** Many companies can calculate reserves and RBC using scenarios with negative interest rates. Some companies have conducted stress tests using negative interest rates. Some companies view the use of negative interest rates as beyond moderately adverse. Many companies indicated that actions considered if interest rates remain low for a prolonged period would also be considered if interest rates become negative.

4. **Actions taken in 2021 for the VA block of business:** Many companies took at least one action in 2021.



Other actions included changing fees for inforce business, adjusting investment strategies, implementing ESG changes, and adjusting asset/liability management.

5. **Potential future actions:** When asked about the timing of potential future actions if interest rates continue to remain low, many companies indicated that at least one action was likely within the next two years.

Potential Future Actions	Company Count* of Action:	
	Likely within 2 years	Likely in 3-5 years
Perform additional testing and analysis	17	
Reprice for new business	13	1
Redesign product(s) for new business	11	2
Make efforts to adjust the sales mix	12	
Discontinue product(s)	6	4
Adjust hedging	9	
Change fees for inforce business	2	5
Adjust investment strategy	4	2

\*If multiple time periods were selected as likely for an action, only the first time period was counted

Other potential actions included adjusting asset/liability management, adding or amending reinsurance, and implementing ESG changes (prior to potentially required ESG changes).

### III. Update on the Economic Scenario Generator

The implementation of a new ESG is in progress. An ESG Drafting Group, consisting of members of the Life Actuarial (A) Task Force and Life Risk-Based Capital (E) Working Group, the selected ESG vendor (Conning), representatives of the Academy and American Council of Life Insurers, and other subject matter experts, developed specifications for an industry field test. Review of field test results is currently underway. This is expected to lead to a recalibration of the ESG, followed by a second industry field test. Ultimately, *Valuation Manual* amendments and RBC instruction changes will be necessary to incorporate prescription of the new ESG, which is now anticipated to be no sooner than 1/1/25.

### IV. VAWG Plans for Future VA Stress Tests

Additional VA stress tests will be considered as needed prior to adoption of the new ESG. However, the ESG field tests enable VAWG to monitor the impacts of negative and prolonged low interest rates. Thirty-one VA writers participated in the ESG field test, representing a high percentage of the industry. Participants include most of the 24 companies that performed the 2021 VA stress test.



**RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE**

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Proposed Receivership Tabletop Overview (Attachment Two) .....	9-673

Draft: 3/28/23

Receivership and Insolvency (E) Task Force  
Louisville, Kentucky  
March 23, 2023

The Receivership and Insolvency (E) Task Force met in Louisville, KY, March 23, 2023. The following Task Force members participated: James J. Donelon, Chair, and Stewart Guerin (LA); Glen Mulready, Vice Chair, represented by Donna Wilson and Jamin Dawes (OK); Mark Fowler represented by Ryan Donaldson (AL); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Jon Arsenault (CT); Doug Ommen represented by Daniel Mathis (IA); Dana Popish Severinghaus represented by Kevin Baldwin and Bruce Sartain (IL); Vicki Schmidt represented by Levi Nwasoria (KS); Sharon P. Clark represented by Rodney Hugle (KY); Gary D. Anderson represented by Christopher Joyce (MA); Timothy N. Schott represented by Robert Wake (ME); Chlora Lindley-Myers represented by Shelley Forrest (MO); Troy Downing represented by Steve Matthews (MT); Mike Causey represented by Monique Smith (NC); Jon Godfread represented by Colton Schulz (ND); Eric Dunning represented by Lindsay Crawford (NE); Marlene Caride represented by David Wolf (NJ); Andrew R. Stolfi represented by Doug Hartz (OR); Michael Humphreys represented by Laura Lyon Slaymaker and Crystal McDonald (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); Michael Wise represented by Ryan Basnett (SC); Cassie Brown represented by Brian Riewe (TX); and Nathan Houdek represented by Mark McNabb (WI).

1. Adopted its 2022 Fall National Meeting Minutes

Smith made a motion, seconded by Donaldson, to adopt the Task Force’s Dec. 14, 2022, minutes (*see NAIC Proceedings – Fall 2022, Receivership and Insolvency (E) Task Force*). The motion passed unanimously.

2. Adopted the Report of the Receiver’s Handbook (E) Subgroup

Baldwin said the Receiver’s Handbook (E) Subgroup met Dec. 21, 2022, and took the following action: 1) adopted revisions to Chapters Three, Four, and Five of the *Receiver’s Handbook for Insurance Company Insolvencies* (Receiver’s Handbook); and 2) exposed Chapters Six and Seven of the Receiver’s Handbook for a 45-day public comment period ending Feb. 6, 2023. The Subgroup received helpful clarifications.

The Subgroup plans to schedule a meeting to adopt Chapters Six and Seven. The drafting groups are continuing their work to complete the remaining chapters. The Subgroup is expected to complete the Receiver’s Handbook project by the fall of 2023.

Hartz made a motion, seconded by Slaymaker, to adopt the report of the Receiver’s Handbook (E) Subgroup, including its Dec. 21, 2022, minutes (Attachment One). The motion passed unanimously.

3. Adopted the Report of the Receivership Financial Analysis (E) Working Group

Wilson said the Receivership Financial Analysis (E) Working Group plans to meet March 23 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss companies in receivership.

Matthews made a motion, seconded by Crawford, to adopt the report of the Receivership Financial Analysis (E) Working Group. The motion passed unanimously.

#### 4. Adopted the Report of the Receivership Law (E) Working Group

Slymaker said the Receivership Law (E) Working Group exposed amendments to the *Property and Casualty Insurance Guaranty Association Model Act* (#540) related to the coverage of policies that are subject to restructuring mechanisms, specifically insurance business transfers (IBTs) and corporate divisions (CDs). The Working Group received comments and alternative amendments. The comments raised some additional considerations and scenarios specifically around novation and assumptions, as well as which sections of the model may also be affected. A drafting group comprised of Working Group members, the National Conference of Insurance Guaranty Funds (NCIGF), and interested parties was formed. The drafting group met March 6 to discuss a revised draft of amendments. There is a remaining item to resolve, therefore, the drafting group plans to meet again before sending the draft to the Working Group.

Slymaker said if the Executive (EX) Committee approves the Request for NAIC Model Law Development related to cybersecurity insurance at its meeting on March 23, the Working Group will also schedule a call to discuss and expose draft amendments to Model #540 for cybersecurity insurance.

Hartz made a motion, seconded by Kaumann, to adopt the report of the Receivership Law (E) Working Group. The motion passed unanimously.

#### 5. Heard an Update on International Activities

Wake said the International Association of Insurance Supervisors (IAIS) Resolution Working Group released for public consultation the application paper on policyholder protection schemes. Comments on the public consultation are due to the IAIS on April 14. The International Insurance Relations (G) Committee will hold a meeting on April 13 to consider comments from the NAIC. Anyone wishing to submit comments for the Committee to consider should send them to NAIC staff by March 27.

Wake said in follow-up to the IAIS's Targeted Jurisdictional Assessment (TJA) for which the U.S. participated and was assessed, the IAIS will conduct a follow-up to assess each jurisdiction's progress in addressing the findings where a jurisdiction did not receive a "fully observed" assessment.

Wake said the IAIS is expected to begin a project to update the IAIS Insurance Core Principles (ICPs) and Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) provisions related to resolution and recovery issues. The ICPs and the related issue papers will be discussed at the IAIS meeting in May 2023.

#### 6. Heard a Presentation on a Proposed Receivership Tabletop Exercise

Peter G. Gallanis (National Organization of Life and Health Insurance Guaranty Associations—NOLHGA) presented a tabletop receivership proposal. He said the NOLHGA and the NCIGF conducted a tabletop exercise on how to respond to the insolvencies of hypothetical insurance carriers. He said there has been a lot of turnover in the receivership community, and many have not had hands-on experience with how troubled insurers are identified by the financial regulators, how the domiciliary commissioner determines remediation steps, developing a rehabilitation plan, liquidation, developing a response to a nationally significant company that triggers the guaranty associations, and management of an insolvency case. The tabletop is a hands-on interactive participatory exercise to talk through various issues. Gallanis said the NOLHGA membership found it to be a very helpful training exercise. He said he spoke with Commissioner Donelon and Tom Travis (LA) about this exercise. State insurance regulators have also seen some turnover. He said he discussed with Commissioner Donelon about the tabletop being an exercise that could provide training to financial regulators, commissioners, and states' receivership staff who may wish to participate and who attend other educational programs or the NAIC national meetings.

Gallanis said he was asked by Louisiana to develop a timeline, provide more details on how to move forward with the proposal, provide more details on who from the financial regulators, receivership staff, and possibly industry would participate, and work with the NAIC to identify a date and time for a presentation such as this (Attachment Two).

Roger Schmelzer (NCIGF) said this is a time of relative strong agreement between state insurance regulators, guaranty funds, and receivers. He said it would be important to go through issues and figure out where the disagreement is before having a real insolvency scenario where stakes become extremely high. The recent banking industry issues with Silicon Valley Bank and others and the actions of the federal banking regulators indicate an inclination for the federal government to be more involved in financial services that are regulated at the state level. This program is a way to take that seriously and be more prepared for what might come.

Bill O’Sullivan (NOLHGA) said as more practical knowledge is gained from the program, as well as a better understanding of the tools, relationships and collegiality are built to be able to better share information and strategies and agree on a common approach to protect policyholders. This program builds the foundation for those kinds of critical relationships.

Schmelzer said the NCIGF is doing more work to plan what a program would look like and get input. Connecting this program with an NAIC meeting or event would facilitate attendance by the state insurance regulators. Regarding timing, Schmelzer said some time in the fall would work if everything can be pulled together. He said the NCIGF welcomes the Task Force’s support in this effort.

Guerin said he agrees that this training would be beneficial for the reason of staff turnover. He said Louisiana had not had a receivership for over 15 years and suddenly had multiple receiverships due to a hurricane. He said this training would have been beneficial and allowed Louisiana to work more expeditiously through some of the issues.

Commissioner Donelon said the receiverships in Louisiana over the past year have the Louisiana legislature and industry looking at modifications to its guaranty fund law and, in particular, the assessments and recoupment of those assessments. He said he agrees with Guerin, and he said Louisiana has been able to contract with receivership experts that have decades of experience doing receiverships. He said the banking challenge Schmelzer referenced is one that state insurance regulators need to gear-up for to be prepared.

Guerin said as the program is still in development, he requested an update at a future time. He said to let the Task Force know if the NOLGHA or the NCIGF have any requests of the Task Force.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/E CMTE/RITF/2023 Spring NM/RITF\_Minutes032323.docx

Draft: 3/29/23

Receiver's Handbook (E) Subgroup  
Virtual Meeting  
Dec. 21, 2022

The Receiver's Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force met Dec. 21, 2022. The following Subgroup members participated: Kevin Baldwin, Chair (IL); Miriam Victorian, Vice Chair (FL); Jared Kosky (CT); James Gerber (MI); Donna Wilson and Jamin Dawes (OK); Laura Lyon Slaymaker and Crystal McDonald (PA); and Brian Riewe (TX).

1. Adopted its July 19 Minutes

The Subgroup met Dec. 21 and took the following action: 1) adopted its July 19 minutes; 2) adopted Chapters 3–5 of the *Receiver's Handbook for Insurance Company Insolvencies* (Receiver's Handbook); and 3) exposed Chapters 6 and 7 of the Receiver's Handbook.

Wilson made a motion, seconded by Kosky, to adopt the Subgroup's July 19 minutes (*see NAIC Proceedings – Summer 2022, Receivership and Insolvency (E) Task Force, Attachment Two*). The motion passed unanimously.

2. Adopted Revised Chapters 3–5 of the Receiver's Handbook

Baldwin thanked the volunteers who had participated in the drafting groups for the chapters of the Receiver's Handbook.

Slaymaker made a motion, seconded by Victorian, to adopt Chapters 3–5 of the Receiver's Handbook (Attachment One-A). The motion passed unanimously.

3. Exposed Revised Chapters 6 and 7 of the Receiver's Handbook

Chapters 6 and 7 had extensive revisions that were presented in the meeting materials as a clean copy.

The Subgroup reviewed changes to Chapter 7 by Patrick Hughes (Faegre Baker Daniels & Reath LLP) and Caryn M. Glawe (Faegre Drinker Biddle & Reath LLP). Additionally, it was noted that to view the original Receiver's Handbook, the current Receiver's Handbook version is posted on the Subgroup's website under the documents tab.

Slaymaker made a motion, seconded by Victorian, to expose Chapters 6 and 7 of the Receiver's Handbook for a 45-day public comment period ending Feb. 6, 2023. The motion passed unanimously.

Having no further business, the Receiver's Handbook (E) Subgroup adjourned.

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*Chapter 3—Accounting and Financial Analysis*

**CHAPTER 3—ACCOUNTING AND FINANCIAL ANALYSIS**

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*Chapter 3—Accounting and Financial Analysis***I. INTRODUCTION: OBJECTIVES OF THE ACCOUNTING FUNCTION**

The purpose of this chapter is to identify and explain the various objectives of the accounting function for an insurer in receivership and provide guidelines for the preparation of reports summarizing the financial position of the receivership.

It is important to highlight the context or perspective from which this chapter was prepared. Any accountant serving a receiver is, by necessity, an integral part of a team of regulatory, legal, actuarial, and other professionals working together to achieve common goals. The nature of these goals is described at length in Chapter 1—Takeover & Administration. In most receivership situations, the duties of the receiver's accountants, investigators, and attorneys will overlap when information about a common topic such as a reinsurance treaty is needed by staff members. While these other individuals have a legitimate interest in accounting and financial information, this chapter has been prepared from the perspective of the accountant serving the receiver.

This chapter will deal with the following issues:

- The objectives of the receiver and how they may vary from the traditional accounting objectives of a going concern.
- The need to gain an understanding and control of the impaired or insolvent company's bank accounts and assets.
- The importance of evaluating the impaired or insolvent company's accounting staffing and consulting needs early on in the receivership, as well as the need for assistance from certified public accountant (CPA) or actuarial firms to do projections, forensic accounting, and tax reporting.
- The need to inventory and safeguard documents, ledgers, contracts, and other financial items that will shed light on the financial position of the insolvent insurer and provide support to the receiver in collecting assets, settlement of balances, litigation, and other matters.
- The need to focus on the corporate structure of the enterprise, the importance of analyzing related-party transactions and intercompany accounts, and consideration of restructuring certain transactions.
- The need to identify and scrutinize tax issues, including necessary informational filings with the IRS (such as 1099s), various areas of tax exposure, premium and payroll tax consequences, and other taxes.
- Considerations related to the nature of the insolvent insurer's investments and safeguarding and valuing the investment portfolio.
- Considerations relating to direct and assumed reinsurance premium receivables, including the need to identify and control treaties, to determine if in-force treaties should be maintained or cancelled, and to quantify setoffs and other issues. Consideration should also be given to ceded reinsurance receivables and the identity of the various lines of business and policies ceded to other insurers. Insurers often have excess of loss or stop-loss reinsurance where recoveries of amounts due the health maintenance organization (HMO) should be investigated.
- The need to prepare financial statements and related information in a format that will support the receiver directly in managing the affairs of the estate and in responding to the needs of various third parties, such as state insurance departments, the courts, guaranty funds, policyholders and other creditors, attorneys, and other parties.
- The need to review and understand the various cost centers and associated expenses and contracted services.

*Receiver's Handbook for Insurance Company Insolvencies*

The overall objective of the accounting function in receivership can be expressed as follows:

**To assist the receiver in securing control of the insurer's assets and to provide timely, relevant, and accurate financial information as to the assets, liabilities, surplus (deficit), and cash flow of the insolvent insurer to support the duties of the receiver, and to assist in making economic decisions.**

The sections that follow will discuss the points above in more detail as they relate to the overall objective of the accounting function in a receivership.

## II. OBJECTIVES DIFFERENT THAN GOING CONCERN

In many respects, the overall accounting function objective discussed above is equally fitting for the accounting function of a going concern. However, the important phrase that distinguishes this objective for receivership is “to support the duties of the receiver.”

For solvent insurers, the accounting function is generally designed to support management and to fulfill the insurer's responsibility to report information to shareholders, creditors, taxing authorities such as the IRS, regulatory authorities such as state insurance departments, and others. The purpose of this information is to allow these parties to monitor the insurer's financial operations and protect their interests (e.g., investment, loan, or tax obligations). The accounting system may be designed to support reporting on the basis of both U.S. generally accepted accounting principles (GAAP) and statutory accounting principles (SAP) prescribed or permitted by the insurer's state of domicile.

For an insurer in receivership, the situation is different. The state insurance regulator has already determined that the insurer is in an impaired or insolvent financial position. A receiver has been appointed. For an insurer in rehabilitation, the objective may be to identify the causes of the impairment, eliminate them, and work to return the insurer to a solvent position. Alternatively, it may be determined that a successful rehabilitation is not achievable, in which case an order of liquidation will be sought. For the insurer in liquidation, the objectives are to identify and marshal the assets of the insurer; identify and evaluate liabilities and determine the appropriate class of each creditor in accordance with the domiciliary state's priority of distribution statute; and liquidate the insurer in a manner that minimizes the cost to policyholders, state guaranty funds, and other creditors.

Thus, the new and important user of the financial information is the receiver. In rehabilitation, pro forma reporting is often used to help the receiver assess the feasibility of potential transactions that have been proposed to mitigate the surplus deficit. Additionally, liquidation-basis accounting becomes an important form of reporting to help the receiver assess the realizable value of the assets of the insurer and the extent such assets will be available and sufficient to cover approved claims of policyholders and other creditors.

It is important to understand the difference between the responsibilities of the receiver and those of former management. In a going concern, management has the responsibility to develop internal controls and procedures covering a variety of items such as payroll, transfers to affiliates, reinsurance balances, etc. However, the receiver will review and perhaps revise these internal control procedures. The receiver will approve disbursements; revise wage and salary schedules (especially for excessive amounts payable to officers); streamline the organizational structure if needed; and place a moratorium on payments to reinsurers, related parties such as the insurer's affiliates and others, pending a complete analysis of the insurer's financial position.

In some instances, the duties of the receiver and that of management will differ in subtle ways. For example, consider an insurer that has been placed in rehabilitation: The insurer is a wholly owned subsidiary of a publicly held insurance holding corporation. The receiver, by statute and court order, has responsibility and authority only for the affairs of the insolvent insurer/company subsidiary. Thus, the accountant working with the receiver may assist in or direct the preparation of financial information relating to the insurer/subsidiary that may ultimately be provided to and used by management of the holding company/parent to prepare its filings with the U.S. Securities and Exchange Commission (SEC) or consolidated tax returns for the IRS. However, it is generally not the

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responsibility of the receiver or his or her accountant to prepare or file such documents that relate to the holding company.

It is not uncommon for the receiver to maintain certain of the insurer's key management personnel on staff because of their knowledge of the insurer and their familiarity with its business, reinsurance treaties, data processing systems, and various other matters. The receiver should ensure that such staff be sensitive to the new responsibilities created by the order of rehabilitation or liquidation. It is unlikely that these individuals have ever been through a receivership before and may unknowingly perform their duties as if it were business as usual, not realizing that the receiver now must be informed of, and approve, procedures and disbursements. Additionally, the receiver should identify those individuals who may conceivably have an interest in concealing or altering information because of their concern about their role in the events that may have precipitated or contributed to the insolvency.

The principal responsibility of the accountant is to the receiver. However, the accountant should be aware that the receiver must provide certain financial information to other parties, including (in no particular order of importance):

- Domiciliary state insurance department.
- Other insurance departments in states where the insurer is licensed.
- The receivership court, other state courts, or federal courts.
- Creditors, including banks, premium finance companies, providers of health care (if an HMO), and reinsurers.
- Shareholders.
- Federal, state, and local taxing authorities.
- State guaranty funds, the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), or the National Conference of Insurance Guaranty Funds (NCIGF)
- Policyholders.
- Prospective investors.
- Other regulatory agencies, such as the SEC.
- Legislatures (state and federal).
- State and federal agencies responsible for Medicaid/Medicare (if an HMO).
- Reinsurers.
- Agents.

Financial information for a receivership is similar to that of an ongoing enterprise with some important differences. These include the following:

- The need to identify and provide for various classes of creditors pursuant to the domiciliary state's receivership priority statute. The receiver's accounting system should be capable of capturing information provided by creditors on proofs of claim in order to review and adjust those claims and to aggregate them by creditor class.
- Reinsurance recoverables must be viewed from a different perspective, particularly ceded unearned premium for property and liability companies. In a going concern, a ceding insurer would not expect to

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receive ceded unearned premium. However, when reinsurance is not renewed, the ceded unearned premium recoverable can be quite substantial if the termination clause of the contract is written on a cut-off basis. In a runoff situation, the insurer would have reinsurance until the ceded premium ran off.

- Setoffs are another reinsurance issue that should be identified and reviewed to determine if they are acceptable under the applicable state receivership statutes. Setoffs (often referred to as “net accounting” in going-concern accounting) frequently occur in reinsurance transactions and may involve setoff of amounts within a contract. These may include premiums due to the reinsurer from the ceding insurer set off against recoverables for paid losses owed by the reinsurer to the insurer, setoff of balances under two or more contracts with the same two entities, or setoff of amounts owed to or from different ceding insurers and/or reinsurers that have been set off by a reinsurance intermediary or broker, usually on a monthly or quarterly net reporting basis to the insurer. If necessary, setoff transactions will need to be recast or set aside. (Note: Identification of setoffs is an accounting function. The receiver’s counsel should address the legality of identified transactions. See Chapter 9—Legal Considerations for discussion of setoffs.)
- The need to separate any commingled assets and liabilities of the insurer from entities affiliated with the insurer, such as the parent corporation, other subsidiaries or affiliates, and employee benefit plans.
- The need to identify transactions that are significant to the receiver because of the potential for recovery from third parties, as well as the possible institution of criminal proceedings. Generally, these may include transactions with affiliates or officers and directors, for example, and preferential payments made within statutorily prescribed periods. (See Chapter 9—Legal Considerations.)
- The need for a clear cutoff date in the accounting records to establish a beginning balance sheet that represents the point at which the receiver has become accountable for the financial affairs of the insurer.
- Payments for pre-receivership transactions may be suspended pending review by the receiver. It is also important to immediately change company procedures and implement controls to assure that the insurer’s assets are not disbursed unless approved by the receiver or his representative. The receiver may wish to consider placing a stop order on outstanding checks, both claims-related and administrative.
- The need to recognize differences between liquidation accounting and statutory accounting practices followed by the insurer as a going concern. For example, certain assets of the insurer—such as furniture, equipment, and overdue agent balances—may not be admitted for statutory accounting. An HMO’s membership may also have potential value that is not admitted for statutory accounting purposes. Nonetheless, in a receivership, they should be considered for possible collection or sale, even if they are not considered in evaluating the solvency of the insurer.
- The need for preliminary assessment of the causes of the impairment or insolvency, with an analysis of whether any parties have potential civil or criminal liability for their role in causing the insolvency. (See Chapter 4—Investigation and Asset Recovery.)
- The need to challenge, with an appropriate degree of professional skepticism, the adequacy of the insurer’s personnel who may be retained by the receiver, and assess skills, loyalties, and potential conflicts of interest that they may have because of their roles in, or knowledge of, events that precipitated or contributed to the receivership.

*Chapter 3—Accounting and Financial Analysis***III CASH AND LIQUID INVESTMENTS****A. Cash**

The receiver must determine the existence, location, and amount of all cash, cash equivalents, and short-term investments through direct confirmation with financial institutions, investment managers, and other parties thought to be holding cash, cash equivalent, or short-term investments. The insolvent company's financial management should be able to provide a listing of financial institutions and contacts.

The receiver should immediately determine who has access to the cash and investments and should consider changing or restricting this access. In this era of electronic banking, Internet banking access should be closely scrutinized. Administrative controls of Internet banking should be evaluated by the receiver as soon as possible and modified as necessary. If the company holds cryptocurrencies, access to the cryptocurrency wallet and any associated hardware should be restricted. Large amounts of cash can be removed from an estate via wire transfer. Procedures should be established with the financial institutions to curtail or limit access regarding wire transfers. Wire transfer capabilities must be limited to receivership staff immediately upon receipt of a receivership order. Operations of the insurer may be affected temporarily, but that situation pales in comparison to allowing large amounts of money to be wired out of an estate.

All financial institutions should be notified immediately of the receivership order. A receivership order should be faxed or emailed to the contact person at each financial institution, and a proof of service should be signed by an appropriate financial institution representative as corroboration that the financial institution received the order. Some receivers, especially in liquidation, advocate immediately closing all existing bank accounts to ensure complete control of cash. The receiver should also consider whether to continue relationships with the banks used by the insurer or to establish new accounts with only the receiver or their designated representatives having signatory authority to disburse funds. The receiver must decide whether to allow certain checks to clear, as a disruption in payments to claimants may cause hardship, lead to complaints, and would be viewed negatively by regulators. Another consideration associated with account closure is the magnitude of penalties and interest that would accompany any substantial delay in payments.

A letter should be sent that gives the bank or other financial institution instructions with regard to allowing or not allowing checks to clear the account. As soon as possible, signatories on bank accounts should be changed to the receiver's designated personnel.

All check stock should be inventoried and bank accounts reviewed to determine which accounts are related to the insurer's business and which accounts, if any, are still needed. If bank accounts are closed, the related check stock should be voided and destroyed. If the accounts are required, an appropriate protocol needs to be established between the banking institution and the receiver. The normal practice would be to freeze all accounts or, at a minimum, the signatories should be changed to individuals on the receiver's staff.

The receiver may consider moving out-of-state assets into the domiciliary state to improve control and lessen the chance they may be subject to attachment by creditors. This step should be completed as soon as possible after the liquidation order is filed with the court. If an ancillary receivership is established, the receiver should work in conjunction with the ancillary receiver when moving assets out of the ancillary state.

Special care should be applied to the identification of accounts not held in the insurer's name but to its benefit. Bank statements, investment statements, cash ledgers, and cash-flow statements should be reviewed. This process should also include any funds held as collateral, letters of credit (LOCs), or other restricted cash.

Credit or debit cards in the company name should be gathered and secured in the same manner as cash. Determine if there are recurring charges on the card and if those recurring charges need to be continued or can be canceled. If the cards are no longer needed, consider canceling the cards. Credit or debit cards are often kept in the accounting or human resources department but could exist in other areas of the company.

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A company may also have recurring charges set up as Automated Clearing House (ACH) transactions. Review all accounts for recurring charges so they can be canceled as appropriate.

Some companies will have gift cards or prepaid debit cards (for example Visa- or American Express-branded prepaid cards) that have been purchased for agent/broker incentives, employee incentives, or wellness incentives. These cards may not be accounted for in the company's general ledger and could potentially be kept by many different departments of the company. They should be gathered and treated in the same manner as cash.

**B. Liquid Investments**

Determine the existence, location, amount, and type of liquid securities (bonds, stocks, mortgage loans, etc.) through direct confirmation with financial institutions, investment managers, and other parties thought to be holding securities. Investment statements from financial institutions, portfolio statements from investment managers, and other similar reports should be secured and used to establish a balance as of the receivership date.

As with cash, company personnel should provide a list of brokerage houses, financial institutions that have custody of investments, and related contact names. All institutions having custody of the insurer's investments should be sent a copy of the receivership order. The brokerage house or financial institution should be given instructions by cover letter that only receivership staff is authorized to buy or sell investments. The receiver should be aware of who has access to the investments and who had the authority to direct the investment managers/brokers. Once again, the investment managers/brokers should only take direction from the receiver.

The receiver should determine whether any of the liquid investments are hedged and who the counterparties are, as well get a description of the entity's hedging program.

Sometimes it is easier for the receiver to transfer securities to a financial institution with which they are familiar. Doing so facilitates transactions, as sales can be efficiently executed to maximize the value to the estate, after obtaining the appropriate advice about the most advantageous time to liquidate a security.

**IV. INITIAL REVIEW OF FINANCIAL STATEMENTS AND PROJECTIONS**

It is imperative that the receiver's accountants perform an initial review of the financial statements that had been produced by the company as soon as possible. Obviously, these financial statements should be viewed with a heavy dose of professional skepticism. However, the receiver's accountants can usually garner a lot of information from company accounting personnel. The receiver's accountants must use professional judgment in determining the accuracy of the information provided by the company or whether further investigation/confirmation is required. In either case, it is critical that the receiver's accounting staff perform an evaluation of the company's surplus and cash position in the first few months (or sometimes weeks) of a receivership. The receiver's accountants must provide this information to the receiver so that objective decisions regarding the company's rehabilitation or liquidation may be made.

The receiver's accountants should obtain the last published statutory quarterly or annual statement that the company filed. If the company is an unauthorized entity or it did not file financial statements, internal financial statements will have to suffice (preferably financial statements that were audited or reviewed by an outside CPA firm). The receiver's accounting staff can use these statements as a starting point for surplus and cash projections. Another source for financial statements is those prepared by insurance department examiners. If the entity is publicly traded, get copies of the latest 10-K and 10-Q at <https://www.sec.gov/edgar.shtml>.

Admittedly, the analysis of a company's cash or surplus position in the early stages of a receivership is not an exact science. In addition to calculating anticipated receiver administrative expenses, the following measures should be incorporated to make projections and analysis more meaningful:

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- Confirm that bank reconciliations are brought up to date.
- Review anticipated premium income. Look at recent premium written reports, and review the timing of any anticipated policy cancellations or non-renewals.
- Review any capitation arrangements, contracts with hospitals and doctors, and the federal Centers & Medicare and Medicaid Services (CMS) for all approved plans.
- Review recent claims and loss adjustment expense (LAE) payment history to use as an estimate for the future claims liability of insurers in receivership.
- Claims payments should begin to decrease after policies are cancelled (if applicable).
- Review all active reinsurance treaties, especially for the current treaty year. Ceded reinsurance is especially important for property and liability companies.
- Review recent large expense payments such as rent, commissions, legal expenses, etc.
- Review potential voidable preferences.
- Review monthly investment income and sources generating the income.

**V. INVENTORY AND DESCRIPTION OF ACCOUNTING RECORDS****A. Inventory of Accounting Records**

As soon after the takeover of an insurer as is practicable, the receiver should identify and secure the books, records, systems, and documents that are necessary to maintain and review the accounting functions of the insurer. Familiarity with the preexisting accounting processes and related accounting records and their location will help the receiver prepare for the many other tasks that will follow. The receiver may find that accounting processes should be consolidated, streamlined, or simplified, particularly for insurers in liquidation. A thorough knowledge of the preexisting accounting systems is an integral step in identifying those systems that can be eliminated or simplified. Furthermore, such knowledge will greatly assist in the investigation and asset recovery processes, which are discussed in the next chapter.

This section summarizes and describes the preexisting accounting records that are typically maintained at various locations of the insurer and/or at affiliated and nonaffiliated entities. This chapter should be read in conjunction with Chapter 1—Takeover and Administration, Chapter 2—Information Systems, and Chapter 4—Investigation and Asset Recovery, which may identify additional records and functions that may be useful to the receiver.

Types of documentation vary, but one thing is certain: The records of an insurer that has been placed into receivership will be, or at least may seem to be, incomplete, confusing, and, in many cases, inaccurate. To the extent systems and account balances are undocumented, some documentation may have to be recreated. Work papers of state insurance examiners, outside auditors, and actuaries may be useful in reconstructing records. In addition, existing personnel may be retained by the receiver to assist in this process because of their knowledge of the insurer's operations and systems.

**B. Records at the Administrative Office of the Insurer**

The administrative or “home” office of the company will, most likely, be the location from which the domiciliary receiver will direct the receivership. The bulk of the insurer's financial and accounting records usually are located and maintained at the home office. However, the domiciliary receiver should be aware



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that the company records may also be located at third-party administrator (TPA), managing general agent (MGA) and branch offices.

The following is an overview and brief description of accounting records that the receiver should attempt to locate and secure. If documentation of this nature does not exist or cannot be located, special effort may be required to understand how the financial data was compiled.

1. Organizational Chart of the Accounting Department, Flowchart of Accounting Process, Procedure Manuals, and Chart of Accounts

An organizational chart may give the receiver an overview of the organization, including the accounting department. It may identify the various functions (e.g., cash accounting, underwriting accounting, reinsurance accounting, etc.) of the accounting department and the individuals responsible for those functions. It can also indicate the reporting hierarchy and help assess the adequacy of segregation of duties consistent with sound internal control practices.

A flowchart of the accounting process might describe what action is taken for the significant functions or accounting processes. The flowchart may summarize the route of the original accounting documentation. Most importantly, the flowchart may well identify the key records relied upon to record financial information; when, how, and by whom it is entered into the accounting records; and how and by whom the resulting balance is verified by reconciliation or other procedures. The flowchart may also identify the responsibilities of each significant function in the accounting department. The flowchart may identify controls. The public CPA firm will normally have a process flowchart for the accounting function of the insurer and the controls within that process if not available directly from the insurer. If a flowchart is not available, the receiver may wish to request that one be created to assist in assessing the adequacy of internal controls over the significant accounting processes.

Procedure manuals may exist that describe the duties and functions to be performed by the accounting department. If the accounting system is computerized, the procedure manual of the computer system may describe the process and controls for specific job functions. Procedure manuals may be detailed by job function or by department function. If available, these manuals will assist the receiver in understanding the accounting process. Care should be taken by the receiver, however, because procedure manuals possibly will be incomplete or out-of-date, and they may be unintentionally misleading as to the actual processes currently in place. A walk-through documentation from CPAs/exams/internal audit of the key systems and/or inquiry of the insurer's personnel will help to confirm the accuracy of such documentation. The degree of the walk-through depends on judgment and internal controls of the insurer.

The chart of accounts should detail the description and purpose of all general ledger accounts. The chart (a manual) of accounts may be a useful tool, especially to an external auditor. Again, care should be taken because account titles and descriptions may not reflect their true nature or use in practice by management. Typically, accounts are numbered in sequential order using the following convention:

- Assets.
- Liabilities.
- Surplus accounts.
- Income accounts.
- Expense accounts.

*Chapter 3—Accounting and Financial Analysis***2. Accounting Records, Including the General Ledgers and Supporting Schedules**

The receiver should find a complete set of records at the home office. The general ledger provides a listing of the dollar amounts in each of the accounts in the chart of accounts. The amounts in the general ledger may be posted on a monthly or quarterly basis. Automated and interfaced systems may post to the general ledger on a daily basis.

Depending on the size of the company and the type of reporting system, the general ledger listing may include:

- A transactional listing that reflects, by account, the items posted to that account by period entered. The period entered and supporting schedule may allow the receiver to locate the “support” or underlying documentation for the entry. This information will be valuable in the audit procedures.
- A journal entry listing that specifies, by period, the accounts and amounts affected by the entry. When a transaction from one particular account has been identified for investigation, this listing will allow the receiver to determine the other accounts affected and the amount.

The accounting records will provide details of balances that are summarized and posted in the general ledger. Some of specific detailed schedules that may be found at the insurer are:

- Investments.
- Agents and/or insured balances.
- Funds held.
- Premiums written.
- Reinsurance recoverables.
- Fixed assets (e.g., furniture and equipment).
- Claims paid.
- Claims outstanding (case reserves).
- Contingent commissions.
- Amounts retained for accounts of others.

Accounting records detail the daily accounting activity of the company. The daily cash activity of the insurer is maintained in the accounting records.

**3. Accounting Files**

Generally, accounting files are maintained by an insurer based on the various accounting functions. Accounting files usually contain original accounting source documentation (check remittance advices, invoices, and purchase orders) or images files of the documentation. The records are all important. The more crucial accounting records are:

- Certificate of deposit files and investment.
- Cash.

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- Agents' and producers'.
- Contingent commission.
- Claim.
- Reinsurance.
- Federal, state, and local tax.
- Accounts payable.

The insurer may have several years of accounting files on the premises and keep the older accounting files/backups at a warehouse location. A records retention policy for the insurer may be available from the chief accounting officer. It is important to suspend any document destruction.

The investment accounting should support the investment transactions of the insurer. Included in the files should be broker slips, bank advices, and custodian statements. If the investment accounting is held by a custodian or asset management firm, the receiver should notify them of the receiver and request records. Monthly reconciliations of the custodian statements/files to the related general ledger account balances may also be found here. For more information on investment files, see Section IX on investments in this chapter.

Cash contains records often from bank lock boxes of cash receipt and disbursement that support the cash entries made on a daily basis. Deposit records, checks or checks images, wire transfer information, and records of disbursements may also be found in these files. In addition, banking records—such as authorized signatory lists, wire transfer instructions, sweep account information (bank orders to transfer daily receipts from depository accounts to investment accountings), and agreements with banks regarding custodial and other matters—may also be found here.

Agents' and producers' records should contain copies/images of the statements and billings to those entities for premiums written. Statements may be gross or net of commissions. Advance commissions statements and copies of agreements with the agents or producers that detail the rate of commission and the authority of the agent may also be found in these files.

Contingent commission records should contain the computations for any contingent commission or profit-sharing commission paid to agents and producers and the associated agent/producer agreements.

The accounting records for reinsurance ceded by the insolvent insurer prior to receivership should contain the details for any of the insurer's reinsurance transactions. The supporting schedules should contain summaries of reinsurance premiums and loss calculations for each treaty or reinsurer. The records should include: account statements; the reinsurance treaty; and endorsements thereto, including the interest and liability (the percentage participation) endorsement that each reinsurer has signed or a digest or summary thereof.

The documentation that an insurer maintains with respect to reinsurance assumed by the insolvent insurer prior to receivership depends on whether it was acquired directly from the cedent or through a reinsurance intermediary.

The direct method of acquiring assumed reinsurance may generate more documentation on the insolvent's end because the direct method generally requires an internal function to solicit or accept business from cedents. On the other hand, the broker market method may not require maintenance of an in-house reinsurance underwriting function because this role is assumed by the intermediaries. Therefore, only bordereaux or other summary information may be found at the reinsurer's offices.

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Nonetheless, the receiver may want to determine that the documentary information maintained by the ceding company or intermediary supports the bordereau.

Tax records (federal, state, local, and payroll) should contain the tax returns that have been filed with each jurisdiction. The records may contain reference to the original source information. The tax issues section of this chapter (Section VIII) has more information on taxes. Copies of filed returns may also be found in the general corporate records, with independent accountants or legal counsel, or can be obtained from the IRS.

Accounts payable records should contain vendor invoices, identification, invoice date, date approved, and date paid.

#### 4. Contracts and Agreements

The accounting, underwriting, or corporate legal department may be the custodian of agreements or copies of contracts into which the insurer has entered for insurance and general business operations. The agreements frequently may be referred to by the accounting department to assure that related transactions are authorized, recorded correctly, reported between the parties, and reconciled.

The contracts and agreements may include: real estate leases, furniture and equipment leases and maintenance agreements, information technology (IT) equipment leases, software licensing agreements, bank custodial agreements, hedging agreements, real estate management agreements, mortgage loan servicing agreements, trust funds, investment service, payroll service, management service, and allocation of federal income tax and expenses with affiliates. Other contracts related more to the insurance business may include agency contracts (general or managing), claims administration services, producer contracts, reinsurance contracts, interest and liability endorsements, and LOC agreements. For HMOs, it is important that the receiver have a complete inventory of all provider agreements, as well as a listing of all commercial groups with renewal dates and coverages.

Chapter 1—Takeover and Administration has more information on contracts, and Chapter 7—Reinsurance has more information on reinsurance treaties and LOCs.

#### 5. Financial Reports, Filings, and Other Records

The accounting department is the originating department and custodian of financial reports, both for internal use and external compliance. The department may also be the originating department for many analytical reports that are used by management, although such reports may also originate from other departments, such as claims or underwriting. Filings for compliance with governing jurisdictions may also be the responsibility of the accounting department.

A list of reports that are produced periodically and a schedule of required filings may be available from the controller. Otherwise, the receiver should discuss what reports and filings are produced and available with the chief financial officer (CFO).

The financial reports that the insurer should have readily available include: NAIC annual statements, NAIC quarterly statements (if required), and all supplemental exhibits that are part of these documents. The last page of the annual statement under “Supplemental Exhibits and Schedules Interrogatories,” if properly completed, reports the exhibits that should be filed. In addition to the reports, the accounting department maintains records and the supporting schedules that identify sources of data and reconcile the reports to the source.

Other external financial reports that may be found in the accounting department include: insurance department financial examination reports, actuarial reports and opinions, and CPAs’ audit reports. Along with these reports, the receiver should request related correspondence files (CPA management letters and management responses to the reports). If the insurer’s stock is publicly traded on a stock

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exchange, the insurer is required to file an annual report and various interim documents with the SEC; i.e., 10K and 10Q for U.S. markets, which are available at: <https://www.sec.gov/edgar.shtml>. These are complex filings that may require involvement of outside counsel and/or external auditors.

The accounting department may also be involved in periodic rate filings made with insurance departments. Folders may be available that support the rate change requested. Responsibility for rate filings and approvals may rest with the legal or underwriting department.

Some insolvent or financially troubled insurers have internal audit departments. The receiver should request a listing of all internal audit reports issued and any internal control procedure documents.

**C. Accounting Records at Other Locations****1. Branch Offices**

Branch offices of an insurer may operate independently of the home or main administrative office. However, the branch offices usually use the same computer system, or they upload data daily to the main office. Branch authority, method of operation, and procedure manuals should be in place both at the home office and with the branch manager.

The branch may have limited authority to carry out only certain insurance functions; i.e., either underwriting, claims adjusting, or both. In such instances, the accounting records at the branch will be limited. The branch office may have claims folders and underwriting folders with original documents.

**2. Claims Offices**

The claims offices facilitate the adjustment and settlement of claims. As such, each claims office should maintain open claim files for losses in its respective region. The receiver should collect any checkbooks that the claims office has on-site. Closed claim files may have been returned to the administrative office.

**3. Off-Site Storage**

Many insurance departments and/or insurers themselves require that copies or duplicates of essential records be maintained at an off-site location for the purpose of reconstruction in the event the records are lost or destroyed at the primary location. If this procedure is followed by the insurer, duplicates of records that cannot be located at the primary location might be found at the off-site storage. The off-site storage may also be the location of periodically stored computer backups for the same purpose. Old files (e.g., accounting, claims, underwriting, etc.) and other records may also be in storage. The off-site storage may be a branch office of the insurer or a contracted warehouse. An inventory list of records at the off-site storage location may be available from the controller or CFO. Review the inventory and compare with any retention policies.

**D. Records at Offices of Other Parties****1. Managing General Agent**

The types of records to be found at the offices of the MGA will depend on the authority of the MGA. If the MGA has the full powers of the insurer—including accounting, underwriting, rate filings and reinsurance—then all related accounting records, as previously described, may be at the MGA's office. If the MGA has limited authority, then only records that pertain to the specific function will be in the MGA's office. The insurer may have duplicate copies of some of the records at its main administrative office, although these frequently include only summarized reports or bordereaux.

*Chapter 3—Accounting and Financial Analysis***2. Third-Party Administrators**

TPAs should maintain sufficient records to perform their assigned function. Authority from the insurer may be necessary before any action is taken by the TPA. Alternatively, certain limited discretionary authority may be granted in the agreement with the TPA. Copies of written authority granted should be available from the insurer and/or the TPA.

**3. Reinsurance Intermediaries**

The intermediary should have in its office copies of reinsurance treaties, interest and liability agreements, endorsements, lists of reinsurer participations, files on LOCs, and historical records on premiums paid to and losses collected from the reinsurers. Reinsurance intermediaries should also have details to support the balances due, including details of amounts set off.

**4. Agents and Brokers**

Both agents and brokers will have files for policies that have been issued to insureds. Agents and brokers periodically (monthly) submit to the insurer a list of policies that have been issued. The agents and brokers may be responsible for the collection of premiums. In such instances, the insurer will bill them for the premiums due. Otherwise, the insurer bills the insured directly.

Producers are compensated by a commission on the premiums written. If the insurer uses the direct billing method, the agent or broker may have been paid an advance commission until the premium is collected from the insured. Otherwise, the insurer may bill the agent or broker on a basis net of the commission due. The insurer may also require the producers to pay the full amount of the premium. In turn, the insurer will pay the commission. Producers will have records of all business placed with the insurer.

**5. Department of Insurance**

Insurers are required to file numerous documents with the insurance department of the state of domicile and/or other states where the insurer is authorized to transact business. The receiver may consult legal counsel, state statutes, or the department's staff for specific state requirements. In addition to the annual, and possibly quarterly, statements and financial and market conduct examination reports, the following documents may be on file with the insurance department: contracts (reinsurance, agents, management, investments, etc.), dividends payment approvals, holding company and related party transaction approvals, rate filings, minutes of meetings, and biographical affidavits of officers and directors.

The insurance department examiners, as part of the documentation for support of their findings, may have photocopied certain documents, flowcharts, procedure manuals, or other materials that may be of interest to the receiver. The copies would be found in the examination workpapers that are kept by the insurance department.

**6. Certified Public Accounting and Actuarial Firms**

The CPA firm that performed the last financial audit may be a valuable source for copies of many of the insurer's documents. As part of their workpapers, the auditors may have copied pertinent documentation from the various accounting files. The auditors may also have documented and flow-charted the various significant functions of the accounting department and their related controls. Similarly, independent actuarial firms may have copies of insurer documents and/or working papers that document the calculation or evaluation of the carried reserves or pricing of business.

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## 7. Banks

Banks may be able to furnish images of canceled checks, check number sequence issued, bank statements, loan files, collateral files, safe deposit box records, and correspondence (signatories and requirements).

## 8. Internal Revenue Service

The IRS may be a source for the insurer's income tax returns and filed payroll tax forms.

## 9. Securities and Exchange Commission

If the insurer is regulated by the SEC (publicly traded company or public debt offering), then copies of any documents (10K, 10Q, etc.) filed with that agency may be obtained at [SEC.gov | Filings & Forms](https://www.sec.gov/filings).

**E. Internal Controls**

In an increasingly complex business, receivers manage insolvent insurers' investments, accounting systems, and other operations, all of which require close scrutiny and professional care in the safekeeping of the company's resources. If the company under receivership had an internal audit/control department, the receiver should request and review any internal control procedure documents and reports available.

There is currently no requirement that receivers of insolvent insurers prepare a report acknowledging responsibility for establishing and maintaining an adequate internal control structure. Even so, efforts should be made to ensure and promote effective controls. Further, the receiver should determine if, and to what extent, internal controls and other requirements of federal Sarbanes-Oxley Act-type documentation were created and maintained. All such documentation should be reviewed and matched to the processes and procedures observed and analyzed for identification of obvious control weaknesses.<sup>1</sup>

The receiver should consider establishing internal control policies and procedures and then periodically audit to determine compliance with established directives. Documentation of the receiver's accounting staff's evaluation or internal audit will be useful in identifying controls that should be maintained or strengthened, in providing a baseline for ongoing evaluations, and in demonstrating to other interested parties the rationale used in making the assessment.

This section addresses internal controls by identifying the broad functions typically found in a failed insurer.

The evaluation of controls over particular applications depends on the sources of information that flow into the applications and the nature of the processes to which the data are subject. These processes can be viewed as:

**Accounting estimation processes:** Processes that reflect the numerous judgments, decisions, and choices made in preparing financial statements. Examples of this include the actuarial reserve estimates or tax projections.

**Routine data processes:** Accounting applications/systems that process routine financial data (the detailed information about transactions) recorded in the records (e.g., the processing of receipts and disbursement transactions, other transaction processing, and payroll).

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<sup>1</sup> The federal Sarbanes-Oxley Act of 2002 was in many respects a response to high-profile corporate scandals, but the Act contains corporate governance and accounting regulation concepts that had been proposed even before these scandals became public. Although, in most respects, the Act is directly applicable only to publicly held companies, many Sarbanes-Oxley concepts may eventually be brought to bear on mutual or privately held insurance companies through state regulation, changes in delivery of accounting and auditing services, adaptation of bank lending covenants, insurance and/or reinsurance requirements, and court decisions in state law fiduciary duty litigation.

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**Non-routine data processes:** Other less-frequently applied processes used in conjunction with the preparation of financial statements (e.g., financial statement consolidation procedures, gathering of financial information for special reports, actuarial estimates of reserves, etc.).

In evaluating controls over an application/system, it is important to note that routine data processes generally are subject to a more formalized system of controls because of the objectivity of data and volume of information processed. Conversely, because accounting estimation processes and non-routine data processes typically are more subjective (involving estimates), or because they are performed less often, these processes typically do not have controls at the same level of formality. Consequently, the risk of errors occurring may be greater, and therefore additional scrutiny of the controls may be required.

It is suggested that the approach for evaluating internal controls consider five broad control objectives that affect the reliability of information in the accounts, records and financial statements of the insolvent insurer:

**Segregation of duties:** Are procedures in place to ensure that employees with the responsibility for recording or reporting transactions do not have custody of the assets on which they are reporting?

**Authorization:** Are controls in place to ensure that transactions are executed in accordance with the receiver's general or specific authorization?

**Access to assets:** Are controls in place to ensure that access to assets (including data) is permitted only in accordance with the receiver's authorization?

**Asset accountability:** Are controls in place to ensure that amounts recorded for assets are compared with the existing assets at reasonable intervals, and that appropriate action is taken regarding any differences?

**Recording:** Are controls in place to ensure that all transactions are recorded and that all recorded transactions are real, properly valued, recorded on a timely basis, properly classified, and correctly summarized and posted?

## VI. AUDIT/INVESTIGATION OF FINANCIAL STATEMENTS

The first step in performing an audit/investigation of an insurer's financial statements is to secure the insurer's cash and investment assets (as discussed above), and then obtain the most recently published financial statement. This may be the most recent annual, quarterly, or monthly financial statement submitted to the domiciliary state insurance department. As discussed later in this chapter, control should be obtained over all automated and manual records of the company, including financial, underwriting and claims records.

Computer systems should be secured at the date of takeover, which includes creating a backup to preserve data at the time of takeover, limiting physical access, changing locks and passwords, and obtaining and taking inventory of all computer disks and related backups. (See Chapter 2—Information Systems.)

All manual records of the insurer, including those at off-site locations, should be inventoried. A central location for all records should be established, and all records should be transported to this location. An electronic inventory system should be created to track the location of records/files.

A review of internal controls should identify the nature and extent of significant problems within the insurer and the segregation of duties. This review should ideally be performed by independent auditors at the beginning of the receivership and on a periodic basis thereafter.

An examination of all accounts as of takeover date and a balance sheet as of the date of receivership may be required for reporting purposes or to support litigation. The balance sheet can be prepared using GAAP-basis, statutory-basis, or cash-basis accounting. The accounting department, insurance department personnel, or independent



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accountants may perform this function. The balance sheet should be prepared using the accounts and the general ledger, as well as current bank statements, investment statements, cash reports, and other supporting documents.

The receiver's accountants should obtain workpapers from the last completed audit and/or from the preliminary audit done by an independent accounting firm. These workpapers and any documents or correspondence related to the audit should be reviewed, focusing on restricted assets, related-party transactions, commitments and contingencies, disclosure items, and any other support documentation or unusual items noted. The accountant may be asked to comment on the adequacy of the financial statements opined upon by the insurer's former accountants.

The accountants should also obtain the most recent audited annual statements, SEC reports, 10Ks, 10Qs, filed statutory blanks, and internal audit files and reports, again focusing on restricted asset documentation, related-party transactions, unusual items noted, and internal control studies.

The principal types of assets and liabilities that an insurer could have and the recommended procedures for establishing the balance sheet at the date of receivership and for securing assets on a prospective basis are discussed below.

**A. Cash**

As addressed in Section III, the existence, location, and amount of all cash, cash equivalent, short-term investments, and cryptocurrencies should be verified through direct confirmation with financial institutions, investment managers and other parties thought to be holding cash or investments. Special care should be applied to the identification of accounts not held in the insurer's name but to its benefit. Bank statements, investment statements, cash ledgers and cash-flow statements should be reviewed. This process should also include any funds held as collateral, LOCs, or other restricted cash. The initial procedures established with the financial institutions regarding wire transfers, as well as the identity of all who have access to the cash and investments, should be reevaluated and further consideration given to changing, restricting, or curtailing this access.

**B. Investments**

As with cash, the existence, location, amount, and type of liquid securities (bonds, stocks, mortgage loans, etc.) should be confirmed directly with financial institutions, any joint venture managing partners, investment and real estate managers, and other third parties thought to be holding securities. Investment statements from financial institutions, portfolio statements from investment managers, and other similar reports should be secured and used to establish a balance at the receivership date. Purchases, sales, and transfers of any kind, especially recent transactions, should be reviewed, with special attention to related gains/losses. A focus on related-party or affiliate transactions is important, as it could be helpful to the receiver and attorneys. The receiver should be aware of who has access to the investments and the authority to direct the investment managers/brokers. The receiver should consider changing and restricting this authority.

A review of the investment policies should be made and guidelines and procedures established regarding the future investing of securities. State law(s) should be researched to determine if there are any applicable restrictions. Receivers should take into account how they act in a fiduciary capacity, and any investment decisions and guidelines should reflect that. If an investment management firm is controlling allocations according to the investment policy, the receiver should inform them of any difference in the allocations. Allocation of this function between in-house personnel and independent investment services should take into consideration the current dollar amount of investments, projection of future investments, capability of the company personnel, and the complexity of transactions. The receiver should investigate company ownership of derivative and options instruments (see Schedule DB of the annual statement) and obtain a description of the company's hedging strategy.

The market value of investments as of the date of receivership should be ascertained to determine the realizable value of the assets.

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Examples of the various types of investments that may be recorded on the insurer's books include:

- Stock
- Bonds.
- Mortgage or asset-backed securities (ABS).
- Short-term investments (e.g., money markets, overnight deposits). (See cash above.)
- Government securities.
- High-yield, high-risk bonds.
- Mortgage loans.
- Joint ventures.
- Partnerships.
- Investments in subsidiary, controlled, or affiliated (SCA) entities.
- Real estate.
- Companyowned automobiles.
- Other assets, including health care-related receivables (for health-related receiverships).

The receiver should also be aware of the risks associated with the various investments recorded on the books of the insurer and should consider liquidating high-risk investments in favor of more conservative investments. Certain risks can be defined as:

- Credit risk
  - The risk that default may occur on an obligation.
- Market risk
  - The risk that values are affected adversely by changes in interest rates or similar type price changes.
- Liquidity risk
  - The risk that the ability to sell investments readily has diminished, resulting in an inability to generate cash to pay off obligations.
- Off-balance-sheet risk
  - The risk that a potential loss may occur in excess of the amount recorded on the financial statements. This loss may be related to guarantees or commitments entered into by the insurer with respect to a particular investment.

The insurer may have entered into hedge transactions or other sophisticated investment contracts; the receiver should have an understanding of these arrangements before undertaking any transactions relating to them.

*Receiver's Handbook for Insurance Company Insolvencies***C. Real Estate**

Determine the existence, the location, and the amount of related mortgage/debt and/or income from properties. Obtain any real estate-related management contracts. Consider obtaining current valuation of the properties through an appraiser or based on current market conditions. Transactions should be identified and quantified with related parties or affiliates on recent transactions within the voidable preference period. Management of existing properties should be reviewed by the receiver. The bank/lender holding related mortgage/debt should be notified of the receivership. If any of the real estate is held in a joint venture/partnership, obtain and review the joint venture/partnership agreements.

**D. Reinsurance Recoverables**

A present-day evaluation of the collectibility of reinsurance recoverables should be performed by the receiver based on current balances, aging of recoverables, and valuation of allowance for doubtful accounts by reinsurer. The processing of claims by the guaranty funds and the reporting of paid losses should be monitored by the receiver for adherence to protocols regarding completeness and timeliness and the effect of delays on its ability to collect reinsurance recoverables. (See Chapter 2—Information Systems and Chapter 6—Guaranty Funds.) Further, consideration should be given to whether ceded reinsurance premiums should be paid and the legal effect of refusal to pay. In the context of a life and health receivership, the receiver should be mindful of the guaranty associations' right to elect to continue reinsurance in accordance with Section 612 of the *Insurer Receivership Model Act* (#555) and Section 8(N) of the *Life and Health Insurance Guaranty Association Model Act* (#520), as adopted in the states.

A receiver should, as part of their evaluation of all reinsurance contracts, determine if there is a contingent commission component and if so, find out whether the estate qualified and received any present or future contingent commission.

Most reinsurance contracts reward contingent commission by way of the ceding commission; i.e., if the loss ratios are within the contract terms that trigger the contingent commission, it typically would be reflected in an increase in the percentage on the ceding commission.

**E. Prepaids**

Identify prepaid assets, which could include insurance coverage, taxes, pension benefits, etc. If a prepaid asset relates to property insurance coverage, cross reference the insured property to the real estate section, making sure that the property has been identified and recorded under the real estate section. Focus on any prepaids for services from related parties and affiliates.

**F. Agents' Balances**

Review agents' balances, focusing on additional information that should be recorded on the books of the insurer versus the agents' books. Examine agreements and commissions, and check for unlawful setoffs, evidence of broker funding, and other netting activities. Investigate any advance commissions, or bonus or delayed payment arrangements with agents. Consideration should be given to lags in the reporting of premium (and thus exposures), particularly when MGAs, TPAs, or multiple agents/brokers are involved. Particular attention should be paid to determine if there are any unearned commissions due to the cancellation of policies caused by the liquidation. Often the agency agreement makes the agent responsible for collection of premium. Under those agreements, if the agent is carrying an account receivable for uncollected premium and the amount of the uncollected premium has not already been paid to the insurance company, the receiver can demand that the agent make payment for the premium even though it has not been collected by the agent. Agent agreements also vary as to the terms for collection of audit premium. Some make the agent responsible for collection of audit premium, while some leave audit premium collection to the insurer. If the audit or audit collection responsibility lies with the agent, the receiver will want to enforce that, at least to the extent that the agent actually collects audit premium. Whether premiums

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are to be remitted to the receiver in gross or net of commissions is an issue of state law that should be resolved by the receiver in consultation with counsel.

**G. Loans or Advances to Affiliates or Agents**

Determine whether any receivables have been written off without an effort to collect.

**H. Personal Property**

Obtain a complete inventory of all personal property, such as furniture, fixtures, and equipment, including any depreciation schedule. Care should be taken to verify that the insurer is the owner of these assets as opposed to an affiliate or another entity. For example, some assets may be leased as a form of financing. If the company is a staff model HMO, the receiver should also obtain an inventory of medical equipment and a pharmacy or medical supplies inventory.

**I. Other Assets**

Review other assets, determining existence, location, and amount. Verify expiration dates and adequacy of trust accounts and LOCs posted as collateral by reinsurers, policyholders, and others. Ascertain whether any assets have been sold or transferred for less-than-adequate consideration. Review sales contracts and independent appraisals, and focus on any transactions with related parties and affiliates.

For health care-related receiverships, health care receivables can include items like provider risk sharing receivables, coordination of benefits, provider overpayments, and/or subrogation recoverables among other items.

**J. Accounts Payable and Accrued Expenses; Debt**

Identify and quantify liabilities outstanding for all general and secured creditors and employee-related expenses. Employee-related expenses include payroll and bonus, severance, vacation, and personal time. Obtain pension and deferred compensation program documentation where applicable. These items can be determined by using the payroll register, personnel policies and procedures, and personnel records. Confirm that all personnel receiving monies are currently employed by the insurer, and review all related-party transactions.

Notify any bank/lender of the receivership, and confirm outstanding balances as of the date of receivership. Review debt agreements, loan files, and collateral files to determine that liabilities are properly recorded on the financial statements as to type of debt and classification; i.e., short-term versus long-term.

**K. Claim Reserves and Incurred but Not Reported (IBNR) Claims**

Obtain an understanding of the insurer's policy on booking reserves, and determine whether the policy has been consistently followed. Make any necessary adjustments to the financial statements. Continue to monitor claims for ongoing evaluations and reporting of case reserves.

The receiver must consider the use of in-house actuaries or independent actuaries to determine the adequacy of reserves. Consider commissioning a new actuarial study, as of the liquidation date, to establish ultimate losses in a property/casualty (P/C) receivership or to evaluate blocks of business in life, accident, and health carriers. The additional cost of the study may be justified by the receiver's enhanced ability to finally commute reinsurance or to adjust account balances that involve retrospectively rated policies. (See Chapter 5—Claims.)

Determining the adequacy of claims reserves and incurred but not reported (IBNR) claims is especially critical for HMOs. It is also important to identify the inventory and associated liability for claims that are in-house but have not been processed through the HMO's claims system. The receiver may consider hiring

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a TPA or other outside claims processing service to process the claims and determine the ultimate liability. The receiver may also consider hiring an actuary to establish the medical loss ratio (MLR) for each of the HMO's product lines in order to determine whether a line of business is profitable.

**L. Income and Expense**

Examine any unusual income and expense items, including sales to or purchases from related parties or affiliates, significant gains/losses, and unusually high expenses in relation to the size of the insurer and type of business.

**M. Equity**

Review surplus accounts, and investigate any unusual changes in surplus, statutory to GAAP adjustments, recent capital contributions, recent capital issues, and other activity that appears unusual.

**VII. RELATED PARTY TRANSACTIONS**

Insurers often enter into many different types of transactions with various related-party entities. Each of these transactions should be scrutinized carefully because of the potential that they were not the result of arm's-length bargaining. Further, even fairly negotiated transactions may not have been carried out according to the terms of the agreement. Finally, the transaction may not be exactly as it appears. For example, a sale of an asset at a huge loss may in fact amount to a fraudulent transfer. Related parties may include a parent company, affiliates or subsidiaries, shareholders, directors, officers, and employees. Transactions with affiliates are required to be disclosed in Schedule Y, Part 2 of the annual statement. Related parties may also include entities or individuals that are not as easily identified, as they may be owned by individuals associated with the insurer (such as directors, shareholders, officers, or employees), or they may be entities that have entered into significant transactions with the insurer. These transactions may be significant as to the number of transactions or as to the amount of money involved. Alternatively, the transactions may be immaterial from the standpoint of assets changing hands, but they may be significant because of the nature of the transaction (guarantees, debt forgiveness, etc.).

It is important to identify related parties and transactions between the insurer and any related party as quickly as possible for many reasons, including to preserve the assets. Often, related-party transactions are not appropriately reflected on the insurer's books; sometimes the transactions may not be reflected at all, therefore misstating the insurer's assets or liabilities. The transactions may be accounted for (if at all) on the incorrect entity's books, and funds or entries may be commingled by management, thinking that all the companies are part of a consolidated group or owned by the same parent. However, the legal corporate entities are important, especially when one or more of them become insolvent. Insurers are subject to the jurisdiction of the insurance commissioner. Other entities are governed by bankruptcy law and are generally not subject to the jurisdiction of the commissioner; however, they may be subject to the jurisdiction of the receivership court in certain circumstances. On Aug. 17, 2021, the NAIC adopted a new provision, Section 5A(6), of the *Insurance Holding Company System Regulatory Act* (#440), which provides that the affiliated entity whose sole business purpose is to provide services to the insurance company is subject to the jurisdiction of the receivership court. This applies to affiliates performing services for the insurers that are an integral part of the insurer's operations or are essential to the insurer's ability to fulfil its obligations.<sup>2</sup>

Further, with regard to commingled data and records, the 2021 revisions to Model #440 and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) specify that records and data of the insurer held by an affiliate are identifiable and are segregated or readily capable of segregation at no additional cost to the insurer. The models' reference to "at no additional cost to the insurer" is not intended to prohibit recovery

<sup>2</sup> The full text of Section 5A(6) of the *Insurance Holding Company System Model Act* (#440) is available at [https://content.naic.org/sites/default/files/MO440\\_0.pdf](https://content.naic.org/sites/default/files/MO440_0.pdf). The 2021 NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) may not yet be adopted in every state. Therefore, receivers should refer to the applicable state's law.

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of the fair and reasonable cost associated with transferring records and data to the insurer. Because records and data of the insurer are the property of the insurer, the insurer should not pay a cost to segregate commingled records and data from other data of the affiliate.

Related-party transactions may give rise to culpability on the part of the interested entities or individuals. Preferential transfers, fraudulent transfers, and other bases for liability are discussed further in this chapter and in Chapter 9—Legal Considerations.

Organization charts showing a parent, affiliates, or subsidiaries may be obtained from a schedule within the annual statement (Schedule Y, Part 1), board minutes, or SEC filings. Additionally, relationships with insurance groups and entities that share common ownership can be found on Schedule Y, Part 3. It is more difficult to identify individuals who might have been involved with related-party transactions, and often that list of individuals is much longer. However, the receiver should start with the list of officers and directors of the insolvent insurer; its parent, subsidiaries or affiliates, again listed in the annual statement or SEC documents; and board minutes. Stockholders' names should be listed in shareholder records maintained, possibly, by legal counsel or trustees. Lists of employees may be obtained from payroll registers. When these transactions are reviewed, it may be determined that a significant number or dollar volume of transactions have occurred with one individual or entity. This may indicate that the involved entity or individual is also a related party.

Once an initial list of related parties is established, the types of transactions that may have occurred between these entities can be determined. The types of transactions that may be identified relate to various types of business transactions. An understanding of the related entities and how they are affiliated will help the receiver to identify and formulate the types of transactions that may have occurred between them. Many insurer company groups have established affiliates to act as investment vehicles or managers, brokers, reinsurers, MGAs, TPAs, premium finance companies, and computer service companies, or to accept select types of risks. A parent holding company may have been established. It is important to ascertain the related parties and their affiliation because the insolvent insurer may have claims against affiliates.

The receiver should review the notes to financial statements in the annual statement, the independent auditor's report and the state insurance examiner's report. These reports typically identify and summarize some of the significant related-party transactions. Also, board minutes will frequently contain discussions or resolutions pertaining to specific significant transactions involving related parties.

Brokerage, agency, or management agreements may exist between the insurer and its affiliates. There may also be reinsurance (both assumed and ceded) or pooling arrangements among affiliates. Expense-sharing arrangements may exist. An affiliate may provide data processing services. (The receiver needs to determine immediately if they can continue to obtain these services and how to secure the data.) Leasing arrangements for offices, data processing equipment, and furniture and fixtures may also exist. With respect to all agreements with affiliates, the receiver should be alert to possible differences between the apparent transaction and its real substance.

Holding companies may also provide management expertise for which there is a management agreement and/or expense allocation agreements. Tax-sharing agreements may also exist between all the affiliates and parent.

Insurers may have management agreements with unaffiliated parties, or control may be maintained through interlocking directors of the management company and the insurer. For example, an HMO may be controlled by a provider group such as hospitals. Therefore, these agreements or contracts need to be reviewed to determine if they are arm's-length transactions.

It is important to identify these transactions as quickly as possible, not only for the identification of assets and liabilities that may be recovered by the insurer, but also to determine if alternative data processing, management, facilities, etc., should be obtained, as these services may no longer be available from the affiliate. Alternatively, such services may be available on more favorable terms from nonaffiliated providers.

The types of transactions that may have occurred between the insurer and its directors, officers, employees, and stockholders may be the same as some of the above, but they may also include items such as travel and expense

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advances, unsecured loans, or loans secured by personal or real property. Companies owned by any of these individuals may also be responsible for providing services discussed above, including leases, data processing, brokerage, reinsurance, etc.

To determine the existence of these types of transactions, their validity, and the appropriate accounting for the transactions (both in the books and records of the insurer and in cash flow), the tasks described below should be performed.

**A. Identify Related Parties**

The receiver should obtain or develop organizational charts to identify any and all affiliates and related parties. These affiliates should be identified as: 1) parent companies; 2) subsidiaries; or 3) affiliates (which would be organizations owned or controlled by the same parent company, but not owned by the insolvent insurer). Schedule Y, Part 1 of the annual statements provides an organization chart of the insurance holding company system; Schedule Y, Part 2 includes transactions with affiliates; and Schedule Y, Part 3 includes further information on insurance groups and entities that share common control.

After preliminary identification of these related entities, the receiver should determine the status of these related entities:

- If the related parties are financially troubled, are the parties under the jurisdiction of the insurance regulator of their state of domicile, or are the parties under the jurisdiction of corporate bankruptcy laws?
- Does the insolvent insurer need to file a proof of claim against the related entity to preserve its claim? (The receiver should consult with counsel about the risks of submitting to a foreign court's jurisdiction on issues other than those set forth in the proof of claim.)
- Are the entities affiliated, in which case the insolvent insurer may have access to the assets of the related entities?
- Is cash commingled among the companies?
- Are the entities operating as alter egos?

The receiver should also obtain lists of individuals, as well as their related entities who might also be related parties, beginning with the directors and officers of the insurer listed in its annual statement and the officers and directors of the insurer's subsidiaries and affiliates. The receiver should also obtain a list of all shareholders and employees of the insolvent entity. Each of these individuals may be categorized in a manner similar to that described above for companies that are related entities. Each can be evaluated for the types of transactions that may have occurred between them and the insurer. It should be kept in mind that these individuals may have been involved with other entities that appear not to be related but, in fact, may have had sufficient transactions with the insolvent entity that they, too, become related entities.

**B. Find Supporting Legal Documents for Transactions**

The receiver should obtain all key documents and agreements entered into between the insurer and its various related entities. As discussed above, these agreements may have been collected through the inventory of documents in the takeover period. If these documents have not been located, a search may be made to locate any agreement or documents that indicate arrangements between the insolvent insurer and the various related entities.

As the receiver completes the procedures described below and in Chapter 4—Investigation and Asset Recovery, identified transactions may indicate the advisability of searching for additional documents.

*Chapter 3—Accounting and Financial Analysis***C. Identify Amounts Associated with the Related Party Transactions**

Next, the receiver should review the various accounting records of the insurer, including the chart of accounts, general ledger, journal entry listing, and transaction listings. It must be noted that when dealing with related-party transactions, the receiver should attempt to obtain the corresponding records of related entities to cross-reference transactions and amounts as described in the procedures below.

The chart of accounts may be obtained and reviewed for any accounts that appear to be intercompany receivables, intercompany payables or loans to affiliates, related parties, directors, officers, shareholders, employees, etc. This may be an easier task for some companies than others. Often separate accounts will be established for all related-party transactions. On the other hand, the transactions may be difficult to identify if they were charged to accounts with innocuous titles such as “other assets” or “miscellaneous expense,” or if they were netted with other transactions. Some transactions, particularly insurance-related transactions, may be buried in the normal transactions of the insurer. However, if the receiver reviews the chart of accounts to identify preliminarily the accounts that may be with related entities and individuals, subsequent procedures will help identify buried transactions.

After particular accounts have been identified as possibly containing related-party transactions, the general ledger should be reviewed to ascertain the dollar amount in the identified accounts. The receiver may want to prioritize the items reviewed by the dollar magnitude of the balances. However, caution should be taken at this point, as the dollar magnitude alone may not be indicative of the significance of the transaction. Understanding the types of transactions recorded in the particular account is helpful, especially if there is a high volume of transactions that have been netted. A small balance in an account with a significant volume of transactions may have other implications. No cash may have changed hands in the case of guarantees or debt forgiveness.

The next step is to obtain the transaction register by month to see the actual transactions that have been posted to the account. This will be the beginning of the investigation, or audit phase of the review. As mentioned above, depending on the size and type of systems the insurer used, it is possible that the general ledger listing also will provide the listing of transactions posted to the various accounts, meaning that a separate transaction listing is not necessary or available.

It may be beneficial to obtain a listing of disbursements sorted by payee. This can help identify related-party transactions that, as mentioned above, may not appear significant standing alone and that may be buried in other transactions of the insurer.

The above steps are easily accomplished if the insurer had an efficient, effective accounting system. Unfortunately, this is often not the case with many insurers that become insolvent. Frequently, the accounting system may not have been operational as originally designed due to budgetary concerns, cutbacks of manpower, and other problems during the period immediately preceding the insolvency, or there may have been intentional distortion of the system to hide improper transactions. In any case, it may be necessary to reconstruct information.

**D. Cross-Reference to Affiliates’ Books**

If the receiver has access to the related entities’ books, they should be obtained from those entities. A receiver who does not have ready access should attempt to obtain access promptly. The reciprocal accounts for those entities may then be reviewed and cross-referenced to see that the amounts recorded on the related entities’ books are in fact the reciprocal of the amounts on the insolvent insurer’s books. Differences should be investigated. In addition to the cross-referencing, the receiver may also perform all the analytical procedures discussed above for the related entities’ identified accounts. Through this process, the receiver may find other transactions that need to be evaluated and analyzed. In the absence of a court order, the receiver will usually be unsuccessful in his/her attempt to obtain the books and records of related entities.



*Receiver's Handbook for Insurance Company Insolvencies***E. Analyze All Transactions**

Once related-party transactions have been identified, detailed analyses of most of the transactions can be completed to determine whether they were business transactions entered into at arm's length and for valid business reasons with appropriate support. The arm's-length aspect of some transactions may be difficult to determine (or refute); however, all such transactions should be reviewed with an appropriate degree of skepticism. The analysis of the identified transactions may be completed by the accounting department or by the audit/investigation team.

The receiver may attempt to segregate transactions into types for analysis. Otherwise, the task may seem too large to accomplish. The transaction types may be determined by the accounts that have been identified as including related-party transactions and the relationships of the related parties. For example, if the related-party accounts include advances to or from, or accounts receivable or payable, then one of the transaction types might be cash advances or loans to related parties. The following are some of the transaction types that may be identified for analysis:

- Advances/loans to related parties.
- Reinsurance receivable/payable.
- Premiums due to/from.
- Commissions due to/from.
- Operating expenses receivable/payable (leases, management, computer services, etc.).
- Payment of dividends.
- Purchase or sale of assets from or to related parties.

The receiver should then systematically review the transaction types in each of the identified accounts. This would include noting the description of the transaction in the transaction listing.

It may be necessary for the receiver to search for the underlying documentation for all entries. The journal entry listing and other documents obtained in the document search may be helpful in this effort. Also, the various schedules in the annual statement should be reviewed. In any event, the receiver will have to seek any underlying information that may indicate the substance of the recorded transaction. The receiver may also have access to current or former employees who can shed light on the nature and intent of these transactions, locate documentation, and otherwise interpret such documents. Once the transaction entry has been obtained and the underlying documentation has been obtained and reviewed, the receiver can determine whether the information was recorded appropriately on the insurer's books. At that time, the receiver should add the correct dollar amount of this item to the schedule of items for ultimate determination of action. This schedule should be prepared on a gross basis, without netting of balances, to enable the receiver to see the full impact of the transactions.

The receiver should systematically analyze all significant transactions in all identified accounts, as demonstrated above, until all transactions have been reviewed and scheduled for ultimate disposition.

As each of these transactions is being reviewed and scheduled, it is always necessary to cross-reference to other related parties' books and records, if available.

**F. Evaluate All Identified and Analyzed Transactions**

After all transactions have been reviewed, analyzed, and scheduled, the receiver will have to evaluate the propriety of the transactions and any action necessary. Some of the transactions might not stand depending

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on the type of transaction and when it occurred relative to the date the insurer was declared insolvent. If the related-party transactions result in receivables to the insolvent entity, it may be necessary for the receiver to file a proof of claim in another proceeding if the other party is in some form of receivership. If the related-party transaction resulted in payables from the insurer, the receiver may have creditors that need to be notified of the insolvency.

**G. Potential Reconstruction of Records**

If the insurer does not have the types of records listed above, it may be necessary to use available records to reconstruct the needed information. In such cases, the receiver should begin with the insurer's annual statement. From this, the receiver may find supporting documents for the numbers entered and filed in this statement. If the underlying information does not agree with the annual statement, the discrepancies should be identified and the reason for the discrepancies determined. The receiver may be able to obtain information from the insurance department or outside auditors, which can be of great benefit when reconstructing records.

If a total reconstruction is required, the receiver should start with all the bank statements for the past year (at a minimum). The receiver should review the receipts and disbursements from the most recent year to determine if there are additional types of transactions that were not previously disclosed in the last filed annual statement. This detailed analysis should include a schedule that categorizes disbursements by type and segregates those related to the payment of claims or reinsurance and other underwriting expenses from those that were pure operating expenses. Disbursements that may have been to related entities should also be segregated and identified. The same type of schedule should also be prepared for all cash receipts.

If available, any financial information regarding affiliates, subsidiaries, or the parent company would be useful in this reconstruction.

**H. Data and Records of the Insurer Held by an Affiliate**

The *Insurance Holding Company System Model Act* (Model #440 and *Model Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) contain provisions that address data and records of the insurer that are held by an affiliate. While the models have contained provisions since 2010, on Aug. 17, 2021, the NAIC adopted revisions to further clarify owner of data and records.<sup>3</sup>

Specifically, the Model #440 specifies the following:

- The books, accounts, and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.
- All records and data of the insurer held by an affiliate are and remain the property of the insurer, are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation, at no additional cost to the insurer, from all other persons' records and data. The affiliate may charge a fair and reasonable cost associated with transferring the records and data to the insurer. However, the insurer should not pay a cost to segregate commingled records and data. Therefore, if records and data belonging to the insurer is held by an affiliate (e.g., on the affiliate's systems), upon request, the affiliate shall provide that the receiver can:

<sup>3</sup> Although in 2021 the NAIC adopted revisions to Model #440 and *Model #450* related to receivership matters including records and data, these revisions may not yet be adopted in every state. Therefore, receivers should refer to the applicable state's law.

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- Obtain a complete set of all records of any type that pertain to the insurer's business.
- Obtain access to the operating systems on which the data is maintained.
- Obtain the software that runs those systems either through assumption of licensing agreements or otherwise.
- Restrict the use of the data by the affiliate if it is not operating the insurer's business.
- The affiliate shall provide a waiver of any landlord lien or other encumbrance to give the insurer access to all records and data in the event of the affiliate's default under a lease or other agreement.
- The revisions to Model #440 and Model #450 also describe that records and data that are otherwise the property of the insurer, in whatever form maintained, include, but are not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records, or similar records within the possession, custody, or control of the affiliate.
- Section 19 of Model #450 lists provisions that should be included in agreements for cost-sharing services and management services between the insurer and an affiliate, which includes certain provisions specific to the insurer being placed in supervision, seizure, conservatorship, or receivership.
  - All of the rights of the insurer under the agreement extend to the receiver or commissioner to the extent permitted by state law.
  - Records and data of the insurer are the property of the insurer, are subject to the control of the insurer, are identifiable, and are segregated from all other person's records and data or are readily capable of segregation at no additional cost to the insurer.
  - If the insurer is placed into receivership, a complete set of records and data of the insurer will immediately be made available to the receiver or the commissioner, shall be made available in a usable format, and shall be turned over to the receiver or commissioner immediately upon the receiver or the commissioner's request, and the cost to transfer data to the receiver or the commissioner shall be fair and reasonable.
  - Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed into supervision, seizure, conservatorship, or receivership.
  - Specify that the affiliate will provide the essential services for a minimum period of time (specified in the agreement) after termination of the agreement, if the insurer is placed into supervision, seizure, conservatorship, or receivership.
  - Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure, notwithstanding supervision, seizure, conservatorship, or receivership.
  - Specify that if the insurer is placed into supervision, seizure, conservatorship, or receivership, and portions of the insurer's policies or contracts are eligible for coverage by one or more guaranty associations, the affiliate's commitments under certain provisions of Section 19 of Model #450 will extend to such guaranty association(s).<sup>4</sup>

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<sup>4</sup> The full text of Section 19 of Model #450 is available on the NAIC website at: [https://content.naic.org/sites/default/files/MO450\\_0.pdf](https://content.naic.org/sites/default/files/MO450_0.pdf).

*Chapter 3—Accounting and Financial Analysis***VIII. TAX ISSUES**

In virtually every receivership, federal tax issues must be considered. The insurer cannot be discharged or liquidated without the filing of federal income tax returns. In addition, consideration should be given to the payment of federal corporate income and other taxes. The receiver can be held personally liable for the payment of certain unpaid taxes if specific procedures are not followed.

Because of the complexity of federal income taxation issues, the potential personal liability of the receiver and the additional complexities associated with receiverships—and the significant impact on the estate from items such as forgiveness of debt, consolidation rules, and other matters—the receiver should hire individuals with expertise in these areas. Such experts could include independent CPAs or counsel with experience in such matters. Furthermore, because of the continuously evolving nature of federal income taxation issues, many of the issues addressed in this chapter may have changed. This is a reason that the receiver should hire individuals that will be as up to date as possible in these areas and why receivers should seek updated guidance on tax matters (both federal income and state premium tax issues) in reference to the issues addressed in this Handbook.

The receiver should ascertain the insurer's tax status as part of the takeover procedure, in addition to securing copies of tax returns and company tax payment records. Foremost, the receiver should learn whether all tax returns due have been filed and any amounts owing have been paid. In addition, the receiver should learn whether the insurer was part of a consolidated group filing or party to any tax sharing or similar contractual agreements. The receiver should also obtain and carefully review and understand the provisions of any tax-sharing agreements between the insurer and any related parties. In almost all receiverships, the receiver takes over the insurer but not necessarily its holding company or other affiliated group with which the insurer may be consolidated for tax purposes. In addition, the insurer may own nonregulated subsidiaries that are taxed differently from the insurer.

Prior years' returns and any correspondence with the IRS also should be reviewed. Discussion may be held with any outside CPAs or counsel who may have been involved in filing the returns or in handling any disputes with the IRS. The receiver should be alert to any contingencies that may exist for payment of taxes, penalties, and interest resulting from failure to file on time, failure to pay tax due on the return, inappropriate treatment of income or deductions on the return, etc. Contingency reserves recorded on the balance sheet of the insurer or its parent should be reviewed and analyzed for purposes of determining tax positions taken by the company that are not "more likely than not." The receiver should consider these contingencies when allocating distributable assets of the estate in light of the priority generally alleged by the federal government and accorded by the applicable priority statute. (See Chapter 9—Legal Considerations.)

The receiver may request an account transcript from the IRS for the receivership entity. The transcript, available by type of tax (Form 1120, Form 941, etc.) and year, may be obtained by filing form 4506-T, Request for Transcript of Tax Return. An account transcript typically contains information on tax payments (amounts and dates) and filing of returns (dates).

Income taxation of insurers is somewhat different from conventional corporations, with additional provisions that are applicable to life insurers contained in Part I of Subchapter L of the Internal Revenue Code (IRC) and specific provisions applicable to other insurance companies contained in Part II of Subchapter L of the IRC.

Even though an insurer may have substantial statutory losses, it is possible that based on its taxable income, federal income taxes may be due. See discussion in this chapter of deferred income that may be taxed when a company loses its status as a life insurance company for federal tax purposes. There also exists the possibility that the insurer is entitled to recover prior years' taxes because of the existence of capital losses, operating losses, or tax credits. Operating losses can be carried back two years and carried forward 20 years by P/C insurers. Prior to 2018, life insurers were allowed to carry back ordinary losses for three years and carry forward losses for 15 years. No carryback is allowed for operating losses of insurers other than P/C insurers for taxable years after Dec. 31, 2017, but these insurers are allowed indefinite carryforwards, which are limited to 80% of taxable income in each year to which the operating loss is carried. All insurers are allowed to carry back capital losses three years and carry forward up to five years to offset capital gains. Tax credit carrybacks vary depending upon the type of credit, so you should

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always check with a tax advisor. The insurer may also have made estimated tax payments that can be recovered. Additionally, an insurer may be entitled to a tax recovery because of its inclusion in a consolidated tax filing where its losses were used to set off taxable income from affiliated entities. Tax recovery due to tax sharing agreements will not be recoverable from the IRS but must be recovered from affiliated entities. Therefore, income tax recoverable may not be collectible and, as such, should not be booked. In addition, under Section 848 of the IRC, an insurer must capitalize its estimated acquisition expenses, which are then amortizable (deductible) over the ensuing 10-year period for amounts capitalized prior to through Dec. 31, 2017, and over a 15-year period for amounts capitalized after Dec. 31, 2017 (five years for smaller companies).

The receiver should be aware that IRC Section 6511(a) places a deadline by which claims for credit or refund of taxes must be made. In many instances, this deadline will be three years from the due date of the return for which the claim for refund is being made. However, if the claim for refund results from the carryback of losses to preceding tax years, the deadline will be three years from the due date of the return that generated the loss. Due to the critical nature of properly determining these deadlines, the receiver should consider consulting independent CPAs or counsel with experience with these matters.

In addition to federal corporate income taxes, the receiver also has to be concerned about foreign taxes, state corporate income taxes, federal and state payroll taxes, premium taxes, real estate taxes, federal excise taxes, state franchise and excise taxes, sales taxes, and personal property taxes, along with myriad reporting and filing requirements. The receiver will also need to file final tax returns upon the closing of the receivership estate.

**A. Notice**

Within 10 days from the date a receiver is appointed, Form 56 (Notice Concerning Fiduciary Relationship) must be filed with the IRS. A certified copy of the court appointment should be attached. This form should be filed for all forms of receivership. The receiver should specify that they are to receive notice concerning income, excise, sales and property, and payroll tax matters. The list of tax forms should include Form 1120L (for life companies) or Form 1120PC (for P/C companies), Form 941 (quarterly payroll tax returns), Form 940 (Federal Unemployment Compensation Tax), and Form 720 (Federal Quarterly Excise Tax Return). If the insurer owns subsidiaries, the receiver should also file a Form 56 notice for each subsidiary.

In addition to the federal filing, many states have similar notice requirements. Even without a specific requirement, sending similar notice to the taxing authorities of those states and foreign countries where the insurer did business or had employees should be considered.

Form 56 is not to be used to update the last known address of the receivership entity. The receiver should file form 8822, Change of Address, with the IRS.

**B. Income Taxes**

Under Section 1.6012-3(b)(4) of the federal income tax regulations, a receiver or trustee who, by order of a court of competent jurisdiction, by operation of law or otherwise, has possession of or holds title to all, or substantially all, the property or business of a corporation, must file a return in the same manner and form as the corporation.

The due date for filing federal corporate income tax returns for insurance companies is the 15<sup>th</sup> day of the fourth month (generally April 15) of the year following the year end of the company. (For years beginning prior to 2016, the due date was the 15<sup>th</sup> day of the third month [generally March 15] of the year following the year end of the company.) A six-month extension to Oct. 15 can be obtained for the filing of the return if the extension form is sent to the IRS prior to the April 15 deadline. This extension, however, is only for the filing of the return and not for the payment of tax liabilities. The April 15 deadline is applicable to calendar-year companies only. There may be certain non-insurance companies under the receiver's authority that have fiscal year-ends.

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Once an affiliated group of corporations files a consolidated return, it must continue to do so as long as the group remains in existence. Therefore, consolidated returns must continue to be filed with the insurer’s subsidiaries. In addition, the IRS has ruled under PLR 9246031 that an insurer in liquidation under state law generally is required to be included in its common parent’s consolidated federal income tax return. The receiver may request approval from the IRS to file separate returns. This permission may be granted on a case-by-case basis for good cause shown. Pursuant to the consolidated return regulations (1.1502-75), the parent of the affiliated group must request deconsolidation for good cause. A deconsolidation may weaken the IRS’ position; as such, the granting of a deconsolidation is not guaranteed.

Following is a list of various insurance or insurance-related entities and the federal income tax form that should be filed:

<b>Type of Insurer (Based on Business Written)</b>	<b>Federal Income Tax Form</b>
P/C	1120-PC
Life	1120-L
HMO	1120-PC
Staff Model HMO	1120
501(c)(15)(A) - Tax Exempt	990
Title	1120-PC
Blue Cross Blue Shield Association	1120-PC
Health	1120-PC
Health w/Noncancellable and/or Guaranteed Renewable Contracts	1120-L

For a company to be considered an “insurance company,” at least half of its business during the taxable year must be the issuing of insurance or annuity contracts or the reinsuring of risks underwritten by insurance companies.

For a company to be considered a “life insurance company,” it must be engaged in the business of issuing life insurance and annuity contracts (either separately or combined with accident and health [A&H] insurance), or noncancellable and/or guaranteed renewable contracts of health and accident insurance. Also, its life insurance reserves plus unearned premiums—and unpaid premiums on unpaid losses and on noncancellable life, accident, or health policies not included in life reserves—must make up 50% or more of its total reserves.

In certain special situations, managed care organizations may qualify for tax exempt status; if so, they would file Form 990.

1. Life Insurance Companies

Life insurers (whether stock, mutual, or mutual benefit) that meet certain reserve requirements file Form 1120-L. If a life insurer does not meet the reserve requirements, then it must file Form 1120-PC. If a stock life insurer loses its life insurance tax status because its life insurance reserves fall below the minimum requirement, then taxes that were deferred in earlier years may now become due. In Revenue Procedure 2018-31, Section 26.03 provides for an automatic accounting method change when there is a change in qualification as a life insurance company as defined in Internal Revenue Code (IRC) Section 816(a).

For taxable years ending before Jan. 1, 2018, life insurers with less than \$500 million in assets are entitled to a small life insurer deduction of 60% of their “life insurance company taxable income.” This deduction is available for income up to \$3 million and then is gradually phased out on income from \$3

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million to \$15 million. For taxable years after Dec. 31, 2017, the small life insurer company deduction is repealed, and the alternative minimum tax for corporations is repealed as well.

## 2. Non-Life Insurance Companies

Non-life insurers (stock and mutual) file Form 1120-PC. Non-life companies generally are taxed on their statutory income with certain modifications, including the discounting of loss reserves and the non-deductibility of 20% of the increase of the unearned premium reserves. The non-deductible 20% of the unearned premium reserve (UPR) gives the taxpayer a tax benefit when the UPR is reduced, but the effect of the reversal of the 80% deductible portion has a greater impact and may create taxable income. As previously stated, the receiver should consult their tax consultant regarding the ramifications of these issues.

Non-life insurers whose written premiums for the year do not exceed \$2.2 million (an amount that is inflation-adjusted for each taxable year beginning after 2015) may elect to be taxed only on investment income under Code Section 831(b). The premium limits are based upon the premiums of a “controlled group” of corporations as defined by Code Section 1563(a), with the exception that more than 50% is the definition of control. The fact that an insurer is in receivership does not remove it from a “controlled group.” The company also must meet certain diversification requirements with regard to premiums and owners as prescribed in IRC Section (831(b)(2)(B)). Taxation on investment income may not be advantageous to companies that are currently generating or using net operating losses, as the company may lose the benefit of those losses. IRC Section 831(b)(3) prescribes limitations on the use of net operating losses for insurance companies taxed only on investment income.

Prior to Jan. 1, 2005, small non-life insurers with less than \$350,000 of premium income could qualify to be exempt from income tax under Code Section 501(c)(15). Many receivers took advantage of this provision to exempt liquidation estates from federal income taxation. In 2004, IRC Section 501(c)(15) was amended to provide tax exempt status only to those non-life insurers with gross receipts less than \$600,000, and then only if more than 50% of the gross receipts were from premiums. Because most companies in liquidation have virtually zero premium income after the first couple of years of the liquidation, and because most have annual income exceeding the \$600,000 cap, this amendment to Code Section 501(c)(15) generally eliminated its applicability to insurance receiverships.

The impact upon insurance companies in receivership was considered as Code Section 501(c)(15) was being amended in 2004, and the applicability of the exemption to insurance companies in receivership was specifically extended through calendar year 2007. However, as of Jan. 1, 2008, any insurers in liquidation that may have previously been qualified for exemption under the pre-2005 provisions of Code Section 501(c)(15) became ineligible for such exemption and are subject to federal income tax from that time forward unless they met the new requirements.

## 3. Special Relief

Under Revenue Procedure 84-59, the receiver may apply to the district director of internal revenue for relief from the filing requirements under limited circumstances. In order to request this relief, the insurer has to have ceased operations and no longer have assets or income.

## 4. Prompt Audit

The receiver may request that a prompt determination be made under Revenue Procedure 2006-24 whether the income tax return is being selected for examination by the IRS or is accepted as filed. The receiver will be discharged from any liability upon payment of the tax shown on the return if the IRS does not notify the receiver within 60 days after the request that the return has been selected for examination, or if the IRS does not complete the examination and notify the receiver of any tax due within 180 days after the request. This procedure enables the receiver to proceed with the receivership, or enhances the possible sale of the insurer, by resolving contingencies relating to taxes due for prior

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periods. The prompt audit provisions specifically apply to bankruptcy proceedings, not state liquidations. Certain IRS offices have approved applying the provisions to state liquidations. However, the approval is not automatic. When this is the case, a request for prompt assessment should be made under IRC §6501(d). This will reduce the statute of limitations for assessment to 18 months. The request contemplates a corporate dissolution in 18 months and requires the submission of Form 4810 to the IRS.

## 5. Carrybacks

An insurer often becomes financially troubled because it incurred operating and/or other losses. Such losses may be deductible for income tax purposes. A review may be made of the deductibility of such losses to determine if the losses were deducted in the correct fiscal year and may be carried back to recover previously paid income taxes. If the losses were not deducted in the correct years, prior years' income tax returns may have to be amended. Under the federal Tax Cuts and Jobs Act of 2017 (TCJA), net operating losses of non-life insurance companies can still be carried back two years and carried forward 20 years (IRC Section 172(b)(1)(C)). However, there is no carryback for life insurance company net operating losses arising in 2018 and later years and an unlimited carry forward period (IRC Section 172(b)(1)(A)). Operational losses of life insurers arising in 2017 and earlier are carried back three years and forward 15 years. A non-life insurance company can use the full amount of its net operating losses to offset taxable income (IRC Section 172(f)). A life insurance company is limited to an 80% net operating loss deduction against taxable income (IRC Section 172(a)(2)).

An example of a restructuring technique used in the liquidation of Reliance Insurance Company to address significant net operating loss carryovers is available in Exhibit 3-4.

## 6. Carryovers

To the extent that there is a discharge of indebtedness, any net operating loss carryover may be reduced by the amount of the discharge. If guaranty funds or other creditors are entitled to future funds, there may not have been a complete discharge.

Net operating losses are allowed an indefinite carryover period in taxable years beginning after Dec. 31, 2017. The net operating loss deduction is limited to 80% of taxable income (without regard to the deduction) for losses arising in taxable years beginning after Dec. 31, 2017. Therefore, even when there are net operating loss carryovers available, discharge of indebtedness could still result in income tax liabilities due because of the carryover taxable income limitations.

## 7. Deferred Taxes

The deferred taxes for both deferred tax assets and liabilities should be reassessed. For example, the deferred tax assets that rely on further taxes payable to be realized may no longer be realizable.

**C. Premium Taxes**

If the insurer is in rehabilitation, the receiver may be required to continue paying state and municipal premium taxes. Insurers are usually required to pay premium taxes that are calculated as a percent of direct premiums written. Many state and local tax authorities require insurers to pay estimated premium taxes. In many cases, a financially troubled insurer may experience a decrease in premium volume, or policies in force may be canceled. This may result in a reduction in premiums written and the related premium taxes. A review may be made to determine whether the insurer is entitled to premium tax refunds. It may then be necessary to refile the most recent returns to reflect the reduction in premium income. In addition, the receiver may attempt recovery of any prepaid or estimated premium taxes. If premium taxes are owed in a liquidation, many states may relegate premium tax claims to a lower or general creditor status.



*Receiver's Handbook for Insurance Company Insolvencies***D. Payroll Taxes**

Insurers are required to withhold federal income tax and Social Security tax (as well as state and local income taxes) from the wages and salaries of their employees. All of these taxes are considered trust fund taxes and must be remitted periodically to the various taxing authorities. The receiver should promptly ascertain that all payroll tax payments have been remitted by the insurer. If the receiver finds that taxes have not been paid, the Special Procedures Office of the IRS should be notified. In this way, the taxes or 100% penalty can be assessed against the former officers or persons with the responsibility for paying the taxes. The receiver may be asked to complete Form 4180 or Form 4181, which are questionnaires relating to the payment of trust fund taxes.

If the receiver fails to follow these procedures and funds that could have been used to pay trust fund liabilities are used for other purposes, the receiver may be held personally liable. The receiver should make certain that any plan filed with the court for the distribution of assets provides for the payment of these outstanding federal tax liabilities.

Many states have similar laws relating to withheld payroll taxes, and the receiver should be aware of the responsibilities imposed by these laws. The receiver should continue to file Form W-2, as well as Form 940 and Form 941, for employees of the insolvent insurer.

**E. Other Taxes and Assessments****1. Real Estate and Corporate Personal Property Taxes**

The receiver should ascertain whether all real estate tax payments have been made, including those that the insurer has been collecting on mortgages it holds or services. The tax collector should be notified of the receivership proceeding and instructed to send any notices to the receiver.

**2. Guaranty Fund Assessments**

State guaranty funds assess insurers to cover their administrative and claim costs. If the insurer is operating under supervision or rehabilitation, it remains liable for guaranty fund assessments, though a guaranty fund may defer or abate an assessment, in whole or in part, under certain circumstances. In liquidation, guaranty fund assessments are paid in accordance with the domiciliary state's liquidation priority statute.

**3. Excise Taxes**

Some insurers are required to remit excise taxes to the IRS because of foreign reinsurance premiums. These taxes are also considered trust fund taxes, and the same care should be afforded these taxes as is given to withheld payroll taxes.

**4. Commissions and Other Payments**

At year-end, insurers are required to file Form W-2 and/or Form 1099 for all commissions and other payments to an individual or partnership in excess of \$600 during the year. In addition, the receiver is required to prepare 1099 forms and send them to policyholders of life companies while business is still being serviced by the insolvent insurer. In addition, if the insurer has received interest from mortgages, the receiver is required to prepare and provide Form 1098 to the payer. If more than 250 1099 forms are to be issued, the filing is required to be done electronically. However, relief from this electronic filing may be secured upon request to the IRS. The receiver should be able to demonstrate that an electronic filing would place an undue hardship on the insolvent insurer. The IRS can assess penalties for both the failure to issue the forms to agents and the failure to file the forms with the IRS. If the receiver has not already sought relief and the estate is assessed, the IRS may waive the assessment upon request. Additionally, most states and some localities have filing requirements.

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## 5. Franchise Taxes

Several states have franchise taxes. The tax basis can be the net worth of the insurer, the assets of the insurer, the number of shares of authorized stock, or the amount of paid-in capital. The failure to file and pay these taxes may result in the cancellation of the insurer's corporate certificate of authority.

## 6. Other State Taxes and Licenses

Insurers are subject to numerous state taxes and assessments, including: workers' compensation; second injury funds; firemen's and policemen's pension funds; medical disaster funds; major medical insurance funds; arson, fire, and fraud prevention funds; fire marshal tax; insurance department administrative assessments; federal Fair Access to Insurance Requirements (FAIR) Plan assessments; and motor vehicle insurance funds. In addition, many localities have licenses and taxes unique to insurers. Comprehensive summaries are published by several insurers groups, including the Property Casualty Insurance Association (APCIA) and the American Council of Life Insurers (ACLI). The receiver should also ascertain if the insurer has any responsibility for filing informational returns and/or paying other state or local taxes such as sales and use taxes, water and sewer taxes, business and occupational privilege licenses, and taxes for employment training funds. Before paying these taxes, consideration should be given to the importance or lack of importance of maintaining state corporate certificates of authority and/or licenses.

All taxes should be reviewed to determine how any liability should be included in the priority scheme. The receiver should consider whether the certificate of authority or licenses have value before they are allowed to expire or be cancelled.

**IX. INVESTMENTS**

Investments may represent the largest group of assets on the balance sheet of an insurer. The purpose of the investments is to provide the company with resources and a steady flow of investment income to meet obligations as the obligations become due. A priority of the receiver is to take over full responsibility for all investments. This section will attempt to guide the receiver and identify any hidden elements in the following steps: seizure and control, inventory/identification, balancing, valuation, and other considerations.

The investment management function may be delegated to a bank or other professional manager. Depending on the receiver's evaluation of the company's investment manager, that person or entity may be retained with or without additional restrictions on their discretionary authority. Further, the receiver should consider that prior company investment objectives of high-yield, equity-related gains, and acceptance of reasonable risk may no longer be appropriate. Concerns of safety and liquidity may be foremost.

**A. Seizure and Control of Investments**

To seize investments, the receiver should identify the various custodian institutions, investment brokers or managers, and the pertinent account numbers for the insurer. Most of the essential information may be obtained by review of the annual statement and the workpapers of the last full statutory examination or CPA audit. The examination workpapers will most likely include year-end statements and confirmations from the various institutions that are holding the investments. A review of the last filed annual statement will disclose the brokers that are most frequently used for the purchase and sale of investments.

The receiver may also corroborate all the pertinent information with the chief investment officer of the insurer.

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If the investment managing function has been contracted to an outside institution, the receiver should promptly notify the institution of the receivership action. The external manager may be allowed to continue with their duties at the direction of the receiver, but transfers to other non-managed accounts should be restricted. The manager's discretionary authority should be reviewed to determine if additional restrictions should be placed on the manager to maintain investment balances in safe, liquid, and/or insured securities. The receiver should consider the difference between investment goals related to rehabilitation versus liquidation.

The receiver should notify all banks, custodians, depositories, brokers, and managers of the takeover as soon as possible and by the most expeditious method practicable under the circumstances. Time may be of the essence in preventing insiders from absconding with company funds. The notification should be specific as to account numbers but not limited to those account numbers. (Include any other accounts that bear the name of the insurer.) The notification should be accompanied by a copy of the court order of receivership. The institutions should be instructed as to their continuing duties and what is expected of them.

As part of the notification, the receiver should instruct the institutions to add the receiver's name as a signatory, deleting all others.

A matter that may need priority attention is the immediate suspension of wire transfers. Today, many insurers are electronically connected to financial institutions. Funds can be transferred by use of a personal computer (PC) or by telephone instructions (wire transfers) in a matter of minutes. Until the receiver has had an opportunity to review the process and change access codes and requirements, wire transfers should be suspended.

To avoid the exchange of good quality investments for lower quality investments, the receiver should review the authority for purchases, sales, and reinvestment of securities. The receiver might choose to impose a temporary restriction that only maturing securities may be liquidated to issuing institutions. This will provide the receiver an opportunity to review the quality of the investment portfolio. The receiver may desire the opinion of an outside service company in the evaluation of the portfolio. If the investment function is internally managed, the receiver may want to consider the economies and expertise of an outside investment management company. The receiver may also consider moving out-of-state assets into the domiciliary state to improve control and lessen the chance the assets may be attached by creditors.

**B. Identification and Inventory of Investments**

An inventory will help establish control of the investments. A good initial control list may be the investment schedules of the last annual statement, including Schedule A—Real Estate; Schedule B—Mortgage Loans; Schedule BA—Other Long-Term Invested Assets; Schedule C—Collateral Loans; Schedule D—Long-Term Bonds and Securities (which includes bonds, common and preferred stock, SCAs, etc.); Schedule DA—Short-Term Investments; Schedule DB—Financial Options and Futures; and Schedule E—Cash and Cash Equivalents. Also, the General and Special Deposit Schedules found in the annual statement will identify investments on deposit with various regulatory jurisdictions.

The receiver should confirm investment holdings with the appropriate institutions. The insurer should have detailed listings of investments held, transaction statements, bank notices and advices, and broker slips and statements. These documents will assist the receiver in the identification and inventory of investments.

The insurer's financial statements may not disclose all investments in which the insurer has an interest. Subsidiaries of the insurer accounted for on the equity method will have separate listings of investments owned. The equity method (as opposed to the consolidation method) permits the parent company to report the net value of (or the equity in) the subsidiary as an investment. Therefore, the assets and liabilities of the subsidiary are not evident in the books of the parent company. In the case of a pension plan, the assets are owned by the pension plan and will not be listed on the insurer's statutory annual statement. Even though pension funds may come under the receiver's control, these funds should be maintained in a separate account. The receiver should also be aware of significant restrictions that may exist on the investment and

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use of the funds. Generally, pension funds are subject to the federal Employee Retirement Income Security Act (ERISA), which imposes severe penalties for mishandling funds and governs the dissolution of the pension plan.

Many states require that purchases and sales of investments be approved by the insurer's board of directors. The board minutes may reflect all purchases and sales. A review of the minutes may assist in the identification of investments.

Insurers from time to time may purchase debt obligations directly from the issuing company, without the assistance or the evaluation of a broker. Private placements indicate that the underwriting of the investment was solely the responsibility of the insurer. The insurer should have an underwriting file containing documentation of matters taken into consideration and copies of correspondence regarding the decision to purchase the instrument. The document of indebtedness may be located on the premises of the insurer, rather than with a financial depository or custodian. If securities that are not publicly traded are to be listed in the annual statement as admitted assets, all insurers must submit to the Securities Valuation Office (SVO) of the NAIC documentation to support the market value of the securities. The SVO will evaluate the documentation and assign a market value and a quality grade to the securities. The receiver should check with that agency to determine if management sought such valuations, possibly indicating the existence of additional assets not otherwise apparent from the accounting records.

An insurer should identify those securities with a high risk as to the potential of a loss of principal. While derivative instruments are reported in Schedule DB, the receiver should also be aware of other securities, such as structured securities, included in Schedule D that maintain significant risk. See the section on audit/investigation of financial statements in this chapter for a listing of risks inherent to certain investments. The receiver should determine whether such securities are consistent with the current investment strategy of the insolvent insurer and conclude whether the insolvent insurer should hold or sell the security and the timing of such action. Often, insurers use derivative instruments as a hedge to reduce exposure to other risks incurred by the insurer. With respect to hedge transactions, the receiver should consider whether the hedge transaction effectively reduces the insolvent insurer's exposure to losses arising from other aspects of the insurer's operations or investment portfolio. A common hedge used by insurers is an interest rate swap. The NAIC *Accounting Practices and Procedures Manual* (AP&P Manual) describes an interest rate swap as "a contractual arrangement between two parties to exchange interest rate payments (usually fixed for variable) based on a specific amount of underlying assets or liabilities (known as the notional amount) for a specified period." Insurers have used swaps for various reasons, including matching returns on assets to contractual obligations. The AP&P Manual provides additional examples, for both life and P/C companies, of complex investment arrangements entered into by insurers. The receiver should consider engaging an investment/derivative expert to review the insurer's hedging program and make recommendations.

State insurance laws differentiate between real estate owned and occupied, and real estate owned for investment purposes. Some state laws require that real estate owned for investment purposes be income producing. If no income is generated within a set period of time, the property must be timely and properly disposed of (sold). Non-income-producing real estate should be investigated for possible alternative, non-investment objectives or accommodations. The receiver should review the pertinent statutes and consult with legal counsel regarding possible improprieties.

The insurer may own property in varied capacities. The insurer should have in its possession documentation for each property owned, including the deed (registered with county clerk), appraisal, survey, title policy, lease agreement (if rented), mortgage agreement (if any), schedule of future payments, hazard insurance policy, evidence of real estate tax payments, correspondence, related real estate management agreements, and other pertinent information.

The insurer may own a share of an investment property or may be part sponsor of a capital venture through a limited partnership, and it should have adequate documentation to support the investment. The

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documentation should include the partnership agreement, contracts with project managers, projections of cost and time to complete, projections of future income, expert evaluations and opinions, plans of operation and financing, description of any guarantees or financing commitments, and current status reports from project managers.

The insurer should have an individual file for each mortgage loan that contains the signed mortgage note, trust deed, recorded lien, appraisal report, amortization schedule, documentation of hazard insurance, and evidence of real estate tax payments. The insurer may have mortgage servicing agreements, and the receiver should obtain those servicing agreement documents.

Collateral loans are investments that are covered by other assets of the borrower. For each collateral loan, the insurer should have an instrument securitizing the insurer, a description of the borrower (possibly financial statements of the borrower), description and value of property pledged as collateral, and the repayment schedule.

**C. Balancing and Reconciliation**

The control list of investments that the receiver has developed can be reconciled to certified listings of brokers, custodians, and other depositories. The insurer should have in its investment files the supporting broker slips and bank advices for all investment transactions. A detailed statement of account activity can be obtained from brokers and custodians. The control list should also be reconciled to the general ledger and investment subledger. All discrepancies should be noted and resolved.

Investment transactions should be audited for possible unauthorized transfers. Reference is made to the chapter on investigation and asset recovery in this Handbook.

**D. Location of Investments**

Usually, the bulk of an insurer's investments will be on deposit for safekeeping with a custodian (a financial institution) to facilitate the transfer of securities for purchases and sales. The safekeeping also minimizes and transfers the risk of theft or misplacement to the custodian. Securities in the custodian's possession may include bonds and publicly traded stocks, option and future contracts, and, on occasion, stocks of subsidiaries.

Many states require securities to be deposited with the insurance department or the state treasurer's office as a prerequisite for the insurer to write business in that state. Alien insurers may be required to place various assets in a trust for the protection of U.S. policyholders. Deposits may be held by non-U.S. jurisdictions. The receiver should notify all jurisdictions and, where possible, obtain the return of all deposits to avoid costly jurisdictional battles with creditors.

Investment brokers may also be holding securities that the insurer has purchased and not yet settled or that have been pledged as collateral for options.

Other investments—such as real estate, mortgage loans, collateral loans, private placements, common shares of subsidiaries, etc.—may be held in an in-house safe or vault for safekeeping. The receiver should make a complete detailed list of documents in the in-house safe. If any items are marketable, the receiver should take appropriate steps for the safekeeping of the items. Since the receiver may not be able to ascertain who has access to keys or codes for such safes, consideration should be given to changing locks or setting up a new safe deposit box under sole control of the receiver.

The insurer may have rented a safe deposit box at a financial institution. An inventory of the box will be necessary and appropriate safeguards taken against access by others. The receiver should obtain the access log for the safe deposit boxes. If the boxes have been accessed just prior to the receivership order, the receiver should investigate the reasons for entry.

*Chapter 3—Accounting and Financial Analysis***E. Valuation of Investments**

The determination of value for securities that are publicly and actively traded should not be a problem because prices are published on a daily basis through various data feeds. The receiver should consider the published market value rather than the NAIC value in the evaluation of the liquidation value of assets. Often, a receiver is compelled to sell investments prior to maturity to generate cash flow. The NAIC value, which generally shows stocks and preferred stock at fair value while bonds are usually at amortized cost, will not necessarily reflect the amount the receiver will receive from the sale of investments.

The market value should approximate the amount of cash that may be generated from the sale of investments. The market valuation reflects an adjustment for current market rates as compared to the fixed interest rate on the investment and for the credit-worthiness of the debtor.

Private placements will be the most difficult to value, and the opinion of outside experts may be necessary. The receiver may wish to employ an investment specialist to determine the values and liquidity of below-investment-grade private placements or non-publicly traded stocks. The financial statements of the borrower may be sought. A review of the financial statements may tell whether the company is in sound financial condition and whether it is able to repay the obligation. Prepayment at a discount may be an alternative for both parties.

Several values may be placed on real estate that is occupied by the insurer. The value may be the cost paid less depreciation, construction cost less depreciation, appraisal value, or market value. The receiver may consider the latest appraisal of the property and determine the possible market value. Economies may warrant the sale of the property and rental of other quarters.

Real estate that is held for investment ordinarily should be income-producing. A large negative cash flow may warrant disposal of the property. An appraisal may be necessary to assess the marketability, which will disclose the sale price of similar properties in the area. If comparable sales are not available to estimate market value, the receiver may consider using a discounted cash-flow approach to valuing the real estate. The receiver may wish to obtain outside professional support in determining proper values, methods of valuing, investments in real estate, mortgage loans, and real estate joint ventures or limited partnerships.

The book value of mortgage and collateral loans is usually the unpaid principal balance. The receiver may also assess the value of the property that has been pledged as collateral. Many states' insurance laws require that mortgage loans be first-lien mortgages. A second-lien mortgage is of greater risk and subordinate to the first-lien mortgage. Insurance laws require the amount of the mortgage, at inception, not to exceed a specified percentage of the appraised value of the property. The receiver should research compliance with the statutes. Possible accommodations given to affiliated parties should be investigated.

**F. Other Considerations**

The insurer may be the owner of various tangible and intangible assets that may not be apparent on its statutory balance sheet. The receiver should try to identify and value all possible assets of the insurer, including insurance licenses, the value of the shell of the company, assets that have been previously written off, and any assets that are listed in Schedule X of the annual statement.

**1. Pension and Deferred Compensation Plans**

The insurer's employee benefits may include participation in either a defined-benefit or defined-contribution pension plan. The plan may require or allow that a percentage of the assets of the plan be invested in shares of the insurer. It is not uncommon for the trustees of the plan to be officers of the insurer. Also, the plan administrator may be the insurer itself or an outside financial institution. The regulatory action will create several uncertainties in relation to the plan. The receiver should be familiar with the provisions of the plan and whether a complete liquidation and distribution is required. The provisions of the pension plan agreement and the Employee Retirement Income Security Act of 1974

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(ERISA) may clarify some of these issues. It is recommended that the receiver retain the services of a consultant CPA firm to audit and provide independent opinion regarding compliance with IRS and ERISA requisites.

If the insurer is insolvent and the plan is heavily invested in shares of the insurer, then the plan may be insolvent also. The administrator, therefore, may need to liquidate the plan. If the pension plan is solvent, the administrator must continue with its duties. If the insurer is the plan administrator, the receiver may become the plan administrator by succession. If the plan administrator is a third party, the receiver may wish to evaluate the propriety of changing administrators.

The insurer may have hidden equity in other employee benefit plans. A saving plan that requires the insurer to partially match amounts contributed by the employees may be such a plan. The plan agreement will detail the operation of the plan and when the insurer's contributions vest to the employees. The plan should have provisions for possible employee termination on a voluntary or involuntary basis. Depending upon the terms of the plan, the receiver may recover contributions that have not vested to the employees, or the receiver may amend terms, for example, to eliminate employer matching of contributions.

Pension considerations may be further complicated if an employee benefit plan is established to cover the employees of a parent holding company and its many subsidiaries, of which the receiver has authority only for one or more insurer subsidiaries. The desire of the receiver to terminate the plan and attach excess assets (or reduce additional exposure to underfunding) may be mitigated by excise tax issues on termination, ERISA, and other considerations.

It should be noted that under some state liquidation priority statutes, amounts, and priorities due employees may be limited. Compensation and benefits due officers and directors may also be excluded in their entirety.

## 2. International Considerations

As insurers become part of a global economy, the receiver may be confronted with the issues of investments and other assets held in other countries. The receiver should try to gain control of the investments or assets and bring their value back to the estate. An ancillary receiver may be appointed by a foreign country, which may make that difficult, since the ancillary receiver may need the assets to settle claims in the ancillary jurisdiction. The ancillary receivers will need to cooperate with the domiciliary receiver. The value of the foreign assets will fluctuate with the exchange rate of the foreign currency, and the receiver should try to match in foreign denomination the assets and liabilities (claims) by the foreign country. This should indicate whether any excess assets are held in the foreign country. The receiver should ascertain if the company's Schedule DB contains derivative instruments covering foreign currency exchange risks. Because foreign countries may have currency restrictions for repatriation of assets, the receiver should consult with legal counsel.

Special deposits and general deposits with insurance regulators in other jurisdictions in the U.S. and outside the U.S. may also present problems to the receiver. Many U.S. courts have ruled that the state of domicile has the duty to liquidate the insurer and, therefore, all deposits should be returned to the domiciliary receiver. In the case of a non-U.S. jurisdiction, the foreign receiver may claim the right to the deposits for purpose of distribution in his jurisdiction. In this situation, the receiver should consult legal counsel. The receiver should consider whether they can divest themselves of the responsibility for foreign claims.

## 3. Structured Settlements

In the insolvency of an annuity insurer, special consideration should be given to any single premium immediate annuities that were issued to form the basis of funding periodic or lump sum payments in personal injury settlements, commonly known as "structured settlement annuities."

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These annuities are normally issued to qualified assignment (QA) companies in order to comport with numerous IRS tax codes (primarily 104 (a)(2)) and various revenue rulings in order to preserve the tax benefit to the beneficiary or payee. However, some older annuities (prior to 1986), although not issued to a QA company, may nonetheless enjoy the same tax benefits. Generally, periodic payments are excludable from the recipient's gross income only if the payee is not the legal or constructive owner of the annuity and does not have the current economic benefit of the sum required to purchase the periodic payments.

When these blocks of business are resolved in the insolvency context (typically through assumption reinsurance), extreme care must be taken to ensure that the resolution does not compromise the tax benefits to the payees. It is strongly recommended that competent and experienced tax counsel be retained to guide the receiver through this potentially complicated process.

**X. RECEIVABLES****A. Uncollected Premiums**

The amount of uncollected premiums may vary from company to company, but may be a significant asset.

**1. Methods of Billing**

The billing and recording of insurance premiums differ, depending upon the insurer (e.g., direct billing of policyholders versus billing of agents) and type of insurance (e.g., primary versus reinsurance). Following are four of the more common types of billing methods:

**a. Direct Billing**

Some insurers bill the policyholder directly for the full amount of the premium. A separate liability is established for any commissions allowed to brokers or producers.

**b. Agency Billing**

Insurers that use agency billing send monthly statements to their agents, listing premiums written during the month, including any adjustments and endorsements of previously issued policies. Commissions allowed to the agent are deducted on the statement to arrive at the net amount due to the insurer.

**c. Account Current Billing**

This method is used when the agent submits a statement to the insurer. The account current sets forth premiums written by the producer during the month, less the commissions. This method requires the insurer to maintain a premium difference register to account for differences between the premiums reported by the agent and insurer's records. Differences are usually resolved by communicating with the agent. (Use of the agency billing method will transfer the premium difference reconciliation to the agent.)

**d. Item Basis**

The item basis of billing is generally used when each item is remitted when collected by the producer, as is the case when business is submitted by many independent brokers. The amount of the bill is usually net of the broker's commission.



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## 2. Different Types of Premiums

## a. Property/Casualty Insurance Premiums

Most property and liability policies provide for the payment of a single premium for the entire term of the policy (usually one year). Different types of property and liability premiums include:

- **Installment premiums**—Some insurers issue policies that are payable on an installment basis. Even though the premiums may be payable on an installment basis, the insurer must record the full annual premium when the policy is issued, except for those policies that are recorded or billed monthly because of changing exposures. Premiums that are due currently are billed using any of the foregoing methods. The billing of future installments is deferred until the due date of the installments.
- **Retrospectively rated premiums**—Retrospectively rated policies are used when the ultimate premium is based on the individual policyholder's claim experience. The ultimate claim experience may not be known until several years after the policy has expired. Usually a deposit (estimated) premium is billed using any one of the above methods when the policy is issued. However, the ultimate premium will be developed by applying the retrospective factor set forth in the policy to the policyholder's claim experience. The ultimate premium will not be less than the minimum nor more than the maximum premium set forth in the policy.
- **Audit premiums**—Some premiums are based on the amount of the policyholder's payroll or sales (reporting values). For these policies, the insurer will bill an estimated or deposit premium at the inception of the policy and, upon determining the reporting values, the final premium will be billed. Sometimes insurers send auditors to determine and/or verify the reported values. These premium adjustments are called audit premiums. The billing of the deposit and audit premiums may be done by using any combination of the aforementioned methods.
- An insurer should maintain an inventory of policies with adjustable premium features such as retrospectively rated premiums and audit premiums. Typically, retrospectively rated premiums are popular features of workers' compensation policies and reinsurance treaties. The receiver should be aware of adjustable features included in contracts of the insolvent insurer and ensure that all contracts with such provisions are summarized. In the preparation of financial statements, appropriate accruals should be recognized for these contractual features based on the related claim experience and premiums paid under the agreement as of the date of the financial statements. The receiver should further ensure that appropriate action is taken to collect monies owed the insolvent insurer under these contractual provisions and that proper recognition of liabilities arising from these contractual provisions is provided in the financial statements. If the accrual is significant, a receiver may consider performing a systematic review of the related accounting support, focusing the review on policies with premiums that are substantial to the overall population.

## b. Life and Accident and Health Premiums

Unlike property and liability insurance policies, life and A&H insurance policies can be guaranteed renewable contracts and are generally accounted for as long-term contracts. Premium payment plans for life, annuities, and A&H insurance vary. Some policies may be payable monthly, as is frequently the case with group insurance. Others may be payable quarterly, semiannually, and/or annually. Some may be fully paid up when issued. For HMOs and health insurers, it is important

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for employer groups and government plans like Medicaid that premiums are reconciled monthly to enrollment tapes to ensure that additions and deletion of members are updated promptly.

c. Assumed Reinsurance Premiums

Assumed reinsurance premium billing, recording, and collection methods and procedures primarily depend on the reinsurance treaties, which specify the relationship between the parties.

- Facultative premiums—Facultative reinsurance may be billed and recorded using any combination of the methods described above for direct insurance. It is usually billed and recorded on a direct basis or account current basis.
- Treaty premiums—Premiums due on assumed treaty business are usually reported to the reinsurer either directly by the cedent or by the reinsurance intermediary.

3. Policy Control

An insurer normally prenumbers its policies when printed. A control procedure should be in place routinely to identify and follow up on skipped and missing policy numbers. The receiver should ascertain the insurer's policy control procedures and ensure that missing and skipped policy numbers are properly accounted for because a skipped or missing policy number may represent an unbilled, in-force policy. In the case of multiple offices and multiple agents with policy-issuing authority, there may be several sets of policy numbers.

4. Setoff Against Uncollected Premiums

State insolvency statutes may restrict setoffs that previously were allowed against uncollected premiums due the insurer when it was solvent. In many cases, no setoffs may be allowed, even if:

- a. Agents were previously permitted to: (i) deduct commissions from premium remittances; and (ii) return premium owed to one policyholder from an amount owed to the insurer on another unrelated policy.
- b. Cedents were permitted to: (i) set off ceding commissions and loss payments from premium remittances; and (ii) settle balances for a variety of assumed and ceded contracts on a net basis.

The propriety of recognizing setoffs should always be reviewed with the receiver's legal counsel.

5. Commission Recoverable on Cancellation of Policies In Force

Agents and brokers are usually prepaid their full commission when the premiums are collected, even though the premiums are earned over the life of the policy. They frequently deduct their commissions from their remittances to the insurer.

Upon cancellation of the policies in force by the receiver, the policyholders are entitled to a return of the premiums applicable to the unexpired term of the policy (unearned premium). Such return may be fully or partially paid by a state guaranty fund. The policyholder may file a proof of claim with the receiver for any amounts not paid by the guaranty funds. In any event, the receiver should look to the agents and brokers for the return of prepaid commissions applicable to the refundable unearned premiums.

6. Summary

A variety of methods and procedures are used by insurers to bill, record, and collect premiums. A combination of methods may be used. Since uncollected premiums are usually a significant asset, it is

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important that the receiver become familiar with the insurer's premium billing and recording procedures in order to most effectively marshal these assets. If necessary, new systems and procedures may be required to collect these assets subsequent to liquidation.

Finally, the applicability of federal and state debt collection statutes should be considered by counsel. Receiverships may be entitled to governmental exemption from certain statutes.

**B. Bills Receivable Taken for Premium**

Insurers sometimes accept a promissory note from the policyholder for a portion of the premium due. The promissory note includes a payment schedule and is subject to interest on the unpaid balance. Some companies record the principal amount of the note, plus the total interest to scheduled maturity, as a receivable and set up a contra account for the unearned portion of the interest. Others record only the principal amount of the note as an asset and separately accrue the interest as it is earned. Statutory accounting treats bills receivable differently than agents' balances and notes receivable. (See *Statement of Statutory Accounting Principles (SSAP) No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due from Agents and Brokers.*) The realizable value of these receivables should be ascertained.

**C. Life Insurance Policy Loans**

Policy loans usually are a significant asset to a life insurer that writes permanent plan life insurance. Unlike term insurance, permanent plan life policies build cash surrender values that may be borrowed by the policyholder either as a:

- Conventional loan where the policyholder makes an application to borrow all or part of the policy's available cash surrender value.
- Automatic premium loan (APL) where the policy provides, or the insured has elected in the application for insurance, that the policy shall not terminate (lapse) because of the nonpayment of premiums as long as there is adequate cash value to cover the unpaid premiums and any other amounts owed under the policy.

If the policyholder dies before the policy loan is repaid or the policy is surrendered, the proceeds payable by the insurer should be reduced by any outstanding policy loan.

**D. Salvage and Subrogation (Property/Casualty and Health)**

## 1. Salvage

Salvage is an amount received by an insurer from the sale of damaged property or recovered stolen property for which the insured was indemnified by the insurer. In the claim settlement process, the insurer will obtain title to the property and sell it for its remaining value. This asset needs to be addressed quickly because property often is stored, and storage fees are being incurred. Salvage on surety bonds (e.g., construction performance bonds) may be of considerable amount. Due to the intricacies of the surety line of business, consideration should be given to the hiring of external experts to manage the salvage of uncompleted projects.

## 2. Subrogation

Subrogation is the legal right of an insurer to recover from a third party who was wholly or partially responsible for a loss paid by the insurer under the terms of the policy. In the case of a property accident, where there is a dispute between the parties, an insurer will often pay its policyholder's claim and assume the policyholder's right to pursue the negligent third party.

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## 3. Accounting Practices

Until 1992, under statutory accounting practices, an insurer was not allowed to recognize salvage and subrogation recoverables until they were collected. In 1992, the AP&P Manual began allowing accrual of salvage and subrogation recoverables. However, certain states may still disallow the asset. GAAP requires that an insurer recognize an asset or reduce its liability for unpaid claims for the amount of salvage recoverable on paid and unpaid claims. Therefore, an insurer should have records, systems, and procedures to identify and follow up salvage and subrogation recoverables on both paid and unpaid claims.

## 4. Summary

A receiver should ascertain how an insurer identifies and follows up on its salvage and subrogation recoverables. This becomes more difficult when claim files are turned over to a guaranty fund. Salvage and subrogation practices may vary among the guaranty funds. Salvage and subrogation collected by a receiver or guaranty funds may have to be held in trust for certain beneficiaries (e.g., where the policyholder's claim is subject to a deductible, or the loss is a reinsured loss and the reinsurer previously reimbursed the insurer for the full amount of the claim). The right to the salvage and subrogation proceeds should be discussed with legal counsel.

## 5. Salvage and Subrogation (Property/Casualty – Deductible Recoveries – Only)

## a. Deductible Recoveries

Large-deductible recoveries are amounts received by an insurer from an insured covered under a policy having an endorsement providing that the insured is responsible to indemnify the insurer for losses and certain LAE incurred that are for amounts below the high deductible. The high-deductible definition varies, but it is often for deductibles up to \$100,000. While these policies share some characteristics with retrospectively rated policies, the accounting treatment of recoveries under the two types of policies is different. If the policy form requires the reporting entity to fund all claims including those under the deductible limit, the reporting entity is subject to credit risk, not underwriting risk.

## b. Accounting Practices

Under statutory accounting practices, reserves for claims arising under high-deductible plans are established net of the deductible. However, no reserve credit shall be permitted for any claim where any amount due from the insured has been determined to be uncollectible. Reimbursement of the deductible is accrued and recorded as a reduction of paid losses simultaneously with the recording of the paid loss by the reporting entity. Therefore, these amounts are not easily identified on the balance sheet. It is important that the receiver examine the records, systems, and procedures to identify and follow up large-deductible recoveries on both paid and unpaid claims. It is also important to understand the insurer's process for obtaining collateral to mitigate credit risk on high-deductible policies. The receiver should examine the scope of the large-deductible business written, as well as the collection and collateral procedures employed by the company. The High Deductible Disclosures, Note 31 in the Annual Statement Disclosure and the related guidance in *SSAP No. 65—Property and Casualty Contracts* should aid the state insurance regulator in this review.

**E. Reinsurance**

For additional information on reinsurance, see Chapter 7—Reinsurance.

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## 1. Reinsurance Recoverables

For P/C insurers, reinsurance recoverables on unpaid losses are not reported in the cedent's financial statement as receivables, but they are accounted for as a reduction of its gross liabilities for unpaid losses and LAEs. Reinsurance recoverables on loss payments and LAEs are, however, recorded as an asset in an insurer's financial statement. However, GAAP reporting now requires reporting reinsurance recoverables on paid as well as unpaid losses as an asset (FASB No. 113). All insurers—both P/C and life—use a variety of internal accounting procedures to bill and record paid loss reinsurance recoverables. Unfortunately, financially troubled insurers do not always have adequate internal controls and procedures in place to properly quantify and identify their recoverables by individual reinsurer. Consequently, a substantial amount of record reconstruction may be necessary by the receiver's staff, not only to identify all present recoverables, but also to install appropriate systems and procedures to bill and monitor future paid recoverables.

## 2. Funds Held By or Deposited With Reinsured Companies

The reinsurance treaty between the reinsurer and its cedent may require the cedent to withhold a portion of the premiums owed to the reinsurer and/or the reinsurer to deposit funds with the cedent. The purpose of such an arrangement is to collateralize the reinsurer's obligations for unpaid losses owed to the cedent. Care should be taken by the receiver to ensure that proper credit is taken against invoices submitted by the cedent for any such deposits.

## F. Health Care-Related Receivables

Insurers and HMOs may have receivables for provider claims overpayments, pharmacy rebates, provider risk sharing recoveries, capitation arrangements, and loans/advances to providers.

**XI. ACCOUNTING AND FINANCIAL REPORTS TO THE RECEIVERSHIP COURT AND THE NAIC**

Accounting and financial reports will be required by the receivership court at the date of the receivership and subsequently to monitor the progress and status of the receivership. To prepare these reports, the receiver will need to continue processing and recording transactions and producing related reports. The results of the accounting transactions described in the preceding sections of this chapter should be incorporated into the company's financial information and subsequently produced financial reports. Exhibit 3-1 is a representative summary of the format required to be input into the NAIC's GRID Global Receivership Information Database (GRID) system.

Additional information is often critical to the daily management of the receivership. Perhaps the most needed additional reports are: 1) daily cash reports (Exhibit 3-2); and 2) a budget to monitor costs (Exhibit 3-3).

**A. Timing of Preparation**

Within 180 days after the entry of an order of receivership by the receivership court, and at least quarterly or annually thereafter, the receiver shall comply with all requirements for receivership financial reporting as specified by existing state receivership laws. The financial reports should include: a statement of the assets and liabilities of the insurer; the changes in those assets and liabilities; and all funds received or disbursed by the receiver during that reporting period. (See Exhibit 3-1.) These reports are also to be filed with the receivership court. Receivers in those states without Model #555 may be required to file some or all of these reports with the receivership court. The receiver may qualify any financial report or provide notes to the financial statement for further explanation. The receivership court may order the receiver to provide such additional information as it deems appropriate. The reports should include claims and expenses submitted from each affected guaranty association.

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For good cause shown, the receivership court may grant relief for an extension or modification of time to file the financial reports by the receiver.

In the early stages of a receivership, especially one involving an insurer with limited liquid assets, daily cash reports are critical to determine whether the insurer should be in conservation, rehabilitation, or liquidation. A budget is useful to manage the costs of the receivership and should be produced in the first year after the initial receivership court order.

**B. Necessary Sources and Records**

The following is a listing of information that may be used to prepare the financial reports:

**1. Trial Balance and Detail Subledgers**

The trial balance normally is produced on a monthly basis and details all assets and liabilities on a cumulative basis, plus income and expenses for the period. The line items on the trial balance can tie directly to the general ledger or can consist of a grouping of several general ledger accounts. The detail subledgers exist for accounts payable and contain more detailed information about an account, such as individual account information, vendor name, and due date of payment. The totals of these subledgers either tie directly to the general ledger account balances, or they are reconciled and differences are identified. If the corporate structure consists of more than one company, then a consolidated trial balance should be produced that consolidates all individual companies.

**2. General Ledger**

The general ledger details the account information, showing the activity in an individual account during the period. Totals tie to the trial balance on an individual basis, and sometimes accounts and subaccounts are detailed and grouped into one line item that ties to the trial balance. The general ledger typically gives more detailed information on the transactions that were recorded during the period. An individual general ledger usually exists for each company/legal entity.

**3. Bank Reconciliations**

Bank reconciliations are useful in reporting on and projecting available cash for the operations of the receivership.

**4. Investment Ledger**

The investment ledger contains investment activity, investment income, types of securities, and realized and unrealized gains and losses. Totals should tie to the general ledger.

**5. Accounts Receivable and Reinsurance Recoverable Aging**

The accounts receivable and/or paid recoverable aging contain detail of accounts receivable and paid recoverable balances by account and ages the receivable based on number of days it has been outstanding. Reinsurance recoverable ledgers will also be kept here. Reinsurance recoverables will be included in the aging. The aging will be used in establishing allowances for uncollectible items.

**6. Reserves**

With respect to P/C insolvencies only, loss and LAE reserves (case, IBNR, and LAE reserves) tend to be the most significant amounts on the balance sheet, as well as the most subjective. If an outside actuary is used to evaluate the existing reserves and to project the ultimate losses, the resulting actuarial studies may be used when preparing the financial statements, and any adjustments should be reflected in the statements. With respect to life insurance insolvencies, there are substantial non-loss reserves for expected future benefit payments on various policies or contracts.

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## 7. Paid Loss Information

Losses paid by the guaranty funds on behalf of the insurer should be recorded as liabilities in the insurer's records.

## 8. Cash Disbursements and Cash Receipts

A check register of all amounts paid during a given month, including payee and amount, should be maintained. Cash receipts are actual cash items received monthly and deposited into the estate's bank accounts.

## 9. Budget Versus Actual Report

A receivership budget for expenses and income by department should be established within 12 months of the date of receivership. On an ongoing basis, a report should be generated detailing budgeted versus actual expenditures for the reporting period. All significant variances should be investigated by the receiver.

**C. Responsibility**

The responsibility of preparing the financial and accounting reports can be assigned to the insurer's accounting and finance departments, the receiver's personnel CPA, or independent CPAs. The use of independent CPAs should be considered if the receiver questions whether the remaining insurer's personnel are capable of completing the report, or the receiver does not have sufficient staff.

A specific individual should be designated as the party responsible for the distribution of the reports to the receiver, attorneys, personnel, applicable state agencies, and other predetermined parties.

The filing of the completed reports with the courts should be assigned to the attorneys handling the receivership.

*Chapter 3—Accounting and Financial Analysis*

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*Chapter 4—Investigation and Asset Recovery***CHAPTER 4—INVESTIGATION AND ASSET RECOVERY**

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*Receiver's Handbook for Insurance Company Insolvencies***I. INTRODUCTION**

Insurance receivers generally have two principal duties: 1) marshalling assets; and 2) paying or otherwise disposing of claims. Typically, the marshalling of assets involves selling real and personal property, collecting reinsurance recoverables and/or commuting treaties, collecting earned premium, filing preference and fraudulent conveyance actions, and bringing lawsuits against former owners and management.

In any receivership, the receiver is responsible for maximizing and safekeeping the assets of the insolvent insurer. One of the receiver's early priorities is to examine the insurer's records to identify the insurer's assets, marshal them as necessary or appropriate, and then determine whether litigation should be pursued against any persons or entities liable for causing or contributing to the insurer's financial difficulty.

It is important for the receiver to keep in mind that the receiver's investigation and asset recovery activities may be subject to approval by the receivership court, with notice to guaranty associations and other interested parties. Furthermore, the receiver should take special care to review any applicable state or federal laws.

As a general rule, most state statutes require receivers to seek court approval before they may sell, assign, transfer, or abandon assets having an individual or aggregate value above a threshold dollar amount. Therefore, a receiver seeking to sell an asset or settle a claim of the type described below may need court approval before closing the transaction.

**II. DISPOSITION OF ASSETS ALREADY IN THE ESTATE****A. Title to Assets—Legal Versus Equitable Title**

The first issue to address before a receiver may dispose of an insurer's assets is whether the receiver is vested with title to those assets. The NAIC *Insurer Receivership Model Act* (#555), also known as IRMA, gives possession of all assets of the insurer to all receivers. Title to an asset may be legal or equitable or both. Legal title is ownership of the asset; equitable title is the right to the benefits or possession of the asset. Normally, both titles are held together, but in some cases, they can be divided. In a trust situation, the trustee is the legal owner of the asset, but the beneficiaries receive the benefits of the trust and so are the equitable owners of the asset. A receiver can only transfer the interest the insurer held. If an insurer had both legal and equitable title, the liquidator has the full power to dispose of the asset. If the title was bifurcated, the holders of the legal and equitable titles must join in the transfer in order to pass full ownership of the asset to the purchaser. Counsel should be consulted to assure that all equitable interests are identified prior to attempting to sell any assets.

**B. Payment Terms**

The principal reason for entering into a sale transaction is to generate income for the insolvent insurer, with a view to maximizing the distribution of assets to its policyholders and creditors. If creditor distributions will not occur until a later date, the receiver can entertain installment terms, possibly attracting purchasers or an increased purchase price not attainable in an immediate lump-sum sale.

**C. Tax Consequences of a Disposition**

All disposition of assets will result in tax implications, which will need to be reported on the company's tax returns. Appropriate professional advice should be sought.

**D. Other Terms**

Most assets are sold on an "as is" basis with limited representations and warranties to prevent the receiver from being exposed to liability for matters for which it has limited knowledge. If the buyer is unwilling to

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purchase the asset “as is,” the receiver may consider giving limited representations and warranties, but only subject to the receiver’s “knowledge” and restricted to facts concerning the asset to be sold that the receiver has learned during the conduct of the receivership proceedings.

An asset sale agreement may also contain provisions designed to maintain confidentiality of its terms. Confidentiality is particularly desirable if the receiver subsequently may enter into similar transactions with other third parties on more or less favorable terms. Venue over all disputes should remain in the receivership court. Finally, the breadth of release given by and to the receiver should be carefully considered in light of the transaction being documented and the receivership proceedings as a whole.

**E. Supervising Court Approval**

Court approval may be required prior to disposition of an asset.

**F. Identification and Collection of Statutory/General and Special Deposits**

The receiver should make every effort to identify and collect all estate assets held by other states or entities as statutory/general or special deposits. The receiver should have specific policies and procedures regarding the identification and collection of these assets. These should address:

- Location and current status/value of the deposit.
- Determination of creditors within state holding deposit.
- Discussion with the state insurance department holding the deposit about their intentions regarding:
  - Possible full ancillary receivership.
  - Holding the deposit due to open claims within their state.
  - Releasing the deposit to the receiver.
  - Releasing or assigning the deposit to the guaranty funds.
- Review and execution of release agreement.

**G. Disposal of Assets**

Once the receiver has identified and inventoried all assets, the focus should turn to the process of sale and disposal of assets. Assets should be sold at the most opportune time to recover their maximum value by approved sales and disposal methods that are transparent and avoid any appearance of a conflict of interest.

**III. INVESTIGATION AND PURSUIT OF CLAIMS AGAINST THIRD PARTIES****A. Objectives of Investigation and Asset Recovery**

The goal and the scope of the investigative examination should be tailored to fit the specific situation. In all cases, the examination is crucial to analyzing the insurer’s financial difficulty. The examination also may reveal corrective actions that the receiver should implement for successful rehabilitation. In all cases, the thrust of the investigative examination is to disclose what went wrong, determine what corrective action is necessary, reconstruct critical data/programs to support asset collection, and identify those legally

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responsible for the demise of the insurer. In appropriate cases, life and health guaranty associations may be able to provide support and assistance in connection with asset recovery efforts. In life and health, joint and common interest agreements are commonly used by regulators, receivers, and guaranty associations to preserve protections for privileged communications and work product. Quite often property/casualty (P/C) guaranty funds enter into confidentiality agreements with receivers to exchange information and work towards preparing a company for liquidation if that is the ultimate outcome.

The receiver may retain the services of accountants or examiners who have expertise in determining whether the insurer's financial condition gives rise to any causes of action, as well as marshalling assets and quantifying liabilities. The job of such an examiner goes beyond the role of an auditor. Here, in addition to probing for the cause of the financial difficulty, the examiner must identify for the receiver all transactions or business dealings that may produce assets for the insurer's policyholders and creditors, either by avoidance or rescission of certain transactions or by other legal action. Some state insurance departments may have experts in-house whose services are available to the receiver; otherwise, the receiver should consider retaining appropriate outside consultants.

**B. General Conduct of an Investigation or Post-Receivership Examination**

The receiver and the examiners should make themselves aware of the state statutes governing insurer receiverships. These statutes frequently detail the elements of causes of action that the receiver and examiners should investigate. For example, certain transactions are deemed preferential and may be voidable. Other transactions may be classified as fraudulent and may be set aside as such. The receiver and the examiners should seek advice of legal counsel on such statutes and, in particular, the applicable statutes of limitation. (See Chapter 9—Legal Considerations.) (Counsel also may be helpful by providing guidelines for examiners to follow in conducting the investigation.) It is crucial that the receiver take the requisite legal action in timely fashion to avoid the bar of such statutes.

The investigative examination of an insurer can start with records maintained by the insurance department. These records may include: transcripts and exhibits from administrative proceedings against the insurer; holding company registration statements; market conduct reports rate filings; recent Form A filings; work papers related to the last statutory examination, including the report thereon; annual and quarterly financial statements; and correspondence files. The receiver should also procure a complete set of the audit work papers of the insurer's certified public accounting firm, including the firm's permanent and correspondence files, as well as a complete set of the work papers from the insurer's consulting actuaries. The receiver should also thoroughly review the minutes of meetings of the board(s) of directors and any board or executive committees of the insurer and its subsidiaries. If possible, the minutes of any related holding company should be reviewed.

These records may provide the receiver with specific areas of concentration for the investigative examination. The examination will be broad in scope with a special emphasis on large or unusual transactions. The insurer's files on any suspect transactions must be reviewed completely; the receiver may need to engage a forensic accountant to assist the receiver's counsel in this review.

Once the examination reveals potential causes of action to pursue, a cost-benefit analysis should be conducted. If the potential benefit does not warrant the anticipated cost of the legal action, administrative remedies may be available. In order to conduct such an analysis, the receiver needs a full understanding of the potential claims, including the legal requirements that must be met in order to prevail on them.

**C. Reference to Special Issues Regarding Claims Involving: Federal Home Loan Bank, Life/Health, and Large Deductible**

In Chapter 5, there is a section that discusses special issues regarding particular claims, namely: 1) claims of the Federal Home Loan Bank (FHLB); 2) life and health claims; and 3) claims under large-deductible programs. As large-deductible programs involve both policy claims and the collection of amounts due under those policies, both subjects are covered in that subchapter.

*Chapter 4—Investigation and Asset Recovery***IV. VOIDABLE PREFERENCES**

The receiver of an insolvent insurer faced with the need to gather the assets of the insurer's estate should bear in mind that many state liquidation statutes authorize the receiver to retrieve property transferred by the insolvent insurer to another party if the transaction constituted a "voidable preference" as defined by statute. In general, these statutes permit the receiver to recover assets that the insurer transferred to a creditor to satisfy prior debts and resulted in the creditor receiving a greater percentage of its claims against the insurer than other creditors in the same class. The statutes in various states differ significantly in substance, scope, and form. Some states may not have voidable preference provisions in their insurance receivership statutes. However, provisions regarding voidable preferences may exist in a state's general laws, and there may be applicable case law on the subject. The receiver should consult the statutes and case law in the insurer's state of domicile to ascertain which voidable preference laws may be applicable and to learn the requirements of those statutes.

The concept and general elements of voidable preferences are discussed in detail in Chapter 9—Legal Considerations of this Handbook. In general, a voidable preference may be found if:

- There was a transfer of the insurer's property.
- The transfer was made during a statutorily specified time period.
- The transfer was made to satisfy an "antecedent debt."
- The transfer results in a "preference."

It may be necessary for the receiver to establish that there was intent to create a preference or that the creditor had reason to believe the insurer was insolvent in order for the transfer to be voidable. It may also be possible for the receiver to recover a voidable preference from persons other than the party to whom the insurer's property was transferred, such as "insiders" of the insurer who were involved in the preferential transaction and, in some cases, subsequent holders of the property. In some instances, however, the receiver's right to pursue such remedies may conflict with the rights of other creditors to pursue the same.

Preferences are dealt with in Section 604 of Model #555. This provision delineates the conditions under which a receiver can avoid a preference and attempt to recover the assets that were given to the antecedent creditor. The preference period under Model #555 is two years. Not all preferences can be avoided by the receiver. Subsection 604(B) provides that preferences can be avoided if:

- The insurer was insolvent at the time of the transfer.
- The transfer was made within 120 days before the filing of the petition commencing delinquency proceedings.
- The creditor receiving it or being benefited thereby had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent.
- The creditor receiving it was:
  - An officer or director of the insurer.
  - An employee, attorney, or other person who was, in fact, in a position to effect a level of control or influence over the actions of the insurer comparable to that of an officer or director, whether or not the person held that position.
  - An affiliate.

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Subsection 604(C) states which preferences may not be avoided even if they would otherwise be avoidable under Subsection 604(B). Basically, preferences may not be avoided if they were made in exchange for an item of value to the insurer, if they were made in the ordinary course of business in accordance with ordinary business terms, or if they were in the form of an appeal bond.

**V. FRAUDULENT TRANSFERS**

Receivers typically have the authority to recover assets conveyed by the insurer in transactions that constitute fraudulent transfers. The receiver's authority to recover fraudulent transfers may stem from any of the following sources: 1) a specific state statute; 2) the Uniform Fraudulent Conveyance Act to the extent adopted in the particular state; and/or 3) the common law of fraud. Fraudulent transfers are covered by Section 605 of Model #555. The receiver should consult counsel to ascertain which theories are available to recover fraudulently transferred assets.

Like voidable preference statutes, rules against fraudulent transfers authorize the receiver to rescind certain transactions and bring previously transferred assets back into the insolvent insurer's estate. Fraudulent transfer laws vary from state to state, but most permit the receiver to avoid transfers for inadequate consideration or transfers aimed at obstructing or defrauding other creditors.

Receivers may be able to recover fraudulent transfers from the person who received the transfer, "insiders" at the insurer who were involved in the transfer, and, in some cases, subsequent holders of the property transferred. Certain additional requirements may be applicable, and special rules may apply to certain reinsurance transactions, such as commutations. The receiver should consult Chapter 9—Legal Considerations for further details.

**VI. OTHER SIGNIFICANT TRANSACTIONS**

In addition to considering fraudulent transfer laws and voidable preference statutes, a receiver reviewing the reasons for an insurer's financial problems and attempting to marshal its assets should determine whether there have been any suspect transactions. Suspect transactions are unusual transactions that would not normally occur in the ordinary course of business. Some of these transactions may at first glance appear to be ordinary, but upon closer examination, they are found to have not been entered into for the benefit of the insurer. These are transactions that may have deceptively portrayed the insurer's financial condition, delayed discovery of its insolvency, or resulted in actual losses for the insurer. Included in the category of suspect transactions are transactions that did not comply with applicable legal requirements, were not commercially sound, or lacked financial viability.

A receiver may advance various theories to recover funds for the estate regarding losses or damages caused by suspect transactions. For example, causes of action for recovery may be based upon common law fraud, violations of the federal Racketeer Influenced Corrupt Organizations Act (RICO), fraudulent transfers, or breach of fiduciary duty. These and other causes of action are addressed fully in other sections of this Handbook and are not repeated here.

This section focuses on identifying potentially suspect transactions that are not discussed elsewhere in this Handbook. The transactions identified do not frame an exhaustive list of all suspect transactions, nor are the identified transactions necessarily fraudulent. In fact, if properly negotiated and administered, the transactions may be perfectly legitimate. However, the receiver should review the following types of transactions for due diligence. Suspect transactions may be difficult to detect and may consist of combinations or variations of one or more of the transactions described.

**A. Reinsurance**

Reinsurance balances often represent significant assets and liabilities of insolvent companies, whether from assumed or ceded business. It is commonly the case in a P/C insurer insolvency that these balances will represent the largest asset to be marshaled. Because reinsurance transactions are complex and involve large sums that may have a material effect on the balance sheet, these transactions present numerous opportunities

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for fraud, misappropriation, or mismanagement by or upon the insolvent company. The receiver's investigation should, therefore, include a review of the company's reinsurance structure, and especially any extraordinary transactions in the years immediately preceding the company's demise.

### 1. General Considerations

Delegation of the collection of reinsurance recoverables, without proper accounting and management controls, to managing general agents (MGAs) and other third parties has been a common source of large accruing balances. Therefore, the more common asset recovery activity in this area is in record construction and documentation of the accrual of balances due (see Chapter 7—Reinsurance). Aside from the instances covered below, the larger amount of the receiver's reinsurance recovery work usually should focus on the concepts that: 1) reinsurers respond and pay based on a proper accounting and documentation of the balances due; and 2) because of the frequent mismanagement of these transactions by insurers that have become insolvent, reinsurers are skeptical of information from an insolvent insurer. The receiver must dispel this skepticism.

It is often necessary to conduct a full review or reconstruct reinsurance transactions accruing pre-receivership, as well as documenting post-receivership reinsurance balances. Post-receivership balances include reinsurance balances resulting from claims covered by the guaranty funds and adjudication of non-fund covered claims. See Chapter 2—Information Systems (especially the UDS section), Chapter 5—Claims, and Chapter 6—Guaranty Funds for more on the relationship between post-insolvency accruing liability and reinsurance recoverable balances.

In the context of life and health company insolvencies, state laws generally provide the life and health insurance guaranty associations the right to elect to continue reinsurance and to succeed to the rights and obligations of the insolvent ceding insurer with respect to contracts and policies covered, in whole or in part, by the guaranty association. The election must be made within 180 days of the liquidation date and is subject to certain statutory requirements. This right to continue reinsurance is reflected in the Section 8(N) of the NAIC's *Life and Health Insurance Guaranty Association Model Act* (#520), which has been adopted in most states.

Footnote suggestion: Section 612 of Model #555 similarly reflects the rights of life and health guaranty associations to elect continue reinsurance and to succeed to the rights and obligations of the insolvent insurer under reinsurance agreements, subject to the requirements of state receivership and guaranty association laws.

### 2. Secured Reinsurance Balances

Reinsurance balances frequently will be secured to ensure collectability and preserve the insurer's statutory accounting credit. The receiver should identify and closely review these security arrangements early in the receivership. The security often includes letters of credit (LOCs) and trust accounts. Notices to financial institutions or others involved in security arrangements are critical to preserve the security by ensuring compliance with terms of the security arrangements and the exercise of any related rights or obligations.

It may be necessary to establish procedures to monitor the security during the receivership. Some LOCs will require renewal, while others will have an "evergreen clause" providing for automatic renewal. Also, some security arrangements may require that the amounts held be increased by the reinsurer. Pre-receivership transactions regarding these security arrangements should be reviewed to ensure compliance with the related reinsurance agreements, security agreements, and statutes.

### 3. Commutations

A commutation is a mutual release of all obligations between the parties for consideration. Commutations terminate the rights and liabilities between parties, including premiums due, paid losses,

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outstanding losses and incurred but not reported (IBNR) losses, loss adjustment expenses (LAE) where applicable, and present or projected profit. There are many valid reasons for commutations. They may provide immediate cash for the receivership estate, avoid future uncertainties, resolve disputes between insurers and reinsurers, and provide some protection or limitation of exposure from the insolvency of the reinsurer.

Commutations, however, may also give rise to abuses. A commutation may unfairly benefit the reinsurer by relieving the reinsurer of considerable exposure for less than fair consideration. Further, in a rehabilitation proceeding, if the cash payment received from a commutation is less than the loss reserves that must then be recognized by the insurer, then the surplus of the insurer will be reduced.

Statutory accounting principles allow an insurer's reserves to be reduced by authorized reinsurance. If an insurer's net reserves have been carried at nominal value due to a substantial credit for reinsurance recoverable, the elimination of the reinsurance setoff credit as a result of a commutation could have had an adverse impact on the insurer. For example, a related reduction in surplus could have an adverse impact on the insurer's solvency ratios and could exacerbate capacity problems. Under such circumstances, a receiver should carefully review the commutation to determine whether the benefit to the insurer outweighed the disadvantages.

In measuring the surplus impact of a commutation and comparing the assets and liabilities assumed, it should be kept in mind that the assets received are usually easily quantifiable, whereas the reserves are not. Thus, what may appear to be a break-even transaction on the surface may, in fact, result in a large loss to one party because of the way the reserves were determined. It usually is helpful to know if a qualified actuary has reviewed the assumed block of reserves, supplementing case reserve estimates with projections of IBNR development, related LAEs, and use of industry data where necessary. Also, because of the inability of insurers to discount their reserves for statutory purposes, a commutation may appear on the surface to produce a loss to the insurer. The long-term economics of the transaction, however, may be sound when consideration is given to the future investment income to be earned from the commutation process. The receiver should also assess the potential adverse consequences of any commutation. In sum, commutations should be reviewed to determine if they were negotiated at arm's length and were fair and reasonable to the insurer; the receiver may need to engage an independent actuary to assist in this review.

Section 605 of Model #555 addresses the avoidance of reinsurance transactions incurred on or within two years before the date of the initial filing of a petition commencing delinquency proceedings under certain conditions. Section 612 of Model #555 relates to the continuation of life, disability income, and long-term care (LTC) reinsurance in liquidation and the right of the GA to elect within 180 days of the liquidation to continue that reinsurance subject to the requirements of Section 612 of Model #555. Some states' voidable preference and fraudulent transfer statutes include specific sections dealing with commutations that occur within a short period before the filing of a petition for the appointment of a receiver. The receiver should be aware of these special rules, which may allow the rescission of a commutation for the benefit of the insurer and its creditors.

#### 4. Stop-Loss Treaties

A stop-loss treaty, or aggregate excess reinsurance contract, indemnifies an insurer if in any year the losses on retained accounts exceed a specified amount. The determination of whether the specified amount has been exceeded is usually made after the application of all other reinsurance and the benefits or recoveries under surplus, quota share, and catastrophic excess of loss treaties. The premium for a stop-loss treaty can be based on a fixed dollar amount, or it may be a ratio of annual retained premium (calculated by reducing gross premium income by premiums for other reinsurance, such as surplus treaties, quota share treaties, and catastrophic excess of loss contracts). The purpose of a stop-loss treaty is to protect against an aggregation of losses during a particular period of time.



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Stop-loss treaties are also subject to abuse and, consequently, should be carefully evaluated. The amount of loss protected against may be unreasonable in light of the loss experience of the insurer. As a result, there may have been an improper motive in paying a premium for a stop-loss treaty for which the insurer was not likely to receive any real benefit. The premium may have been excessive when compared to similar coverage generally available.

#### 5. Unauthorized Reinsurance

Unauthorized reinsurance is reinsurance placed with non-admitted or unauthorized reinsurers that are not authorized to transact insurance business in the cedent's domiciliary state. Under statutory accounting principles, an insurer's liability for loss reserves is carried net of reinsurance. Generally, unauthorized reinsurance may not be used to reduce loss reserves unless the reinsurer's liability is secured by trust funds, funds held by the cedent, or LOCs. Care should be taken to ensure that these potential estate assets are identified and secured.

Unauthorized reinsurance may be appropriate when placed with a financially sound reinsurer. The placement of reinsurance with unauthorized reinsurers, however, is subject to abuse. For example, it may be a means of diverting funds to an affiliate. The placement of reinsurance with financially weak non-admitted reinsurers may indicate an improper motive for obtaining such reinsurance.

#### 6. Portfolio Transfers/Loss Assumption Reinsurance

Generally, a portfolio is one of the following: 1) an entire book of business; 2) a book of business in force at a certain time; or 3) outstanding losses unpaid at a certain time. Typically, in a portfolio transfer, the reinsurer assumes the reinsureds' obligations to pay losses on the assumed portfolio in return for the payment of a premium and the transfer of related loss reserves and security, as applicable.

Portfolio transfers should be reviewed to ensure that the transfer was entered into for legitimate business reasons and inured to the insolvent insurer's benefit. The receiver should consider whether the business transferred was an integral part of the insolvent insurer's business. Did it represent a highly profitable segment of the business, or was it marginal or even a contributor to operating losses? What were the long-term prospects for the portfolio transferred? How did it fit with the balance of the business retained by the insurer? Did the transfer effect a novation of the underlying insurance policies or reinsurance contracts? Did the transferor's policyholders or reinsureds consent to the novation? Answers to these questions should indicate whether a particular portfolio transfer might be a suspect transaction.

Transfers of a profitable portfolio could temporarily prolong the insurer's life while undermining the long-term financial viability. Transfers between affiliated parties should be carefully reviewed. Because certain bulk transfers require insurance regulatory approval, it should be determined if there was compliance with applicable requirements.

#### 7. Surplus Relief Treaties

Comparing premium income to surplus is a common test of whether an insurer is taking on too much risk. Typically, the desired ratio is 3:1. In other words, annual premium income greater than three times surplus may be a warning signal that the insurer is assuming too much risk. Regardless of the test applied, if an insurer reaches the maximum amount of premium income supportable by its surplus, it either must cease writing new business or shed some of its premium income or liability to maintain its financial health.

One method of reducing premium income is to enter into a reinsurance treaty whereby the insurer cedes premium in exchange for a *pro rata* reduction in its liabilities. This practice allows the insurer to continue to write business. A surplus relief treaty is generally considered to be proper if the liabilities ceded are not set off by commission paid to the reinsurer and if the reinsurer does not protect itself against an adverse loss experience by having the insurer ultimately pay the liabilities. In other words,

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if the insurer has ceded the premium for the business and has transferred the underlying liabilities, the treaty likely will not be a suspect transaction. (See Chapter 9—Legal Considerations.)

If scrutiny of the surplus relief treaty reveals that the insurer superficially ceded premium and the business but in reality provided a stop-loss to the reinsurer or otherwise protected the reinsurer from liabilities, then the transaction may have been improper. It may be difficult to trace such a transaction because it can be accomplished in separate documents. This type of arrangement would give a false picture of the insurer's solvency, as it would mask its true premium-to-surplus ratio by understating premium and, at the same time, not relieve the cedent of the risk of loss associated with the underlying business.

#### 8. Finite Reinsurance

Another way that an insurer occasionally attempts to improve its balance sheet is by entering into financial reinsurance transactions. There are many forms of these, but the potential concern behind these types of transactions is to examine whether they were performed simply to shift liabilities off the books of the insurer onto the books of the reinsurer without any real transfer of risk for those liabilities. Any reinsurance contracts that do not appear to have effectuated a real transfer of risk of loss to a reinsurer should be examined closely by the receiver. These contracts may not only be voidable, but there may be additional recourse against the reinsurer for participating in the financial reinsurance transactions. (See Chapter 7—Reinsurance and Chapter 9—Legal Considerations.)

#### 9. Affiliated Reinsurance

In some cases, the insurer cedes its risks to an affiliated reinsurer. The reinsurer then dividends funds to common ownership. There are also affiliated pooling transactions that may be used to inappropriately transfer funds among the pool participants.

### **B. Large-Deductible Policies**

1. NAIC has adopted a *Guideline to Administration of Large Deductible Policies in Receivership*, and the guideline or similar policy has been adopted in several states. Large-deductible recoveries can represent a significant source of recoveries for insolvent companies, especially those P/C companies that wrote workers' compensation insurance. These recoverables may be a significant amount, and the receiver should examine the scope of the large-deductible business written and the collection and collateral procedures employed by the company.

#### General Considerations

- a. The receiver's recovery of large-deductible recoverables is dependent on the claims handling and reporting of both claims covered and those not covered by guaranty funds.
- b. The key to effective collection and collateral administration is ensuring that the historical records for paid losses under the deductible policies and the program design are maintained and available. Another key is retaining the personnel that have knowledge and history of the insurer's deductible business operations.
- c. Collateral for Large-Deductible Balances.
  - The importance of collateral cannot be overstated; adequate collateral must be established prior to liquidation and maintained throughout the receivership.
  - Large-deductible balances frequently will be secured to ensure collectability and preserve the insurer's statutory accounting credit. The receiver should identify and closely review these security arrangements early in the receivership. Particular attention should be paid to security arrangements where the insured's collateral is held by third parties, especially affiliates of the insurer.

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- Notices to financial institutions or others involved in security arrangements are critical to preserve the security by ensuring compliance with terms of the security arrangements and the exercise of any related rights or obligations

## 2. Communication

Deductible collection, in addition to requiring collateral, is dependent on communication of all parties (i.e., between receiver and insured, receiver and guaranty association, and guaranty association and insured). It must be quickly established with insureds as to the procedure for ongoing claim processing, continuation of their responsibility to reimburse the deductible payments, and responsibility to maintain appropriate collateral. Guaranty associations must also recognize that they will be required at times to communicate with insureds regarding claims handling. All parties should be mindful of security concerns related to communication of sensitive claims data. The SUDS server hosted by the National Conference of Insurance Guaranty Funds (NCIGF) is a useful tool for communication between receivers and guaranty associations. The collection process should proceed with minimal delay as the passage of time will affect the success of collection efforts. In these efforts, it is imperative that the guaranty associations and the receiver work together and offer consistent messages to the insured regarding any collection issues. It should also be noted that the release of collateral from a receiver to a guaranty association may not fully satisfy the policyholder's obligation for costs related to the claim under a state's guaranty association law.

## 3. Deductible Collection Procedure

- A working process must also be established quickly between the receiver and the guaranty associations to provide claim handling, payment information, and all other required claim financials to allow the receiver to bill and collect loss payments.
- The information would include the receiver providing the guaranty associations all pertinent information to establish the policies that are deductibles along with effective dates, deductible limits, treatment of allocated loss adjustment expense (ALAE), and deductible aggregates where available.
- Copies of deductible policies should be made available if required.
- Guaranty associations will provide, through the establishment of a UDS data feed, all financial information regarding deductible claims that they are handling.
- The receiver will collate data from guaranty associations and review historical billing information to invoice the insureds on a monthly or quarterly basis.
- The receiver will calculate and track the payment history pre-liquidation and post-liquidation within the deductible and within a deductible aggregate for the policy if applicable. This ensures that the insured is only billed for amounts that remain within its deductible.
- To assist in the collection process, the receiver and the guaranty association should work to provide sufficient information and explanation to allow the insured to recognize its obligation. In the event where the insured refuses to pay, the receiver will either begin litigation or draw on collateral—or both. This should be coordinated with the guaranty associations.

## 4. Professional Employer Organizations

- Policies issued to professional employer organizations (PEOs) often have large-deductible endorsements.
- Because of the prevalence of abuse in the underwriting of PEOs, post-liquidation collection of deductible payments may be challenging.
- Clients may have been added without notice (or payment) to the insurer. Client class of business may have been misrepresented or expanded to include riskier classes of business—all of which may lead to inadequate or exhausted collateral.

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- d. Client companies of PEOs may not have received notice of cancellation, leading to coverage disputes. If collateral is inadequate and the PEO does not have assets to pay the deductible reimbursement in full, the policy terms might make the client companies liable for the shortfall, either for their own exposure or on a joint-and-several basis. However, this might not be a meaningful source of recovery because it could be impractical, inappropriate, or impossible to collect significant amounts from the clients.
5. Commutations
    - a. Generally, commutations are negotiated terminations of the rights and liabilities between insurers and large-deductible insureds. A commutation is a settlement of all obligations, both current and future, between the parties for a lump sum payment.
    - b. There are many valid reasons for commutations of large deductibles. They may provide immediate cash for the receivership estate, avoid future uncertainties, resolve disputes between the insurer and the insured, and provide some protection or limitation of exposure from the insolvency of the insured. Commutations of long tail business (i.e., workers' compensation) may be essential for the early termination of the receivership.
    - c. Commutations, however, may be a detriment to the receivership if the commutation is consummated for less than fair consideration. A receiver should carefully review the commutation to determine whether the benefit to the insurer outweighs the disadvantages.

**C. Inappropriate Investments**

Inappropriate investments may have the effect of overstating the insurer's assets on its annual statements and, at the same time, result in an actual loss if the investments are poor. In some instances, earnings from investments are less than they should have been. Investments may be inappropriate for four general reasons: 1) the investments are prohibited and not allowed as admitted assets by insurance laws or regulations; 2) while allowed as admitted assets, the investments are too speculative at the time of investment, given their materiality to the insurer's financial condition; 3) the investments did not meet the insurer's need for liquidity; or 4) the assets do not match the corresponding policy liabilities.

While some states' insurance codes prohibit the acquisition of certain assets, many view such acquisitions as non-admitted assets. However, regulators retain the right to order disposal of assets acquired in violation of law. A receiver should determine whether such acquisitions have occurred and whether the assets still are held by the insurer. If so, the receiver must identify the losses that have occurred on previously acquired assets and losses likely to occur on assets currently held by the insurer. Additionally, a separate inquiry should be made to determine whether the insurer was damaged. If such investments were booked as admitted assets, the result may be an inaccurate financial statement.

It is difficult to evaluate the culpability for making investments in admitted assets that are highly speculative or illiquid. While code provisions require all investments to be sound, an analysis of what are sound investments involves the application of the business judgment rule. This rule protects management, who made informed decisions in good faith without self-dealing, from being judged in hindsight. Insurance codes have prohibitions and limitations on the types and amounts of investments both on an individual and aggregate basis. Insurance codes generally enumerate the types of assets permitted, but that is beyond the scope of this discussion. In general, an insurer first must invest its minimum paid-in capital and surplus in certain defined investments, which generally are thought to be safer than other types of investments. Generally, these types of investments are government obligations. Once the insurer has invested its minimum paid-in capital and surplus in these allowed investments, there are other limitations on investment of an insurer's assets (excess funds investments). The codes are quite detailed with numerous descriptions and limitations, including limitations on the amounts that may be invested in real estate (if any), affiliates, and common stock, as well as the relative percentages of certain investments. (Although affiliates are generally admissible, such assets are usually illiquid if not publicly traded. If they make up a significant portion of surplus, then an investigation should be made into their acquisition and value.) Other

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inappropriate investments may include those that, although admitted, are either high-risk, or are not matched properly to the insurer's cash flow needs.

Investments that violate the applicable insurance code or regulations will not qualify as admitted assets on the annual statement. If such investments have been identified, the receiver should determine:

- When the investment occurred.
- Who authorized the investment.
- For what purposes the investment was made.
- The details of the transaction, including cost.
- Whether corporate formalities were followed.
- The broker and other persons involved.
- Whether the investment is with a related party.

It also is important to review how the questionable investments were reflected on the insurer's annual statement. The booking of non-admissible assets as admitted assets may identify a problem affecting the true financial condition of the insurer and may necessitate further investigation of corporate officers and directors. If the investments have already been disposed of, it is important to determine whether this resulted in a gain or loss. If disposed of at a reasonable gain, then a judgment must be made as to whether it is worth proceeding further with the analysis. If losses were incurred or will be incurred, there may be substantial questions of legal responsibility.

A review of recent transactions should reveal realized losses, and an evaluation of investments still held should reveal where unrealized losses exist. In the event that realized or unrealized losses are identified, a case-by-case evaluation should be made as to whether there is any culpability surrounding the acquisition or disposition of these types of investments. Once again, all the details surrounding the acquisitions should be thoroughly reviewed, particularly focusing on any close or suspicious relationships between the insurer's management, officers or directors and the management, officers or directors of the acquired investment, or with any brokers or agents involved in the sales transaction.

To identify investments that violate insurance laws and, consequently, are not admitted assets, a receiver should begin with a review of examination reports and work papers. Examiners tend to be thorough with respect to identifying assets or investments that are not admitted assets. If no examination report has been prepared, accountants or auditors should review the most current annual statements and supporting schedules to identify and list all investments that are not admitted assets. The following exhibits and schedules should be reviewed:

- Exhibit of Net Investment Income.
- Exhibit of Capital Gains (Losses).
- Exhibit of Non-Admitted Assets.
- Schedule A – Real Estate.
- Schedule B – Mortgage Loans.
- Schedule BA – Long-Term Invested Assets.

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- Schedule D – Bonds and Stocks (including valuations of subsidiary, controlled and affiliated companies).
- Schedule DA – Short-Term Investments.
- Schedule DB – Derivatives.
- Schedule E – Cash, Cash Equivalents, and Special Deposits.

General Interrogatories (which could contain information concerning cryptocurrency and other assets). Other sources include internal and external audits, U.S. Securities and Exchange Commission (SEC) periodic reports (such as annual and quarterly reports on Forms 10-K and 10-Q), and investment committee minutes.

**D. Dividends and Intercompany Transactions**

State insurance codes have strict limitations on how much money can be paid out as dividends from insurance companies. Some insurance codes provide for the recovery of dividends paid within a certain time period prior to the insurer's insolvency. Accordingly, all dividends should be reviewed to determine compliance with these statutory limitations. The receiver also should determine whether the financial statements were manipulated to make otherwise impermissible dividends possible. Regulators who had responsibility for reviewing the dividends may be contacted to determine what representations were made by company personnel when the dividends were approved.

As part of this process, intercompany transactions should be reviewed to look for disguised dividends. Many companies will have been part of a holding company structure. Oftentimes, a company will have entered into cost-sharing agreements, tax-sharing agreements, investment management agreements, marketing agreements, and other such transactions with affiliates. These transactions should be reviewed closely. When a company is precluded from paying dividends, it may try to disguise what, in fact, are dividends under transactions pursuant to these agreements.

Illegal dividends may be recovered in fraud actions or breach-of-fiduciary-duty actions. The failure of the company's outside accountants or auditors to detect illegal dividends also may form the basis of an action in negligence against the accountants and/or auditors.

**E. Management by Others**

Another area of suspect transactions is the management of insurers by other entities, including MGAs or third-party administrators (TPAs) acting pursuant to management contracts, as well as corporate or individual attorneys-in-fact. A close examination of the overall relationship, including all contracts, should be made since there is a potential for abuse of these relationships. In some instances, the management contract may be arranged so that, in essence, the insurer fronts for the MGA or the attorney-in-fact, who retains all the profits, and the insurer retains all the liabilities. It may raise a difficult question as to whether there was proper compensation for services or if the MGA or attorney-in-fact misappropriated corporate opportunities. Another abusive practice is causing the insurer to pay the MGA, TPA, or attorney-in-fact for services that it did not provide but were provided by the insurer's employees at the insurer's expense. This, in effect, results in double payment. Detection requires a thorough review of the contracts and an analysis of which entity pays for which function, which may be especially difficult when the operations are all in one facility.

**VII. RECEIVERSHIP INVOLVING QUALIFIED FINANCIAL CONTRACTS**

Section 711—Qualified Financial Contracts (or Similar Provision) of Model #555 addresses stays termination, transfers of netting agreements, or qualified financial contracts (QFCs).

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When financial markets are uncertain, it causes heightened scrutiny in the capital markets and among financial institutions about identifying, managing, and limiting risk, as well as the need for adequate capitalization and for understanding the interdependency of the different financial sectors. One source of risk to financial market participants that rises due to the lack of certainty in the financial markets is the treatment of QFCs and netting agreements in the event of the insolvency of state regulated insurers.

**A. Definition of Qualified Financial Contract**

Model #555 defines a QFC as “any commodity contract, forward contract, repurchase agreement, securities contract, swap agreement and any similar agreement that the commissioner determines by regulation, resolution or order, to be a qualified financial contract for purposes of this Act.”

- Commodity contract is defined by reference to the Commodity Exchange Act (7 U.S.C. § 1) (Commodity Act) and is a contract for the purchase or sale of a commodity for future delivery on or subject to the rules of a board of trade or contract market subject to the Commodity Act; an agreement that is subject to regulation under Section 19 of the Commodity Act commonly known as a margin account, margin contract, leverage account, or leverage contract; an agreement or transaction subject to regulation under Section 4(b) of the Commodity Act that is commonly known as a commodity option; any combination of these agreements or transactions; and any option to enter into these agreements or transactions.
- Forward contract, repurchase agreement, securities contract, and swap agreement shall have the meanings set forth in the Federal Deposit Insurance Act (FDIA), 12 U.S.C. § 1281(e)(8)(D), as amended from time to time.

It should be noted that an insurance contract is not a derivative or a QFC because an insurance contract includes the indemnification against loss. Therefore, reinsurance agreements would not be considered a swap agreement.

**B. Insolvency Treatment of Qualified Financial Contracts Under the *Insurer Receivership Model Act*, Section 711 Provision<sup>1</sup>**

Model #555, Section 711 provides a safe harbor for QFC counterparties of a domestic insurer. The provision largely tracks similar provisions in the Federal Bankruptcy Code and the FDIA, as well as laws of other

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<sup>1</sup> Except where the state has adopted *Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts* (#1556).

**Guideline #1556 Drafting Note:** State receivership and insolvency laws may permit a contractual right to cause the termination, liquidation, acceleration, or close-out obligations with respect to any netting agreement or qualified financial contract (QFC) with an insurer because of the insolvency, financial condition, or default of the insurer, or the commencement of a formal delinquency proceeding. These laws are based upon similar provisions contained in the federal bankruptcy code and the Federal Deposit Insurance Act (FDIA). The FDIA also provides for a 24-hour stay to allow for the transfer of QFCs by the receiver to another entity rather than permitting the immediate termination and netting of the QFC. 12 U.S.C. § 1821(e)(9)-(12). States that permit the termination and netting of QFCs may want to consider adopting a similar stay provision following the appointment of a receiver for certain insurers—generally larger entities that may be significant in size but outside of being subject to a potential federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) receivership.

States that consider the enactment of a stay should take into account the relevant federal rules. In 2017, the Board of Governors of the Federal Reserve System (Federal Reserve), the Federal Deposit Insurance Corporation (FDIC), and the Office of the Comptroller of the Currency (OCC) each adopted final rules and accompanying interpretive guidance (Final Rules) setting forth limitations to be placed on parties to certain financial contracts exercising insolvency-related default rights against their counterparties that have been designated as a global systemically important banking organization (GSIB). The Final Rules include the definition of master netting agreement that allows netting even though termination of the transaction in the event of an insolvency may be subject to a “stay” under several defined resolution regimes, including Title II of the federal Dodd-

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foreign jurisdictions. These safe harbor provisions for QFCs were adopted to avoid disruptions resulting from judicial intervention that can cause unintended chain reactions and significant systemic impact. Section 711 applies in both rehabilitation and liquidation proceedings.

Section 711 states that a right to terminate, liquidate, or accelerate a closeout under a netting agreement or a QFC with an insurer either due to the insolvency, financial condition, or default of the insurer or the commencement of a formal delinquency proceeding is not prevented by any other provision of Model #555. Section 711 allows a counterparty to net different contracts and realize on collateral without a stay.

Section 711 addresses transfer of a netting agreement or QFC of an insurer to another party. In a transfer, the receiver has to transfer all of the netting agreement or QFC and all of the property and credit enhancements securing claims under the agreement or QFC. This prevents “cherry-picking” and requires the transfer of everything; i.e., all of both the “in-the-money” and “out-of-the-money” positions.

### C. Considerations of Qualified Financial Contracts Held by an Insurer Receivership

- Although the *Investments of Insurers Model Act (Defined Limits Version)* (#280) does not include limits on the amount of collateral an insurer is allowed to post, some states have restrictions on derivatives use, including quantitative limits, and limits on the pledging of collateral, based on type and credit quality. The receiver may also need to determine if a derivative use plan, if required, is in effect and if it dictates any collateral requirements.
- If the ability to net exists and there is no stay requirement, it is important that the regulator understand the QFC portfolio before the insurer's failure, either through a recent or ongoing financial examination or through an assessment made during regulatory supervision that precedes a receivership order, while recognizing that the market value of the derivatives positions can vary substantially over relatively short periods of time. The receiver also needs to have a good understanding of the relationship of the QFC contracts to the rest of the insurer's balance sheet. Because most derivatives transactions are used for hedging purposes, if those contracts are terminated as a result of netting, the assets and liabilities will no longer be hedged. It is important

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Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) and the Federal Deposit Insurance Act (FDIA), as well as comparable foreign resolution regimes. Notwithstanding the NAIC's request for inclusion, stays under the state insurance receivership regime (state receivership stays) were not included as an exemption within the definition. Therefore, unless the Final Rules are amended to recognize state receivership stays, if a state implements a stay as contemplated by the Guideline, insurers would find themselves disadvantaged, potentially resulting in additional costs and/or collateral requirements given the regulatory treatment for contracts that do not meet requirements for qualified financial contracts (QFCs). Therefore, if a state is considering implementation of this Guideline, consideration should be given to whether the rules of the Federal Reserve, the FDIC, and the OCC have been amended to recognize state receivership stays. For example, a state could adopt a stay that would be effective if and when the Final Rules recognize state receivership stays.

**References:** *Restrictions on Qualified Financial Contracts of Systemically Important U.S. Banking Organizations and the U.S. Operations of Systemically Important Foreign Banking Organizations*; Revisions to the Definition of Qualifying Master Netting Agreement and Related Definitions, 82 FR 42882 (13 November 2017), available at <https://www.federalregister.gov/d/2017-19053>; *Restrictions on Qualified Financial Contracts of Certain FDIC Supervised Institutions*; Revisions to the Definition of Qualifying Master Netting Agreement and Related Definitions, 82 FR 50228 (30 October 2017), available at <https://www.federalregister.gov/d/2017-21951>; *Restrictions on Qualified Financial Contracts of Certain FDIC-Supervised Institutions*; Revisions to the Definition of Qualifying Master Netting Agreement and Related Definition, 82 FR 61443 (28 December 2017), available at <https://www.federalregister.gov/d/2017-27971>; and *Mandatory Contractual Stay Requirements for Qualified Financial Contracts*, 82 FR 56630 (29 November 2017), available at <https://www.federalregister.gov/d/2017-25529>.



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to quantify the effect of the loss of the contracts if possible. The receiver may wish to engage outside resources to assist in evaluating the QFC portfolio.

- The receiver should be aware that there may be areas of contention and disagreement by parties in the netting, termination, and closeout of QFC agreements—for example, disagreement over the valuation or in the resolution of transactions where the parties wait too long to terminate the contract.
- Some counterparties may have been accepting less liquid assets, such as private placements based on the relative financial strength of the insurance company; typically, collateral for a QFC will be cash and U.S. Treasury bonds. The moving of over the counter (OTC) derivatives to centralized clearinghouses (CCHs) will gradually eliminate less liquid assets, as well as assets with more volatile market values being used as collateral. It is also worth noting that it is possible to have non-admitted assets eligible as collateral. Where assets exceed concentration limits, the excess can be collateral without being an admitted asset.
- The impact of CCHs will be to standardize documentation and collateral requirements. The standard rules for collateral will be more restrictive and be applicable to all parties. These rules will generally allow for only high-quality assets that are more liquid and are expected to have less market value volatility. In addition, all parties will be subject to the same rules for both initial margin and variation margin. In the past, it was not uncommon for counterparties to not require initial margin from their higher quality clients. This will not be the case going forward.

**D. Recommended Procedures for State Insurance Regulators/Receivers**

To the extent possible, in a pre-receivership situation:

- To the extent a company has a small number of large QFC contracts that are important to the overall investment portfolio and operations of the insurer, in pre-receivership and in rehabilitation, the state insurance regulator or receiver should reach out to the counterparty to determine if the counterparty is agreeable to continuing the contract and performing on the contract when the insurer enters receivership.
- Consider practical strategies for successfully managing the netting agreements and QFCs, not only at the inception of the receivership, but also ongoing during the receivership process.
- Evaluate if the insurer is engaged in netting agreements and QFCs through a market-facing affiliate or non-affiliate, whereby the insurer's contract is with that market-facing entity and the market-facing entity has the contracts with the counterparties.
- Consider the applicability of any federal master netting agreement rules and regulations to the insurer's netting agreements and QFCs. (See the references to applicable federal rules in the preceding footnote in this chapter <sup>2</sup>.)
- Evaluate the need to consider the use of a bridge financial institution to transfer and manage the netting agreements and QFCs in a pre-receivership proceeding; i.e., administrative supervision. See Chapter 11—State Implementation of Dodd-Frank Receivership of this Handbook for guidance on the use of bridge financial institutions for a federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) receivership.
- Carefully review the most recent financial statement filings and interim company records to identify the netting agreements and QFCs active at the time of receivership; understand the terms of the agreements and the valuation of the QFCs; and identify the securities held as

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<sup>2</sup> See footnote 1 of this chapter.

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collateral and counterparties to the contract. See the Appendix for a Summary of Statutory Annual Statement Reporting of QFCs or the most current Statutory Annual Financial Statement and Instructions.

- Consider how ongoing hedging of obligations and assets can be accomplished during and following a receivership.

Once a rehabilitation or liquidation order has been entered:

- Provide notice of the receivership to counterparties, as appropriate under state law.
- Consider implementing a 24-hour stay on termination of netting agreements and QFCs, if allowed under state law. (See the *Guideline for Stay on Termination of Netting Agreements and Qualified Financial Contracts* [#1556] and the accompanying drafting note in the preceding footnote in this chapter<sup>3</sup>.)
- It is important for the receiver to keep track of which transactions have been terminated validly and which have not so that appropriate action can be taken when the validity of the termination is contested.
- Once the set off has occurred, if the receiver disagrees with the counterparties' valuation of either the collateral or the QFC transaction, the receiver would take the next steps to try to negotiate the correct amount and, if unsuccessful, pursue legal action.
- Consider engaging an investment expert to assist in the auditing, investigating, and management of the netting agreements and QFCs within the investment portfolio. Refer to Chapter 3.VI of this Handbook for more guidance on auditing and investigating the investments of the receivership estate

#### **E. Exhibit—Qualified Financial Contract Annual Statement Reporting (As of 2021)**

The subsequent information provides a general description of how and where QFCs are reported within the *Accounting Practices and Procedures Manual* (AP&P Manual) and the statutory financial statements.

##### Derivative Instruments—Accounting Practices and Procedures Manual Disclosure

- *Statement of Statutory Accounting Principles (SSAP) No. 27—Off-Balance-Sheet and Credit Risk Disclosures*
- *SSAP No. 86—Derivatives*
- *SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees*

##### Derivative Instruments—Annual Statement Disclosure

- Schedule DB – Part A, Section 1 – *Open Options, Caps, Floors, Collars, Swaps, and Forwards*
- Schedule DB – Part B, Section 1 – *Open Future Contracts*
  - Within Part A and Part B, Section 1 identifies the contracts open as of the accounting date, and Section 2 identifies contracts terminated during the year.
- Schedule DB – Part C – *Replication (Synthetic Asset) Transactions*
  - Section 1 contains the underlying detail of replicated assets open at the end of the year. Section 2 is reconciliation between years of replicated assets.
- Schedule DB – Part D, Section 1 – *Counterparty Exposure for Derivative Instruments Open*
- Schedule DB – Part D, Section 2 – *Collateral for Derivative Instruments Open*
- Schedule DB – Part E – *Derivative Hedging Variable Annuity Guarantees*
  - Specific to derivatives and hedging programs under SSAP No. 108
- Schedule DL – Part 1 & 2 – *Securities Lending Collateral Assets*
- Notes to Financial Statement – *Investments*

<sup>3</sup> See footnote 1 of this chapter.

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- Notes to Financial Statement – *Derivative Instruments*
- Notes to Financial Statement – *Debt (FHLB Funding Agreements)*
- Notes to Financial Statement – *Information about Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk*
- Notes to Financial Statement – *Fair Value Measurements*

On a quarterly basis, the insurer only reports derivative instruments that are open as of the current statement date. Schedule DB – Part A – Section 1 lists the insurer’s open options, caps, floors, collars, swaps, and forwards. Open futures are reported in Schedule DB – Part B – Section 1, replications are reported in Schedule DB – Part C – Section 1, and counterparty exposure for derivatives instruments are reported in Schedule DB – Part D.

Repurchase Agreements—AP&P Disclosure

- *SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*

Repurchase Agreements—Annual Statement Disclosure

- Notes to Financial Statement– *Investments*
- Notes to Financial Statement – *Debt*
- Repurchase agreements are disclosed in various investment schedules within the Annual Financial Statement depending on the type of investment (Schedule D, DA, E, Supplemental Investment Risk Interrogatories). The Investment Schedule General Instructions provide the following list of codes to use in the appropriate investment schedule code column regarding investments that are not under the exclusive control of the reporting entity, and also including assets loaned to others. For example, a bond subject to a repurchase agreement would be detailed in Schedule D Part 1 – *Long-Term Bonds Owned* and use a code of RA in Code Column.

Codes

LS – Loaned or leased to others

RA – Subject to repurchase agreement

RR – Subject to reverse repurchase agreement

DR – Subject to dollar repurchase agreement

DRR – Subject to dollar reverse repurchase agreement

C – Pledged as collateral – excluding collateral pledged to FHLB

CF – Pledged as collateral to FHLB (including assets backing funding agreements)

DB – Pledged under an option agreement

DBP – Pledged under an option agreement involving “asset transfers with put options”

R – Letter stock or otherwise restricted as to sale – excluding FHLB capital stock (Note: Private placements are not to be included unless specific restrictions as to sale are included as part of the security agreement.)

RF – FHLB capital stock

SD – Pledged on deposit with state or other regulatory body

M – Not under the exclusive control of the reporting entity for multiple reasons

SS – Short sale of a security

O – Other

**VIII. POTENTIAL RECOVERY FROM THIRD PARTIES**

As noted above, a number of persons inside and outside of the insolvent insurer may have caused or contributed to the reasons for the insurer’s insolvency. Such acts or omissions may be unintentional, but the result is harm to the insurer and thus its policyholders, claimants, and creditors. This section and the next identify by category the acts and omissions of such persons, the causes of action that may be brought, and the foundation that the receiver must establish to prevail in such causes of action.

Not all actions listed here may have contributed directly in the insurer’s problems, and inclusion of an action in the following list does not necessarily indicate that a receiver will find a basis for seeking legal remedies from identified persons. Each situation must be evaluated on its own merits and circumstances. For example, the facts may clearly indicate that an agent wrongfully withheld funds due the insurer, but an investigation of the agent’s financial condition might show that there would be little hope of collecting any judgment resulting from successful civil

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litigation. Therefore, the cost to the estate of pursuing this particular agent may outweigh the ultimate benefit, if any, to the estate.

**A. Breach of Fiduciary Duties**

Any person empowered to collect and hold funds on behalf of another has a fiduciary duty with respect to any funds collected. MGAs, TPAs, reinsurance intermediaries, brokers, and others may have violated this obligation by:

- Failing to maintain a premium trust account where required by law.
- Skimming premiums.
- Withholding funds without authorization.
- Failing to collect and remit premiums.
- Paying affiliates more than market rate for services.
- Deducting excess commissions and/or fees.
- Taking improper set-offs.
- Improperly using funds to make loss payments.

The investigative examination initiated by the receiver may indicate the presence of these problems. The receiver may need to conduct a more intensive investigation of transactions arising from the suspect MGA or TPA agreement, reinsurance treaty, etc., to determine whether a violation has occurred and the extent of injury to the insurer. Some examples of the information that may suggest a need for further investigation are:

- A significant decline in reported premium volume from one period to the next.
- Gaps in policy number sequence.
- Sharp increases in agents' balances receivable.
- Inordinate delays in collecting reinsurance balances receivable.
- Increase in consumer complaints.

**B. Abuses Related to Risk Selection**

An insurer may have delegated the authority to bind risks to an MGA or TPA, or may have given a reinsurance intermediary the power to cede or assume reinsurance on behalf of the insurer. Delegation of authority carries with it the duty to perform on the underlying agreement that binds the agent or intermediary to adhere to the insurer's articulated underwriting guidelines and limitations. To the extent any agent exceeded these limits and caused the insurer to suffer financially, the receiver may be entitled to appropriate remedies.

Some of the ways in which underwriting authority may have been abused are:

- Accepting excluded classes of business.

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- Violating territorial limits.
- Exceeding premium and/or product mix limits.
- Using binders improperly.
- Misrepresenting risks.
- Placing reinsurance with insolvent reinsurers.
- Improperly placing reinsurance with affiliated or unauthorized reinsurers.
- Failing to obtain adequate security for balances due the ceding.
- Misrepresenting reinsurance coverage.

As noted above, the takeover investigation may indicate that these problems exist and that a more intensive examination of performance under specific agreements may be in order.

Some examples of information that may suggest a need for deeper investigation in this area are:

- Unusual line codes or state codes in statistical reports or state pages of reports.
- Variances from sales plans and volume projections.
- Schedule F or S problems, mismatches, and unexplained differences.
- Reinsurers' resistance to or questions regarding claims presented.

**C. Loss Settlements**

As with risk selection, the insurer may have delegated claims settlement authority to a third party, be it an MGA, TPA, or loss adjuster. The third party has the duty to adhere to any guidelines and limitations stipulated in the delegation agreement, as well as to comply with fair claims settlement practices. Typically, these agreements will stipulate the third party's settlement authority, reporting practices, reserving practices, and use of outside experts.

Potential abuses include exceeding the claims settlement authority and establishing inadequate loss reserves in order to maintain a relationship with the insurer. Other indicators of problems are:

- Fluctuations in reported incurred losses.
- Unusually high LAEs.
- Unexpectedly high losses.
- Late development of reported losses.
- Policyholder complaints.
- Low salvage recoveries and/or high ratio of salvage costs to amount recovered.
- Low subrogation recoveries and/or high ratio of subrogation cost to recovered amount.
- Negative market conduct examination report comments.

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- Claims payments exceeding clean claim guidelines in health insurance.

To the extent that an agent's actions caused the insurer's financial suffering, the receiver may wish to pursue litigation or other available remedies.

**D. Abuses Relating to Premium Computations**

This area is closely related to risk selection in that the parties to whom underwriting authority has been delegated may also have the authority to compute the premium for the risks, as well as compute, collect, and remit premium adjustments.

The compensation of the party in question, especially an MGA, is generally a commission based on premiums written. Consequently, the agent may deliberately underprice the premium or fail to compute additional premiums in order to write the risk and generate a commission.

Similarly, the insurance broker, the policyholder, and intermediary (if reinsurance is involved) might deliberately suppress information relating to compensation. The receiver should look for:

- Change in pattern of premiums audit activity.
- Unusual lag in reporting losses.
- Unexpectedly high incurred loss ratios.
- Uncollectible adjustment premiums.
- Captive cell arrangements

**E. Professional Malpractice**

Insurers frequently retain outside professionals, including attorneys, auditors, certified public accountants (CPAs), investment advisors, actuaries, and loss reserve specialists. The receiver should retain an expert from the same profession to review the activities of the insurer's professionals and to determine if their actions met the minimum standards of the profession.

Types of actions that may result in litigation or other proceedings against such persons include:

- Incompetence or failure to meet professional standards.
- Failure to divulge conflicts of interests.
- Billing abuses.
- Failure to timely discover or disclose insolvency or other deficiencies of the insurer that prolonged the insurer's operations and increased its debts.

Many professional organizations promulgate a code of ethics and technical performance standards that the receiver may wish to obtain as a source of professional standards against which a breach may be measured. This is an area of considerable complexity, however, so the receiver should consider retaining the services of knowledgeable legal counsel.

It is particularly important for the receiver to review whether certain professionals who were responsible for reporting on the financial condition of the insurer, such as auditors and actuaries, performed their duties in accordance with their applicable standards. Even in cases where the actual cause of insolvency was due

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to misfeasance or malfeasance by the directors and officers (D&O), other professionals may be liable for not discovering and disclosing the problems. If an auditor breached and/or failed to meet its duties of care, such breach and/or failure may be the proximate cause of damages to the insurer and its policyholders, creditors, and shareholders by reducing the value of the insurer and deepening the insurer's insolvency. For instance, if an auditor gives a clean opinion on an annual statement, reporting an insurer to be solvent when it should have detected and reported the insurer's insolvency if it had properly performed its duties, then the insurer's financial condition may continue to deteriorate, causing an even greater loss of surplus or increase in insolvency.

Some jurisdictions have awarded damages against auditors for what is referred to as the "deepening of the insolvency." This theory of damages was initially used in bankruptcy cases but has been applied to the insurance insolvency settings. Some courts have found "deepening of the insolvency" to be a separate cause of action even though it would still primarily be based upon some kind of professional negligence action. However, this theory is not universally accepted. In most states, auditors are required, as a condition of providing annual audit services to insurers, to provide a letter of qualification to the commissioner of insurance stating that they understand that the annual audited financial statements of the insurer and the auditor's own report with respect thereto will be filed and that the insurance commissioner intends to rely on this information in the monitoring and regulation of the financial position of the insurer. Such reliance may form the basis of a claim. Examples of professional malpractice of an auditor may include the failure to detect and disclose:

- Risks and accounting errors associated with an insurer's insurance program.
- Dissipation and mispending of funds by the insurer's officers and directors or controlling companies.
- Inadequacy of an insurer's reserves.
- Diversion of audit premiums or other assets.
- Existence of retroactive reinsurance or other reinsurance that could not be counted as an asset.
- Any significant deficiencies in the insurer's internal controls.

If such failures mask the true financial condition of the insurer so that the insurer continued to operate and slide further into insolvency, the auditor could be liable for the increase in insolvency from the date of that failure (i.e., the failure to report the insurer's deficiencies or insolvency) and the date when the insurer was actually placed into an insolvency proceeding.

Similarly, other professionals, such as actuaries, may be liable for the deepening of the insolvency if they breach their standards of performance and understate the insurer's reserves to the extent that, had they properly stated the reserves, the insurer would likely have been put into an insolvency proceeding sooner.

**F. Income Tax**

Insurance companies placed into liquidation often have net losses for federal income tax purposes. They are required to file federal income tax returns. (See Chapter 3—Accounting and Financial Analysis.) In addition, they may carry back the net operating losses and capital losses for a three-year period and recover prior years' federal income taxes. If the company is included in a consolidated return, the losses may be used to offset income from other companies in the consolidated group.

As part of the receiver's investigation, it should be as certain whether the company has entered into a tax-sharing agreement. A tax-sharing agreement provides for the allocation of tax among members of a consolidated group may enforce the insurer's rights to tax recoveries. The receiver should determine

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whether any tax obligations or refunds due the insurance company have been paid and should be aware that intercompany tax allocations are frequently not recorded.

See *Exhibit 4-1* for a chart of potential recoveries from third parties.

## **IX. POTENTIAL ACTIONS AGAINST MANAGEMENT (DIRECTORS AND OFFICERS), SHAREHOLDERS, AND POLICYHOLDERS/OWNERS**

### **A. Directors and Officers**

The receiver may seek to recover damages from an insurer's D&O under one or more of the following theories:

#### 1. General Mismanagement

In most states, case law requires that corporate officers and directors exercise ordinary or reasonable care and diligence in discharging their duties. The standard varies by jurisdiction. In most states, officers and directors are protected by the "business judgment rule" for their good faith actions. (See Chapter 9—Legal Considerations.)

The receiver should focus on what the D&O did or did not do. Accordingly, the receiver should begin the investigation by identifying the D&O and examining their qualifications to serve in their respective capacities. Such persons are held to minimum requirements of background, experience, and skill for each position. These prerequisites may be defined by statute or contained in the company's bylaws. The receiver should ascertain that the minimum requirements were met. The statutory remedy for an officer or director failing to meet qualifications is removal. However, willful failure of other officers and directors to enforce timely action may lead to their liability if it contributed to the insurer's insolvency.

The receiver should pay attention to the directors' and officers' actions during the time leading up to the commencement of the receivership. If, prior to initiation of receivership, the D&O knew or should have known that the company was hopelessly insolvent, their failure to take remedial actions may be considered mismanagement. That is, continuing operations of the company may result in a larger dollar amount of the insolvency than would have occurred had management taken remedial actions, such as ceasing to write new business, going into run-off, or voluntarily consenting to receivership. In some jurisdictions, this "deepening of the insolvency" is considered an element of damages in an action against the D&O.

An officer or director is accountable for the results of the operations of the insure. Whether accountability translates into liability in directors' and officers' litigation would appear to be dependent on answers to the following questions:

- Did the officer exercise reasonable and ordinary care in monitoring the behavior of subordinates?
- Did the officer act promptly to take appropriate corrective action?
- Did the officer attempt to conceal the failings or wrongdoing?
- Was the officer an active co-conspirator?
- Did the officer obtain adequate information before making a judgment?



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The receiver should review all minutes of the board, board committee meetings, and related activity. Records of attendance at board meetings should be scrutinized. Particular attention should be given to officers' compensation and directors' fees, as well as to excessive travel or preferential use of company property. The receiver also should examine investment transactions for improper or self-dealing in ventures in which officers and/or directors had an interest. An absentee or empty-headed/pure-hearted director is not absolved and may incur additional liability because of continuous absences or non-feasance.

## 2. Racketeer Influenced Corrupt Organizations

The availability of the federal RICO Act to receivers is discussed in-depth in Chapter 9—Legal Considerations.

At least some causes of action under RICO require demonstration of fraud. In such cases, the concern expressed below regarding collectability of reinsurance and errors and omissions (E&O) liability coverage would apply to these RICO actions as well.

## 3. Fraud

Civil liability is not the only remedy available to a receiver. In appropriate cases, consideration should be given to referring the matter to local, state, or federal law enforcement authorities for criminal enforcement. Alleged fraudulent or criminal activity may involve only one or two persons. It is not necessary to prove a pattern of activity, and it should include a comprehensive evaluation on impact to the estate. Fraud is often used as a defense or basis to deny coverage by liability insurers covering D&O of the insurer and may be used as a defense by reinsurers.

## 4. Voidable Preferences and Fraudulent Transfers

As discussed earlier, statutes prohibiting voidable preferences and fraudulent transfers often allow the receiver to pursue insiders who knowingly participated in the prohibited transactions. A forensic analysis will help identify potential voidable preferences or fraudulent transfers.

## 5. Activities that Give Rise to Potential Recoveries

Recoveries from the directors and/or officers may be founded on a variety of acts or failures to act that may be difficult to uncover. Major things to consider are outlined in the following paragraphs. Refer to Chapter 9—Legal Considerations for more detail.

### a. Self-Dealing

All transactions between the insurer and vendors owned or controlled by D&O and/or their immediate family members should be examined for propriety. Leases of office space, data processing equipment, and furniture and equipment can be used to skim funds from insurers for the improper benefit of owners/officers. Similarly, there have been instances in which the insurer paid excessive management fees to organizations controlled by related parties. Other possible areas for abuse are claim service organizations, software vendors, auto repair shops, attorneys, consultants, and shared office space.

### b. Executive Compensation

Travel and expense reimbursements to officers and directors should be examined for abuses, such as travel with no clear business connection, travel to resort areas accompanied by family members, etc. Special facilities, such as leased or company-owned luxury cars, boats, or residences maintained for executives may also be suspect.

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Some scandals have identified artworks, antiques, oriental rugs, or other high-end items purchased with company funds for the primary benefit of its officers.

## c. Investment Transactions

Real estate owned by D&O may have been sold to the insurer at an inflated value or exchanged for other property of greater value. Mortgage loans may have been granted to family members based on overstated appraisals or in violation of company investment policies.

Other areas of potential abuse include secured loans in which the collateral may be improperly secured or below investment quality.

## d. Underwriting Transactions

Poor underwriting results may have been the result of actionable misconduct, such as:

- Accepting risks in violation of the insurer's published underwriting guidelines.
- Failing to prevent or correct over-lining (writing prohibited classes of business).
- Failing to obtain motor vehicle records on automobile risks and safety, and engineering reports on commercial property risks or workers' compensation risks.
- Taking on additional risk when the premium is insufficient to cover the risk.
- Placing reinsurance with unacceptable reinsurers and/or failing to obtain adequate security (LOCs, trust funds, or funds withheld) to cover unauthorized reinsurance.
- Failing to keep new business writings within prescribed limits.
- Failing to monitor the activities of MGAs and TPAs.

## e. Claim Operations

Claim operations are vulnerable to liability for unlawful conversion of funds, which usually requires active participation by an employee or agent of the insurer. Persons in senior management positions may be culpable and subject to litigation to the extent that they were aware of activities, such as:

- Improper payments to claimants.
- Payments made to non-existent claimants.
- Payments to non-existent providers or service vendors.
- Inflated invoices for LAEs linked to a kickback scheme.
- Deliberate and material under-reporting of incurred losses.

The degree of culpability will be determined by answers to at least the following questions:

- Did the officer exercise reasonable and ordinary care?
- Did the officer take prompt corrective action?
- Did the officer attempt to conceal the failings or misconduct?

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- Was the officer an active co-conspirator?

## f. Actuarial and Financial

An officer may have negligently or intentionally misstated actuarial data, either through improper valuation of policy reserves or case reserves for P/C losses, or by negligent or intentional failure to maintain sufficient data on which to base a reasonable estimate of loss reserves. The degree of culpability would appear to hinge first on intent and then on the qualifications of the officer. Alternatively, a group of officers and/or directors acting in concert may have intentionally tampered with reserve data or deliberately filed false financial statements.

## g. Failure to Act in the Best Interests of the Company

A corporation's officers and directors have a common law duty of loyalty to that corporation that precludes, among other things, seeking private profit or advantage from their office. In most cases, the standards of conduct are clearly defined. The officer or director must not place his or her private gain above the best interests of the company and its survivability as a going concern. The receiver should carefully scrutinize insider stock trading, employment contracts, "golden parachutes," "poison pills," bylaws, etc., to verify that key personnel did not breach this duty.

## 6. Directors and Officers Indemnification

Consideration should be given to the existence and effect under applicable law of indemnification provisions in the company's bylaws and in state corporate laws.

## 7. Errors and Omissions, and Directors and Officers Insurance

Many companies purchase E&O and D&O insurance that may provide coverage for certain types of conduct described above. As part of the receiver's investigative examination, all such policies should be identified and examined. These policies will almost certainly be claims-made policies that should be reviewed to determine the deadline for notifying the carrier concerning possible claims. Additionally, the policies may provide for the purchase of "tail coverage," which could extend the time in which to file a claim. In most cases, the receiver should purchase the tail coverage if his/her investigations have not been completed. The presence of insurance may be a factor in the cost/benefit analysis with respect to assessing causes of action against officers and directors. If insurance does exist, consideration should be given as to whether causes of action are covered by the insurance. Certain causes of action may be excluded by the policy, and it is important for counsel to review the policies before any suits are filed. One common exclusion that should be considered is the "regulatory exclusion" clause, which will likely be present in the policy under review. Another common exclusion is the "insured versus insured" clause, which may be in the policy under review.

**B. Shareholders and Policyholders/Owners**

Some jurisdictions permit alter-ego actions against shareholders, usually in closely held corporations, under common law or by statute. It may not be necessary to establish that management was negligent or guilty of fraud to recover from the shareholders. Where permitted, such recoveries may be limited, as in Arizona, to the par value of the outstanding shares.

In certain situations, it may be possible to assess policyholders or shareholders. Reciprocal inter-insurance exchanges and some old-line mutual insurers may have issued assessable policies that required policyholders to pay amounts over and above their premiums. Impairment to surplus usually is sufficient to trigger assessment.

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Recoveries from shareholders and policyholders are special situations not likely to be encountered in most receiverships, and the amounts to be recovered and the procedures for recovery are specific. Thus, the receiver's attention is directed to the statutes and other authorities.

**C. Significant Developments in the *Insurer Receivership Model Act***

In litigation between the receiver and affiliates of the insolvent insurer, Section 113 of Model #555 prohibits the affiliate from using any evidence that was not included in the records of the insurer at the time of the transaction. As an example, it is not unknown for inter-affiliate loans from the insurer to have side agreements excusing repayment under various circumstances. Under Section 113, if the side agreement is not fully documented at the time of the loan in the records of the insurer, the borrowing affiliate may not present that agreement as a defense to the receiver's collection efforts.

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Chapter 5—Claims

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*Receiver's Handbook for Insurance Company Insolvencies***I. INTRODUCTION**

Claims processing is the most visible, tangible part of a receivership proceeding. Because policyholder protection is the basic goal of any insurance receivership, the adjustment and adjudication of claims is closely monitored by interested parties. Accordingly, the claims process should be carefully developed and administered.

A receiver should consider the different circumstances under which claims are adjudicated. There are several variables that may affect the way the claims process is handled, each of which, as well as state law, will have an impact on the type of claims procedure that must be established:

- Whether the insurer has any assets.
- Whether the insurer is a primary carrier, an excess carrier, a professional reinsurer, or a primary carrier that assumed reinsurance obligations.
- Whether the insurer underwrote property/casualty (P/C); fidelity/surety; a health maintenance organization (HMO) or a preferred provider organization (PPO); or life, accident, and health risks.
- Whether guaranty associations are involved.
- Whether the proceeding is judicial or administrative.
- Whether the proceeding is a conservation, rehabilitation, or liquidation.
- Whether the claim arises under an insurance policy or other contract.
- Whether the insolvency crosses state or international borders.
- Whether the insurer handles claims adjudication internally or outsources this function to third parties.

For a discussion of the legal aspects of claims processing and payment, see Chapter 9—Legal Considerations.

**The following discussion is ordered chronologically and, unless indicated otherwise, assumes that the insurer is insolvent and that the receivership proceeding is a liquidation. One of the first tasks for any receiver is to establish a claims procedure and publish the procedure to potential claimants. Once established and published, the claims procedure is implemented. It may be prudent to file the claims procedures with the receivership court and seek the court's approval of the procedures prior to implementation of the procedures. The receivership court ultimately approves the claims that the receiver has adjusted and recommended for payment or denial. Establishing appropriate reserves is an integral part of the process. The final step is payment.**

This section addresses the timetable for the filing of claims, the different types of creditors and their claims, and provision of notice to claimants. The receivership court's order defines the required notice to potential creditors and establishes deadlines for the filing of claims.

**A. The Fixing Date**

One of the first steps in any insurance insolvency proceeding is to establish the exact date upon which the rights, obligations, and liabilities of the insurer and its creditors are determined or "fixed." Most states use the date of entry of the liquidation order or, in some cases, rehabilitation order, for this purpose. (See

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Section 501(B) of the *Insurer Receivership Model Act* [#555], also known as IRMA.) However, as to some policyholder claims, the fixing date is often required to be the date when the statute or court order terminates the insurer's policies. The effect of the fixing date is significant: It provides a reference date upon which the insurer's liability and creditors' rights are determined. The most common legal distinction made is that between contingent and absolute claims. In essence, a claim is contingent if a liability-imposing event has occurred, but it is uncertain that the claim will be made or coverage and liability established. An absolute or non-contingent claim is one of certain liability. Although there may be a question as to the ultimate amount of the liability or when it may be due, there is no doubt that some debt will be due. An example outside the liquidation context helps to illustrate these distinctions. Assume that A negligently drives his car into the rear of B's automobile. As a result of the incident, B has a contingent claim against A. If B sues A, and B is awarded a final judgement, B has an absolute claim against A. In short, a claim remains contingent until liability is certain.

Identification of the fixing date may be subject to statutes applicable to both life/health and P/C insolvencies in several states that require continuation of coverage for a specified period after liquidation, usually 30 days. Most state statutes require that a life insurer's policies continue in full force and effect, at least until the receiver reinsures or transfers the policy liabilities to another insurer.

**B. Claim Filing Deadlines**

## 1. What Is a Claim Filing Deadline?

A claim filing deadline is the deadline for filing proofs of claim against the estate. (See Section 701(A) of Model #555.) The purpose of the claim filing deadline is to enable the receiver to: identify existing or potential claims against the estate; adjust and adjudicate claims; make distributions; and eventually close the estate. A claim received after the filing deadline should be classified as a late claim. Timely filed claims may be amended or supplemented subject to certain limitations provided notice of the loss or occurrence giving rise to the claim was provided on or before the claim filing deadline. Late-filed claims may be accepted but may not be paid until all timely filed claims of the same priority have been paid in full, or it will be moved to a lower priority of distribution within the estate. Under Model #555, late-filed claims are assigned to Class 9, provided that the claim was late due to certain specified criteria (Model #555, Section 701 and Section 801(I)). Other claims filing dates may apply.

In some circumstances, claimants need not file a claim to preserve their rights (e.g., policyholders of a life insurance company). Unearned premium claims may be treated similarly in P/C liquidations. It is recommended that the receiver discuss with the guaranty association which claimants are required to file a proof of claim. It is the receiver's responsibility in such circumstances to develop a list of claimants who are deemed to have filed claims prior to the claim filing deadline. As always, it is imperative to check local statutes for the appropriate procedure and rule of law.

## a. Effectiveness as Against Federal Claims

Whether claim filing deadlines cut off untimely claims of the federal government pursuant to federal super priority statute 31 U.S.C.A. § 3713 remains unsettled. For a more extensive discussion of this and other claims issues, see Chapter 9—Legal Considerations.

## b. Applicability in Rehabilitations

Whether a claims deadline date will be established in a rehabilitation proceeding depends upon the specific circumstances and applicable law. In rehabilitations of a limited or set duration, a claim filing deadline may enable the rehabilitator to ascertain the amount of outstanding claims and implement a plan to return the insurer to solvency. A deadline may also allow the rehabilitator to conserve liquid assets to pay current obligations while a rehabilitation plan is

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being developed or the amount of outstanding claims is being assessed. In other rehabilitations, it may be appropriate to set no claim filing deadline until a final dissolution plan has been settled.

## 2. How Is a Claim Filing Deadline Established?

A court order is required pursuant to the applicable statutory requirements to establish the claim filing deadline for a particular receivership. (See Section 701 of Model #555 and Chapter 6—Guaranty Associations for claim deadlines applicable to guaranty associations or ancillary receiverships.) The claim filing deadline established for claims against the receivership estate will also apply to the claims against a guaranty association.

Some state statutes specify the maximum period of the period of time for the claim filing deadline bar date. If there is flexibility within the statute, the length of this period often will depend upon the complexity and size of the receivership and the type of business written. The assumption of blocks of business by a solvent insurer may eliminate the need for many claims to be filed at all. There can be a general correlation between the length of the claim filing deadline and the amount of the estate's administrative expenses.

## 3. Deemed Filed Claims

In circumstances where the insurer has better information about claims than the policyholders have, the receiver may be able to avoid the administrative expense of handling some or all proofs of claim by establishing a “deemed filed” procedure. Under such a procedure, the receiver may establish a list of policyholders and claimants based on the insurer's books and records, which shall provisionally state the amounts claimed. Each person whose name appears on such a list shall be deemed to have filed a proof of claim in a timely manner. Claimants are given notice and provided an opportunity to correct errors and prove their claims before final allowance. This procedure works well for unearned premium claims and claims for investment values in life insurer insolvencies. Most state statutes do not require holders of life or annuity contracts to file claims.

## D. Developing the List of Creditors

The first step in this process is to develop a master mailing list of creditors from the insurer's books and records and other interested parties.<sup>1</sup> Most state statutes or receivership courts require notice by first class mail to the last known address of the known claimants, as well as by publication. In some states, notice shall be given in a manner determined by the receivership court.

The following persons usually will be included in the insurer's mailing list:

- Guaranty associations.
- Policyholders.
- Third-party claimants.
- Secured creditors.
- Government agencies.
- Wage claimants.

<sup>1</sup> See *Elmco Properties, Inc. v. Second National Federal Savings Ass'n*, 94 F.3d 914 (4th Cir. 1996) for a receivership involving a savings association.

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- General creditors.
  - Reinsurers and reinsureds.
  - Intermediaries.
  - Managing general agents (MGAs) and third-party administrators (TPAs).
  - Claims adjusters.
  - Defense attorneys.
  - Vendors.
- Equity (stock or share) holders.

**E. Proof of Claim Forms**

Once the list of claimants is developed, the receiver typically sends a proof of claim form to each person identified. The proof of claim form, which is the basic prerequisite to the allowance of a creditor's claim, serves a number of useful purposes. First and foremost, it identifies the claimant and the nature and extent of the claim. The receiver also may use the form to calculate the extent of the insolvency, to identify any obligations the claimant may owe the insurer (e.g., through the identification of any setoffs), to set reserves, and to determine the estate's right to collect reinsurance. In some cases, health claims may not have to file a proof of claim. An example is where the health insurer uses a TPA and is covered by the guaranty fund; there should be no need for the TPA to adjudicate the same claims twice.

Many proof of claim forms have been developed over the years. Claim forms to be used in any particular proceeding should be tailored to the circumstances presented. For example, the receiver should consider whether claims forms must be filed by all claimants. Most state statutes permit the receiver to dispense with the issuance of claim forms in a life receivership. The receivership simply draws a list of creditors from the insurers' books and records. In some states, filing with a guaranty association may constitute filing with the receiver for purposes of satisfying a claim filing deadline, but the receiver may need additional information from the claimant that the guaranty association did not elicit. Guaranty associations and receivers should coordinate their respective claim filing procedures to the extent possible. With receivership court approval, receivers may deem open claims as reflected on the books and records of the delinquent insurer as timely filed. In such circumstances, proofs of claim need not be filed by insureds or third-party claimants for such claims.

Before a proof of claim form is created, the receiver may wish to determine the number and types of claim forms that will be needed. The first task is to identify in broad categories the various classes and types of claimants. Then the receiver can determine what information is required for each type of claim. With this information, specific proof of claim forms can be developed for each category of claimant based on the type of business written. Some receivers use only one claim form but use control numbers (such as an alphanumeric system) to designate the type of claim presented in the form. This saves the cost of developing separate forms. Receiverships involving surety business may necessitate the use of a separate proof of claim form for each type of surety bond. The objective is to facilitate the exchange of information between the claimant and the receiver in order to adjust and later adjudicate a claim.

The more specific the information that can be elicited in the initial proof of claim form, the less follow-up will be required. Receivers should be encouraged to request submissions from creditors that the company in receivership has reinsured in accordance with the format of reporting under the reinsurance contracts in question. This should just be complemented by a comprehensive overview and breakdown of the total claimed by such reinsured creditor. The receiver, however, may require the claimant to present

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supplementary information or evidence, may take testimony under oath, may require production of affidavits or depositions, or may otherwise obtain additional information or evidence. (See Section 702(C) of Model #555). The class determinations should be subject to a right of appeal by the claimant. The prompt determination of creditor class permits a faster wind down, as well as facilitates more prompt calculations and distributions for creditor claims. It may be unnecessary to determine the amount of receivership claims for a creditor class if receivership assets are unavailable for that creditor class.

Most statutes require claimants to provide certain basic information. (See Section 702 of Model #555.) The following information typically is required:

- The nature and particulars (e.g., the who, what, when, where, and amount) of the claim asserted.
- The consideration for the claim.
- The identity and amount of any security held on the claim.
- Any payments made or received on the claim.
- A copy of each written instrument upon which the claim is founded or a statement of the reasons a copy of the instrument(s) cannot be provided.
- The amount and a description of the source of any salvage or subrogation collected or that may be collected.
- An affirmation (notarized) that the insurer justly owes the sum sought and that there is no setoff, counterclaim, or defense to the claim (Section 702 A of Model #555).
- The name and address of the claimant and any attorney representing the claimant.

Additionally, Model #555 requires that the claimant provide: 1) its Social Security number (SSN) or federal employer identification number; and 2) any right of priority of payment or other specific right asserted by the claimant (Section 702 A of Model #555).

The receiver may decide to use the same claims and policyholder service forms that the insolvent company previously employed because the information required is fairly uniform, and the use of different forms could be confusing to the service providers and policyholders. Additionally, many estates make proof of claim forms available for easy access via the receiver's office website.

The receiver decides what additional supporting documentation will be required to prove a claim and in what form it should be submitted. (See Section 702 C of Model #555.) Different documentation will be needed for different types of claims. For example, death benefit claims require the furnishing of a death certificate. Accident and health (A&H) claims may require a physician's certification and copies of medical bills. Return premium claims may be established simply by submitting a bordereau of all cancelled policies and return premium amounts attributable thereto, while computer summaries may be required to prove cumbersome or complicated claims. When policyholders claim return premium, the receiver may require additional documentation, such as copies of cancelled checks. Reinsurance claims may require yet another form of documentation. Life insurance claims usually require the policyholder to furnish the original policy. If the original cannot be provided, a copy thereof may suffice. If neither the original nor a copy of the policy can be furnished, a lost policy form should be executed and submitted to the receiver.

The level of detail required in the proof should conform to industry standards and statutory guidelines, as well as make it convenient for the receiver to communicate with the claimant and add the information to its database for claims management. Some estates may not process a claim that does not include all the

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requested information. One of the most critical needs of general creditors involves financial information on an insolvent ceding company. Providing regular financial statements of the company would be beneficial to interested parties, such as guaranty associations, reinsurers, and other receivers or regulators. It should be noted that whenever a reinsurer of the company in receivership has claims against the estate or where a reinsured creditor at the same time is a reinsurer of the estate, receivers should use the guidance provided in Subsection F—Coordination and Communication With Reinsurers.

The receiver must determine who may submit a proof of claim on behalf of an entity and what form of verification is required. Because corporations can act only through their designated agents, it is best to determine and inform corporate claimants who may sign on their behalf (e.g., officers, directors, MGAs or attorneys). Generally, a director does not have authority to act for a corporation because directors must act as a body unless otherwise authorized by the company's bylaws. In most instances, the notarized signature of an individual who attests to his authority to do so will suffice. The signature of a trustee should be received when dealing with trust claims, and the trust document should be provided to the receiver to verify the identity of the trustee. If in doubt as to the capacity or authority of an individual who submits a claim on behalf of a corporation, partnership, or trust, the receiver may require that the claimant provide a certificate of incumbency, signed by another authorized officer or representative, as to the signer's authority to bind the entity. In the case of a corporation, partnership, trust, or individual, the receiver may also require a signature guarantee if in doubt as to the identity of the individual executing the claim. Careful drafting of the attestation will ensure that such authorization has been given to the signatory. Note that the availability of notarizations may depend upon the residence of the claimant. Although most foreign countries maintain their own systems for verification, notaries may be found at most American embassies. Consideration should be given to electronic signatures and proof of claims submission.

When developing proof of claim forms, it is helpful to have in mind the volume, type, and class of claims that creditors may submit. Claimants, including guaranty associations and reinsured creditors, may have hundreds of outstanding claims against the insured. Some claimants may be permitted to file a single omnibus proof of claim for all claims against the receivership estate. Section 702(D) of Model #555 allows a single omnibus claim to be filed by guaranty associations, which may be periodically updated without regard to the claim filing deadline, and the guaranty association may be required to submit a reasonable amount of documentation in support of the claim. Also, for reinsured creditors, the receiver will want to decide whether these claims need to be submitted individually or on a bordereaux basis. There are certain advantages to bordereaux submissions, which are dictated by the sheer volume of claims, the requirements of the treaty, and the receiver's need to efficiently process reinsurance recoveries. Ceding treaty retrocessionaires may only be able to file claims on bordereaux. There are other claims submission methods that might be used for reinsurance recoveries, depending upon the complexities of the situation. In the final analysis, the preferred submission approach ordinarily is the one that permits an orderly and efficient administration of claims on a computer system and often closely follows the procedures formerly in effect when the company was in operation.

In some states, if applicable, claims must be submitted on the liquidator's proof of claim form unless the liquidator grants an exception. Therefore, one approach to the claims filing process for reinsurers would be to allow for claims to be submitted in any format acceptable to the receiver; if the receiver (or the court) agrees, a claim would not have to be submitted on a proof of claim form.

To the extent omnibus proof of claims by reinsurers/intermediaries are allowed under your state's law, another consideration to expedite the filing of certain types of claims would be to allow reinsurers/intermediaries to file "place holder" claims, like those of guaranty associations, whereby the reinsurers/intermediaries timely file claims but are permitted to supplement their claims as additional information becomes available later in the receivership process. When appropriate, deem filing practices would be allowed for certain claims in receiverships. Generally, such orders are only sought in situations involving claims for which adequate claims documentation/proof exists within the records of the insolvent insurer.

*Receiver's Handbook for Insurance Company Insolvencies***III. NOTICE**

Once a receivership order has been entered, whether it is for rehabilitation or liquidation, one of the first actions taken is to mail notices of the receivership to the company's agents, policyholders/members, reinsurers, and other parties related to the receivership. These notices should contain information regarding the claims processing filing process and references to the receiver's office website. The website should be kept updated with receivership information relevant to interested parties. The receivership website should not only provide information for consumers, but also provide an overview of the current status of the receivership, including past and upcoming deadlines, as well as provide access to court orders relevant to the receivership. To simplify the administration of the website, such information can be provided in the format of a simple table as some receivers' websites already do. Similar receivership notices are also provided to insurance departments of other states where the company is licensed.

Once a claims procedure has been established, the next step is communicating the procedure to all creditors. The receiver should check the domiciliary statute for any applicable time constraints in sending notice.

Ideally, in the case of surety bonds, insureds, their agents, and obligees should be advised of the status of their policies and of the procedures to be followed to make a valid claim. Among other things, the notice typically will inform them of the insurer's insolvency, whether policies have been or will be cancelled, and the procedures for presenting claims. The notice also may be used to describe, in general terms, the anticipated course of the liquidation. Some states require the notice to describe the guaranty association's involvement, if applicable. If a guaranty association is or may be involved, the receiver may want to jointly draft the notice with the association. The receiver should be cognizant of the effect of the receivership on guaranteed renewable and non-cancellable business.

The form of notice should be adapted to the circumstances. The notice may consist of the actual proof of claim form, with appropriate instructions for its use. The notice should identify the rights fixing date and claim filing deadline and its significance. Highlighting the penalty for failing to file by the claim filing deadline may help to avoid problems later. Posting notices, proof of claim forms, and claim filing deadlines on the receiver or estate's website is a best practice.

In multistate receiverships, notices to life insurance policyholders and annuity or investment contract holders should be coordinated with affected guaranty associations through the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA). The receiver also may consider coordinating with the National Conference of Insurance Guaranty Funds (NCIGF) in multistate receiverships on the issuance of notices sent to P/C policyholders. Guaranty associations may request that the receiver include appropriate guaranty association information in the receiver's notice.

**A. Contents: Plain Language**

Most people will be receiving a receivership notice and proof of claim form for the first time. It is important that all forms be written as simply and clearly as possible. When appropriate, bilingual or multilingual notices can be issued.

**B. Service**

For the initial mailing of proofs of claim, receivers may send notices and proofs of claim as claimants are identified or initiate the mailing process once all potential claimants are identified. For ease of reference

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and tracking, proofs may be numbered either before issuance or upon receipt, and a procedure may be implemented for recording the mailing, undelivered return, receipt and processing of all proofs. Notice commonly is given by mail and occasionally by publication. The receiver should be aware that there are constitutional issues with respect to the deprivation of property rights. Specifically, identifiable creditors of the estate, who have a known or reasonably ascertainable address, may be entitled to mailed notice of the proceedings affecting their claim. *Elmco Properties Inc. v. Second National Federal Savings Association*, 94 F. 3d 914 (4th Cir. 1996). (See Chapter 9—Legal Considerations.) Mailing should be done in the manner and form prescribed by the domiciliary receivership statute (e.g., certified, first class, bulk), with appropriate documentation and records to demonstrate issuance, in case a challenge arises later. Publication may be required by law and is advisable for unknown claims. In most cases, the court order establishing a claim filing deadline will also require published notice of the receivership. Refer to applicable statutes or the court order to determine the timing, media, and frequency of published notice.

**Proofs of claim themselves may be issued by mail or through the receiver’s website. A copy of the entire proof of the claim distribution list should be maintained and supported by verification by the individual(s) handling the distribution.**

**IV—CLAIMS PROCESSING**

The receiver should make decisions at the commencement of the liquidation about proof of claim filing requirements and the claim evaluation process. Making these decisions upfront affords timely notice to claimants prior to the expiration of any claim filing deadlines and permits the development of claim forms and procedures consistent with such decisions. Each of these topics are discussed below:

**A. Filing Methods**

State laws typically permit the presentation of claims by a variety of delivery methods, including U.S. mail, personal delivery, or private delivery service. The receiver may also allow claimants to present their claims by facsimile or electronic (i.e., computer) transmission. The receiver should determine in advance whether to require original or electronic signatures, verification under oath, and acceptable forms of supporting documentation—whether actual receipt, postmark, or receipt of delivery to a courier by the claim filing deadline.

State law may provide the receiver with discretion to exempt preexisting claims from the proof of claim requirement. In exercising such discretion, a receiver would notify claimants with pending claims reported prior to the entry of the receivership order that their claims are deemed on file. Upon finalizing such decisions, the receiver should develop clear and timely communication protocols that address the requirements for presenting claims against the estate.

In developing claim filing protocols, the receiver should be cognizant of information-sharing requirements with other stakeholders, such as state insurance regulators, guaranty associations, and reinsurers.

**1. Documenting Receipt of Proofs of Claim**

As noted, the receiver should determine at the outset what constitutes “receipt” of a claim; i.e., whether proofs of claim are considered received on the date they are mailed or on the date they are actually received at the designated address. This determination will affect whether claims are timely filed or late. Documenting the date of receipt of proofs of claim is a critical receivership function that should follow established business protocols.

**2. Guaranty Association Claims**



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The receiver should establish effective communication with the affected guaranty associations at the earliest possible date in the insolvency. (See Section 303 and Section 405 of Model #555.) This is the essential first step to efficient referral of claims to the appropriate associations. After claims have been referred to the guaranty associations, claimant inquiries can be directed to the appropriate guaranty association or claim handler. The receiver may also need to monitor claims where more than one guaranty association is involved. If guaranty associations are unable to commence claim payments shortly after the liquidation date of the insolvent insurer, the receiver may want to establish a transitional prepayment plan for hardship categories, such as workers' compensation claims, pharmacy benefits, or impounded automobiles. Such payments may be appropriate for subsequent treatment as early access distributions to or direct reimbursement by affected guaranty associations. See Section 802(D) of Model #555. (Note: Section 802(D) of Model #555 relates specifically to workers' compensation payments in P/C cases). In the case of a life and health multistate insolvency, such payments may be used to provide funding to support assumption transfers of business or to provide initial funding for covered claims. In either event, the funding would be considered early access in accordance with Section 803 of Model #555. The referral of a claim to a guaranty association does not terminate the receiver's involvement with the claim. The receivership estate may have responsibility for claims that are excluded from guaranty association coverage or for portions of claims that exceed the applicable guaranty association coverage limit. A collaborative approach to the resolution of such claims between the receiver and guaranty association should be considered. Where guaranty associations administer covered claims, it is also critical for the receiver and guaranty association to coordinate information sharing so that the receiver is able to notify, cede, and recover losses from reinsurers. Many state laws exempt guaranty associations from proof of claim requirements and claim filing deadlines. Model #555 permits guaranty associations to file a single omnibus proof of claim for all claims of the association, which may be updated periodically without regard to the claim filing deadline. (See Section 702(D) of Model #555.)

**B. Proof of Claim Evaluation**

This section outlines the general steps a receiver usually takes when reviewing claims filed against an insurer. It also identifies policy or administrative questions the receiver should consider at the beginning of the claims evaluation process. Model #555 provides that the liquidator may adopt, with the approval of the receivership court, procedures for the review, determination, and appeal of claims that will be preliminary to review by the receivership court. (See Section 707(A) of Model #555).

Prompt and efficient resolution of claims should be management priorities for the receiver. Model #555 provides that the liquidator shall review all duly filed claims and shall further investigate as the liquidator considers necessary. However, a liquidator is not required to process claims for any class until it appears reasonably likely that assets will be available for a distribution to that class. (See Section 703(A) of Model #555). If there are insufficient assets to justify processing all claims for any class, then the liquidator shall report the facts to the receivership court and make appropriate recommendations for handling the remainder of the claims. (See Section 703(K) of Model #555.) The liquidator may allow, disallow, or compromise claims that will be recommended to the receivership court unless the liquidator is required by law to accept the claims as settled. (See Section 703(A) of Model #555).

The receiver should manage the claim staff to achieve these goals. To the extent that the ultimate claim resolution is dependent upon the outcome of a guaranty association's claim administration, the receiver should consider coordinating with the applicable guaranty association on ultimate claim resolution when closure of the receivership estate is in view.

Completion of the claims evaluation process will enable the receiver to effectuate distributions to policyholders and creditors; generate insurance recoverables; and resolve subrogation and salvage, coordination of benefits, and loss-sensitive underwriting recoveries. The receiver in a health insurance insolvency should evaluate coordination of benefits owed from other parties, as well as

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subrogation recoverables. Inquiries to be made include whether collateral is being held by the creditor in connection with the claim and whether there are other third parties who may be pursued, such as indemnitors. Proof of claim forms can be a source of such information.

Receivers and guaranty associations may need to coordinate on entitlement to collect and retain salvage and subrogation recoveries. The decision in *Cal. Ins. Guarantee Ass'n v. Superior Court*, 64 Cal. App. 4th 219, 220-21 (Ct. App. 1998) resolved whether the receiver or the California Insurance Guarantee Association (CIGA) was entitled to the sums CIGA recovered through subrogation actions after it had paid covered claims. The Court held that to the extent CIGA pays covered claims, it was entitled to retain the amounts it recovers through subrogation actions. Conversely, to the extent CIGA pays covered claims with “early access distributions” or other assets from the insolvent insurer’s estate, the estate is entitled to proceeds of any subrogation action. *Id.* at 229. In instances where pre-receivership payments were made by the insurer prior to guaranty association assumption of a claim, those payments typically constitute subrogation of the receivership estate under state law. In the case of surety claims, the receiver will need to review the underwriting file to determine subrogation or salvage potential and the identity of any third-party indemnitors. The estate should notify third-party indemnitors and solicit their involvement and support in settling the claims. Failure to properly and timely notify third-party indemnitors can result in the loss of indemnification through failure to give the indemnitor reasonable opportunity to minimize loss.

#### 1. Review of Timely Filed Claims

Timely filing of a proof of claim may determine whether a claimant receives priority payment and, if so, at what level of priority. The receiver accordingly must determine whether each claim is timely filed.

Determinations of timeliness are made with reference to the claim filing deadline and the receipt or postmark rule. Claims received thereafter are categorized as late and subordinated in priority under state law. State law may provide a limited exception to the claim filing deadline for late claims. The receiver should review the applicable state law to determine whether a claim qualifies under the limited exception. (See Section 801 of Model #555.) For example, in some states, a late-filed claim may be a deemed timely filed claim if the claimant can show that they were entitled by virtue of an open claim on the books and records of the company to receive actual notice of the receivership and claim filing procedures but was not sent such notice. In one jurisdiction, a court held that the claims filing deadline should not be extended as a remedy for a receiver’s failure to give notice of the appointment of a receiver. (See *In re Liquidation of American Mutual Liability Insurance Company*, 802 N.E.2d 555, (Mass. 2004.)

Although the law on this point is fact-intensive, a receiver may not be able to rely on constructive or published notice in circumstances where the existence of a claim was contained in the insurer’s books and records.

Other examples of deeming late claims timely may include: 1) creditors who received transfers that were subsequently voided by the receiver or surrendered assets transferred to them; 2) secured creditors whose security was valued below the amount of their claims (Section 701(B) of Model #555); and 3) reinsurers whose reinsurance contract is terminated by the liquidation, giving rise to a termination claim under Section 701(C) of Model #555.

- Post-Deadline Maturity of Timely Filed Claims

Certain timely filed claims may not be absolute for a variety of reasons. The receiver may request the Court to set an absolute, or final, or contingent claim deadline, by which timely filed claims must be made absolute or fixed. Claims not made absolute, liquidated or mature by that deadline are date would be denied.

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## 2. Review as to Form

- Policyholder Protection Claims

Some jurisdictions permit policyholder protection claims by first party insureds for claims that are incurred but unreported or not known at the time of the claim filing deadline. Such claims may be allowed if they are amended or supplemented consistent with statutory or judicial rules and procedures. The receiver should consult applicable law to determine whether to allow such claims. Other states expressly prohibit policyholder protection claims. (See Chapter 9—Legal Considerations.) Statutes in some states either provide expressly, or courts have decided, that such claims may be allowed. Absent such guidance, some receivers require that the initial proof of claim be specific and may not be amended in any material respect after the claim deadline expires. Other receivers allow proof of claim amendments of all types until assets are distributed. Receivers should consult their local statutes and applicable court decisions on this issue.

- Contingent Claims

Most states provide for the filing of contingent claims by first-party insureds, subject to an additional deadline for liquidating such claims. Contingent claims may be allowed if the claim is liquidated and the insured presents evidence of payment of the claim on or before the contingent claim filing deadline established by the Court. A contingent claim is a known loss or occurrence that is presented by an insured prior to the entry of a judgment or a determination of the insured's liability. Contingent claims do not include, and should be distinguished from, claims presented by third parties where liability or damages had not been established prior to the filing of the claim. (See Section 705 of Model #555.)

Model #555 and most state laws provide third-party claimants with a direct right to file claims with the liquidator prior to the expiration of the claim filing deadline. (See Section 706 of Model #555.) In such instances, an insured may also file a contingent claim for the same occurrence raised by the third party. Section 706 of Model #555 provides that the liquidator may make recommendations to the receivership court for the amount allowable on insured/third-party claims, basing this recommendation on the probable outcome of third-party claims against the insured. But distributions will be withheld and reserved pending the outcome of such a dispute or litigation between the insured and the third party. When the third-party claim is resolved, the reserved distribution will be paid to the insured or third-party claimant, as appropriate, and any excess amount reserved will be redistributed pro rata to other claimants in the receivership.

Section 706 of Model #555 provides a procedure for resolving multiple claims filed by different parties against an insured that may exceed policy limits. In the case of multiple claims and irrespective of the Model #555 provisions, it is imperative to apportion the varying claims without preference to the policy proceeds, and it is important to file for claim approvals with the receivership court before any claims are paid under the insurance policy. The receivership court claim approvals should be filed with due and proper notice to all parties that may be affected by such claim payments. It is recommended that defense costs be paid pro rata, even before all claims have been resolved and settled against a policy, provided that proper notice is sent to all affected and interested parties.

Section 706 of Model #555 provides that the third-party claimant waives certain rights against the insured by filing a claim against the liquidator for the insured's insurance policy benefits, but the waiver will be ineffective if the claimant withdraws the claim or the liquidator avoids insurance coverage.

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- Amendment and Supplement of Claim Information

Amendment and supplement of information supporting a previously asserted timely filed claim can assist the receiver in the disposition of a claim that was contingent, unliquidated, or immature at the time of its filing. Consistent with the applicable statutory requirements, the receiver may determine the types of amendment or supplement that will be allowed. Amendments may include, but are not limited to, correcting or updating the amount, correcting technical defects, and providing sufficient documentation supporting payments or damages. Some states may allow insureds to file contingent claims that include reasonable attorneys' fees for services rendered after the date of receivership in defense of approved claims, provided the insured has actually paid the fees and evidence of payment is presented prior to applicable deadlines established by the Court or before assets are distributed.

- Assumed Reinsurance Claims

As for the policies of a P/C insurer, the liability for claims that a P/C reinsurer has assumed generally are limited to those arising out of reinsured events that occurred on or before the liquidation date (unless the court or statute directs otherwise). A receiver should decide at the beginning of the receivership how to evaluate the claims of ceding companies under reinsurance contracts. This decision will dictate the form of notice to ceding companies and the form of the proof or documentation cedents must use to file claims against the insurer. The receiver may opt to let the insurer's assumed reinsurance business run off and have cedents file their current claims against the insurer, allowing the cedents to amend their claims from time to time.

Another option that receivers have proposed is to require all ceding companies to file a proof of claim against the insurer as of the date of the receivership order (or a reasonably close date) for all reported and unreported losses. Under this alternative, the receiver takes a snapshot at the fixing date. Paid losses are recognized as reported if covered under the reinsurance contract. Outstanding claim reserves and incurred but not reported (IBNR) claims reserves are actuarially calculated and discounted to present value. This method allows the receiver to evaluate cedents' claims at an earlier stage in the receivership. Because the receiver will want to employ consistent evaluation methods for all claims that include IBNR, the proof of claim form may require that the claimant report the basis for the IBNR calculation. It is important for the receiver to determine the existence and extent of retrocessional reinsurance that might be available to cover assumed claims. This reinsurance can represent a significant asset of the estate. (See Section 3(b).)

- Claims Under Occurrence Policies Under the *Insurer Receivership Model Act*

Model #555 provides insureds the right to file a claim for the protection afforded under the insured's policy, irrespective of whether a claim is then known or if the policy is an occurrence policy. Further, any obligee shall have the right to file a claim for the protection afforded under a surety bond or a surety undertaking issued by the insurer as to which the obligee is the beneficiary, irrespective of whether a claim is then known. When a specific claim is made by or against the insured or by the obligee, the insured or the obligee shall supplement the claim, and the receiver shall treat the claim as a contingent or unliquidated claim. (See Section 704 of Model #555.)

Having concluded that a proof of claim was timely filed (or properly amended), the receiver should next review the claim to determine if all required information has been provided and if the form has been completed in accordance with the applicable instructions. Model #555 provides that the liquidator need not review or adjudicate any claims that do not contain all applicable information and may deny or disallow any such claims (subject to notice). (See Section 703(I) of Model #555.)

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If additional information is required, the receiver should specify a deadline for its submission, advising that the claim will be denied if the information is not submitted by that date. Review of applicable statutes for guidance on this point is suggested.

### 3. Review of Claims Based on Contract Provisions

The next step in the review process often consists of a substantive review of the claim. Here the receiver determines whether the claim may be allowed on its merits. This section presumes that the receiver has claim files to review (i.e., that the files are not in the possession of a guaranty association). The initial issue is the review of coverage: Is the claimed loss covered under the terms and conditions of the insurer's policy or contract, or is it excluded from coverage? The issue is resolved by referring to the policy or contract, the insurer's claims manuals, and underwriting files.

- Policyholder Claims

The starting point in the review of any policy claim filed against an insurer is the insurance policy or contract. The receiver treats the claim as if the insurer were reviewing it in the normal course of business prior to receivership. The receivership process and the procedures required by the receivership statutes and court are not a substitute for the sort of policy examination and initial claim review that the insurer followed before receivership.

The receiver first determines whether the policy was in force at the time of the loss. If not, the receiver will ascertain why the policy was not in force. Did the policy expire because of the insured's failure to pay premium? Did the term of the policy expire prior to the loss? If the insurer or insured cancelled the policy before receivership, the receiver must decide whether the applicable statutory or contractual procedures for cancellation were satisfied. The receiver also must determine whether the loss occurred before any cancellation of the policy by court order or by operation of law as a result of entry of the order of receivership. In the case of surety bonds, the receiver needs to determine that the bond was in force at the time of the occurrence upon which the claim is predicated. The receiver should be aware that some bond forms cover events that may have occurred prior to issuance of the bond, as well as during the term of the bond. In addition, the receiver will need to determine whether the obligee (claimant) has adequately discharged its obligations under the contract to both principal and surety in such a fashion as not to have prejudiced the surety's position.

Next, the receiver reviews the terms of the policy to ascertain whether the claim is within the scope and limits of coverage of the policy and not otherwise excluded. Model #555 provides that no claim shall be allowed in excess of the applicable policy limits or otherwise, beyond or contrary to the coverage provided. (See Section 703(A) of Model #555.)

In the case of a policy with aggregate limits, the receiver should determine how many claims have been filed against the policy and whether the aggregate limit has been exhausted. (See Section 706(D) of Model #555). If guaranty associations are paying claims under the policies, they should be notified of the extent to which the aggregate limit has been eroded. The receiver also will want to determine if the policy's terms provide procedural defenses to the claim, such as late notice, lack of cooperation, coinsurance, or coordination of benefit provisions (e.g., in a health insurance policy).

The insurance policies under which the claims arise must be read in conjunction with the insolvent insurer's reinsurance agreements. A reinsurer's obligation to pay may only be triggered if the claims under a policy exceed a specified retention point. In some instances, the retention point may only be met if claims under a policy can be characterized as a "single incident" under the terms of the reinsurance agreement. The receiver must determine when claims under a policy constitute a single incident for reinsurance recovery purposes. As the reinsurer may argue that the claims at issue involve multiple incidents, the receiver should carefully review case law from the applicable jurisdiction when making this determination.

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In the case of claims under policies of life insurance, the receiver should be sensitive to contestability issues. For example, some claims may be contestable because of misrepresentations contained in the policy application. Suicide claims may not be payable if the death occurred within the policy's contestable period, typically two years. In the case of A&H claims, the receiver should be alert to preexisting conditions that might render a policy claim void. Other areas to watch for are work-related claims that could be covered under a workers' compensation policy or claims resulting from automobile accidents that could be covered by the insured's auto policy.

Model #555 provides that a judgment or order against an insured or insurer entered after the date of the initial filing of a successful petition for receivership, or within 120 days before the initial filing of the petition, and a judgment or order against an insured or the insurer entered at any time by default or by collusion need not be considered as evidence of liability of the amount of damages. (See Section 703(E) of Model #555.)

- Assumed Reinsurance Claims

Most states accord cedent claims the same priority as claims of general creditors. (See Chapter 9—Legal Considerations.) In cases where there are insufficient assets to satisfy all policyholders' claims, the receiver should determine whether a review of general creditor claims is necessary. If it appears that the insurer's assets will cover only a portion of policyholder priority claims, there may be no need to evaluate general creditor claims unless the insolvent company has retroceded a portion of its reinsurance business. In such case, the receiver will need to evaluate and fix the amount of all or at least certain ceding company claims in order to pursue available reinsurance recoverables.

Assuming reinsurance recoverables are available or that assets are available to distribute to general creditors, the receiver will review all such claims. Review of the individual reinsurance contract ensures that the reinsurance contract covers the claim being asserted. The receiver should verify that the contract was in force at the time of the receivership, because the cedent and the insurer may have entered into a commutation agreement terminating the reinsurance agreement or some other agreement that establishes the rights of the parties (such as a novation, loss portfolio transfer, assumption, assignment, or settlement). If so, then the receiver should determine whether the commutation should be honored or whether there is some basis for setting it aside (such as the creation of a voidable preference). If the commutation is determined to be valid, no other claims should be allowed against the insurer under that reinsurance agreement.

As with a direct policy claim, the receiver should determine whether reinsurance claims are covered, proper notice of the claim was provided, and premium and other amounts due under the reinsurance contract have been paid. The receiver should also offset claims due from the cedent (e.g., for unpaid premium, salvage, etc.).

- Certain Other Types of Contracts

The receiver may need to review the terms of the employment contracts with directors, officers or other individuals. Model #555 provides that claims under employment contracts should be limited to payment for services rendered prior to the receivership order unless explicitly approved in writing by the commissioner prior to receivership or by the receiver post-receivership. (See Section 703(F) of Model #555.) The receiver also should carefully review the terms of all leases. Model #555 provides that the claim of a lessor for termination of a lease shall be disallowed to the extent the claim exceeds the rent reserved by the lease (without acceleration) for the greater of one year, or 15% (not to exceed three years) of the remaining term of the lease following either the date of the filing of the petition or

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the date of repossession or surrender of the leased property (whichever comes first), plus any unpaid rent due. (See Section 703(L) of Model #555.)

The receiver also should carefully review the terms of all netting agreements or qualified financial contracts (QFCs). Model #555 provides suggestions for the receiver as to how to deal with these types of contracts. (See Section 711 of Model #555.)

#### 4. Review of Guaranty Association Claims

When a receivership triggers guaranty association coverage, the receiver should coordinate the approval and disapproval of claims with the guaranty association(s). Consulting the applicable statutes may enable the receiver to determine whether guaranty association payments bind the receiver. Coordination affects, among other things, the amount recovered under the insurer's reinsurance treaties or reinsurance agreements.

The receiver should establish appropriate procedures at the beginning of the receivership in order to accommodate guaranty association claims. For example, receivers often allow guaranty associations to file an omnibus proof of claim form that can be amended from time to time. Typically, the receiver's forms for guaranty associations will include sections asking the guaranty association to segregate its claim by administrative expenses, allocated and unallocated loss adjustment expenses (LAEs), unearned premium payments, and policy loss payments. The receiver should review the guaranty association's claim for validity of liability and reasonableness of amount claimed. The receiver should be cognizant of the operational differences between life/health guaranty associations and P/C guaranty associations. P/C guaranty association claims are typically related to terminated policies, whereas life/health guaranty associations obligations can also include claims related to the continuation of benefits under the insolvent insurer's contracts.

Life/health guaranty associations may satisfy coverage obligations by transferring those obligations to a different insurer through an assumption reinsurance agreement negotiated by the NOLHGA or through ongoing administration of policies and claims in run-off where assumption reinsurance is not available. Consequently, the nature of the claims and expenses incurred by life/health guaranty associations can differ from the claims and expenses of P/C guaranty associations. In addition, life/health guaranty associations have statutory and subrogation claims to assets of the insolvent insurer to assist the association in satisfying its obligations. Early access agreements frequently permit the receiver to audit the guaranty association's records concerning the association's handling of claims.

The level of scrutiny given to a guaranty association claim depends on the circumstances. When the guaranty association provides complete coverage for affected policyholders, the receiver in cooperation with guaranty associations may wish to so notify policyholders (or have the associations do so) and thereafter deal only with the omnibus proof of claim filed by the association. Most state guaranty association statutes provide that a guaranty association's adjustment of covered claims usually binds the receiver, up to the amount the guaranty association has allowed, subject to statutory limitations. Although Section 703(A) of Model #555 obligates the liquidator to accept claims as settled by a guaranty association when required by law, it prohibits the allowance of any claim in excess of the policy limits or contrary to the coverage provided under the terms of the insurance policy.

In other situations, limitations on guaranty association coverage—including caps, crediting rate limits, copayments, deductibles and net worth—may make it necessary for the receiver to undertake a separate review of claims. The receiver should keep accurate records for, and coordinate with, all affected guaranty associations concerning the tracking of per-occurrence and aggregate limits of coverage under policies where there are multiple claims and claimants. Coordination with guaranty associations is essential.

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Claims covered by guaranty associations may be reinsured. It is important for the guaranty associations to report development on these claims so that reinsurance notice requirements can be met. Lack of reporting can hinder the collection of reinsurance recoverables. Because guaranty associations ultimately benefit from reinsurance collection, the receiver and the guaranty associations have a common interest in collaboration.

#### 5. Review Claimant Standing

A claimant's standing to file a particular claim against a receivership estate should also be reviewed by the receiver. Model #555 provides that with respect to claims of co-debtors, if a creditor does not timely file a proof of the creditor's claim, then an entity that is liable to the creditor together with the insurer (or that has secured the creditor) may file a proof of the claim. (See Section 709 of Model #555.)

### C. Claims Valuation

All claims should be assigned a value for allowance. In general, the determination of a claim's value is subject to the contractual agreement under which it arose and any statutory limitations. However, the receiver may be inhibited by statute from valuing claims in the same manner as the insurer did before receivership. In a typical surety insolvency, for example, the receiver and the receiver's legal counsel may face myriad issues as to what must have occurred prior to the fixing date for the bond claimant to pursue a claim in the receivership (e.g., how the bond claim is to be valued when the receivership order has interrupted the normal surety repair/completion of a bond principal's default, etc.). Model #555 permits the liquidator to apply to the receivership court for approval to disallow *de minimis* claims. A *de minimis* amount shall be any amount equal to or less than a maximum *de minimis* amount approved by the receivership court as being reasonable and necessary for administrative convenience. (See Section 703(H) of Model #555.)

#### 1. Secured Claims

Generally, the value of security held by secured creditors can be determined by converting the security into money according to the terms of the security agreement, by agreement with the receiver or by the supervising court. Model #555 allows the value of security to alternatively be determined by agreement or litigation between the creditor and the liquidator. (See Section 710(A) of Model #555.) The value of the security is then credited against the claim. Valuation of secured claims may affect the overall recovery and distribution of assets to the other creditors of the estate. Model #555 provides that the claimant may file a proof of claim for any deficiency, which shall be treated as an unsecured claim. If the claimant surrenders the security to the liquidator, the entire claim must be treated as unsecured. The liquidator may recover from property securing an allowed secured claim, the reasonable, necessary costs and expenses of preserving, or disposing of, the property to the extent of any benefit to the holder of such claim. (See Section 710(C) and (D) of Model #555.)

A receiver should proceed with caution when valuing secured claims. The value of the security may be overstated on the books and records of the insolvent insurer.

#### 2. Claims Estimation

The long-tail nature of certain claims, such as workers' compensation or mass tort, in a P/C receivership can present special issues for receivers. Under some rehabilitation plans, claims may be permitted to develop in a normal fashion. In other rehabilitation proceedings and almost all liquidation proceedings, however, the receiver may be ready to distribute assets before all claims are fully developed. In addition to the typical issues of coverage, liability, and damages, the receiver should have a plan for valuing long-tail claims that complies with applicable state law.

Before a claim may be allowed, the receiver needs timely and accurate evidence:



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- That the policyholder has, in fact, sustained a loss within the coverage of a valid policy and in a specific or determinable amount. The receiver evaluates the merits of the underlying claim. Under many states' statutes, a judgment against the policyholder entered after (and, in some states, even before) the date of liquidation may not be binding evidence of either liability or the amount of the loss. Nor does an insured's settlement bind the receiver, unless the insured can demonstrate that it is both bona fide and fair to the insurer as well as the insured. Collusive or side agreements between the insured and one or more of the claimants, consent judgments, and covenants not to execute should be reviewed to determine whether the judgment or settlement is reasonable.
- That a third party has asserted and proven a claim against the policyholder on a timely basis, in an amount that can be reasonably determined. Again, judgments should be evaluated by the receiver for reasonableness. Each claim must be evaluated on its merits.

Some claims will fail to meet the requirements for proof and liquidation set out above, even though, were it not for the receivership's requirements, the claims would eventually have matured into enforceable claims. Late-maturing and even "contingent" claims are nevertheless an important component of the company's liabilities, both because of the significance of the claims themselves and because, when allowed, late claims may generate reinsurance recoverables for the estate.

- The receiver's flexibility in dealing with late-maturing claims may be limited by statute. Nevertheless, a procedure to deal with late-maturing claims should be developed in any estate involving long-tail exposures or where reinsurance recoveries are a consideration. The methodology used by the receiver will depend upon the individual estate, applicable state law, and the nature of the claims and the records available. A number of alternative approaches are available to the receiver:
  - The receiver might deny all claims that have not matured within a specific period after entry of the liquidation order. This "cut-off" approach may be appropriate where the insolvent insurer wrote simple, short-tail business or where the estate has few assets and recoverables. However, if the insolvent insurer wrote more complex business with a longer tail, the cut-off approach may defeat policyholder expectations and limit the receiver's right to collect from reinsurers.
  - Extensions of a claim filing deadline may ameliorate, but not eliminate, the risk that a policyholder with a legitimate claim will be left without a remedy. It sometimes helps and may be statutorily required to establish a second claim filing deadline, prior to any distribution to stockholders, in order to afford late claims an opportunity for recovery. Where permitted by state law, some receivers have obtained approval for plans under which a claim deadline is extended and policyholder claims are allowed for distribution as they mature. This "run-off" approach may delay the distribution of assets and/or closure of the estate.
  - Model #555 provides that a claim that is not mature as of the coverage termination date may be allowed as if it were mature, except it shall be discounted to present value. (See Section 703(D) of Model #555.)
  - The receiver should determine whether the law in the domiciliary state would allow a plan to estimate and pay claims pro rata. While some states' receivership statutes (e.g., Illinois, Missouri, and Utah) expressly permit the estimation of policyholder claims, receivers in other jurisdictions might seek receivership court approval for a claims estimation plan with proper notice to interested parties. Case law that allows for claims estimation when a state statute permits estimation for the payment of

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claims or recovery of reinsurance proceeds includes *Angoff v. Holland-America Ins. Co.*, 937 S.W.2d 213 (1996), providing that “the Missouri insolvency statutes grant the receiver considerable discretion in evaluating the determining claims by estimation using actuarial evaluation or other accepted methods of valuing claims with reasonable certainty, including determinations for IBNR losses to the extent that those types of claims can be determined with reasonable certainty.” State law may provide that estimated contingent claims may be allowed, but at a lower priority level than non-estimated claims (e.g., Illinois). Case law in another state provides that the receiver should not pay receivership distributions based on actuarial estimates of claims. See *In re Liquidation of Integrity Ins. Co.*, 2006 WL 2795343 (N.J. Super. A.D.). (The court rejected the holding in the *Holland-America Insurance Company* case that permitted claims estimation because it was based on Missouri statute, whereas New Jersey had no such provision.)

Assuming that a claim estimation plan is in accord with state law, the receiver should be aware of the following:

- Some state statutes have been amended to address the handling of contingent and unliquidated claims by providing an opportunity for estimation of contingent claims without lowering the priority of distribution of the claim. These few state statutes specifically allow for the estimation of claims, but some (e.g., Illinois) provide a separate priority of distribution level for holders of such allowed claims.
- Another approach to estimation assumes that each policyholder is assigned a case reserve established in the policyholder’s name and a proportionate share of the total projected IBNR. Although largely untested in this country, this technique has worked well in other countries in the liquidation of reinsurers.
- Even if IBNR estimations are acceptable for purposes of distribution from the estate, estimation may not be a valid basis for recovering reinsurance. (See Section 611(I) of Model #555.)
- . Claims in a Life/Health Insolvency

Few receivership statutes directly address the issue of valuing life and annuity claims, but there is a well-developed body of case law on the subject. In any event, it often will be necessary to assess the type of policyholder claims at issue to evaluate whether groups of policyholders are being fairly treated in any rehabilitation, liquidation, or assumption reinsurance transaction.

- Mature Claims

Life insurance claims have the advantage that, in most cases, the condition precedent to claim liability is fairly clear: The policyholder is either alive on the relevant date or not. If the events triggering the insurer’s obligation to pay on a life policy have occurred on or before the fixing date, then the receiver’s claims process is substantially similar to that of a going concern, centering on proof of death, premium and cash value accounting, and beneficiary designation. Immediate annuities present slightly different problems, but essentially the claim of the owner of such an annuity ought to be the present value of the future stream of payments.

- Immature Claims

Challenges can arise in connection with policies for which the principal liability-creating event has not yet occurred at liquidation. Few such claims would be considered contingent

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because the policyholder usually has significant rights at the liquidation date, including surrender rights or rights to unearned premium. Court decisions, going back to the early 1800s and ending in the 1940s as the assumption/guaranty system developed, support the allowance of claims based on these immature policies in the amount of a fairly adjusted reserve, or alternatively in the amount of the difference between premiums expected to be paid in the future and claims expected to be recovered by the policyholder—all discounted to present value.

In evaluating policyholder claims against life insurers, the receiver should look at the company's own reserves, after suitable investigation, to quantify individual policy claims. These reserves will typically equal or exceed cash or surrender value on the policies. Cash or surrender value, being the sum that the policyholder could obtain at any given moment from a solvent insurer, is usually the largest component of such a reserve and establishes a minimum number for the receiver's valuation. Other policy features are usually captured in the company reserves as well, including special premium considerations, renewal commitments, advantageous mortality charges, and above-market crediting rates. Annuity contracts may have features that affect the actual value of the contract. There may be a cash value, an account value, a surrender value, or other valuations used by the company to represent the amount payable to a claimant at a given point. Also, tax consequences may be incurred by a contract holder if their tax-qualified retirement contract is paid out and not rolled over into a qualifying contract within the time allowed by the IRS.

On the other hand, statutory reserves usually do not reflect the likelihood that some policyholders, had the insurer continued in business, would have permitted their policies to lapse. One approach to lapse issues would be to consider that because lapse is an election completely within the control of the policyholder, it would not be appropriate to reduce the claim in respect of an election that, at the date of liquidation, the policyholder had not made. Other analyses, however, are also possible.

In a life/health receivership, the receiver will frequently conclude that traditional proofs of claim are either unnecessary or irrelevant. The company's records often form a better base for a claim valuation than anything the policyholder could construct. The actuarial techniques that ought to be employed in the valuation are outside the competence of most policyholders. Finally, application of a single actuarial method to all claims will permit them to be evaluated on a consistent basis. Part or all of the policyholder claims arising from life insurance policies and annuity contracts will be covered by guaranty associations. State guaranty association statutes typically require a pro rata distribution of receivership assets to guaranty associations based upon the reserves that should have been established for the covered policies. In addition, guaranty associations may have other creditor rights. Accordingly, the receiver should coordinate with the affected guaranty associations as to valuation issues.

**D. Notice of Claims Determinations**

Once the receiver has completed the review of proofs of claim, the claimants should be advised of their claim determinations. In some states, the receiver will not send a determination letter if the claim has been resolved by a guaranty association. Some receivers merely file with the supervising court a report or recommendations as to the allowance or disallowance of each claim and require claimants to file any objections with the court. Other receivers give claimants notice and an opportunity to object before reporting to the court. As discussed below, Section 703(B) of Model #555 follows this procedure. If the latter procedure is used, notice of the full or partial allowance of a claim should inform the claimant of the amount that the receiver will recommend to the supervising court for adjudication and the class of the claim for priority of distribution purposes.

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In the case of the partial or total disallowance of a claim, the notice should state the reason for the disallowance and inform the claimant of the amount of time (specified by statute or court order) that the claimant has to object to the determination. Many states provide that claimants be given 60 days from the date the notice was mailed to submit written objections to the receiver. Model #555 provides 45 days. (See Section 703(C) of Model #555). Model #555 allows the liquidator to accelerate the allowance of claims by obtaining waivers of objections. (See Section 703(C) of Model #555.) Model #555 also provides that preliminary notice of the amount of the claim determination may be given to any reinsurer that is or may be liable with respect to the claim at least 45 days before the notice is given to the claimant. If the reinsurer does not object to the claim determination, it is bound by the determination. (See Section 703(B) of Model #555.) Advance notice to reinsurers may not be practical under some circumstances, such as where the case is settled at mediation on the eve of trial or where the reinsurer has expressed disinterest in the claim determination because it intends to dispute liability. Notice to a reinsurer can help establish proper documentation when a reinsurer denies having been notified of the loss.

Once an objection is received, the receiver should consider whether the determination should be altered before proceeding to a court hearing on the objection. Model #555 provides that whenever objections to the liquidator's proposed treatment of a claim are filed, and the liquidator does not alter the determination of the claim as a result of the objections, the liquidator shall ask the receivership court for a hearing. (See Section 707(B) of Model #555). However, there is case law supporting the proposition that the commissioner may not have a statutory obligation to provide claimants a formal hearing when determining a claim (*Garamendi v. Golden Eagle Insurance Company*, 128 Cal. App. 4th 452, 27 Cal. Rptr. 3d 239 (Cal. Ct. App. Dist. 1. Div. 1. 2005)). Because it may be cost-prohibitive to have hearings on every claim objection, the receiver may settle or otherwise resolve an objection without the need for a hearing. The procedures for hearings on claim objections are discussed further below.

Prior to the court's approval, the receiver may revise the determination. This enables the receiver to correct any errors that were made and to amend the determination in light of any subsequently provided information or negotiations. The receiver should remind the claimant to advise the receiver of any change of address or the information provided in the proof of claim. Naturally, if the receiver changes an initial denial of a claim to an allowance or partial allowance determination, the receiver should notify the claimant of the amended determination.

In addition to policy claimants, the receiver should give notice of claim determinations to other directly affected persons, such as reinsurers. (The reinsurance contract contemplates the reinsurer receiving notice and an opportunity to participate prior to the court approving the claim.) The receiver should pay particular attention to the requirements contained in the insolvency clauses of applicable reinsurance agreements. Similarly, if the insurer underwrote surety bonds (such as contract performance or payment bonds), then the receiver will want to provide notice of the determination to indemnitors of the bonds, any collateral depositors, and the bond principal. Notice will enable the receiver to obtain any information those persons have with respect to the claim and will put them on notice that the receiver may be looking to their collateral or indemnification agreements for reimbursement of the insurer's liability under the bond. If not established by statute, the receiver should set a deadline for the claimant to respond to the claim determination. If a timely response is not received, the claim determination should become final, subject to court adjudication.

**E. Judicial Review of the Receiver's Claims Determinations**

Depending upon the degree of oversight exercised by the supervising court, the receiver may be expected to account to the court for all claims processed. Model #555 provides that the liquidator shall present reports of claims settled or determined by the liquidator to the receivership court for approval. The reports will be presented from time to time as determined by the liquidator and shall include information identifying the claim and the amount and priority of the claim. (See Section 708 of Model #555.) After the receiver makes the claims determinations, those decisions may be presented to the supervising court in the form of a recommendation for allowance or disallowance, in whole or part. This next section outlines

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the procedural steps that may be taken in making, filing, and presenting recommendations for final court approval.

### 1. Documenting the Recommendation

The first step is to make sure that claims determinations have been properly documented. The receiver may want to have a separate file for each claim filed in the receivership, containing the proof of claim and other relevant information. Files may be organized numerically either on a date of loss or policy basis. A status sheet or checklist may be attached at the front of each file detailing the status of the claim, including the recommendation to allow or disallow the claim, the priority of the claim, status of reinsurance, and other notes. Information in the status sheet should be entered into an electronic claims system. After the recommendation has been documented, the receiver then presents the claim (depending upon its status) to the court for approval or for a contested hearing, if the claimant filed a timely objection to the receiver's determination.

### 2. Presenting Recommended Approvals to the Supervising Court

The receiver may obtain court approval of recommended claim allowances, or the receiver may obtain advance approval for the payment of claims within a specified claims priority. In the event of advance approval, the receiver may report back to the receivership court if there is uncertainty as to whether claims fall within the approved claims priority class.

If the receiver does not seek advance approval for payment of claims within a creditor class, claims may be presented to the court by listing the claims and amounts approved or, if required, by a full financial accounting. The court usually will enter an order confirming the allowed claims. When the court approves a claim and all possible appeals have been exhausted, the receiver's staff should be notified that the legal action has concluded so that the allowed claims may be placed in line for eventual distribution.

### 3. Review of Recommended Rejections

This section outlines a general procedure for the denial of claims in a receivership. Model #555 provides that disputed claim procedures are not applicable to disputes with respect to coverage determinations by guaranty associations as part of their statutory obligations. (See Section 707(C) of Model #555.) Some states follow the practice of conducting individual hearings on denied or disallowed claims. The receiver's goal is to complete the process as quickly and smoothly as possible. The receiver may use in-house counsel or retain outside counsel to handle hearings, depending upon the complexity of the receivership and the disputed claims. The receiver should consider the potential expense involved in contested claims proceedings in deciding whether to force a hearing or pursue settlement or arbitration.

The claims hearing process begins when the receiver files a notice with the supervising court and notifies the claimant and other directly affected persons. Various courts require different notices, and legal counsel should be consulted to assure that the receiver is following the correct procedure. Usually, the notice sets forth: 1) the time and date of the hearing; 2) the procedure to be followed at the hearing; 3) the amount claimed; 4) the relevant priority status of the disputed claim(s); 5) the reason for the denial or priority status assigned; and 6) whether an objection was filed. In some instances, due to the volume of claims, a special master may be appointed to hear the disputed claims rather than the judge of the supervising court. If a special master is appointed, the parties should meet as soon as practicable to establish the exact procedure to be followed. The receiver's staff should work closely with the legal counsel conducting the proceeding.

Assuming all notice requirements have been satisfied and any special procedures have been implemented, claims hearings typically follow a routine procedure. If permitted, multiple hearings should be scheduled at the same time to conserve estate assets and resources. Depending upon the

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complexity of the hearing involved, the receiver's staff and other resources may be needed. The receiver's counsel generally will need testimony from members of the claims staff or the receiver, along with production of relevant records. Expert witnesses also may be required. Receivers should take care to discuss the need for expert witnesses with legal counsel due to the costs involved.

At the close of a claims hearing, the court typically issues a report or decision. Assuming the receiver's recommendation is upheld, the receiver should note the deadline for appeal of the order. If there is an appeal, it is best to complete the appeal process as soon as possible. If the decision is not appealed (or an appeal is concluded), the final order of the court can be entered into the receiver's records, along with any change in claim status. The final disposition by the receivership court of a disputed claim is deemed a final judgment for purposes of appeal. (See Section 707(D) of Model #555.)

#### 4. Arbitration

Judicial review of the receiver's determinations is not always mandatory. Depending upon the nature of the legal right or claim involved and the applicable law, arbitration may be required. Although the arbitration provision contained in a policy or reinsurance agreement may be unenforceable against a receiver (review of applicable law on this point is essential), careful review of these contracts is necessary to determine whether arbitration may benefit the receiver or the estate and, if not, whether arbitration can be avoided. Legal counsel may assist the receiver make this determination. If arbitration is an attractive option or cannot be avoided under applicable law, then the receiver should become familiar with the specifics of the arbitration clause in each contract.

Arbitration is a contract-based proceeding, subject to statutory and case law in the particular jurisdiction whose law may govern the proceeding. Careful review of the agreement with legal counsel is essential. Numerous legal questions arise in the context of arbitration proceedings, and no receiver should enter into arbitration without the assistance of competent counsel. For example, the choice of arbiters can be critical. The receiver may wish to consult with other receivers to identify arbitrators for recommendation. If one party refuses to name an arbiter, however, the other may seek court intervention to facilitate the process.

Section 105(E) of Model #555 recognizes the propriety of arbitration to resolve reinsurance disputes. (See Chapter 7.)

### **F. Establishing Claim Reserves**

Establishing appropriate claim reserves may be just as important to an insurer in receivership as to a solvent company.

#### 1. Why Reserve?

The nature of the receivership will dictate if, how, and when reserves should be established. A rehabilitator is particularly concerned with the company's reserves in assessing the company's prospects for a successful rehabilitation. It may appear that a liquidator should not be concerned with reserves because the insurer usually has been adjudged insolvent, and the liquidator's charge is to adjudicate the claims and close the estate. However, the liquidator will be concerned about reserving from the standpoint of reinsurance claims. Reinsurers need data from which to establish IBNR loss reserves, as well as reserves for existing claims. The receiver's failure to furnish this information on a timely basis may lead reinsurers to attempt to avoid their obligations.

Accordingly, the receiver should determine the reporting requirements established in the insurer's reinsurance contracts and other reserve requirements imposed by the court or by law. Accurate reserve information is equally important for determining the prospects for attracting a potential purchaser or investor and for calculating the availability of assets for early access distributions to

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guaranty associations. It is frequently possible to bring significant assets into the estate of a P/C company by negotiating commutations with reinsurers, but such an effort is difficult without reliable, credible, and current reserves. The receiver also should determine when reserve information must be presented to the court, if at all. And there also may be deadlines imposed as to when reserve information must be submitted. This often is the case where receiver reports must be submitted to the court, guaranty associations, or regulators within a specified period. In other words, it is important for the receiver's staff to know the needs of the different users of reserve information.

Further, it may not be useful to obtain an actuary's estimate of IBNR claims and applicable reserves more than once per calendar year, as there may not be enough new data or developments to change the earlier reserve estimate for IBNR. This also means that to the extent that the receivership's claims payment rate is affected by estimates of IBNR claims, the claims payout rate may not be adjusted more than once per calendar year.

Whether a receiver can use actuarial estimates of IBNR for the purpose of collecting reinsurance proceeds from reinsurers depends upon the applicable statutes and case law. (See *Angoff v. Holland-America Ins. Co.*, 937 S.W.2d 213 (1996); *Quackenbush v. Mission Ins. Co.*, 62 Cal. App. 4th 797 (1998)). In *Holland-America*, claims estimation for reinsurance recoveries was permitted on the basis of a state statute that authorized claims estimation for that purpose. In the *Integrity* and *Quackenbush* cases, claims estimation of future IBNR losses would not be permitted for collection of reinsurance proceeds because, in those cases, the applicable state statutes required that unliquidated or undetermined claims could not share in the assets of the insolvent insurer.

IBNR claims will arise in two contexts, namely: 1) IBNR losses from policyholder protection proof of claims in which the actual claim is unknown and has not been submitted to the receiver; or 2) further IBNR loss development from known claims, but the amount or extent of the future IBNR loss development is unknown. A final bar date by which all claims must be presented should be established so that the estate can determine the universe of claims and wind down its affairs over time, thereby saving the costs of keeping a receivership estate open indefinitely. Although the final claims deadline may resolve whether IBNR claims may be presented for policyholder or protection claims, the final claims deadline is likely to allow, as timely filed and proper claims, known claims for which there may be continued IBNR loss development.

How IBNR loss development on known claims may affect reinsurance recoveries, recoveries by insureds, and third parties from guaranty associations or recoveries by guaranty associations from receivership estate assets are important issues. For example, at the closure of the receivership, there may be many known claims for which the future stream of benefit payments could be calculated by the receiver, guaranty association, and/or claimant, such as the value of future benefit payments for workers' compensation claims. If the receiver or guaranty association purchased an annuity in settlement of all future benefit payments due a claimant (including an IBNR component), would the *Integrity* and *Quackenbush* courts reject the settlement because it included IBNR loss development? Or would a claim settled in this way be considered liquidated and non-contingent? The settlement payment should satisfy the court's concerns about having a liquidated and determined claim, but this would be a case of first impression.

Without any accommodations being made for future loss development, guaranty associations may still have obligations to the aforementioned claimant after the receivership is closed but will not receive any distributions from the receiver for these losses. Similarly, claimants will receive no payments for their post-receivership loss development if such development is not allowed by the receivership court or guaranty associations.

Receivers should address IBNR claims before making final receivership distributions and closing the receivership estate, bearing in mind: 1) whether the applicable state statute permits IBNR claims; and 2) whether IBNR loss development can be made liquidated and certain under different alternatives

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(e.g., an annuity in settlement of all known and unknown losses as described above). Receivers should also evaluate the extent of reinsurance recoverables available for IBNR losses, and the reinsurers of the insolvent insurer should be given notice and an opportunity to participate in the settlement of claims involving IBNR.

In the case of a life insurer, an actuarial evaluation may be necessary both to value the business (within a positive or negative range) and to estimate total liabilities so that the guaranty association or the receiver can effectuate assumption of the in-force blocks of business by a solvent insurer. The evaluation should be done for each line of business. Life, annuity, and A&H blocks should be considered separately. Proper liability reserving is necessary in any receivership to project ultimate distribution amounts to various creditor classes. Caution must be exercised in establishing loss reserves, however, as reserve reductions that do not reflect actual liabilities can trigger negative tax consequences.

## 2. Reserve Adjustment

It may be appropriate to adjust outstanding case or claim reserves. In some cases, case or claim reserves will be adjusted continually as additional information becomes available. Reserve adjustments may be required if, for example, amendments to proofs of claim are permitted after the claim filing deadline or the supervising court extends the claim filing deadline. Such adjustments typically affect the amount of a letter of credit (LOC) that a reinsurer must post, early access distributions, tax liabilities, and the future payout rate for other claims. The receiver should also estimate the future administrative costs to pay all claims and to wind up the receivership, including the cost of concluding litigation to recover assets.

Notice of reserve adjustments should be disseminated as necessary. The receiver may be required to report the adjustments to reinsurers and the supervising court, among others. The timing of these reports will depend upon the court's requirements and applicable law. The receiver's staff should identify the needs of the different users of information and determine when information should be provided.

## G. Assignment of Claims Issues Considerations and Guidelines

There has been an increase in the number of assignments of claim that are presented to receivers. The development of best practices for administering the assignment of claims was undertaken by the NAIC's Receivership Technology and Administration (E) Working Group, which drew upon the experience of receivers, state insurance regulators, and interested parties to develop best-practice guidance. [RTAWG GUIDANCE attached as reference. Note to publishing link to guidance on NAIC web-site in electronic version.]

## V. PAYMENT OF APPROVED CLAIMS

Theoretically, distribution of the insurer's assets to claimants in a liquidation proceeding is different from normal business practice. While claims against an insurer in rehabilitation may be paid either in the normal course of business as they become due or pursuant to a rehabilitation plan, in a liquidation proceeding, the insurer's assets must be distributed to creditors in the order set forth in the priority of distribution statute. This section addresses some of the many issues the receiver must address once the claims evaluation and approval process has been completed and the asset distribution process begins. See generally Article VIII of Model #555.

### A. Priority of Distribution in Receiverships

All state receivership statutes and Section 801 of Model #555 provide a priority of distribution scheme. The liquidator must become familiar with the priority of distribution scheme of the domiciliary state's



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receivership statute at the outset of the receivership process. Typically, statutory priority schemes require that claims in a higher priority class must be paid in full or funds reserved to pay them in full before any payment may be made to lower priority claims. Also, the statutes typically require that all claims in a class must receive substantially the same *pro rata* distribution.

The receiver must keep in mind that the same claimant may hold several claims, not all of which have the same priority. There also may be different types of claims within a particular class of creditors (e.g., landlord claims, vendor claims, and assumed reinsurance claims are different types of general creditor claims). A receiver must avoid creating subclasses within a priority class. (See *In re Conservation of Alpine Insurance Company*, 741 N.E. 2d 663 (Ill. Ct. App. Dist. 1. Div.4. 2000).) The following discussion is based on the scheme of priorities established by Section 801 of Model #555. Secured creditors and special deposit claimants are outside the scheme of priorities established by Section 801. Secured creditors are covered by Section 710 of Model #555, and special deposit claimants are covered by Section 1002(C) of Model #555.

### 1. Secured Creditors

Secured creditors include anyone holding a perfected security interest in or lien against the property of the insurer (e.g., mortgages, trust deeds, pledges and security interests perfected under applicable law, excluding special deposit beneficiaries). Once determined, the value of the security is applied against the creditor's claim, with the deficiency, if any, treated as an unsecured claim. The priority of the deficiency claim depends upon applicable state law. Model #555 also provides guidance to the receiver for the disposition of specific types of secured claims; i.e., claims involving surety bonds or undertaking, and obligees or completion contractors. (See Section 710(B) of Model #555.)

### 2. Special Deposit Claimants

Some states require deposit or trust accounts for the benefit of policyholders as a condition to authorization of the insurer to transact business in that state. Although owners of special deposit claims often are loosely referred to as secured, they do not, strictly speaking, have a "security interest." Some special deposits are made for the benefit of all policyholders, while others specially protect residents, property, or lines of business in the state where the deposit is established.

States differ in their treatment of special deposit beneficiaries' claims in the domiciliary receivership. Some apply the rules applicable to holders of partially secured claims; i.e., treating the deficiency as an ordinary policyholder claim. Another method gives effect to the special deposit arrangements, but it applies the "hotchpot" principle to payment of any deficiency. Under this method, special deposit beneficiaries receive no additional payment on their claim until all other claimants in the same class have received assets sufficient to make their percentage distribution equal to that of the special deposit claimants. The treatment to be accorded special deposit claimants may be articulated in the receivership statute.

There has been litigation in various state jurisdictions regarding the handling of special deposits for insurance company liquidations. A Massachusetts case provides that an insurance commissioner, acting as ancillary receiver of a foreign insurance company, cannot take any action to remove special deposit funds until all special deposit claims have been satisfied. (See generally, *Commissioner of Ins. v. Equity Gen. Ins. Co.*, 191 N.E.2d 139 [Mass. Sup. Jud. Ct. 1963].)

In North Carolina, a "special deposit claim" has been defined as any claim secured by a deposit pursuant to statute for the security or benefit of a limited class or classes of persons. (See *State ex rel. Ingram v. Reserve Ins. Co.*, 281 S.E.2d 16, 20 [N.C. 1981]. N.C. GEN. STAT. § 58-30-10 [19]). Special deposits are expressly excluded from general assets. *Id.*

In most receiverships, it is difficult for receivers to collect special deposits posted in other state jurisdictions without a court order and provision having been made for the payment of all

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policyholders in such state jurisdictions. Thus, the receiver will need to develop a claims distribution plan that takes the special deposits into account and avoids unlawful preferences, being mindful that the state jurisdiction in which a deposit is posted may use the special deposit to satisfy unpaid policy claims in that state jurisdiction.

### 3. Class 1—Receiver’s Administrative Expenses

The expenses of the receiver in marshaling and distributing the insurer’s assets are paid out of the unencumbered assets before any other claims are paid. Most statutes treat administrative expenses as claims having a first priority. Some statutes accord the same priority to a guaranty association’s administrative expenses. However, some guaranty association expenses may be classified as policyholder benefits, which is an area of disagreement between guaranty associations and receivers. As will be discussed below, Section 801 of Model #555 provides two alternatives as to classification of the priority of guaranty association claims. Reinsurers may argue that if the receiver is making reinsurance recoveries under reinsurance treaties, then all premiums due under the treaties should be treated as an administrative expense. Under general contract law, ratification of a contract may be found under a variety of circumstances, such as: intentionally accepting benefits under the contract after discovery of facts that would warrant rescission; remaining silent or acquiescing in the contract for a period of time after having the opportunity to avoid it; or recognizing the validity of the contract by acting upon it, performing under it, or affirmatively acknowledging it (17A C.J.S., Contracts § 138). Reinsurers’ claims should be evaluated on a case-by-case basis, but there may be benefits to the estate from treating the reinsurers’ claims as administrative expenses. The reinsurance contract obligations may be binding on the receiver as administrative expense obligations if the receiver has legally “ratified” the reinsurance contract. The assets available to pay all other creditors are those remaining in the estate, net of the cost of recovering and administering them. The process of estimating administrative expenses is a difficult one, as it will depend on many factors, some of which are beyond the control of the receiver. The receiver should establish a contingency reserve for administrative expenses before recommending any payments on claims of lower priority.

### 4. Class 2—Guaranty Association Expenses

Guaranty associations may have several types of expense claims, not all of which may have the same priority. Model #555 provides two alternative priority schemes depending on how a state wishes to classify certain expenses of guaranty associations. The first alternative places expenses of the guaranty associations, including defense and cost containment expenses of a P/C guaranty association, in Class 2; i.e., after administrative expenses of the receiver. The second alternative places the defense and cost containment expenses of P/C guaranty associations in Class 3 with other policyholder-level claims, while the remaining expenses of the guaranty associations are placed in Class 2. No significance or deference should be given alternatives under Model #555 based on whether an alternative is labeled as alternative one or two. Receivers should note case law providing that however a guaranty association’s claims are classified, the claims of an out-of-state guaranty association should be of equal priority with the claims of the guaranty association in the receivership state (in *re Liquidation of American Mutual Liability Insurance Company*, 747 N.E.2d 1215 [Mass. 2001]).

### 5. Class 3 and Class 4—Claims for Policy Benefits

Many state statutes accord priority status to claims for policy benefits behind only the administrative expenses of receivers and guaranty associations. This status applies not only to the claims of policyholders, but also to those claiming through them, including guaranty associations and liability claimants whose claims were covered under one of the insurer’s policies. Claims under life insurance or annuity policies include claims for investment values, as well as death benefit and annuity payments. Premium refunds and unearned premium claims, however, are treated as general creditor claims under the former Model Act, and some state statutes, although guaranty associations often

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cover such claims, at least in part. Some states and Model #555 accord the same priority rank to policy loss and premium refund claims. A review of the applicable receivership statute generally will inform the receiver as to how to treat such claims. As sub-classifications within a priority level should be avoided, case law provides that the receiver cannot divide policyholders into those who were insured only by the insolvent insurer and those who had additional insurance through other carriers (in re *Conservation of Alpine Insurance Company*, 741 N.E. 2d 663 [Ill. Ct. App. Dist. 1. Div. 4. 2000]).

## a. Deductible and Limits

The policyholder's claim is for the amount that the insurer should have paid. The insurer's liability attaches after the deductible has been paid by the insured (non-advancement policies). However, for some policies (e.g., some workers' compensation policies), the insurer is required to pay the claim and seek the deductible from the insured (thereafter, known as large deductible policies). It is common for insureds to post collateral with the insurer for deductible payments that may be made by the insurer, for which the insurer then seeks reimbursement from the insureds. There are three available model alternatives that provide for the disposition of large deductible policy recoveries between receivers and guaranty associations: 1) Section 712 of Model #555; 2) the *Guideline for Administration of Large Deductible Policies in Receivership* (#1980); and 3) the NCIGF Model Large Deductible Act (NCIGF Model). Individual state statutes based on the NCIGF Model or Guideline #1980 may differ from Section 712 of Model #555 in certain respects. See Section ---- for more information on large-deductible programs.

## b. Previous Guaranty Association Payments

A guaranty association that pays all or part of a policyholder's claim acquires the policyholder's rights in the receivership estate (with occasional additional privileges, such as an exemption from certain filing deadlines). The policyholder's claim (or the claim of the liability claimant under the policy) is reduced proportionately, but it usually is not expunged. In some states, a guaranty association may make payment directly to the liability claimant if the claimant waives any further claim against the insured. The receiver should remember, however, that guaranty associations only process "covered" claims and that insureds with claims that the guaranty association does not cover will be instructed to handle their own claims and then seek reimbursement from the estate.

## c. Cut-Through

As an enhancement to security, insurance policies or reinsurance agreements sometimes obligate a reinsurer to pay the policyholder directly in the event a covered loss cannot be paid due to the insolvency of the direct insurer, pursuant to a cut-through clause or endorsement. A number of controversies have resulted from these provisions, including the issue of the validity of such agreements. Insofar as the arrangement purports to affect the obligation of the reinsurer to the cedent, or of the cedent to the insured, the receivership estate may be affected. The receiver should seek the guidance of legal counsel concerning rules applicable in the local jurisdiction. Some jurisdictions have allowed insureds direct access to reinsurers even in the absence of a cut-through clause or endorsement. In such cases, courts will look to the relationship among the parties. (See *Koken v. Legion Insurance Co.*, 831 A.2d 1196 (2003), where the court allowed a cut-through where the insolvent insurer had fronted the reinsurance arrangement.)

## d. Assignments

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Policyholders sometimes assign to a third person their rights to recover from the insurer. Although the general rule is that the assignee stands in the shoes of the assignor, the receiver should determine the validity of any assignment with reference to applicable law.

e. Separate Accounts for Life and Annuity Policyholders

A special form of assets is separate account assets. Separate accounts are accounts established by life and annuity insurers in association with specific types of policies or other business, such as pension plans. Generally, separate accounts are created and administered in accordance with specific regulatory or statutory guidelines. Typically, such statutes provide that assets properly maintained in separate accounts will not be chargeable with liabilities arising out of any other business of the insurer. It has been held that the status of separate account assets is preserved in receivership.

6. Class 5—Federal Government

In general, claims of the federal government may be paid after administrative and policyholder claims. However, the receiver is well-advised to obtain a release from the federal government prior to making any final distributions. This is because the federal government may not be bound by the receivership court's claim filing deadline or the estate's classification and payment of certain claims, and it could seek to hold the receiver personally liable if, for instance, it takes the position that it should have been paid in the place of other creditors.

For a discussion of the federal super priority statute and the 1993 U.S. Supreme Court decision in *U.S. v. Fabe*, see Chapter 9—Legal Considerations.

7. Class 6—Employee Compensation

Most priority of distribution statutes assign a higher priority to certain claims for employee compensation earned pre-receivership. This priority generally applies to wages limited in amount and earned within a specified time, but it may not apply to the wages of the insurer's officers and directors, including stockholders who are employed in such positions.

8. Class 7—General Creditors

The populace of general creditors is often large and diverse. It frequently includes the persons described below.

a. Brokers, Agents and Intermediaries—Personal Versus Agency/Derivative Claims

These categories are considered together, since the primary problem arising in connection with broker balances and similar claims is a tendency of all concerned to lose track of the capacity in which the obligation is incurred and to attempt to lump together amounts that derive from quite different sources. A distinction should be made between the divergent and often conflicting interests of the intermediary (especially a broker) acting as the insurer's agent for the collection of premiums as the representative or subrogee of the insured, and acting on his own account, notably for commission. Identifying the capacity in which the broker served is essential for the receiver to determine the relative priority of the broker's claims and the extent to which such claims may be combined (if at all) for purposes of setoff.

b. Cedents

In the relatively few cases where creditors of this class receive a distribution, the receiver may be able to set off interest deemed received by cedents on premature draw-downs of LOCs against the

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distributions due them. Legal counsel should be consulted on the issue of setoff. (See Chapter 9—Legal Considerations.)

c. Certain Claims of Directors and Officers

Model #555 provides that, except as expressly approved by a receiver, expenses arising from a duty to indemnify the directors, officers, or employees of the insured should be excluded from the class of administrative expenses and, if allowed, are Class 6 claims. (See Section 801 of Model #555.) (But see *Weingarten v. Gross*, 563 S.E.2d 771 [Va. 2002]). Here, fees and costs incurred by directors in their defense of an action brought by a receiver were held to be entitled to payment as an administrative expense under applicable statutory law.)

d. Reinsurers

Reinsurers may be creditors of insolvent ceding insurers for premiums or other contract-based financial obligations, such as salvage and subrogation recoveries. Receivers should be aware of the fact that such recoveries may be held in trust and, thus, would be payable in full, not *pro rata*. Similarly, the cedent may hold as the reinsurer's trustee funds withheld and the proceeds of drawn-down security until such time as the funds are applied to appropriate claims. Excess amounts then may have to be returned directly to the reinsurer instead of merged with the general assets of the estate, and the reinsurer's claim to such amounts may be considered the claim of a trust beneficiary, not a general creditor. Depending on the terms, express or implied, of the instrument creating the relationship, the reinsurer's claim for interest on these amounts may not be valid. Setoff is an issue when addressing reinsurers' claims, and legal counsel should be sought. Before making payments of salvage, subrogation, or other amounts due the reinsurers after the receivership commences, it is advisable to obtain written assurances from reinsurers that they will honor reinsured claims submitted by the receiver.

e. Other General Creditors

This category includes: trade creditors, landlords, and utilities (for pre-receivership debts); bondholders (excluding surplus noteholders); secured creditors with deficient security: and, in some jurisdictions, late-filing insurance creditors and claimants for unearned premium.

9. Class 8—State and Local Government Claims and Some Legal Fees

State and local government claims that are not included in another class are placed in this class. Some examples of non-Class-8 governmental claims are policy benefit claims under policies issued to the government entity or current sewer or water bills on the insurer's office.

Class 8 also includes the legal expenses incurred by the management of the company in defending against the receivership proceeding. There are significant limitations on these claims.

10. Class 9—Claims for Penalties, Punitive Damages, or Forfeitures

If the policy issued by the insolvent insurer specifically covered punitive damages, penalties, and forfeitures, these claims would be in the policy benefits class.

11. Class 10—Unexcused Late-Filed Claims

Under Model #555, if the claimant can show that there was good cause for the delay, claims filed after the claim filing deadline (as discussed above in Section II(B)) are evaluated in the class they would have been in if timely filed. If there is no good cause, the claims are placed in Class 10. Most receivership statutes have standards for good cause. (See Section 701(B) and (C) of Model #555.) In some state receivership statutes, there may be some ambiguity on the treatment of late-filed claims.

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## 12. Class 11—Surplus Notes

Model #555 provides that claims within this class will be subordinated to other claims in this class if there is a pre-receivership subordination agreement in existence.

## 13. Class 12—Interest

Interest is not often allowed on claims in receivership after the date of entry of the receivership order, on the general theory that if interest were allowed, it would run equally in favor of all claimants and simply result in a proportionately greater deficiency. Special cases, however, do exist: Holders of secured interests may be allowed interest to the extent their security is sufficient, and creditors in general sometimes may collect interest on their debts before any distribution to shareholders, on the theory that the receivership is to be conducted as if there were no insolvency. Many state laws are silent on this point, but others provide that interest on a given class of claims should be paid or provided for before such payment is made to any lower class. A review of the state's receivership statute may indicate whether interest should be paid as part of any claim. Model #555 allows interest on claims in Classes 1—11 if the liquidator proposes and the court approves a plan to pay interest. (See Section 801(K) of Model #555). Even if the contract upon which the claim is based allows for interest, legal precedent provides that interest shall not be allowed if statutorily prohibited. (See *Swiss Re v. Gross*, 479 S.E.2d 857 [Va. 1987].) Also, legal precedent provides that if claimants are entitled to post-allowance interest on claims, such interest should not be paid at the same priority level of the underlying claim (in re the *Liquidation of Pine Top Insurance Company*, 749 N.E.2d 1011 [Ill. Ct. App. Dist. 1. Div. 4. 2001]).

## 14. Class 13—Equity Interests

After all higher priority classes are paid, any remaining funds are paid to the owners of the insolvent insurer. Like surplus notes, any pre-liquidation subordination agreements among the owners will be honored. Before making a distribution to the owners, the liquidator should be sure to reserve adequate funds to pay any post-discharge expenses, such as the cost of responding to future inquiries from claimants and the costs associated with disposal of estate records.

**B. Setoffs**

In general terms, the claim of a creditor or debtor in a receivership is defined as the net amount due after the application of any permissible setoff. Section 609 of Model #444 addresses setoff. As the subject of setoffs in an insurer receivership is complex and often the subject of litigation, the receiver should consult legal counsel. For a detailed analysis of this subject, see Chapter 9—Legal Considerations.

**C. Currency Conversion**

Variations in foreign exchange rates can become a problem in the distribution of the insurer's assets if the insurer has creditors in foreign countries. The receiver may need to evaluate foreign currency in three situations:

- An insured incurs a loss in a foreign country under a policy denominated in dollars. In issuing such a policy, the insured may be deemed to have assumed a certain degree of foreign exchange risk for foreign currency exposures. However, the insured did not assume the risk of exchange variation during the period when the insurer's insolvency delays payment of the claim.
- An insured incurs a foreign currency loss under a policy denominated in the foreign currency. In this case, the insured may have assumed the risk of currency variation either between loss and payment or pending the insurer's receivership.

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- At the time of receivership, the insurer holds funds or other assets in foreign currency. Some can readily be converted to dollars while others (such as reinsurance assets and outstanding premium receivables) cannot.

Foreign exchange risk characteristically is quite random and runs both ways. Prudent financial management does not attempt to predict the direction of future currency variation, but it only plans to match anticipated foreign debt with foreign assets. Unfortunately, this matching produces difficult problems that the receiver must sort out.

Receivers are forced, sooner or later, to restate the value of all assets and claims in a common currency; otherwise, they cannot calculate a distribution. The only question is when they should do so. The English Insolvency Rules still automatically use the date of liquidation, which is certainly the most straightforward technique. American law does not generally contain direction on this point. Applying a differential standard is likely to seriously complicate the claims process without appreciably improving the fairness of the result. Where the foreign exchange balances are significant, the prudent course may be to accept claims denominated in foreign currency, converting them to dollars at a date shortly before distribution, and planning the conversion of assets to occur at or near the same date.

The actual process of conversion of claims valuation may not be as complicated as it sounds. For example, the receiver might announce a suitable benchmark standard, such as the average of bid and asked prices for the relevant currency as published in *The Wall Street Journal* or offered by major banks. The U.S. Department of Treasury (Treasury Department) also maintains a listing of values for the purpose of assessing *ad valorem* (value-added) customs duties.

Expert assistance may be needed in cases where the currency in question is not readily transferable or has little or no market. Experts also may be helpful in the management of foreign currency assets between takeover and distribution, as well as the matching of assets to anticipated liabilities.

It is helpful to address currency issues at the outset of the receivership, particularly in the case of international insolvencies. Some statutes do not contemplate such issues. The receiver should have the supervising court approve the receiver's practices and procedures on this point when the court enters the order allowing claim payments.

## VI. INTERIM AND FINAL DISTRIBUTIONS

With the approval of the receivership court, a receiver may declare and pay one or more partial distributions on claims (as those claims are allowed), as well as a final distribution. All claims allowed within a priority class are paid at substantially the same percentage. (See Section 802(A) of Model #555.) Model #555 specifically permits the liquidator to pay benefits under workers' compensation policies after entry of the liquidation order if certain conditions are met and only until the appropriate guaranty association assumes responsibility for payment or determines that the claim is not a covered claim. (See Section 802 D of Model #555 and Chapter 6—Guaranty Associations.) Procedures for continuation of pharmacy benefits should also be addressed. In some cases, it will be preferable to continue the company plan for a period of time. In other cases, the guaranty funds have ongoing vendor relationships and can make a transition expeditiously. Model #555 and most state laws also require the liquidator to make early access payments to guaranty associations from distributable assets of the liquidation estate. (See Section 803 of Model #555 and Chapter 6—Guaranty Associations.) State law should be reviewed in all cases to determine specific requirements and authority regarding partial distributions, priority of claims, workers' compensation prepay procedures, pharmacy benefit continuation, and early access.

In determining the percentage to be paid on claims, the receiver may consider the estimated value of the insurer's assets (including estimated reinsurance recoverables) and the estimated value of the insurer's liabilities. (See Section 802(B) of Model #555.) But see, for example, the aforementioned *Integrity*, *Quackenbush*, and *Holland-*

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*America* legal cases for additional information on how IBNR claim estimates and corresponding reinsurance recoveries were addressed in other receiverships.

An insurer's assets often consist of readily available (i.e., liquid) assets and those that may not be readily collected or liquidated. The latter category may include litigation recoveries, subrogation and salvage recoveries, reinsurance recoverables for claims that the receiver recently approved, the proceeds of difficult collection actions, or the sale of real estate. If liquid assets are substantial and the collectibility of other assets is uncertain, the receiver may be able to pay an interim distribution from available assets, with later payments coming from other assets, if and when liquidated.

Distribution of property in kind may be made at valuations set by agreement between the liquidator and the creditor and as approved by the receivership court. (See Section 802(C) of Model #555.)

A receiver may find that estate closure can be expedited by entering into a settlement with the guaranty funds on long tail liabilities, such as workers' compensation, that may remain open after the estate is otherwise resolved. The settlement should be negotiated with the involved guaranty funds and include a distribution for claim payments, as well as administrative expenses. The NCIGF can assist with coordination with the appropriate guaranty funds.

**A. Unclaimed Funds**

Often, small sums of money remain at the end of the distribution process, usually unpaid distributions (i.e., misdelivered or unclaimed checks). The receiver should not treat these assets as "found money." State law typically requires the receiver to retain unclaimed or unproved assets for a specified time, during which the assets should be deposited with an appropriate financial institution, and at the end of which the assets may escheat to the state. The receiver should consult the relevant receivership statute, escheat statutes, and legal counsel, particularly in regard to circumstances in which a state may be entitled to interest on funds held for escheat. The retention of escheated funds may also present challenges for closing the receivership. The receiver should consider the use of a trust for escheated funds on approved claims if the receiver is ready to close the receivership estate, but the required time period has not passed for the payment of escheated funds to states. Under the trust approach, the escheated funds are paid to the trust, the receivership is closed, and then the trustee (the commissioner or former receiver) of the trust pays the escheated funds to states permitted under applicable state law.

Model #555 provides that any funds that are unclaimed after the final distribution should be placed in a segregated unclaimed funds account to be held by the commissioner for two years, or in the alternative, that such funds should be handled in accordance with state unclaimed property laws. (See Section 804 of Model #555.)

Receivers should also check the applicable state agency for escheated funds to see if there are unclaimed funds that are owed to the entity in receivership.

**B. Surplus Assets**

In rare cases, assets may remain after the principal amount of all non-equity claims have been paid "in full." In some states, payment in full means principal plus interest on all timely filed claims. In a few states, where assets remain after such claims have been paid in full, a second claim filing deadline may be set, and the foregoing process may begin anew, albeit on an abbreviated basis. The receiver should review the applicable law to determine how to proceed in such cases. It has been held that a receiver may request court approval for payment of statutory interest on allowed claims where receivership assets exceed the amount necessary to pay all claims in full. (See *Wenzel v. Holland-America Insurance Company*, 13 S.W.3d 643 [Mo. 2000].)

**C. Equity Distributions**



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Finally, in the rarest of cases, shareholders, mutual insurer members, and other owners of an insurer are paid. The receiver should take care to ensure that the administrative expenses of the estate are paid before the final distribution is made and should retain an amount sufficient for common post-receivership expenses (e.g., record storage, etc.)

## VII. SPECIAL ISSUES REGARDING CLAIMS

This section discusses special issues regarding particular claims, namely: 1) claims of the Federal Home Loan Bank (FHLB); 2) life and health claims; and 3) claims under large-deductible programs. As large-deductible programs involve both policy claims and the collection of amounts due under those policies, both subjects are covered in that subchapter

### A. FEDERAL HOME LOAN BANK CLAIMS

#### 1. Overview

Insurance companies are increasingly likely to be members of, and have a borrowing relationship with, one of the 12 FHLBs (each, an “FHLBank”). The FHLBanks are federally chartered cooperatives under the Federal Home Loan Bank Act (FHLBank Act), regulated by the Federal Housing Finance Agency (FHFA), and their business practices are subject to the terms and limitations of the FHLBank Act and FHFA regulations. Although each FHLBank is a separate legal entity with its own geographical territory and its own specific policies, the FHLBanks share a common mission and have similar business models.<sup>2</sup>

2. An insurance company can only be a member of the FHLBank in the district where the insurer is domiciled or where it maintains its principal place of business as defined by FHFA regulations
3. If a newly appointed receiver finds that the delinquent insurer has a relationship with an FHLBank, they should promptly determine from the insurer’s records:
  - i) The amount owed to the FHLBank.
  - ii) The interest charged on that debt.
  - iii) The payment due dates.
  - iv) The collateralization of this debt, and whether and how it is over-collateralized.
  - v) The amount of FHLBank stock held by the insurer.

Armed with this data, the receiver should establish goals for the program, including whether it is better to service the loan due to its low cost or to repay it, and whether reduction of overcollateralization or stock redemption would aid the receivership materially.

Once the goals are established, an initial friendly dialogue should be undertaken with the bank. In general, the bank’s principal concern will be avoiding default. Overcollateralization will be important to the bank in service to this first goal. If the receiver can persuade the bank that some reduction in collateral will not unduly increase default risk for the bank, the bank may be more accommodating. While prepayment may create hedging issues for the bank, avoiding prepayment is generally a secondary goal, and the bank may

<sup>2</sup> For additional information regarding the mission and purpose of the FHLBanks, visit <http://www.fhlbanks.com>.

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show greater flexibility in permitting it. Similarly, stock redemption may be permitted more freely if the bank is in sound financial condition. For the dialogue to be productive for the receiver, they should first become generally informed about the bank's condition and management structure. It will be helpful for the receiver to remind the bank that (at least as of this writing) no FHLBank has ever lost a penny due to an insurer insolvency. The receiver should strive to induce the bank to treat resolution of the insurer's financial problems as a common public policy goal in which the bank should be interested at least for the preservation of harmonious relations between the FHLB system and insurance regulators.

The Federal Home Loan Bank (FHLB) Claims Supplement that follows elaborate on these topics.

[Note: To Publishing create hyper-link in electronic version. ]

**B. LIFE/HEALTH CLAIMS**

## Overview

The processes for handling claims in life/health and P/C receiverships differ substantially due to the nature of the policies and the coverage provided by the guaranty associations. In a life/health receivership, coverage will continue for policies covered by the guaranty association to the extent provided by the state guaranty act, and a primary focus is dealing with these continuing obligations.

## Role of Guaranty Associations and the National Organization of Life and Health Guaranty Associations

In a multistate life/health insolvency where guaranty associations across the country are triggered, the guaranty associations will—to the extent of their statutory limits—guarantee, assume, or reinsure policy obligations, and in turn will be subrogated to the policyholder claims against the estate. In these situations, the NOLHGA will play a key role in the coordination of policy and financial analysis, preparation of bid packages, analysis of bids, negotiation of assumption agreements, and policyholder notification. For a description of how the NOLHGA operates, see Chapter 6—Guaranty Associations.

Other possible issues relevant to life insurance company insolvencies include notice for and court approval of assumption agreements, opt outs (by policyholders and guaranty associations), closings for transfers of obligations, early access distributions, and guaranty association coverage limits.

## Annuities

In the insolvency of an annuity insurer, special consideration should be given to any single premium immediate annuities that were issued to form the basis of funding of periodic or lump sum payments in personal injury settlements, commonly known as structured settlement annuities.

These annuities are normally issued to qualified assignment (QA) companies in order to comport with numerous IRS tax codes (primarily 104(a)(2)) and various Revenue Rulings in order to preserve the tax benefit to the beneficiary or payee. However, some older annuities (prior to 1986), although not issued to a QA company, may nonetheless enjoy the same tax benefits. Generally, periodic payments are excludable from the recipient's gross income only if the payee is not the legal or constructive owner of the annuity and does not have the current economic benefit of the sum required to purchase the periodic payments.

When these blocks of business are resolved in the insolvency context (typically through assumption reinsurance), extreme care must be taken to ensure that the resolution does not compromise the tax benefits to the payees. It is strongly recommended that competent and experienced tax counsel be retained to guide the receiver through this potentially complicated process.

Structured settlement annuities are typically issued to fund the settlement of underlying tort actions, and the amounts of these annuities tend to be fairly large, reflective of the seriousness of the injuries sustained by the

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beneficiaries. The nature of these policies should be taken into consideration when determining the appropriate notice to these beneficiaries.

#### Non-covered claims

State life and health guaranty acts provide for the continuations of certain policies covered by the guaranty association. The liquidator should determine how any portion of the policy that is not covered by the guaranty association and any non-covered claims should be handled under the state's receivership act and case law.

## **C. BEST PRACTICES FOR SUCCESSFUL BILLING AND COLLECTION OF LARGE-DEDUCTIBLE PROGRAMS IN LIQUIDATION**

### **1. Overview of Large-Deductible Workers' Compensation**

A large-deductible workers' compensation policy or program is a method of insuring workers' compensation risk with the employer assuming some of that risk in a deductible of \$100,000, \$250,000, or even higher per claim and an insurer taking on the remaining risk. Large-deductible programs for workers' compensation can be complex arrangements and depend on the employer's fulfillment of its obligation to reimburse all claims within the deductible. If the employer is unable to fulfill that obligation, the financial consequences to the employer could be catastrophic, and the employer's inability to pay could have a cascading impact on the financial health of the insurer. In order to manage this risk successfully, insurers and state insurance regulators must have a clear understanding of the nature and size of the insurer's exposure. Additionally, they must ensure that there are adequate measures in place to limit and mitigate the risk of the employer's failure to pay and ensure injured workers will receive benefits in compliance with state law.

Professional employer organizations (PEOs) often operate workers' compensation programs that are backed by large-deductible policies. A PEO is an outsourcing firm that provides services to small and medium-sized businesses under a contractual co-employment agreement with its clientele. Where permitted by state law, these services generally include workers' compensation coverage obtained by the PEO in its own name. If the PEO assumes most of the risk of that program by purchasing a large-deductible policy, it recovers the estimated cost through the fees it charges its clients. If those fees are inadequate to cover the actual costs of the claims, or the PEO fails for any other reason to reimburse its share of the claims, the insurer incurs an unexpected liability. The failure of the claim reimbursement mechanism has been a significant factor in a number of insurer insolvencies. For further information and guidance on high-deductible workers' compensation insurance and PEOs, refer to the NAIC's *2016 Workers' Compensation Large-Deductible Study*.

### **2. Administration of Large-Deductible Plans**

The administration of large-deductible plans is affected by entry of an order of liquidation. In such cases, there are three versions of applicable model legislation for states to consider. The most recent is Guideline #1980. The three model alternatives are as follows:

- (a) Section 712—Administration of Loss Reimbursement Policies of Model #555.
- (b) Guideline #1980.
- (c) The NCIGF Model.

Each of these three alternatives provide statutory guidance that articulates the respective rights and responsibilities of the various parties, greatly enhancing the ability to manage complex large-deductible programs post-liquidation. Generally, all approaches provide for the collection of large-deductible reimbursements from

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policyholders, clarify entitlement to reimbursement, and ensure that the claimants are paid. The most significant difference is the approach taken to address the ultimate ownership of and entitlement to the deductible recoveries paid by the employer or drawn from collateral as between the estate and the guaranty fund, and collateral as between the estate and the guaranty fund. Section 712 of Model #555 generally treats these funds as general assets of the estate, while Guideline #1980 and the NCIGF Model apply them directly to the payment of claims. It should be noted that the NCIGF Model has evolved over time based on additional experiences from insolvencies, and the NCIGF continues to modify its model as warranted; as a result, states that have based their laws on the NCIGF Model have done so with varying language.

### **3. Communication and Reporting Between the Liquidator, Policyholders, and Guaranty Associations, Including Administration of Self-Funded Policyholder Programs**

#### I.i.Claim Payment, Reserve, and Reimbursement Reporting

The administration of large-deductible programs requires strong communication and reporting programs between the liquidator, guaranty associations, and policyholders. Under all three model alternatives, the liquidator is required to administer large-deductible programs and related collateral securing large-deductible obligations, consistent with the policyholder's policy provisions and large-deductible agreement (LDA), except where those provisions conflict with the statute. All three model alternatives make provision for two types of LDAs: 1) those that permit direct payment by the policyholder; and 2) those that require initial payment by the insurer or guaranty association with reimbursement by the policyholder. Both arrangements necessitate the reporting of claim payments and outstanding claim reserves to the liquidator for billing, guaranty association reimbursement, and establishing collateral need requirements. The liquidator's Uniform Data Standard (UDS) should be deployed as the reporting protocol for guaranty association claim payments and outstanding claim reserves. Policyholders that continue self-payment under their LDA will need to continue or establish a claim information reporting protocol with the liquidator through the policyholder's third-party claim administrator or through a proprietary claim information aggregator. All three model alternatives require the liquidator to form an independent opinion on outstanding claim reserves reported by policyholders and guaranty associations, including an allowance for adverse development and IBNR liability to ensure that collateral remains adequate throughout the administration of the program.

#### I.iii. Agreements Between the Liquidator and Guaranty aAssociations

An agreement between the liquidator and the guaranty funds may be advisable, though it is less important in states that have enacted one of the three model alternatives or other comprehensive statutory framework for the liquidator's administration of large-deductible programs. The model alternatives can serve as an outline for the issues that should be addressed in such an agreement in states that have not enacted pertinent legislation. Among other things, an agreement should address: 1) whether large-deductible recoveries are estate assets subject to the liquidator's distribution regime or directly pass through to the guaranty association on account of its prior claim payments; 2) claim reporting protocols; 3) frequency of collateral review and reimbursement activity; and 4) administration of collateral for under collateralized non-performing policyholder accounts.

#### I.viv.Converting Policyholder Accounts From an Incurred to Paid Basis Under the Model Act.

Generally, LDAs are on a paid basis with collateral for the reserves. However, liquidators may encounter contractual arrangements where an LDA is constructed such that policyholders pay periodic large upfront payments that were accounted as premium based on losses incurred, as opposed to paid basis. After a certain number of years, the LDA provides policyholders with an opportunity to elect paid basis rather than incurred basis, which converts the incurred payments to collateral. The liquidator may wish to negotiate a conversion at the outset of liquidation. Conversion of a policyholder's LDA at liquidation from an incurred to a paid basis is beneficial to policyholders in several ways. Most importantly, conversion at liquidation treats pre-liquidation incurred loss payments made by the policyholder to the insurer as collateral and, thus, property of the policyholder pledged to the insurer and restricted to the satisfaction of that policyholder's claims, rather than as a general asset of the liquidation estate. Conversion also offers flexibility to a policyholder as to the

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type of security provided to an insurer in satisfaction of the collateral requirement. Conversion affords policyholders the ability to use an LOC to secure an insurer for the outstanding portion of their loss, rather than payment of cash, since the outstanding bill after conversion is reflected in the liquidator's collateral need analysis, rather than an incurred loss billing.

The liquidator should consider notifying large-deductible policyholders of these important policyholder rights at the inception of a liquidation proceeding and offer policyholders the opportunity to elect to convert their large-deductible programs from an incurred to paid basis memorializing any elections with an endorsement that otherwise follows and requires the policyholder to adhere to the provisions of applicable law.

iii. Large-Deductible Billing by the Liquidator

The liquidator should establish a large-deductible billing and collection program that bills policyholders on a periodic basis (e.g., quarterly). The liquidator's invoice to policyholders should communicate a claim payment summary that includes detail such as the insurer or guaranty association's check number, date of payment, payee, account year, and remaining large-deductible limits. Large-deductible programs that are paid directly by policyholders should also report their claim payments to the liquidator on a similar periodic basis so that the liquidator can establish appropriate claim reserves, track the exhaustion of the policyholder's deductible limits, report to reinsurers, and collect reinsurance. Consideration should be given to using one of many proprietary billing and collection software programs to automate the large-deductible billing and collection process. Large-deductible recoveries that are subject to guaranty association reimbursements should be aggregated and distributed on a quarterly or other periodic basis that balances the liquidator's accounting requirements and the guaranty associations' reimbursement needs.

vi. Annual cCollateral Rreview by the Liquidator

Guideline #1980 and the NCIGF Model require the liquidator to perform a periodic collateral review for each policyholder account. Consistent with the typical LDA, this review should be performed annually to ensure that the liquidator holds adequate collateral to support a policyholder's large-deductible obligations and to release any excess collateral held back to the policyholder. This review should include: a report to the policyholder on total incurred claims; claims paid; outstanding reserves, including an appropriate allowance for adverse development and claims IBNR; any additional safety factor; and total collateral need. The liquidator's collateral review should result in a report to the policyholder and an invoice for additional collateral need or a release and distribution of excess collateral. The liquidator should consider whether any additional safety factor should be included for nonperforming policyholder accounts. Guideline #1980 provides flexibility on the timing of the annual review, enabling the liquidator to perform the annual review process throughout the calendar year so that all policyholder account reviews are not due at the same time.

## 2. Administration Fees

Section 712(G) of Model #555 provides:

The receiver is entitled to recover through billings to the insured or from largedeductible policy collateral all reasonable expenses that the receiver or guaranty associations incur in fulfilling their responsibilities under this section. All such deductions or charges shall be in addition to the insured's obligation to reimburse claims and related expenses and shall not diminish the rights of claimants.

Further, Section 712(F) provides, in part:

The expenses incurred by a guaranty association in pursuing reimbursement shall not be permitted as a claim in the delinquency proceeding at any priority; however, a guaranty association may net the expenses incurred in collecting any reimbursement against that reimbursement.

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Several states have adopted statutory provisions similar to the provisions regarding handling of large deductibles in an insolvency and provide for the receiver to retain reasonable actual expenses incurred from the reimbursement to the guaranty association(s). Similarly, statutes may provide for the guaranty association to net expenses incurred in collecting a reimbursement.

Subsection (F) of Guideline #1980 provides:

- (a) The receiver is entitled to recover through billings to the insured or from collateral all reasonable expenses that the receiver incurred in fulfilling its collection obligations under this section. All such deductions or charges shall be in addition to the insured's obligation to reimburse claims and related expenses and shall not diminish the rights of claimants or guaranty associations.
- (b) To the extent the receiver cannot collect such expenses pursuant to paragraph (1), the receiver is entitled to deduct from the collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements.
- (c) To the extent such amounts are not available from reimbursements or collateral, the receiver, or guaranty associations if provided under an agreement with the receiver under Subsection D(5), shall have a claim against the estate as provided pursuant to [insert state priority of claim statute].

When there is no statutory guidance, receivers should include a provision for reimbursement of reasonable actual expenses in an agreement with the guaranty associations regarding the collection and allocation of large deductibles.

### **3.3. Policy and Collateral Definitions**

It is important that state laws define large-deductible workers' compensation policies and large-deductible collateral. Defining the treatment of such policies and associated collateral is imperative for developing policies and processes for administering the collection of assets. The following definition is taken from Guideline #1980. The definitions in the other model acts are similar. However, the term used in Model #555 is "loss reimbursement policy."

"Large-deductible policy" means any combination of one or more workers' compensation policies and endorsements, and contracts or security agreements entered into between an insured and the insurer in which the insured has agreed with the insurer to:

- (a) Pay directly the initial portion of any claim covered under the policy up to a specified dollar amount, which the insurer would otherwise be obligated to pay, or the expenses related to any claim.
- (b) Reimburse the insurer for its payment of any claim or related expenses under the policy up to the specified dollar amount of the deductible.

The term "large-deductible policy" also includes policies that contain an aggregate limit on the insured's liability for all deductible claims, a per claim deductible limit, or both. The primary purpose and distinguishing characteristic of a large-deductible policy is the shifting of a portion of the ultimate financial responsibility under the large-deductible policy to pay claims from the insurer to the insured, even though the obligation to initially pay claims may remain with the insurer, and the insurer remains liable to claimants in the event the insured fails to fulfill its payment or reimbursement obligations.

The dollar amount of "large" will vary by state law. While many states might associate a minimum financial threshold, it is more important to consider the administration of the policy compared to a traditional policy. Deductible amounts can include: claim-related payments by the insurer for medical and indemnity benefits; allocated LAEs, such as medical case management expenses; legal defense fees; and independent medical exam

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expenses. It is critical that the policy specify the claim-related payments that are the responsibility of the policyholder and not be inside agreements or other agreements outside of the policy.

Collateral held by the insurer should be defined as amounts held as security for the insured's obligations under the large-deductible policy. The policy should specify acceptable financial instruments that can be held for the large-deductible policy. Typical collateral requirements include: cash, LOCs, surety bonds, or other liquid financial means held for the benefit of the insurer.

Guideline #1980 defines "large-deductible collateral" to mean "any cash, letters of credit, surety bond, or any other form of security posted by the insured, or by a captive insurer or reinsurer, to secure the insured's obligation under the large deductible policy to pay deductible claims or to reimburse the insurer for deductible claim payments. Collateral may also secure an insured's obligation to reimburse or pay to the insurer as may be required for other secured obligations."

#### **4. Responsible Party for Collection of Large Deductible Reimbursements**

It is critical to immediately establish the party responsible for billing and collecting large-deductible payments or reimbursements. While some states might have specific statutory language that specifies the entity responsible, some statutes might be silent. In the case where the statutes do not specify responsibility, it is recommended that the receivers and guaranty associations enter into an agreement that allows for the most efficient administration of the large-deductible collections.

Specific consideration should be given to large-deductible policies that provide coverage in multiple states and have claimants subject to the jurisdiction of multiple guaranty funds. If feasible, the most efficient approach for such policies would likely be for the receiver to administer the deductible billing and collection process. Throughout the life of the estate, claimants continue to incur benefit payments and expenses, and deductible collection efforts may last beyond the life of the estate. The party responsible for collections needs the ability to compromise and settle the future obligations.

The receiver should make provisions in its discharge motion and court order, to the extent possible, regarding the transition of ongoing deductible collections to the guaranty association, as well as the disposition of any collateral being held by the receiver.

#### **5. Treatment of Collateral in Receivership**

When collateral has been posted by or on behalf of a large-deductible policyholder, what does the receivership estate actually own? The answer is generally found in the documents pledging the collateral to the insurer.

Model #555 defines "property of the estate" to include "all right, title and interest in property ... includ[ing] choses in action, contract rights, and any other interest recognized under the laws of this state."<sup>4</sup> In states without an explicit statutory definition, the common-law definition is substantially similar.

This means that the insurer's right to draw on the collateral automatically becomes an asset of the receivership estate, but the collateral itself is not an estate asset unless and until it is drawn. In the first instance, the conditions and procedures for drawing the collateral should be spelled out in the relevant contract documents (which could include third-party instruments, such as LOCs or surety bonds), but state law could provide additional rights<sup>5</sup> and will specify what the receiver may do when the documents are silent, incomplete, or missing.

<sup>4</sup> Section 104(V)(1) of Model #555.

<sup>5</sup> For example, Section 712(D) of Model #555 specifically provides that the relevant provisions of the policy are not controlling "where the loss reimbursement policy conflicts with this section."

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Possession and control over the collateral are distinct from ownership. The insurer could already be in possession of the collateral before the receivership, or the receiver might act to take possession by enforcing applicable contract rights or by negotiating an agreement. Nevertheless, this does not immediately give the receiver the right to use the collateral to pay claims. The defining characteristic of collateral is that it is intended to serve as a backstop in case the policyholder does not meet its obligations to pay all reimbursements promptly and in full. Commonly, the right to draw on collateral only attaches after the policyholder has defaulted or has consented to a draw, or, if the collateral is an LOC, after the issuer has given notice of nonrenewal (in which case, the receiver must act promptly to call the LOC or obtain replacement collateral). There could also be the opportunity to negotiate an agreement under which the policyholder turns over the collateral and makes a lump-sum payment to commute any further reimbursement obligations, or the collateral might have been structured from the outset as a “working” loss fund from which the insurer was expected to pay claims in the ordinary course of business.

In any case, while it is essential for the receiver to preserve and exercise the right to access the collateral as needed, it is also essential to ensure that collateral is not dissipated to pay claims that the policyholder should be funding. Special consideration needs to be given in situations where the policyholder is at risk of being or becoming judgment-proof, or where rights to the collateral are shared with other creditors of the policyholder and prompt action is necessary to preserve the receiver’s priority.

When the guaranty association is paying the claims, it is generally entitled to receive the proceeds of any policyholder reimbursements, including draws on the collateral. Under laws substantially similar to Model #555, these payments are considered early access distributions (but without the necessity for court approval), which may be subject to subsequent clawback, while Guideline #1980 and the NCIGF Model treat them as the ultimate source of funding for the underlying claims, so that they belong unconditionally to the guaranty association.<sup>6</sup> Either way, however, it is the receiver rather than the guaranty association that has the right and obligation to draw on the collateral,<sup>7</sup> unless there is a formal written agreement assigning that right to the guaranty association.

Finally, there is always the hope that the policyholder’s reimbursement obligations will be oversecured or will become oversecured as claims are run off. In that case, any excess collateral will revert to the policyholder or the policyholder’s guarantor. State law might expressly provide a process for determining when excess collateral is being held by or on behalf of the receiver,<sup>8</sup> or the ability to return collateral before the estate is closed might be part of the general powers of the receiver. However, because workers’ compensation is a long-tail exposure with significant risk of adverse reserve development, receivers must take great care not to make premature or excessive return distributions.

## **6. Issues Raised by Net Worth Exclusions and Deductible Exclusions**

Unlike other lines of insurance, workers’ compensation insurance is generally exempt from the statutory caps on guaranty association coverage so that the guaranty fund is usually obligated to pay workers’ compensation claims in full. However, individual states may have adopted caps on guaranty association coverage.<sup>9</sup> States have created this exception to honor their state’s promise that injured workers will be paid the full benefits to which they are entitled. The general purpose of these exclusions is to avoid any obligation for the guaranty association to pay losses that can and should be borne by the policyholder. Net worth exclusions make guaranty association protection unavailable to policyholders with net worth above a specified threshold, while deductible exclusions expressly prohibit guaranty association coverage for amounts within a policy deductible.

Unless these exclusions are drafted and implemented carefully, there is a risk that they could result in delays in claims payments or even a complete loss of coverage. In some states, claimants might be protected by an

<sup>6</sup> Compare Section 712(C)(3) of Model #555 with Section C of Guideline #1980 and Section 712(C) of the NCIGF Model.

<sup>7</sup> See Section (E)(3) of Guideline #1980 and Section 712(E)(3) of the NCIGF Model.

<sup>8</sup> See, e.g., Section (E)(4) of Guideline #1980 and Section 712(E)(5) of the NCIGF Model.

<sup>9</sup> See Section 8(A)(1)(a)(i) of the *Property and Casualty Insurance Guaranty Association Model Act*. Almost all states have some provision requiring payment in full of workers’ compensation claims, but some states might have caps or other limitations on coverage.



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uninsured employer fund, but that is not the purpose of those funds, so even if such a fund exists in your state, it should be a priority to ensure that however it is done, the estate, employer, or guaranty association will provide for payment in full of all benefits due under the state's workers' compensation laws. If this is not possible under current law, regulators should advocate for a change in the law. A variety of successful approaches are available; there is not a single one-size-fits-all solution that is best for every state.

iii. Net Worth Exclusions

The *Property and Casualty Insurance Guaranty Association Model Act* (#540) contains an optional section with a variety of alternative provisions states can select, excluding coverage for high-net-worth insureds, whether they are individuals or business entities.<sup>10</sup> The base version sets the threshold at \$50 million, while one of the alternatives sets the threshold at \$25 million. Many states have enacted some version of this clause or some comparable net worth exclusion.

The impact on workers' compensation coverage depends on how the exclusion is structured. In states with provisions substantially similar to any of the three alternatives under the Model #540, coverage is excluded completely for first-party claims by high-net-worth insureds, but workers' compensation claims against high-net-worth policyholders are administered by the guaranty association on a "pay-and-recover" basis; that is, the guaranty association has the obligation to pay the claim in the first instance and the right to be reimbursed by the policyholder.<sup>11</sup> Thus, claimants are fully protected, and for large-deductible policies, this mirrors the structure of the policy for claims within the deductible. In states with guaranty association laws similar to Guideline #1980 or the NCIGF Model, this is the same reimbursement right the guaranty association would have as the insurer's successor in the absence of the exclusion.

If the policyholder is cooperative, the guaranty association has the option of negotiating an agreement where the policyholder advances funding for claims within the deductible. However, if the policyholder is not cooperative, guaranty associations have expressed concern that the pay-and-recover framework is burdensome and gives the policyholder too much leverage to avoid or delay paying its obligations in full. If Model #540's Alternative 2 is modified to treat workers' compensation claims the same as other third-party claims, then the guaranty association has no obligation unless the formerly high-net-worth policyholder has become insolvent.<sup>12</sup> Otherwise, the claimant's only recourse is against the policyholder or the insured's estate. As stated above, the injured worker should be protected by some means in these cases.

When a guaranty association net worth exclusion and a large deductible both come in to play on the same claim, it is imperative that the receiver and guaranty association stay in close communication in order to avoid any confusion regarding which entity is responsible for the collection. In Section 712 of Model #555, Guideline #1980, and the NCIGF Model, the guaranty fund is entitled to collect net worth reimbursements. Coordination of these collections with receiver efforts to collect on high deductible will do much to avoid duplication of billings and potential resulting collection delays.

iiii. Deductible Exclusions

Model #540 does not contain any explicit deductible exclusion. Instead, it simply provides that: "In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under

<sup>10</sup> Section 13 of Model #540.

<sup>11</sup> Alternative 1 applies the pay-and-recover obligation to all third-party claims. Alternative 2 excludes most third-party claims as well as all first-party claims, but requires the guaranty association to pay workers' compensation claims, statutory automobile insurance claims, and other claims for ongoing medical payments. Alternative 3 excludes only first-party claims and claims by out-of-state claimants that are subject to a net worth exclusion in the claimant's home state. This alternative does not create any statutory right of recovery when the guaranty association is obligated to pay a third-party claim.

<sup>12</sup> Section 13(B)(2) Alternative 2 of Model #540.

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the policy or coverage from which the claim arises.”<sup>13</sup> However, some states have enacted explicit language further clarifying that there is no guaranty association coverage for amounts within a policy’s deductible or self-insured retention.<sup>14</sup> For example, Minnesota law excludes “any claims under a policy written by an insolvent insurer with a deductible or self-insured retention of \$300,000 or more, nor that portion of a claim that is within an insured’s deductible or self-insured retention” from coverage by the P/C guaranty association.<sup>15</sup>

A Minnesota employer entered into an employee leasing arrangement with a PEO, which obtained a workers’ compensation policy with a \$1 million deductible. Both the PEO and the insurer became insolvent, and the Minnesota Court of Appeals held that there was no guaranty association coverage for workers’ compensation claims against the client employer because of the statutory deductible exclusion.<sup>16</sup> The court observed that the legislature deliberately chose to protect the guaranty association from unlimited exposure, without mentioning that the legislature also deliberately created an exception making the cap on coverage inapplicable to workers’ compensation claims (which strongly suggests that the statute in question, which is tied to the statutory \$300,000 cap on coverage, was not written with workers’ compensation in mind).<sup>17</sup> Likewise, the court took for granted that the statute’s undefined term “deductible” included the contract provision at issue in the case, even though the insurer had assumed the unconditional liability to pay all claims in full. The opinion did not consider the possibility that the legislature’s intent was simply to clarify that the guaranty association has no obligation to drop down and pay claims from the first dollar if the insurer would have had no obligation to pay those claims.

Therefore, if states determine that there is a need to include express provisions addressing deductibles and self-insured retentions in their guaranty association laws, it is essential to avoid unintended consequences. In particular, the key terms should not be left undefined. For this reason, Model #555 coined the term “loss reimbursement policy” in its section addressing these types of policies to distinguish them from true deductibles, where the insurer has no obligation to pay anything except the portion of the loss that exceeds the deductible.<sup>18</sup>

This is the crucial difference between a large-deductible workers’ compensation policy and an excess policy. Although large-deductible policies transfer a significant amount of risk back to the policyholder, they do not extinguish the insurer’s liability. That is why large-deductible policies, in states that allow them, are accepted as a mechanism for satisfying the policyholder’s compulsory coverage obligations, while excess policies generally are not. Usually, excess workers’ compensation policies may only be issued to self-insurers that have been approved by the state. It is the approved self-insurance program, not the excess policy, that satisfies the employer’s compulsory coverage obligation, and the insurer has no liability for any portion of a claim that falls within the employer’s self-insured retention.<sup>19</sup> Thus, despite the terminology that is commonly used, it is the excess policy, not the large-deductible policy, that functions as a “deductible” in the traditional sense of the term.

It is worth noting, however, that commercial self-insured retention and large-deductible policies can vary widely in policy terms and sometimes “side agreements” supplement the policies. Arrangements can contain aggregate

<sup>13</sup> Section 8(A)(1)(b) of Model #540. Compare Section 3(B)(2)(a) of the *Life and Health Insurance Guaranty Association Model Act* (#520), expressly excluding from life and health guaranty association coverage: “A portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner.”

<sup>14</sup> Currently, the only states with language specifically excluding claims within policy “deductibles” are Iowa, Louisiana, Minnesota, Missouri, and Nevada. Louisiana’s exclusion applies only to policies issued to group self-insurance funds, and Missouri’s does not apply to workers’ compensation claims.

<sup>15</sup> Minn. Stat. § 60C.09(2)(4).

<sup>16</sup> *Terminal Transport v. Minnesota Ins. Guar. Ass’n*, 862 N.W.2d 487 (Minn. App. 2015), review denied June 30, 2015.

<sup>17</sup> Minn. Stat. § 60C.09(3).

<sup>18</sup> For example, if a consumer has an auto policy with a collision deductible of \$1,000, and the repair costs \$5,000, the insurer’s liability is limited to \$4,000. “Self-insured retentions” (SIRs) in commercial excess policies are designed to function the same way on a larger scale. If a business is found liable (or a third-party claim is settled) for \$500,000, and its liability policy has an SIR of \$300,000, the insurer is never responsible for more than the remaining \$200,000, even if the policyholder is bankrupt.

<sup>19</sup> In many states, a separate self-insurance guaranty fund protects claimants if a self-insured employer becomes insolvent. Those funds typically operate entirely under the state’s workers’ compensation laws, not the state’s insurance receivership or insurance guaranty fund laws.

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limits, can vary on the obligation for defense cost and expenses, and, in some cases, permit the insured to “self-fund” its claims with an account in the possession of the TPA that is handling the claims. Because of these complexities, policy terms and any related endorsements and side agreements should be carefully reviewed. Whether such side agreements are legally enforceable requires a thorough case-by-case analysis in light of applicable state laws.

*Chapter 5—Claims***Federal Home Loan Bank Claims Supplement**

This supplement will provide additional details for receivers involved in Federal Home Loan Bank (FHLB) transactions.

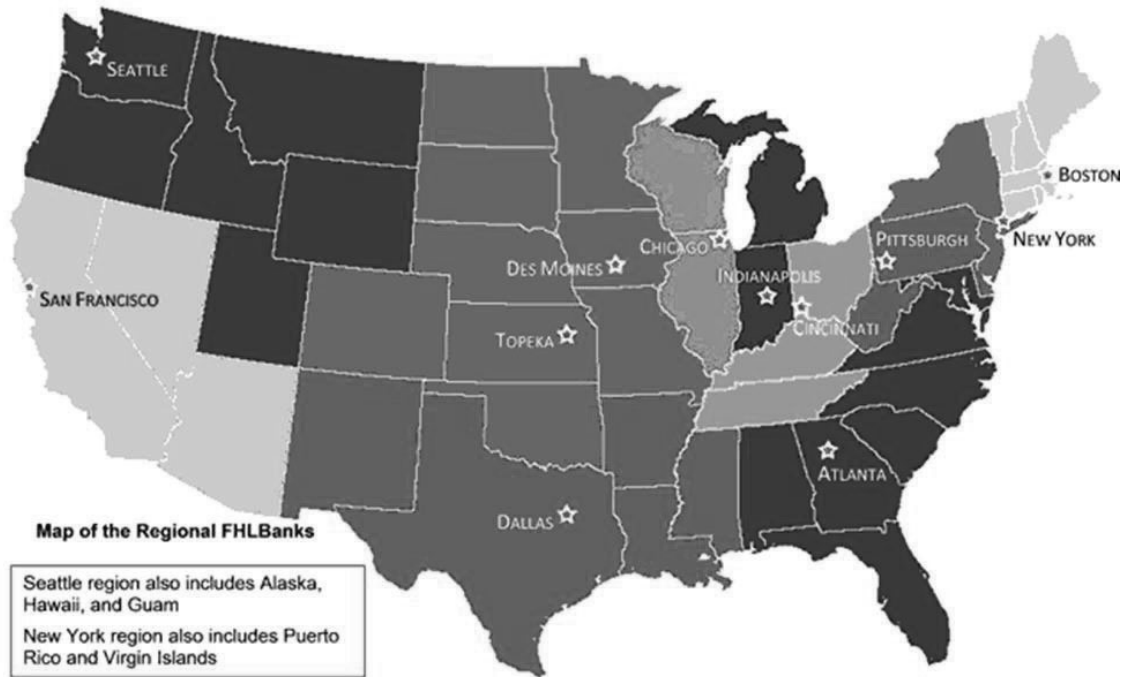
## Definitions Specific to FHLBank Transactions

The following are common terms that a receiver is likely to encounter when dealing with an FHLBank and may be more specifically defined in FHLBank documents:

- a. “Advance” means a secured loan from the FHLBank to its member in accordance with such terms and conditions as are applicable to such loan under an advances agreement, and it includes without limitation a funding agreement executed under an advances agreement.
- b. “Advances agreement” means one or more written agreements, including any written, document, policy, or procedure of the FHLBank and incorporated by reference into such written agreements between the FHLBank and its members pursuant to which the FHLBank makes or agrees to make advances and provide other extensions of credit or other benefits to the member and the member, among other things, grants to the FHLBank a security interest in certain collateral.
- c. “AHP” means the Affordable Housing Program of the FHLBank.
- d. “Assuming insurer” means an insurer that has entered into a purchase and assumption agreement with the insurance department by which the assuming insurer has agreed to assume some or all obligations of a member.
- e. “Member” means an insurer that is a member of an FHLBank. Such members will own FHLBank capital stock and may from time to time have outstanding advances or other obligations to the FHLBank, which have not been satisfied in full, or have not expired or been terminated.
- f. “Capital stock” means all capital stock of the FHLBank owned by a member. Each FHLBank has its own capital plan (which is published on the FHLBank’s website), with its own specific capital stock requirements and policies, but generally, each FHLBank requires a member to purchase membership stock (calculated annually) and activity-based stock. (The required amount fluctuates with the amount of a member’s advances or other obligations outstanding.) By statute, capital stock is collateral for a member’s obligations to the FHLBank.
- g. “Collateral” means all property—real, personal, and mixed—in which either a member or an affiliate of the member has granted a security interest to the FHLBank, or the FHLBank has otherwise acquired a security interest. Each FHLBank has its own policies regarding collateral that the FHLBank will accept to secure advances and other obligations, the minimum amount of collateral required, and how the value of such collateral is calculated for purposes of pledging to the FHLBank.
- h. “Obligations” are any and all indebtedness, obligations, and liabilities of the member to the FHLBank pursuant to the terms and conditions of the advance agreement or any other agreement between the member and the FHLBank, subject to applicable law.

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<b>FHLBank</b>	<b>Title/Department</b>	<b>Phone</b>
FHLBank Atlanta	Member Support Operations	mergers@fhlbatl.com
FHLBank Boston	Director of Credit	617-292-9705
FHLBank Chicago	General Counsel	312-565-5805
FHLBank Cincinnati	Vice President, Credit Risk Management	513-852-7525
FHLBank Dallas	Chief Banking Operations Officer	214-441-8546
FHLBank Des Moines	VP/Credit Risk Officer	515-281-1054
FHLBank Indianapolis	Chief Credit and Marketing Officer	317-465-0459
FHLBank New York	General Counsel	212-441-6822
FHLBank Pittsburgh	Chief Credit Officer	412-288-3425
FHLBank San Francisco	Chief Credit Officer	415-616-1000
FHLBank Seattle	Chief Counsel	206-340-2300
FHLBank Topeka	Chief Credit Officer	785-438-6055

**3. Coordination of Efforts With an FHLBank**

When an insurer that is a member of the FHLBank system is placed in receivership, the receiver must address a number of issues. There is no prescribed order of steps for managing the insurer’s obligations to an FHLBank. The following may facilitate the process:

1. Gain an Understanding of the History and the Current Status of the FHLBank Program<sup>20</sup>

<sup>20</sup> The guidance in Sections B.1, B.8, B.9, and B.10 are intended only to offer practical suggestions for managing the relationship between the receiver and the FHLBank based on the experience of the Shenandoah Life Insurance Company in receivership, related discussions, and circumstances as existed generally at the time of this writing. It is important to note that

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It is imperative that the receiver understand fully the history and components of the program. Important aspects of this basic information include:

a. Contacts

Who are the individuals at the bank (including outside counsel and advisors) who manage the bank's role with the insurer, and how can they be reached, especially if contact on short notice becomes necessary. Similarly, who will be "point" for the receiver in managing the ongoing relationship? Providing the bank with a contact person upon inception of delinquency proceedings will temper the possibility that the bank will take summary protective action for lack of information.

b. Complete Documentation

The receiver should strive to obtain and review carefully all of the documents governing the relationship, including the initial documents establishing the relationship and those related to subsequent advances and repayments.

c. Inception Date and Terms

The terms on which the relationship was established are likely to govern all subsequent advances and repayments. Not only is the formal agreement important, but so are emails and other communications that may provide a more complete understanding of the parties' actual expectations and concerns. Whether or not legally sufficient to alter the formal agreement, course of conduct may be critical guidance on how transactions actually were to be conducted.

d. History of Advances and Repayments

The relationship may have been in place for years and involved a number of advances and repayments. It is important that the receiver gain a thorough understanding of this history to determine whether certain remedial steps (such as stock redemption or release of excess collateral) are indicated immediately.

e. History of Collateral

For similar and other reasons, the collateral requirements upon which the parties agreed when the relationship was established and with each subsequent advance, and how the posting and release of that collateral has evolved over time, are important factors in understanding what company assets are properly hypothecated or pledged to the FHLBank (and, therefore, unavailable to pay other claims or expenses), and which assets may be so identified on the company's records but may in fact be eligible for release from such FHLBank claims. Note that the agreement(s) with the FHLBank may require that the insurer post collateral of a stated value in excess of outstanding advances and may also prescribe a reduction in the value assigned to that collateral (the "haircut"), with the combined effect of leaving the bank over-collateralized. It may be possible to negotiate some relief from the over-collateralization of outstanding advances. Note also that the use of proceeds from advances and posting of collateral from other invested assets of the insurer may create or exacerbate asset-liability mismatches. For example, using previously acquired longer duration, high-grade assets as collateral but using the advance proceeds to acquire shorter duration and/or lower-grade (higher potential yield) investments may result in an

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every situation has its own characteristics and circumstances and that the relationship between one insurer and one FHLBank is likely to differ materially from any other such relationship. Further, no effort is made in this guidance to explore the legal or policy bases for the parties' rights and liabilities, nor to evaluate suggested legislative or regulatory improvements.

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imbalance between the duration of existing liabilities and newly acquired investments intended to fund them.

f. History of Acquisition and Redemption or Disposition of Bank Stock

As a condition of becoming a member of the FHLBank system, and therefore eligible for advances, the insurer will likely have been required to purchase a certain amount of “membership” stock in the FHLBank. There is typically no independent market on which that stock can be sold, and the only way in which the insurer can dispose of it is to sell it back to the FHLBank on redemption terms established by the parties’ agreement. Normally, the agreement requires that the insurer retain the membership stock so long as the agreement remains in place and advances remain outstanding. But redemption by the bank of membership stock may be subject to its discretion informed by the bank’s own liquidity and financial condition. As a result, an insurer may be required to retain membership stock for which there is no market and which has no liquidity long after repaying all advances in full.

Further, with each advance, the insurer may have been required to purchase additional bank stock as “activity stock,” typically in quantities constituting a small percentage of each advance. As with “membership” stock, there is no independent market on which activity stock can be sold, and the only way in which the insurer can dispose of it is to sell it back to the FHLBank on redemption terms established by the FHLBank’s capital plan and the parties’ agreement. The agreements or explicit terms and conditions of the stock may give the FHLBank discretion to postpone the redemption of membership and activity stock.

Because the stock is illiquid and, therefore, of little value to the receiver in managing the rehabilitation or liquidation, exploring prompt redemption of outstanding stock may be prudent.

g. Investment of Advances

It is important to determine whether the collateral obligations created by advances have resulted in the hypothecation of other assets of the insurer in a way that may have resulted in asset-liability mismatches and potential liquidity problems. It is not unusual to find a disproportionate share of the insurer’s high-grade, liquid assets pledged as collateral for advances, the proceeds of which were instead invested to potentially create beneficial leverage or interest rate arbitrage. Over time, and with deteriorating conditions in the capital market, this can create serious challenges for the receiver. The potential substitution of collateral should be explored with the FHLBank to ameliorate these challenges. However, an FHLBank is limited by regulation on the types of collateral it may accept.

h. Performance in Relation to Repayment Obligations

By design, the FHLBank program is structured so that the FHLBank does not take on much risk in connection with advances to members, including insurers. The pricing (interest rates charged) for the advances do not typically contemplate material risk of default, and collateral requirements are intended to all but eliminate such risk. The receiver should familiarize themselves with the history of the relationship to determine whether there are outstanding concerns for the bank that should be addressed promptly so that the bank does not feel compelled to exercise its rights to the collateral in a manner that might prove disruptive to the receivership. Outstanding defaults or near-defaults should be identified and remedied to preserve the collateral.

i. Current Balance of Advances

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Obviously, the amount of outstanding advances and resulting repayment obligations must be understood well by the receiver, particularly in relation to collateral pledges. The records of troubled insurers may not be sufficiently complete or accurate to allow for proper monitoring of these outstanding balances, and efforts should be made to reconcile the insurer's records to those of the bank.

j. Repayment Due Dates and Segregated Cash Account Balance

Advances are made with specific repayment obligations. These obligations will address both interest and principal payment obligations, with specific dates established for both. It is common for segregated-cash-account requirements to be imposed from which the bank can draw some or all of these payments. The receiver needs to identify how much cash the insurer is required to maintain in specified accounts by the agreement(s) and the dates and amounts of required interest and principal payments. Plans should be made to assure liquidity and the ability to comply with these requirements or to make other payment arrangements. If forbearance or accommodations become necessary or desirable, those should be negotiated promptly, if the bank has the ability to provide them.

k. Excess Cash

If the insurer finds itself with more cash than required in the specified account(s), discussions should be undertaken with the FHLBank. Ideally, the receiver and the bank will agree that excess cash will automatically be redirected to the insurer's general account. However, if the bank is unwilling to permit the receiver to withdraw cash from the account to which the bank has no contractual claim, it may be necessary to resort to the receiver's right to seek a court order mandating the release of excess cash collateral.

l. Prepayment Fees

Typically, the agreements discourage early repayment of advances because such repayments may be inconsistent with hedges and other arrangements made by the bank in connection with the advances to the insurer. Prepayment may, therefore, trigger prepayment charges or fees owed by the insurer. However, the bank's need to charge those prepayment fees may be reduced or eliminated by changing circumstances affecting the hedges or other arrangements made by the bank. The receiver should, therefore, consider whether prepayment may be advantageous (e.g., because of associated collateral release or stock redemption). If prepayment would be helpful to the receiver's strategy, discussions with the bank should ensue to determine the most optimal prepayment timing that will result in the lowest applicable prepayment fees.

m. Cash Required

As noted, the agreements typically require the insurer to maintain specified liquidity, likely in segregated accounts at the bank, for the protection of the bank. The receiver will need to address these requirements.

2. Notice of Receivership to the FHLBank

a. Notify FHLBank of Receivership

Immediately following the establishment of the receivership, the receiver should contact the FHLBank (see initial FHLBank contact information above) to inform the FHLBank that the insurer has been placed into receivership.

b. Identify Authorized Individuals



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The receiver should forward electronically to the FHLBank all legal agreements, court orders, and/or notices that evidence the appointment of the receiver and a delegation of authority designating individuals authorized to transact business on behalf of the receiver in a mutually satisfactory form. To protect the receiver, the FHLBank may place the account of the member “on hold,” prohibiting any additional member/receiver-initiated activity until the required agreements and authority delegations are received.

c. Schedule Initial Conference Call or Meeting

The receiver and the FHLBank should schedule a mutually convenient time to meet via conference call following the establishment of receivership.

3. Considerations for the Initial conference Call or Meeting with the FHLBank

a. Identify Contact Person(s)

The FHLBank, the receiver, and the assuming insurer, if applicable, should each identify their primary contact person(s) and business activity coordinator(s). The receiver should also provide to the FHLBank a key point person(s) who will remain involved with the disposition of all residual issues pertaining to the receivership through completion.

b. Identify Outstanding Obligations, Pledged Collateral, and Capital Stock

During the initial conference call meeting, the receiver should request that the FHLBank identify all outstanding advances and any other outstanding obligations of the member, including AHP subsidy exposures, LOCs, and correspondent services exposures. Furthermore, the receiver should request that the FHLBank provide information regarding the amount and nature of collateral pledged, the balance of any member cash accounts or safekeeping accounts, and the member's capital stock.

c. Establish Receivership Timeline

During or prior to the initial conference call meeting, the receiver should inform the FHLBank of the planned receivership timeline and the identity of any other parties involved in the receivership process.

d. Discuss Payment of Obligations and Collateral Releases

The FHLBank will need to know what the receiver's intentions are with respect to the obligations and if it desires to retain continued correspondent services activities during the receivership. Depending on the facts and circumstances, and subject to renegotiation with the receiver, the FHLBank may allow the receiver to:

- Level the obligations outstanding in accordance with their existing terms and conditions, including scheduled interest and principal payment dates and collateral requirements.
- Prepay the obligations, subject to FHLBank policies and procedures regarding prepayments.
- Transfer the obligations to an assuming insurer acceptable to all parties.

The receiver should request that the FHLBank discuss the process and timing for release of any collateral once all or any part of the outstanding obligations have been satisfied, assumed, or secured with other collateral. If a court-ordered or statutory stay is in effect, the receiver and the

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FHLBank may need to execute an agreement detailing the agreed-upon payment of obligations and treatment of collateral.

e. Prepayments

If the receiver wants to pay down advances prior to the scheduled maturity date, the receiver should contact the FHLBank and request that the FHLBank calculate an estimation of the final payment due as of that agreed-upon prepayment date. The requested estimation should include outstanding principal, accrued interest up to the date of prepayment, and applicable prepayment/settlement fees.

f. Assuming Insurer

If the obligations of the member are expected to be transferred to an assuming insurer, such transfer is subject to the approval of the receiver, the FHLBank, and the receivership court. If approved, the FHLBank likely will require that the assuming insurer execute <sup>21</sup>an assumption agreement, and such agreement will stipulate that the assuming insurer is responsible for the timely payment of assumed obligations, direct or contingent, in accordance with the terms and conditions of the advances agreement and any other agreements in effect between the member and the FHLBank.

g. Summary of Call

Following the initial conference call, the receiver should request that the FHLBank provide a detailed closing statement for the receiver along with a summary of other matters discussed and agreed upon during the call. The summary of the call could provide the framework for the development of a memorandum of understanding between the parties.

4. Disposition of Obligations

The FHLBank will expect payment from the receiver in the event obligations are outstanding unless the obligations have been purchased by or assigned to an acceptable assuming insurer.

With the approval of the receiver, FHLBank, and the receivership court, the obligations may be transferred to an assuming insurer through the execution of an assumption agreement that will be provided by the FHLBank. Such obligations will be required to be collateralized in a manner acceptable to the FHLBank prior to any release of collateral pledged by the failed member. Such collateral requirements may differ from the requirements the assuming insurer may be accustomed to if it is a member of another FHLB.

Obligations that the receiver has decided not to resolve immediately will need to remain collateralized in accordance with the advances agreement.

5. Release of Collateral

(Assuming all member obligations have either been satisfied or assumed and fully collateralized by the assignee)

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<sup>21</sup> If the assumption is consummated during a receivership proceeding, then the receivership court would have to approve the transaction, and if the assuming insurer is a U.S. insurer, then the domiciliary insurance department would also have to approve the transaction.

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If mortgages have been listed and/or delivered to the FHLBank or to a third-party custodian, the FHLBank will initiate the delivery of those mortgages to the receiver or the receiver's designee in a timely manner, and the FHLBank will file a UCC-3 termination statement<sup>22</sup> upon request.

If cash or securities have been pledged by the member, the FHLBank's interest in those assets will be promptly released, and the assets will be delivered to the receiver or receiver's designee based on instructions provided.

Partial payment of obligations may allow for partial release of collateral in accordance with the FHLBank's collateral release practices.

#### 6. Capital Stock

Typically, capital stock holdings of the member may be retained by the receiver or transferred to an assuming insurer, if such assuming insurer is a current member of the FHLBank. If the assuming insurer is not a member of the FHLBank, then the capital stock may be repurchased if permissible under applicable laws, regulations, regulatory obligations, and the FHLBank's capital plan and the proceeds of the capital stock transferred to the assuming insurer or receiver as long as the proceeds of the capital stock are not required to be retained by the FHLBank as collateral or as capital required against remaining outstanding business activity, in accordance with the FHLBank's policies, procedures, or practices.

Treatment of capital stock and any payment of dividends are subject to the provisions and restrictions set forth under applicable laws, regulations, regulatory obligations, and the FHLBank's capital plan.

#### 7. Other Matters

If the member was a participant in other FHLBank programs such as AHP or LOCs, collateral will be required to support all obligations that continue to exist past the life of the member. The receiver should request that the FHLBank provide a detailed account of all other programs in which the member participated and the term of exposure and the amount and type of collateral required.

The receiver and the FHLBank should determine an appropriate frequency of follow-up correspondence throughout the receivership process.

#### 8. Areas of Possible Agreement

The receiver seeks to maximize the value of the estate and to protect policyholders, claimants, and beneficiaries of the insurer. To this end, the receiver takes all appropriate steps to marshal and preserve assets for distribution in a liquidation or to facilitate rehabilitation or other resolution of the impaired or insolvent insurer. Apart from maximizing the value of the estate, liquidity is important to both the ongoing operation of the estate and more timely distributions. While more formal means to accomplish the purposes of the receivership are always available and should be pursued if necessary, money and other resources ought not to be devoted to that pursuit unless good faith attempts to reach consensual resolution with the FHLBank have failed. In particular, receivers may seek agreement with the FHLBank in the following areas:

##### a. Release of Excess Cash

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<sup>22</sup> When a secured lender obtains a lien on collateral pledged to it, the lender files a UCC-1 so that there is a public record putting other creditors on notice of the lien. A UCC-3 is a termination statement filed by a secured lender to update the UCC record to reflect the lien has been released.

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As noted, the history of the relationship may have resulted in the insurer porting more cash than required by the agreement in accounts accessible solely by the bank and unavailable to the receiver for other purposes. Release of this excess cash to the general assets of the receivership should be pursued promptly.

## b. Release of Excess Collateral

Over time, the insurer may have caused more collateral to be pledged to the bank than is required by the agreements (e.g., because repayments may not have resulted in full release of the associated collateral or because of the appreciation of the collateral). In addition, because of the deteriorating condition of the insurer, the bank may have had the right to require that the insurer post additional collateral (sometimes as much 25% over the amount of outstanding advances). It may be possible to convince the bank to release some of this excess collateral so that it can be used for other receivership purposes. This is particularly true if the bank can be assured that reducing collateral will not unduly endanger the probability for full repayment when due.

## c. Reduction of Haircut and Excess Collateral Requirements

If the formula for determining excess collateral and haircuts applied to collateral values no longer reflect economic reality, the receiver should work with the FHLBank to recalculate these in the light of current conditions, again resulting in the release of some collateral.

## d. Repurchase of Excess Stock

Over time, the insurer may have accumulated more bank stock, especially activity stock, than is required by outstanding advances (i.e., excess stock) because, for example, the bank may have been slow in repurchasing stock following repayment of advances. Although the bank cannot be required to redeem excess stock upon demand by the receiver, except after expiration of a redemption period (typically five years), if the bank's financial condition is not an issue, and barring any statutory or regulatory prohibition, the receiver might seek waiver of the redemption period in order to negotiate the repurchase of excess stock, converting it into liquid assets available for receivership purposes.

9. Managing the Relationship<sup>23</sup>

Apart from seeking accommodations, the receiver should manage the ongoing relationship.

## a. Evaluate Prepayment

The receivership should consider when it would be optimal to repay outstanding advances and plan accordingly in cooperation with the bank.

## b. Evaluate Need for Extensions

It may be necessary or appropriate to renegotiate the repayment schedule with the bank and to evaluate the cost of doing so.

## c. Evaluate Substitution of Collateral

Due to asset liability matching considerations or for other reasons, it may be helpful to explore the possibility of substituting collateral posted against outstanding advances.

## d. Determine Desirability of Maintaining the FHLBank Program

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<sup>23</sup> See Footnote 3.

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The FHLBank program typically provides the insurer a facility for financing or access to liquidity on desirable terms. The receiver should consider whether continuation of the program may play a useful role in rehabilitation or liquidation plans. If sale of the company is being considered, preservation of the program may add value to potential buyers, making the insurer that much more attractive.

e. Develop an Exit Strategy if Desirable

Conversely, the receiver may conclude that terminating the FHLBank program is the best option. In that case, a thoughtful program for concluding the relationship in cooperation with the bank should be developed and implemented.

10. Share Experience with the NAIC<sup>24</sup>

In any case, because this is a relatively new development in the world of insurance receiverships, sharing the receiver's experience with the NAIC and other receivers is indicated provided that appropriate confidentiality can be maintained under applicable law. Developing a body of knowledge will facilitate the management of these programs by banks and receivers involved in subsequent cases.

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<sup>24</sup> See Footnote 3.



## Solvency Regulation and The Resolution System: 2023 Tabletop Exercise

### Background

NOLHGA and NCIGF propose holding a “tabletop” session on how commissioners, solvency regulators, receivership staff, and the guaranty system can produce the best outcomes for policyholders of troubled insurance companies, and how early and frequent planning and collaboration can best support insurance commissioners in achieving those outcomes. The session will be designed to:

- Promote communication among regulators, receivers, and guaranty system members about the regulatory and resolution systems and how they can best work together
- Identify key questions/issues for further research, process improvements, and regulatory development
- Determine areas for enhanced coordination and planning among regulators, receivers, and the guaranty system to improve policyholder outcomes

### Overview

- The session would be a partial day event (3-5 hours), potentially connected to an NAIC meeting, conference, or training platform.
- A series of interactive panel discussions and breakout sessions would be built around a hypothetical troubled company scenario. Issues to consider include:
  - Early-stage decision making, communication, and information sharing
  - Transitions from oversight to rehabilitation to liquidation
  - Policyholder protection and communication
  - Guaranty system information, data, planning, and execution on consumer protection
  - Receivership court proceedings, other litigation, and third-party involvement/interest
  - Receivership execution

### Participants

- State Insurance Commissioners
- Senior financial regulators and other insurance department personnel
- Receivership leaders (including RITF and its working groups)
- Guaranty system representatives

### Planning

- In 2022, NOLHGA and NCIGF each held similar tabletop exercises (and received very positive feedback from participants). Using those as a starting point, we could support a “turnkey” session that would minimize demands on NAIC staff time.
- Because the Receiver’s Handbook Subgroup has been identifying resolution issues for updated analysis over the last year, the subgroup’s input on designing and executing on the session may be particularly valuable.
- Since an effective session will require coordination with solvency regulators, we suggest early-stage collaboration with FAWG to get input and participation.
- Holding the session around an existing NAIC meeting could increase attendance from stakeholders. We suggest a session in 2023, but adequate notice will be important in securing attendance.
- If successful, similar sessions could be conducted in future years to reach a broader audience and/or cover additional topics.

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**REINSURANCE (E) TASK FORCE**

Reinsurance (E) Task Force March 6, 2023, Minutes ..... 9-675  
Implementation of the *Term and Universal Life Insurance Reserve Financing Model Regulation*  
(#787); Status as of Feb. 22, 2023 (Attachment One) ..... 9-677

Draft: 3/11/22

Reinsurance (E) Task Force  
Virtual Meeting (*in lieu of meeting at the 2023 Spring National Meeting*)  
March 6, 2023

The Reinsurance (E) Task Force met March 6, 2023. The following Task Force members participated: Chlora Lindley-Myers, Chair, represented by John Rehagen (MO); Adrienne A. Harris, Vice Chair, represented by John Finston (NY); Mark Fowler (AL); Alan McClain represented by Chris Erwin (AR); Ricardo Lara represented by Monica Macaluso (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Wanchin Chou (CT); Michael Yaworsky represented by Virginia Christy (FL); John F. King represented by Martin Sullivan (GA); Doug Ommen represented by Kim Cross (IA); Amy L. Beard represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark and Vicki Lloyd (KY); James J. Donelon represented by Stewart Guerin (LA); Gary D. Anderson represented by Christopher Joyce (MA); Timothy N. Schott represented by Robert Wake (ME); Grace Arnold represented by Ben Slutsker (MN); Mike Causey represented by Jan Andrews (NC); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Lindsay Crawford (NE); Chris Nicolopoulos represented by Doug Bartlett (NH); Marlene Caride represented by David Wolf and John Tirado (NJ); Jennifer Catechis represented by Patrick Zeller (NM); Judith L. French represented by Dale Bruggeman (OH); Glen Mulready represented by Eli Snowbarger (OK); Elizabeth Kelleher Dwyer represented by John Tudino (RI); Michael Wise represented by Tom Baldwin (SC); Cassie Brown represented by Mike Arendall (TX); Jon Pike represented by Jake Garn (UT); Scott A. White represented by David Smith and Doug Stolte (VA); and Nathan Houdek represented by Mark McNabb (WI).

1. Adopted its 2022 Fall National Meeting Minutes

Eft made a motion, seconded by Crawford, to adopt the Task Force's Nov. 17, 2022, minutes (*see NAIC Proceedings – Fall 2022, Reinsurance (E) Task Force*). The motion passed unanimously.

2. Adopted the Report of the Reinsurance Financial Analysis (E) Working Group

Kaumann stated that the Working Group meets in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings. He stated that the Working Group met Jan. 31, 2023; Dec. 19, 2022; and Nov. 22, 2022; to approve several certified and reciprocal jurisdiction reinsurers for passporting. He noted that the Working Group will meet several more times during 2023.

Kaumann stated that the Working Group has now approved 55 reciprocal jurisdiction reinsurers and 41 certified reinsurers for passporting, and that 39 states have passported a reciprocal jurisdiction reinsurer. He noted that the list of passported reinsurers can be found on the Certified and Reciprocal Jurisdiction Reinsurer web page.

Kaumann made a motion, seconded by Wolf, to adopt the Working Group's report. The motion passed unanimously.

Rehagen stated that as part of the adoption of *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53), the Valuation Analysis (E) Working Group was directed to assist in the targeted review of asset adequacy analysis related to modeling of business supported with projected high net yield assets. He noted that this work will involve reviewing reinsurance and that the work is only in the early stages.



3. Received a Status Report on the Reinsurance Activities of the Mutual Recognition of Jurisdictions (E) Working Group

Wake stated that the Working Group met Nov. 7, 2022, to reapprove the status of Bermuda, France, Germany, Ireland, Japan, Switzerland, and the United Kingdom (UK) as qualified jurisdictions and to reapprove Bermuda, Japan, and Switzerland as reciprocal jurisdictions. He noted that this process will be completed again during fall of 2023. Wake noted that on Feb. 24, the Bermuda Monetary Authority (BMA) issued a consultation paper on planned enhancements to their regulatory process and that NAIC staff provided this document to the Working Group and the Task Force. He stated that the document has not yet been fully reviewed but that any changes to the BMA's regulatory practices will be evaluated during the annual re-review of their status as a qualified and reciprocal jurisdiction.

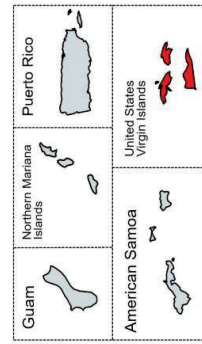
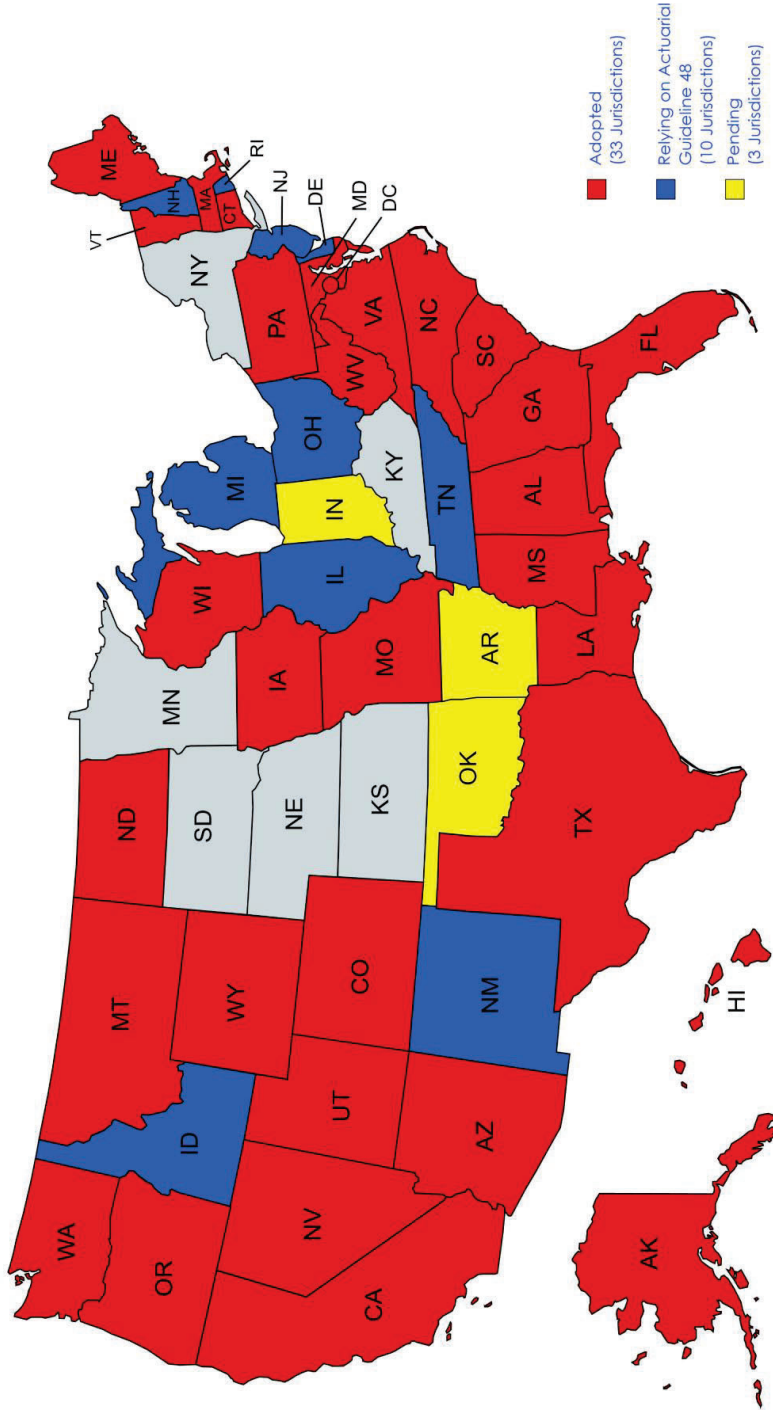
4. Received a Status Report on the States' Implementation of Model #787

Jake Stultz (NAIC) stated that the *Term and Universal Life Insurance Reserve Financing Model Regulation (#787)* became an accreditation standard on Sept. 1, 2022, with enforcement beginning on Jan. 1. He noted that as of Feb. 22, 33 jurisdictions have adopted Model #787, with another three jurisdictions with action under consideration. He noted that Model #787 mirrors *Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48)* and that under the accreditation standards, a state may meet the requirements through an administrative practice, such as an actuarial guideline. He stated that 11 states have advised NAIC staff that they will rely on AG 48, either through an insurance bulletin or through simple adoption of the NAIC's *Accounting Practices and Procedures Manual (AP&P Manual)*. He added that if a state adopts Model #787, it also will need to adopt Section 5B(4) of the *Credit for Reinsurance Model Law (#785)*. He stated that the map showing the current adoption status for Model #787 was included in the meeting materials (Attachment One).

Having no further business, the Reinsurance (E) Task Force adjourned.

NAICSupportStaffHub/Member Meetings/E CMTE/RTF/2023SpringNM/Meeting/Minutes/0 ReinsuranceTFmin 03.06.2023.docx

Implementation of Model #787 (XXX/AXXX)  
Term and Universal Life Insurance Reserve Financing Model Regulation  
[status as of February 22, 2023]



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Disclaimer: This map represents state action or pending state action regarding NAIC amendments to the model(s). This map does not reflect a determination as to whether the pending or enacted legislation contains all elements of NAIC amendments to the model(s) or whether a state meets any applicable accreditation standards.

**RISK RETENTION GROUP (E) TASK FORCE**

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

## VALUATION OF SECURITIES (E) TASK FORCE

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Draft: 4/10/23

Valuation of Securities (E) Task Force  
Louisville, Kentucky  
March 23, 2023

The Valuation of Securities (E) Task Force met in Louisville, KY, March 23, 2023. The following Task Force members participated: Doug Ommen, Chair, represented by Carrie Mears (IA); Eric Dunning, Vice Chair, represented by Lindsay Crawford (NE); Mark Fowler represented by Sheila Travis (AL); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kenneth Cotrone (CT); Michael Yaworsky represented by Carolyn Morgan (FL); Dean L. Cameron represented by Eric Fletcher (ID); Dana Popish Severinghaus represented by Vincent Tsang (IL); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Stewart Guerin (LA); Gary D. Anderson represented by John Turchi (MA); Kathleen A. Birrane represented by Matt Kozak (MD); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by Debbie Doggett (MO); Jon Godfread represented by Matt Fischer (ND); Marlene Caride represented by John Sirovetz (NJ); Adrienne A. Harris represented by Jim Everett (NY); Glen Mulready represented by Eli Snowbarger (OK); Carter Lawrence represented by Trey Hancock (TN); Cassie Brown represented by Jamie Walker (TX); Jon Pike represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA); Mike Kreidler represented by Tim Hays (WA); and Nathan Houdek represented by Amy Malm (WI). Also participating was: Philip Barlow (DC).

1. Adopted its Feb. 21, 2023, and 2022 Fall National Meeting Minutes

Mears said the Task Force met Feb. 21 and took the following action: 1) adopted a *Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual)* amendment to update references to 5GI; 2) adopted a P&P Manual amendment to add instructions for the financial modeling of collateralized loan obligations (CLOs); and 3) discussed a Structured Securities Group (SSG) memorandum on a proposed CLO modeling methodology (excluding scenarios and probabilities).

Kozak made a motion, seconded by Crawford, to adopt the Task Force's Feb. 21, 2023 (Attachment One) and Dec. 14, 2022 (see *NAIC Proceedings – Fall 2022, Valuation of Securities (E) Task Force*) minutes. The motion passed unanimously.

2. Received a Report on the Projects of the RBC Investment Risk and Evaluation (E) Working Group

Mears said the next item is to hear a report on projects before the Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group. Barlow, chair of the Working Group, provided the update.

Barlow said the Working Group met and had a very good discussion on the two main projects that are before the Working Group. The first is the long-term CLO RBC project. An update was received from the American Academy of Actuaries (Academy). The Academy continues to make good progress, and it is working to develop a modeling structure for how CLOs might be modeled for RBC purposes. This is only laying out a framework and not actually creating a model yet. This will help the Academy as it moves forward. It will continue to communicate around the modeling with the SSG, so if modeling is the way to go, the Working Group could build off the work that Eric Kolchinsky's (NAIC) team is doing on modeling. The Academy discussed how to address RBC arbitrage in the CLOs. It was decided that there is no common definition of what is meant by that. The Academy is working to develop a definition of what it means for there to be arbitrage in the RBC calculation, and it will present that to the Working Group.

The other item on the agenda is the interim solution for residual tranches. The Working Group will expose an updated structural change that includes the proposal from the Task Force, except with one bucket for the residual

tranches as opposed to the three that were originally proposed. The Working Group will move ahead with the structural change and debate other aspects of the need for an interim solution. There will be a meeting that will include the Working Group, the Task Force, and the Statutory Accounting Principles (E) Working Group to look at the actual results of the annual statement filings to see where that data is. Another meeting will be scheduled to focus on the discussion of the interim proposal.

### 3. Discussed an Amendment to the P&P Manual to Add Instructions for Structured Equity and Funds

Mears said the next item on the agenda is to receive and discuss comments on a proposed P&P Manual amendment to add instructions for Structured Equity and Funds. This amendment was first discussed at the 2022 Fall National Meeting and exposed for a 60-day public comment period that ended Feb. 13. Three comment letters were received. One was a joint letter from the American Council of Life Insurers (ACLI), the Private Placements Investors Association (PPIA), and the North American Securities Valuation Association (NASVA); the second was from Varagon Capital Partners; and the third was from PineBridge Investments.

Mark Perlman (NAIC) said as mentioned in the Securities Valuation Office's (SVO's) memorandum and at the 2022 Fall National Meeting, Structured Equity and Funds, sometimes called "rated notes" or "feeder funds," are investments that, with the insertion of an intervening entity, such as a special purpose vehicle (SPV) or limited partnership, permit underlying assets that alone may not qualify as "bonds" or be eligible to receive an NAIC Designation under the current regulatory guidance to be reported as "bonds." This regulatory transformation is enabled because the intervening entity issues notes, and those notes receive a credit rating provider (CRP) rating. Typically, the notes are backed by equity or fund investments, some of which may have underlying bonds or loans, but the structure could just as easily be backed by any asset, including those of affiliates, non-admissible assets, real estate, mortgage loans, unrated loans, or an asset type that is ineligible to be assigned an NAIC Designation or use CRP ratings. It is possible that many of the transactions the SVO has mechanically processed as private ratings would qualify as bonds eligible for Schedule D-1 reporting according to the proposed principles-based bond definition, while others would likely not qualify.

The comment letters submitted by interested parties affirmed the SVO's primary regulatory concern. Investments in Structured Equity and Funds are oftentimes circumventing the NAIC's regulatory reporting, statutory accounting, investment risk assessment, and RBC guidance. It was noted in the comment letters that this structure was developed to be "anti-arbitrage," meaning it is intended "... to allow insurance companies to access funds with a capital charge that puts insurance company investors on a level playing field with pension funds, banks, and other non-insurance investors." In other words, the structure is intended to put insurers on a level playing field with entities subject to different regulatory regimes. The creation of investment structures for the purpose of attaining better reporting and capital treatment under the NAIC's guidance should be strongly discouraged. As communicated in the SVO's memorandum, such actions have the potential to undermine the NAIC's regulatory framework. The SVO is aware of at least one insurer using this general structure to transfer CLO Combo Notes, a type of principal protected security (PPS), an asset type expressly made ineligible for filing exemption (FE) by the P&P Manual, into an SPV that issued "rated notes" backed by those CLO Combo Notes.

Charles Therriault (NAIC) said the SVO is very sympathetic that non-life insurers do not get the RBC benefit afforded to life insurers investing in private funds with an SVO-assigned NAIC Designation, and a fund investment can be more operationally efficient, particularly for small insurers, than owning the underlying investments directly. However, if insurers do not like how an asset is treated within NAIC guidance for RBC or investment classification purposes, they should address that treatment with the appropriate regulatory group instead of creating alternate investment structures.

This amendment does not seek to alter the accounting treatment or classification for these investments, and it does not seek to set an RBC factor for them; those are the responsibilities of other NAIC regulatory groups.

However, the SVO is recommending that this amendment be permitted to assess the credit risk of these investments to ensure regulatory reporting equivalency, which is the responsibility of the Task Force. These structures exploit the inherent weakness of the FE process, whereby anything with a CRP rating is assumed to be a “bond”; the rating is assumed to reflect regulatory risk concerns; and the investment is permitted to be automatically processed and assigned an NAIC Designation without any regulatory assessment of its actual risk, structure, or underlying assets. The FE process has effectively positioned CRPs as de facto super-regulators, allowing them to decide what a bond is, what its investment risk is, and by extension, what capital charge it should receive.

Perlman said some of the comment letters suggested that this amendment should wait for the Statutory Accounting Principles (E) Working Group to finish its work on the principles-based bond definition and the RBC Investment Risk and Evaluation (E) Working Group to finish its work on the RBC factors for residual tranches. As previously mentioned, each regulatory group has its own unique area of responsibility and expertise that ultimately creates the overall NAIC regulatory framework and its intentional interdependencies. While the Task Force welcomes feedback, comments, and recommendations from other regulatory groups that utilize NAIC Designations in their processes, the Task Force’s action on this matter is not dependent on the completion of those projects by their Statutory Accounting Principles (E) Working Group and RBC Investment Risk and Evaluation (E) Working Group colleagues.

For example, the RBC Investment Risk and Evaluation (E) Working Group is looking at the RBC factors for residual tranches of CLOs and potentially all tranches of CLOs. The Task Force decided to remove CLOs from FE eligibility in 2024 because ratings, while potentially sound on their own, do not always lead to the appropriate outcome when applied to the NAIC’s regulatory framework, and this will ensure a consistent approach to CLO designations. The Task Force’s mission “... to establish and maintain all aspects of the NAIC’s credit assessment process for insurer-owned securities ...” and assign NAIC Designations did not need to wait for the Working Group to finish its residual and CLO RBC factor analysis, an analysis that may not have any impact on the Structured Equity and Funds’ investments being discussed today.

There were also comments requesting full transparency into the methodologies the SVO would use when assessing a Structured Equity and Fund investment. When assessing insurer investments, the SVO is authorized by the Task Force in Part One of the P&P Manual to “... use any analytical technique or financial modeling approach taught in undergraduate and graduate business school financial analysis curriculum; any analytical technique otherwise widely or commonly used by lending officers, securities professionals, credit rating analysts, valuation professionals, statisticians, or members of similar professions and any special technique of modeling approach that may be appropriate in a special situation [and this next phrase is crucial] that provides a reasonable assessment of risk or valuation for regulatory purposes.”

Therriault said comments compared the lack of express methodology for the Structure Equity and Funds proposal with a very transparent and collaborative process around establishing a CLO methodology. That difference in approach stems in large part from the lack of transparency afforded to the SVO with respect to Structured Equity and Fund investments and the great variety and potentially limitless permutations of these structures and the underlying assets. Structured Equity and Fund investments are not a homogeneous asset class, and they are privately issued and rated. The apportionment of risk between Structured Equity and Funds notes and equity, as well as the types of underlying investments it can hold, vary widely, all of which require the SVO to apply different approaches and methodologies based upon the structure that it is reviewing. It is not possible to produce a generic standardized methodology for what is, by its very nature, a highly bespoke transaction. Some CRPs have developed methodologies for Structured Equity and Funds, and recognizing this methodology may reasonably capture the risk. The SVO included a provision in the amendment that would permit it to consider that rating agency analysis in its review. The CLO modeling methodology benefits from several factors that permit a level of transparency that are not present for Structured Equity and Funds: 1) a broadly syndicated investment; 2) a homogeneous

structure; 3) transparent publicly rated underlying investments; 4) publicly available legal agreements, and 5) widely available third-party data models and software to analyze them.

It was also noted in the comments that since the SVO is receiving private letter rating (PLR) rationale reports, it should already have sufficient transparency into Structured Equity and Fund transactions. The two examples that the SVO included in its memorandum were pulled directly from PLR rationale reports. While those reports helped the SVO identify this issue to raise up to the Task Force, they did not contain sufficient information to fully analyze the transactions or their underlying investments. The Task Force has not authorized the SVO to act on any rationale report that it sees in which it may disagree with the rating.

There seems to be a common misunderstanding around the use of CRP ratings, possibly because the FE process has been in effect for so many years. The SVO is not a rating agency, and NAIC Designations are not ratings. As directed by Part One of the P&P Manual, “An NAIC Designation must be interpreted by the NAIC member in the context of the NAIC Financial Regulation Standards and Accreditation Program, other characteristics of the investment, and the specific financial and regulatory status of the insurance company.”

Other policies in Part One explain, “The NAIC uses publicly available credit ratings, when available, as one component of the services it provides to state insurance regulators concerned with financial solvency monitoring of insurance company investments. In adopting or implementing the procedure described in this section, the NAIC acts solely as a private consumer of publicly available credit ratings. The sole NAIC objective in obtaining and using publicly available credit ratings is to conserve limited regulatory resources (e.g., the resources of the SVO).”

The SVO is recommending that the Task Force add a definition for Structured Equity and Funds and remove them from the FE process, because for the reasons explained, the SVO does not believe the FE process adequately serves the NAIC’s regulatory objectives for these investments. The SVO has the resources it needs through the provisions incorporated into this amendment, such as considering a rating agency’s analysis of complex transactions, to provide a reasonable assessment of risk. If the Task Force wishes to limit the scope of this amendment because of the potential volume that has been suggested, the SVO would recommend restricting this to privately rated securities or those with underlying investments that are privately rated. Privately rated securities already need to be submitted to the SVO, and this would only require some additional information.

Mike Reese (Northwestern Mutual), representing the ACLI, the PPIA, and NASVA, said he wants to clarify the phrase “anti-arbitrage.” It primarily relates to example one, where there was a limited partnership backed by debt instruments, that if an insurer relied upon the normal RBC charge, it would be 30%. The exposure states that the underlying debt would call for a 9% RBC charge, and that presents a similar type of arbitrage because the weighted average of the debt and equity tranche was something less, like 5%. The anti-arbitrage is that insurers want the 9% RBC charge, but they do not want the 30%. The SVO’s point is that it is an RBC charge of 4% in aggregate, and it should be 9%.

The ACLI, PPIA, and NASVA struggled a little bit in responding to the letter, because there were a couple of things commingled. There were three concerns in the letter: 1) the pure regulatory arbitrage; 2) what constitutes a bond; and 3) the lack of transparency. The comment letter suggests that the first issue would be addressed with an updated residual RBC charge. That is the whole point of the residual workstream, because it is the same concern with CLOs where there is arbitrage, so this would be duplicative of that effort.

The second concern relates to the second example regarding the math not quite working in the example. That was a security that would not qualify, or at least certainly in the lower tranche, as a bond. The Statutory Accounting Principles (E) Working Group is defining what a bond is, and that should address what constitutes a bond.



PLR rationale reports are now starting to be filed with the SVO. The vast majority of these are supposedly 10, 20, and 30 pages of detailed data. The rating rationales for these two instruments are not known, but if they are not robust, that would potentially be a problem that should be addressed.

To revert to the specific two examples and just share a few other high-level thoughts of what the other members are potentially concerned about, the first is debt-backed securitization, not too dissimilar in some ways to a CLO. The group believed the residual tranche work would address the issue. The proposed solution of the SVO says there is arbitrage, which is acknowledged. If the RBC charge would be 9%, it would be hard arguing against that. The proposal said the SVO would use the weighted average rating factor (WARF) methodology, which works well in many instances. Where there are waterfall structures, the WARF methodology may not be appropriate. If the underlying debt securities are not rated, the WARF reverts to an NAIC Designation Category of 5.B. That would then result in an RBC charge that would be higher than what it should be. It does not get to the RBC charge that the underlying debt would suggest that that charge should be.

Reese said the residual tranche interim solution is intended to address this issue, and it would be duplicative. The other option is the rating agency rating could be used on that debt; industry would be fine with this as well. If neither of those work, then anything could be used to determine that charge. That is where industry likes transparency because transparency to the methodology is important. Industry has capital certainty, which is not part of what an NAIC Designation is, but as industry looks at investments to buy, capital certainty is important as industry tries to apportion capital for the investment portfolio.

If there are methodologies that the SVO consistently uses, industry would like transparency into them so industry can understand them. If there are not methodologies for every type of security structure, and it is going to be sort of an ad hoc use of them, that is troubling for industry if it is not consistent and not known. What made the examples more confusing is that there was a discussion in the exposure about paid-in-kind (PIK) interest and the potential deferral or extension of principal. There are real business reasons for those, and they are used in the portfolios much more broadly than these types of securities. The example said these could defer principal or interest without accruing interest, and it was hard to ascertain from the exposure if that “could” was used more broadly or if it related to the security in question. The comment letter states that if that is the case, industry would certainly say that is a subscript S or nonpayment risk type security. Just the fact that there are PIK or deferrals of principal, industry does not understand that concern. Raising that concern in this context alarmed many constituents.

The other example that was there was an equity-backed securitization that had ratings. It did not have a residual tranche, and it had two tranches that were rated. Quoting what Therriault said, “Just the fact that someone rates a security does not mean it is a bond.” Reese said he would argue quite robustly that if there was a securitization that had two debt tranches and no equity tranche, at least with the facts that are known, it would be hard to call that a bond, certainly under the new bond standard because it is meant to have substantive credit enhancement. That seems to be more of a definition of a bond type example.

There was some trouble with the scope. The scope seemed to bring in an awful lot of securities that may not be intentional. Industry understands the no arbitrage concept, but not what else was really trying to be scoped in here or if it is anything equity-backed. There are many equity securitizations out there where the residual tranches are not even issued as part of the securitization, and it is retained. There might be 80% asset coverage, which is very thick over collateralization. The scope was what caught a lot of people's attention. This would really require the filing of quite a substantial number of securities and that it be much broader than it should be.

Mears asked if anyone from Varagon Capital Partners would like to speak to its comment letter. She said the themes in that letter were very consistent with things that Reese had just covered. Some of these rated notes, or

feeder structures, are structured and tranced in ways that are similar to what is looked at with asset-backed securities (ABS) in some of the other workstreams.

Helen Remeza (PineBridge Investments) said PineBridge is an asset manager with a deep insurance heritage going back to its American International Group Inc. (AIG) days. It serves insurance companies of all sizes across the nation. Most feeder fund structures serve an important purpose; they can offer an operationally efficient way for insurers to gain exposure to certain asset classes. That also helps level the playing field across smaller insurers. That said, it is understood that there may be limited situations where potential reviews may be necessary. In the comment letter submitted, a simple framework was shared based on the SVO and SSG's proposed red flags to help identify and prioritize these cases. PineBridge supports the Task Force's mission of promoting transparency, as well as enhancing risk assessment.

Mears said a key theme that was in many of the comment letters and discussed somewhat this morning is that there are a lot of ancillary workstreams that cover this in some way. One was this review of residual tranches and the appropriate capital charge to be associated with them. Probably not in all cases, but in many cases, that may be something that mitigates some of the concerns the Task Force has. The concern, anecdotally, as residuals have been reviewed that were reported Dec. 31, 2022, is that these types of residuals are not being seen in that reporting. It is difficult to say that this will be addressed via the residual workstream when they are not being captured in the population of that workstream. There are a variety of reasons why companies that were completing their Dec. 31, 2022, statements may not have done so. Mears would like the Task Force to consider providing direction to make a referral to the Statutory Accounting Principles (E) Working Group to review how it defines the reporting for those types of annual statement lines and what types of investments are in those lines to ensure that substantively similar types of exposures are all captured together as the Working Group's workstream continues. Crawford agreed and said she is supportive of a referral to get the appropriate reporting of these assets and securities, which is very important.

Mears directed the SVO to prepare a referral to the Statutory Accounting Principles (E) Working Group, and she said this is something that was also touched on at the RBC Investment Risk and Evaluation (E) Working Group meeting.

One of the key components of this is the transparency concern. As noted in the examples and the additional example mentioned today that was troubling, in many cases there are quite a few types of things in these structures. That is a concern that is maybe not unique to structured equity. As there continues to be an increase in private transactions and things that originated within companies, there is a lack of transparency. It is difficult, as noted by Reese, when creating a scope to just look at transactions that might be of concern, if there is not enough transparency to write a proposed amendment in such a way that it does not scope in a whole host of other investments that likely fall under very valid uses of these types of structures. Mears said she appreciates that the scoping issue is there, and there is a PLR process that is starting to receive that type of information. In fact, that is where some of these issues were identified. In some cases, complete information may not be received. What will be helpful and aligns somewhat with PineBridge's comment letter is to direct staff to create a more distinct process of how investments within that PLR population can be reviewed and perhaps have those ratings challenged. That goes back to the variety of reasons that there may be concerns, but it is not necessarily possible to say exactly what those are until there is a more transparent process. It is appreciated that industry has a concern that if you went to bed one day and had one rating and woke up the next day and had a different NAIC Designation, that may be troubling. A very distinct process on how any sort of challenging of those existing ratings that are feeding the NAIC Designation process would work. Some communication with the affected insurers and information regarding where to go from there so it is a well-understood and documented process would be beneficial, but there would be transparency needed and then communication with insurers would need to continue from that perspective. Walker said she is supportive of a transparent process when asking industry to be transparent in their investments.

Mears directed staff to document how that process could work and be brought back to the Task Force to review. It would be mostly for PLRs, since that is what is being received and available for review. Where this ends up for some of these problems today, using a stoplight example, is having only FE or not FE, or a red light or green light. Creating a yellow light option will help the process and provide more communication when there are concerns directly to those insurers involved. The Task Force is deferring any sort of adoption of this proposal, realizing that it is trying to put this other process in place and that it is well understood, to make it clear that transparency is still desired, as there are concerns about what can be in many of these structures. The Task Force recognizes that, in many cases, these concerns are extremely valid and are an efficient way for many insurers to invest, but the Task Force can also start down this path so that it is very clear how a review process will work going forward.

#### 4. Discussed Next Steps for the CLO Modeling Project

Mears said the next item on the agenda is to discuss the next steps for the CLO modeling project now that the amendment to the P&P Manual to include CLO as a financial model security in Part Four has been adopted with an effective date of Jan. 1, 2024, for Dec. 31, 2023, financial statements.

Kolchinsky said based on interested party responses to the methodology exposure, staff proposed to rearrange the next step work within the ad hoc group. Specifically, the ad hoc group will first work on the prepay/discount dynamic to demonstrate the quantitative impact of these proposals on tranche losses. This will also allow interested parties to “tie-out” the model, a task we originally slated for further on in the process. Furthermore, this change will also be responsive to those interested parties who commented that it is difficult to give adequate feedback on a methodology without seeing a suite of assumptions.

The main goal for the ad-hoc group will be to demonstrate the effects of prepay/discount purchases to state insurance regulators. This process should take about two months, at the conclusion of which staff and interested parties will report back to the Task Force.

Secondly, the ad hoc group will endeavor to tie out the cash flows on some “dummy” scenarios to ensure that the methodology is adequately specified in documents. Additionally, this arrangement will give time of some interested parties to propose scenarios and more of the work to occur at the RBC Investment Risk and Evaluation (E) Working Group as well.

Operationally, this work will involve three to four proxy CLO deals from industry, which will be run through Stress Scenarios A, B, and C. Please note that staff are not suggesting that these scenarios will be used in the future. They are out there for everyone to implement to tie-out the transactions.

The purpose of the ad hoc group is to resolve and clarify technical and modeling issues. Regulatory policy discussions will be limited and brought back to the Task Force.

To ensure that our time is spent productively, staff request that parties group themselves by interest and only one participant from the group speak at a given meeting. These participants can change, as it is intended to make the meetings go quickly.

Otherwise, the SSG hopes to keep the meetings open, and other parties may submit their concerns in writing to the NAIC. Staff suggest that non-regulatory participants have a technical background for the discussion. Staff will run models and results to get everything set.

Staff hope that at the end of this process, interested parties will have a better understanding of the NAIC’s approach to modeling CLOs, as well as have completed the tie-out of the bulk of the methodology on “dummy”

scenarios. Staff do not anticipate that any of the above will change the timeline for the implementation of CLO modeling.

Mears said the approach of the ad hoc group is to ensure that this is moving forward and is efficient. Having a collection of speakers, a process used in a few other projects across different groups, is really helpful. It is incredibly important to keep the discussion itself tight. If at some point it feels like the group is losing some sort of efficiency because there are too many voices in the room, the Task Force reserves the right to review this process and see if it is something that needs to have more of a closed group that reports back to the Task Force. This is a great way to start, as there are many interested folks, and the intent is certainly not to be exclusionary by any means.

Kolchinsky said the first meeting will be in about two weeks, and information and Webex links will be sent out. Industry participants are asked to think about the deals to use, as those deals should be commonly held by insurance companies and be available in modeling. One standard CLO, one CLO with a bond bucket, and one with a very large triple C bucket that has different CLOs to test was suggested.

#### 5. Discussed Questions for NAIC CRPs

Mears said, as was mentioned at the 2022 Fall National Meeting, there has been a lot of interest in the continuing review of CRPs. There was a small ad hoc group that did work last year. The group went through some of the concerns and tried to come up with a more focused approach to move forward. That group no longer meets because the Task Force is now moving on to a regulator-only review directly with each CRP. The Task Force has made this preliminary list of questions available for feedback, and the questions are for the conversations with the CRPs. The goal is to eventually have a formalized, due diligence questionnaire. This will help inform initial conversations and any later due diligence questionnaires. The questions reflect the range of issues that have been discussed by the ad hoc group. Feedback on these CRP questions before those meetings are scheduled is appreciated, which is why they have been included in the materials. Comments can be sent back to SVO staff or Mears. The CRP questions will not be publicly exposed for comment to allow CRPs to privately provide comments. The Task Force will look at those comments and potentially re-arrange our questions or at least be aware of where there are differences. Some of that can come up with individual conversations with CRPs. Before scheduling those meetings, the Task Force will publish the final list of CRP questions. There will be a 30-day deadline for comments on the CRP questions, and those comments can be sent to SVO staff or Mears.

#### 6. Discussed a Proposed P&P Manual Amendment to Update the Notice of Credit Deterioration for the List of Qualified U.S. Financial Institutions

Mears said the SVO maintains the *List of Qualified U.S. Financial Institutions* (QUSFI), which indicates the financial institutions eligible to issue letters of credit pursuant to the *Credit for Reinsurance Model Law* (#785). The letter of credit can be used to reduce an insurers liability when ceding reinsurance to certain assuming insurers. There are detailed instructions in Part Two of the manual. Perlman will provide a summary of this amendment.

Perlman said the SVO encountered a recent situation in which financial institutions on the QUSFI, namely Silicon Valley Bank and Signature Bank, were closed by their primary regulators and placed in Federal Deposit Insurance Corporation (FDIC) receivership prior to rating agencies taking action and downgrading them below the minimum permitted ratings of BBB-/Baa3 in the QUSFI guidelines in Part Two of the P&P Manual. These situations accelerated very rapidly, and regulatory actions occurred before any rating actions. The proposed amendment would recognize that regulatory actions, either announced or taken, by a financial institution's primary regulator would necessitate removal from the QUSFI. The proposed additional text would read:

If a financial institution on the List of Qualified U.S. Financial Institutions is closed by and/or placed in receivership or conservatorship, or notice is given of such action, by its primary regulator(s), the SVO shall promptly remove the name of the financial institution from the List of Qualified U.S. Financial Institutions. This may result in the SVO being unable to provide Notice of Credit Deterioration.

Given the recent situation, the SVO would recommend a very short exposure period of 15 day if there are no objections by the Task Force, followed by an email vote with a simultaneous referral to the Reinsurance (E) Task Force. Mike Monahan (ACLI) said the ACLI is comfortable with the shortened comment period.

Mears directed staff to expose the proposed P&P Manual amendment to update the Notice of Credit Deterioration for the QUSFI to include actions by the financial institution's primary regulator for a 15-day public comment period ending April 10, with an e-vote to occur shortly afterwards and a referral to be sent to the Reinsurance (E) Task Force.

#### 7. Received the Annual Report from the SVO on Year-End Carryover Filings

Mears said the next item is to hear the annual report from the SVO on carryover filings.

Therriault said as required in Part Two, Operational and Administrative Instructions Applicable to the SVO, of the P&P Manual, the SVO director must prepare a report for the Spring National Meeting identifying an acceptable annual rate of carryover filings for the year-end reporting period. These carryover filings can be identified with the administrative symbols "IF," which are initial filings with a self-assigned NAIC Designation, and "YE," which are annual update filings the SVO has not yet reviewed, and the NAIC Designation from the prior review was carried forward until the current year review is complete. There were 1,199 carry over filings in 2022 versus 828 carryover filing for 2021 and 795 in 2020; 381 were "IF" and 818 were "YE." This represented a carryover rate of 9.2% for 2022, versus a carryover rate of 6.7% for 2021 and a carryover rate of 6.3% for 2020. Overall, the SVO reviewed 12,983 security filings in 2022 versus 12,258 security filings for 2021. A carryover rate below 10% is manageable for the office, given its current staffing, and the 2022 carryover rate is getting close to that threshold. As of March 15, there were 258 remaining carryover filings to review.

There has been a continued rapid growth in privately rated securities. In 2019, the first year the SVO received PLRs, there were 2,850; in 2020, there were 4,231; in 2021, there was 5,147; and in 2022, there were 6,792. The SVO is also seeing a very large number of privately rated securities that are being self-reported without the required general interrogatory (GI) administrative symbol that would be added to the "PL" symbol so they can be identified in the annual statements as PLGI. Self-reporting in the GI without the administrative symbol is only permitted for a very narrow set of securities within the definition of the P&P Manual. The SVO wants to encourage insurers to follow the reporting instructions for the permitted uses of the PLGI.

The office continues to need additional technology resources. Some progress is being made on projects that were delayed for several years. Specifically, the multiple security identifiers that have been mentioned for a number of years using the Global Instruments Cross Reference Service (GICRS) dataset so the SVO can utilize the International Securities Identification Numbering (ISIN) identifier. There are probably other enhancements that could be made that would benefit both NAIC staff and insurers if there were additional resources. Those projects have had to be indefinitely deferred given the current support level.

#### 8. Received a Report on the Projects of the Statutory Accounting Principles (E) Working Group

Mears said the next item is to hear a report on projects before the Statutory Accounting Principles (E) Working Group.

Julie Gann (NAIC) provided a brief update on some of the items in accordance with the coordination initiative. There are two adoptions specifically to note that occurred at the Spring National Meeting. The first was the clarification of what constitutes an affiliate in an investment. The language that was adopted indicates that any invested asset that is held by a reporting entity that is issued by an affiliated entity or which includes the obligations of an affiliate entity, is an affiliated investment, and that is a clarification that goes back to the related party guidance adopted last year.

The Working Group also adopted a new disclosure for 2023 to capture information on aggregate deferred interest and PIK interest, which is something that was discussed earlier this afternoon by the Task Force. Again, this is an aggregate disclosure. It will be required for year-end 2023. The Working Group is moving forward with the blank's exposure shortly after the national meeting, and it will be data-captured. Granular information on a specific investment-level detail is planned as part of the bond project, but this will be an aggregate footnote disclosure for this year-end.

Regarding exposures, the Working Group is moving forward on the principles-based bond definition. At this national meeting, the Working Group exposed revisions to the authoritative Statements of Statutory Accounting Principles (SSAPs). Most of the revisions are limited at this point in time; the term used was window dressing. The Working Group is proposing to incorporate the guidance for residuals in *SSAP No. 21R—Other Admitted Assets*. There was a question with that exposure to industry from state insurance regulators asking how residuals have been amortized in the past and how other than temporary impairments (OTTIs) have been determined. That will assist staff in drafting language for those investments in SSAP No. 21R.

The Working Group also exposed a proposed concept for Schedule BA new reporting lines. This mirrored the guidance that exists now for certain joint ventures, limited liability corporations (LLCs), and partnerships, where there are two reporting lines for each classification of non-debt securities that do not qualify as bonds to separate them between those that have SVO-assigned designations and those that do not. The Working Group is hoping to get comments on that, consider those comments, and then sponsor a blanks proposal in the next round.

Regarding the principles-based bond definition, the Blanks reporting changes for Schedule D, which is about 200 pages long, was exposed by the Blanks (E) Working Group during its meeting in lieu of the Spring National Meeting, and the comment deadline for that is June 30.

The Statutory Accounting Principles (E) Working Group exposed guidance for collateral loans to clarify that if there is a collateral loan, it can only be admitted if the collateral that is pledged to support that collateral loan qualifies as an admitted invested asset. That means if it is a joint venture; LLC; partnership; or something that would qualify as a subsidiary, controlled, or affiliated (SCA) entity, it must be audited in accordance with *SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies* and *SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities*, but the comparison to the collateral loan will be based on audited net equity value instead of fair value.

There was also exposed guidance to incorporate the financial modeling of CLOs, which was adopted by the Task Force, into *SSAP No. 43R—Loan-Backed and Structured Securities*.

The Working Group discussed negative interest maintenance reserve (IMR). There is no exposure for this at the moment. The Working Group directed two referrals, one to the Life Actuarial (A) Task Force and one to Capital Adequacy (E) Task Force, and it directed NAIC staff to put together some guidance for a subsequent exposure, which is planned for after the national meeting.

There are three other informational updates. For those who purchase the *Accounting Practices and Procedures Manual* (AP&P Manual) via Bookshelf, there will be a portable document format (PDF) that comes with it that is

available through Account Manager. The PDF will come with Bookshelf, so there is no additional charge. It is available for download now via the 2023 updates for industry.

The Working Group asked for feedback by April 15 from state insurance regulators so that it could respond to the Valuation of Securities (E) Task Force's referral regarding the acquisition of data so it could do an analytical analysis. Once that feedback has been received, the Working Group will respond with a referral letter.

Lastly, on the editorial listing, Gann said there is a proposal to remove the specific location references to the P&P Manual in the AP&P Manual. The AP&P Manual will still refer to the P&P Manual when it is appropriate, but the proposal would delete all the Part One, Part Two, and Part Three references because it sometimes gets out of sync.

Stolte asked to go back to the Working Group's referral in item #2, and he questioned if the Task Force contemplates delaying the work on the interim solution for the residuals. Mears said what the Task Force identified as something that will potentially be discussed in a regulator-only session when reviewing the results that came out of reporting is that the reporting may not be complete or it may be under-reported just to ensure that whatever decision is made by the Working Group, whether in the short term or long term, is being used for the correct population. The Task Force does not anticipate this affecting the speed of any decisions.

Reese asked Therriault to repeat the numbers for the PLR filings and the comments about the PLGI. Therriault repeated the PLR filing numbers, and he said there are permitted uses for the PLR GI reporting or PLGI under specific scenarios. It appeared in the 2022 filings that there were securities issued in 2022, which would not have been permitted to use the PLGI and would need to be reported to the SVO. The SVO did not receive a PLR in any capacity, either the electronic feed or physically, which is filed in the VISION system. The SVO does not have a match up to a PLR, and the securities were not identified as a PLGI, which probably would not have been permitted anyways. These securities were reported as a PL security, which would not be permitted, so it is a compliance issue with the P&P Manual.

Having no further business, the Valuation of Securities (E) Task Force adjourned.

[https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2023/2023-03-23 Spring NM/Minutes/VOSTF 3.23.23 Spring NM Minutes \(v5 FINAL\).docx](https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2023/2023-03-23 Spring NM/Minutes/VOSTF 3.23.23 Spring NM Minutes (v5 FINAL).docx)

Draft: 3/9/23

Valuation of Securities (E) Task Force  
Virtual Meeting  
February 21, 2023

The Valuation of Securities (E) Task Force met Feb. 21, 2023. The following Task Force members participated: Doug Ommen, Chair, represented by Carrie Mears (IA); Eric Dunning, Vice Chair, represented by Lindsay Crawford (NE); Mark Fowler represented by Sheila Travis (AL); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kenneth Cotrone (CT); Michael Yaworsky represented by Ray Spudeck (FL); Dana Popish Severinghaus represented by Vincent Tsang (IL); Vicki Schmidt represented by Tish Becker (KS); Kathleen A. Birrane represented by Matt Kozak (MD); Gary D. Anderson represented by John Turchi (MA); Grace Arnold represented by Ben Slutsker (MN); Chlora Lindley-Myers represented by Debbie Doggett (MO); Marlene Caride represented by John Sirovetz (NJ); Adrienne A. Harris represented by Jim Everett (NY); Glen Mulready represented by Holly Mills (OK); Carter Lawrence represented by Trey Hancock (TN); Cassie Brown represented by Amy Garcia (TX); Jon Pike represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA); Mike Kreidler represented by Tim Hays (WA); and Nathan Houdek represented by Amy Malm (WI).

1. Adopted a P&P Manual Amendment to Update References to 5GI

Mears said the first item is to consider adoption of a non-substantive proposed *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) amendment to update references to 5GI. This proposed amendment was exposed for a 60-day comment period that ended Feb. 13. One comment letter was received from the American Council of Life Insurers (ACLI).

Marc Perlman (NAIC) said that at the 2021 Fall National Meeting, the Task Force adopted a non-substantive technical amendment to the Private Letter (PL) Securities section in Part Three of the P&P Manual, which clarified that an NAIC 5GI designation is the equivalent of an NAIC 5.B designation category. The Securities Valuation Office (SVO) identified other places in the P&P Manual where the 5GI.B designation category was not specified and proposed a non-substantive technical amendment to make those clarifying changes. The SVO recommends that these changes be adopted.

Mike Reese (Northwestern Mutual representing the ACLI, North American Securities Valuation Association (NASVA), and Private Placements Investors Association (PPIA) said they are supportive of the proposed amendment (Attachment One-A).

Doggett made a motion, seconded by Clements, to adopt the P&P Manual amendment to update references to 5GI (Attachment One-B). The motion passed unanimously.

2. Adopted a P&P Manual Amendment to Add Instructions for the Financial Modeling of CLOs

Mears said the next item is to discuss comments and consider for adoption an updated proposed amendment to the P&P Manual to include collateralized loan obligations (CLOs) as a financially modeled security in Part Four. At the 2022 Fall National Meeting, the Task Force directed Investment Analysis Office (IAO) staff to update the amendment to take into consideration the technical recommendations in the ACLI's comment letter (Attachment One-C), and then re-expose the amendment for a 15-day comment period that ended Jan. 9, 2023. One comment letter was received from the ACLI.



Charles Therriault (NAIC) said this amendment would add CLOs within the scope of financially modeled securities in Part Four of the P&P Manual.

Like the current residential mortgage-backed securities (RMBS)/commercial mortgage-backed securities (CMBS) project, the NAIC will almost exclusively perform surveillance work for CLOs. While the Structured Securities Group (SSG) may be asked to perform some regulatory treatment analysis services (RTAS) on new issue mandates, these are expected to be extremely rare. Surveillance requires significantly less effort and will only be done once a year, along the same schedule as other financially modeled securities that the SSG already models. The actions proposed in the amendment are designed to allow insurers to continue participating in the CLO market without the risk that aggressive structuring puts policyholders and insurer investments in jeopardy.

Two comment letters were received from the ACLI. The ACLI made several constructive technical suggestions in the first comment, which the IAO substantially incorporated into the updated proposed amendment. The second comment letter, dated Jan. 9, asked about the intent of the note in the amendment stating that it was effective as of Jan. 1, 2024. The purpose of this note is to establish when the SSG is authorized to begin modeling CLO investments and provide insurers sufficient notice of this change. It is expected that insurers will follow the existing limited filing exemption (FE) for RMBS and CMBS in Part Four, paragraphs 4–5, for interim reporting. These paragraphs permit securities that cannot be financially modeled, which would be the case for CLOs until the SSG produces its first modeling output for them but are rated by a credit rating provider (CRP), to use that CRP rating to determine the NAIC designation that would be applicable under the FE procedure. Once the security is financially modeled, this limited exemption would no longer apply because it would then be a “financially modeled” security. The SVO did notice that some section titles in the amendment did not include “CLO,” but the detailed instructions within that section did. With the Task Force’s approval, the SVO will make those technical corrections to the final amendment.

Steve Clayburn (ACLI) thanked the Task Force for taking the concerns and suggestions in the comment letter into consideration and explaining the plan with regards to the Jan. 1, 2024, effective date and interim reporting.

Mears noted that the adoption of this finalized amendment would formalize the motion the Task Force adopted at the 2022 Fall National Meeting authorizing SSG staff to take on the CLO analytical function and request the resources it may need.

Stolte made a motion, seconded by Spudeck, to adopt the P&P Manual amendment to include CLOs as a financially modeled security in Part Four with an effective date of Jan. 1, 2024, with the technical corrections noted by Therriault (Attachment One-D). The motion passed unanimously.

### 3. Discussed an SSG Memorandum on a Proposed CLO Modeling Methodology (Excluding Scenarios and Probabilities)

Mears said the next item on the agenda is to hear comments on the SSG memorandum on a proposed CLO modeling methodology (excluding scenarios and probabilities). The modeling methodology was exposed for a 60-day comment period that was scheduled to end Feb. 13, but it was extended, at industry’s request, to Feb. 17. The Task Force will be working through the substance of the details in those comments but will use this opportunity to have the interested parties that wrote comment letters speak, allowing immediate questions and responses so that a dialog can take place to establish next steps. Comment letters were received from:

- ACLI
- American Academy of Actuaries (Academy)

- PineBridge Investments
- Equitable, MetLife, New York Life Insurance Company, Northwestern Mutual, Pacific Life Insurance Company, Prudential Financial, and Western & Southern Financial Group (sent jointly)
- Athene, Everlake Life Insurance Company, F&G Annuities & Life, Global Atlantic Financial Group, and Security Benefit Life Insurance Company (sent jointly)
- American Investment Council
- Structured Finance Association

According to the Task Force’s website, “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.”

As noted several times, it is not under the purview of the Task Force to establish actual risk-based capital (RBC) factors, and there is an initiative underway by the RBC group to address that. It is also not under the purview of the Task Force to determine statutory accounting. That would be under the purview of Statutory Accounting Principles (E) Working Group. However, it is under the purview of this Task Force to establish the credit assessment procedures and finding areas of focus that may end up involving some of those other regulatory groups. Each group has its own unique area of responsibility and expertise that the NAIC utilizes along with interdependencies between the groups.

It has been said multiple times, but it bears repeating, the SVO and SSG are not rating agencies. The Task Force has required them to provide these designations on an annual basis for use in the year-end financial statements for use by regulators in establishing RBC results, in quality assessments, and they are used in some state law provisions. The Task Force does not require them to follow the requirements imposed by the Credit Agency Reform Act, which would apply to nationally recognized statistical rating organizations (NRSROs) who take a different view in terms of an overarching surveillance process and not the annual review that is used for this narrow provision for regulators. While the Task Force relies on the SVO and SSG, there are times when it feels it is appropriate to effectively outsource that review to NRSRO when the results will be consistent with what the Task Force expects moving all the way through the NAIC framework. As noted for the CLOs, the Task Force has identified an instance where it does not feel that the existing process works throughout the entire NAIC framework. The Task Force is assessing the modeling piece for credit assessment of CLOs. The RBC assessment is being looked at by the Risk-Based Capital Investment Risk and Evaluation (E) Working Group and the groups are being collaborative with one another.

Eric Kolchinsky (NAIC) said due to the late nature of the responses, there has not been an opportunity to respond in writing yet but there will be one. Some of the comments were not responsive to the methodology, but instead just discussed the modeling process itself. One of the comments by the interested parties compared the resources at a rating agency, which rates new deals, to what the SSG does, which is a very simple surveillance process. Having previously co-managed what was called the Global Derivatives Group at Moody's Investors Service (Moody's), which included CLOs, collateralized debt obligations (CDOs), and similar products and knowing the resources needed for this product, the SSG is not trying to build a new issue platform, but rather a surveillance process, for which there are adequate resources. As with the current RMBS/CMBS project, the SSG does not expect to analyze any new issues. There is an RTAS process in case that is required, but the SSG currently does at most one every year. The backlog that was mentioned by one of the commenters had to do with new issue process, not surveillance. Lastly, resources are not a theoretical question. The SSG currently runs all the insurance company CLO holdings annually without any extra resources. As the regulators participating in this meeting know, the SSG produces bond-level results for them to use and put up on the Tableau worksheet. This is easily doable going

forward with extra resources.

Overall, there were a lot of miscellaneous textual comments or questions. Most were very good and will be included in responses in terms of detail and working through those issues in the future. The main issue that came up multiple times is that of prepayments and reinvestments. This is going to be the main issue for us working through the methodology. Prepayments are not material, but they do influence two other assumptions in the modeling: having the use of principal to pay overcollateralization (OC) tests, and, much more importantly, the par building process that is sometimes assumed. Using principal proceeds to cure OC tests is extremely expensive. Thinking about the total cost of funds for the deal, it is not expected to be used. The managers have a lot of options not to be used and do not think that is a controversial position. All that it does is switch the risk from the top to the bottom if using principal proceeds. The main issue up for discussion going forward in terms of scenarios is going to be reinvestment. Having prepayments allows principal proceeds, which can be reinvested, and if reinvested at a below par price, then par can build up. That annual ongoing par build allows the offset losses in the modeling. For example, if 20% of the portfolio repays, then take that 20%, and reinvest in something trading at a dollar price over 0.99, then there is more par and that offset approximately 0.2 times 0.1 losses in the modeling. There is some historical precedent to this, as there was a lot of par building by CLOs in the global financial crisis and during the coronavirus pandemic, and it did work out well. Part of the reason it worked out well is because of the Federal Reserve's interventions in the market, which stabilized pricing on risky assets and pushed those prices up, allowing managers to build a par and maintain a safer portfolio. It is not clear whether that assumption should continue.

It is also important to remember, for those of who were there in the past, that the process of buying securities at a discount was the death knell of the collateralized bond obligation (CBO), which was the main product before the CLO. Post the dot-com bubble, reinvested at a discount price created a downward spiral and CBOs have never recovered. This is not a universally positive thing. The SSG is not aware of any rating agency modeling these discounted purchases to build up par. If that is incorrect, the SSG requests that interested parties provide references to public NRSRO criteria that allow it to do that. The SSG's understanding is that it is not something that is modeled for by rating agencies. Next, active management is not to CLOs, so it is something that could theoretically be applied to any active pool, whether it is loans or bonds, but that was not assumed in the modeling for RBC C-1 factors. This is not something that differentiates CLOs from the standard of active management and it is unknown why it would be applied there in the first place. Lastly, Kolchinsky said that he personally has a strong conviction against this par-building mechanic based on his prior experience with CBOs and the dot-com bubble. However, part of the ACLI proposal is only to have it in certain scenarios and he is willing to explore that potentially with interested parties.

Outside of these two issues is primarily that of reinvestment and the assumption that proceeds are reinvested. This will require a greater focus on the reinvestment type assumptions: what rating, what maturity, callable schedule, etc. One of the reasons the SSG proposed a no-reinvestment assumption is because it is simpler. It does not try to overfit the model and is a very simple assumption. Again, it is stylistically better but it can be opened if there are good reasons to do so if it does not overfit the model.

Recall that the main constraint here is the reporting equivalency between a pool of loans and the sum of all the tranches. To that extent, no matter what is discussed in terms of reinvestment assumptions, certainly, the only thing it could do is sort of shift between various tranches and risk levels within the CLO, not necessarily improve CLO performance. There is a limited usefulness of these assumptions, but again SSG is open to discussing them once the process starts going.

Lastly, Kolchinsky said there was one very reasonable comment to release all the assumptions for modeling. This has not been done because the SSG has not written the assumptions. There has been one main constraint, which

is reporting equivalency. How to accomplish that is something the SSG will want to work with interested parties on. With the reporting equivalency, the SSG will continue to work with the Risk-Based Capital Investment Risk and Evaluation (E) Working Group to make sure the view of reporting equivalency is consistent. It is a process working in parallel with that Working Group and continuing communication with them.

To keep this process going and ensure transparency, the SSG would like to ask the Task Force to form an ad hoc group to model deals. The discussion so far has been about theoretics, though, at some point the idea is to nail down as much of those theoretics as possible. At the end of the day, it is going to come down to transactions and looking at those transactions and how the scenarios impact them. Making sure that is effective requires a small number of active participants going back and forth with information. Interested parties are asked to form coalitions, or at least groups, that have a single voice and can take information back to their participants. Once this process is formalized, SSG can begin looking at actual transactions and modelling actual transactions with some of these modifications and without some of the modifications so there are numbers for people to compare.

Mears said there was a lot of information to digest. As a reminder, the Task Force is not taking any actions today and will discuss the ad hoc group after hearing from interested parties on their comment letters. Everett asked if regulators can be part of the ad hoc group as well, to which Kolchinsky replied absolutely.

Clayburn said he is intrigued by the suggestion for an ad hoc group and the ACLI gives a thumbs up on that. The ACLI appreciates the fact that it was allowed to comment, and the overriding thoughts are that the assumptions should not be simplified and should be able to reflect the economic conditions of each point in time in the scenarios that are ultimately developed. The exposed methodology assumes that the non-defaulting portion of each loan matures based on the legal maturity. While commercially available models may have limitations with projecting every possible cash flow scenario, the ACLI recommends that, where practical and reasonable, modeling assumptions should capture loan features such as amortization and callability. Proposed in the letter is to replace no prepayments assumed with prepayment assumptions that vary by scenario and through time within the scenario. A chart was provided that outlines some of those scenarios for the Task Force and the SSG to consider. The letter also proposed replacing reinvestment collateral as purchased at par with pricing levels that vary by scenario and term and included a chart for which to begin the discussion. This was answered on the Task Force's last agenda item. Expected frequency of the designation modeling will be done once a year but ACLI suggests that maybe it could be done more frequently than annually.

As for assigning ratings to underlying assets, the ACLI proposes replacing the fallback assumption that uses the SVO-assigned NAIC designation category with more transparent assumption logic that all parties can instantly use because not everyone has availability to the NAIC designations. The letter suggested using the fallback logic that had been used for reinvestment assumptions that is assigned the weighted average rating factor, or, if not reported, assume it to be, for example, 4.B, which is a B3 or B rating. As for callability of bonds, CLO transactions typically include call provisions that are frequently exercised when market conditions make it economically advantageous. The ACLI suggests considering whether modeling call features would be impactful to the loss projections under the proposed modeling framework, and if so, to evaluate ways of incorporating this feature in the modeling exercise.

Kolchinsky said loans with an amortization schedule, if available, are easy to work on and non-controversial. The things with calls, both on the loans and the tranches where there's optionality, they are just difficult to model but SSG is very much open to seeing how that works out. In terms of the annual frequency, that is the official frequent but SSG will endeavor to do unofficial ones as often as possible. The goal is to work on a detailed process that everyone knows and that is predictable. It is very important that everyone sees what is going on. Currently, what is run is the latest portfolio, as available in trustee reports, running through methodology in batches, as resources

allow.

Mears said the intent once this is complete is that the methodology and scenarios are transparent enough that any user who has access to a modeling framework platform should be able to do it on their own, like a one-by-one deal. Kolchinsky said the hope is that most of the participants who responded and are sophisticated modelers should be able to replicate what the SSG is doing and provide feedback.

Steve Smith (Academy) said Kolchinsky has been transparent and engaging throughout working through the process. The comment really is more of a process-oriented comment. The Academy has been engaged with the Risk-Based Capital Investment Risk and Evaluation (E) Working Group and helping them think through CLO capital. This has involved higher-level, more conceptual issues such as what the statistical safety level should be, how it should think about the concept of RBC arbitrage, etc. As the Risk-Based Capital Investment Risk and Evaluation (E) Working Group works through those problem, they will form the basis for the objectives of any model that would then be built to assign NAIC designations to CLOs, recognizing that it's difficult to disentangle NAIC designations from RBC from C1. The comment is to acknowledge that the Academy finds it difficult to comment on any methodology to a model before the Academy knows what the objectives are. It is premature to be getting into too detailed a conversation on model methodology.

Kolchinsky said it has been great working with the Academy. It has been a mutually great relationship going back and forth. He said the goal is that RBC is the target, and the SSG works on how to reach the target. Kolchinsky said whatever targets may be provided, the SSG is happy to adjust to those.

Mears said the PineBridge Investments comment letter talks about what time frames to look out for some of the data that is being used. PineBridge Investments believes pre-2000 data is not necessarily relevant. It also points to the fact that the NAIC uses Moody's default data and recommends looking more at the Morningstar LSTA US Leveraged Loan Index. There are some other technical comments on recovery rates. Another comment is that since this is starting with CLOs, is it unfairly penalizing CLOs by going through this process that has not yet been done for other types of securitized transactions that may exhibit similar features. This is being done because there is more information on CLOs, and it is a place to start. That will take time and it is an important consideration to work through as the Task Force looks at the overall structured securities universe over time.

Kolchinsky said CLOs are clearest. One always needs to start somewhere. If the Task Force asks the IAO to look at other types, it is happy to assist. As for Morningstar LSTA versus Moody's, Moody's was used to calibrate the defaults for risk-based capital C-1 factors, so it is a consistent apples-to-apples comparison. Mears said this will go back for consideration, too, as work proceeds with the Academy.

Christopher Halldorson (Prudential Financial) said the firms listed in this letter all purchase CLOs and are strongly in support of the NAIC initiative. The firms believe the initiative is going to generate capital requirements that are transparent, consistent across asset classes, appropriately calibrated for tail risks, and designed to minimize capital arbitrage incentives. Highlighting a couple of items for consideration just because they are out there in the ether, some of them have not necessarily been brought up so far. CLOs represent a material risk to U.S. life insurers. That is because of the growth rate versus general accounts, the significant allocations within certain firms, and the fact that insurers are a material capital source for CLOs, in general. By some accounts, insurers look like they are 50% of the mezzanine capital source. And finally, just one other point is that CLOs represent about 3–4% of life insurance holdings. That might sound small, but it is also the size that CMBS was in 2006. It is hard to look back and say that more transparency would not have been wanted in the system.

The firms on the joint letter 100% believe the SVO has the in-house modeling capabilities to appropriately model

CLO for this purpose. The third-party model, transparency, stresses, and parameters used will all mean that it can be replicated. Some insurers have replicated the annual NAIC Capital Markets Bureau studies and have gotten very similar results. There may be disagreements on inputs to those stress tests but can get to the same results. This transparency is needed.

The IAO is not trying to become a rating agency and is just trying to perform a function that the rating agencies are not designed for. Rating agencies do not rate credits to the 96<sup>th</sup> percentile standard that the risk-based capital C-1 factor is designed. This is trying to fill a gap that exists. In terms of capital arbitrage, our firms interpret the no-arbitrage principle as an effort to ensure consistent capital treatment across asset classes and structured tranches. All regulators and industry participants should support that goal.

There should be caution around how one thinks about active management and diversification when getting into tail events. Most leveraged loans are financed through CLOs, so one would have to assume certain CLO managers are outperforming each other, which is a hard thing for the NAIC to do. Also on the diversification front, current C-1 bond factors incorporate the diversification of about 800 mostly investment grade issuers. The typical CLO has 200 or less issuers and mostly high yield. One must be careful about over ascribing diversification to one without looking at it in conjunction with the other. There is a lot of discussion surrounding experience on CLOs and how an experience on a BBB CLO or a BB CLO versus corporate bonds. CLO tranches are designed to have different loss experience relative to corporate bonds. This is by design; it is not good or bad. CLOs have a first loss protection built in, which is there to absorb collateral defaults when they are low. They also have embedded leverage, which can drive material losses when collateral defaults are high. This cliff risk, which the Academy described in its report, is driven primarily by systemic credit downturns, not by idiosyncratic or a few issuers' default. A systemic credit downturn has not been seen to the extent that insurers have held capital for corporate bonds over the past 20 years. That is when insurance companies have had CLOs. Extrapolating the very specific market conditions over the past 20 years that has been had for CLOs is not going to be a sufficient answer to meet RBC standards for corporate bonds held right now. Just as a reminder, the current C-1 bond factor is recalibrated using almost 40 years of default and loss experience. There is no reason to delay this work and there should be some urgency on this moving forward. CLOs should be the easiest structured asset class to model, understand, and provide consistent capital treatment and transparency to regulators.

Kimberly Welsh (Athene) said the firms included on the comment letter believe that any review must be data driven, nondiscriminatory, and result in asset capital charges that align with the risk across all asset classes. A concept called equal capital for equal risk in the letter. The firms are arguing for the appropriate amount of capital for development risk, not necessarily less capital, and believe all asset classes should be modeled and evaluated using the equivalent assumptions and methodologies. Consistency across risk and asset classes, and curve and appropriate allocation of capital and avoid inappropriate concentration from certain risks. It is unclear as to why senior secured loans are vulnerable to be knocked down only within the CLO. The approach in the comment letter is consistent with the NAIC's long-standing class process of data-driven and nondiscriminatory regulations.

Welsh agreed with the NAIC that capital target for CLOs needs to be calibrated and thinks that if the analysis is performed on a bottom-up basis with consistent assumptions across asset classes, it will be determined that capital charges for CLOs rated investment grade will be lower than those for equivalently rated corporate debt. There is no shortage of data and studies that track the performance of CLOs, showing that they performed better and have less risk than equivalently rated corporate bonds. But beyond performance, a recent paper by Professor Robert A. Jarrow from Cornell University concluded that CLO tranche loss probabilities are, on average lower than comparably rated corporate debt. A discussion in the Academy and a recent white paper on structured debt are linked in the submission and should be considered as well.

Welsh said Kolchinsky responded to some of the concerns raised in the letter about the current ability for the SSG to dynamically model CLOs. There may be a need for more clarity on that. It is a heavy lift, and the NAIC is encouraged to more extensively evaluate the gaps in the current analysis and service of the credit reporting providers, which could be helpful in this process. Also, the letter provides technical feedback on the stress test methodology. It is difficult to provide complete feedback without understanding the full scope of the proposed changes and without certain plans for that. It would be helpful to back test the analysis and impact analysis of filing exempt (FE) ratings mapped to intrinsic price.

Mears said that this process began not quite a year ago and introduced the concept. At the time, it was within an existing RBC and designation framework and considered a different way to map those to those existing categories. This is how the concept of RBC arbitrage came up. Since then, it has been said multiple times that is not a reflection on the CLOs themselves. CLOs are not arbitrage type investments. The RBC group has since picked up reviewing the overall capital charges in general. This would effectively solve for that capital arbitrage to Smith's point earlier, as there would be something to calibrate and map to that makes sense. The comments are appreciated but to some extent they may be somewhat dated with this presumption that it would result in punitive capital charges for CLOs. That is not part of the methodology. The idea of the very highly rated CLOs having perhaps lower capital charges than corporate bonds has been on the table for a while and would likely come out of the RBC process, where ultimately that will reside. Additional commentary on this is better placed with the RBC group.

Kolchinsky said he did not have a view of the final outcome and did not want to prejudice the process. It may be possible that mezzanine AAA and AA rated tranches get a little more capital charge on this framework. Knowing the results would require knowing the probabilities, which is something that will be worked out in this ad hoc group. The overall constraint is reporting equivalency. Back testing is something that would apply to a black box model, but since this is going to be transparent, each company can run the back testing however they want. Back testing is done on a closed model to see how it does as proof and all the companies that do that work as part of the analysis.

Welsh said the second part was impact analysis. Kolchinsky said absolutely, and that as the stress tests are run, the process for stress test analysis is there. The idea is transparency so that everyone can do it and if something comes up, and it would be shared. To clarify the notching leveraged loans in the CLOs, mentioned in the technical comments, is only the rating on the loan if there is no issuer rating or no corporate rating. Those need to be mapped to default probabilities. It is very similar to what rating agencies do to take the default probability, because the rating on the loan itself, the issue rating incorporates recovery assumptions as well. There is no penalty for leveraged loans; rather, the default probability is extrapolated, similar to what is done by rating agencies.

Mears said there were quite a few technical comments that can be taken into consideration as well as other broader comments that have been addressed in this discussion already. If something has not been addressed, it will be as the comments are reviewed.

Dallin Merrill (Structured Finance Association (SFA)) said substantively, most of the comments are from issues that have already been raised. The SFA does strive for consensus in two areas. Firstly, in eliminating capital arbitrage and supporting the NAIC and the regulators in that. Secondly, on the need for fleshing out the modeling assumptions in the scenarios. The SFA would be interested in any working groups that form to help advance that work so the modeling assumptions can be made clear.

Mears directed Kolchinsky to coordinate the creation of this ad hoc group. Task Force members can participate as they would like. For this to be a very efficient group, representatives should have the technical expertise to really

work through some of these modeling processes. Additionally, the coalitions that are formed in the trade groups can put forth one person to be the communication point back to their group. Full representation is wanted, as there are some varying opinions on some of these topics, and so that the persons involved are actively engaged, and in tune with the conversations.

The modeling process is on the SSG website and not in the P&P Manual. As changes are made, they would be communicated back to this group and published on the website. The methodologies are not adopted. Once there is something that everyone can wrap their arms around, direction would be provided to continue to move forward with that methodology. For those not participating in the ad hoc group, please remain engaged with your various counterparts. The Task Force will continue to be transparent with this group about changes to that process.

Having no further business, the Valuation of Securities (E) Task Force adjourned.

[https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2023/2023-02-21 Interim Meeting/Minutes/VOSTF 02.21.2023 Minutes v5 - \(FINAL\).doc](https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2023/2023-02-21 Interim Meeting/Minutes/VOSTF 02.21.2023 Minutes v5 - (FINAL).doc)





Mike Monahan  
Senior Director, Accounting Policy  
202-624-2324 t  
[mikemonahan@acli.com](mailto:mikemonahan@acli.com)

February 13, 2023

Ms. Carrie Mears, Chair  
Valuation of Securities Task Force  
National Association of Insurance Commissioners  
110 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

**Re: Non-substantive technical amendment to the Purposes and Procedures Manual  
Clarifying the Corresponding NAIC Designation Category for NAIC 5GI**

Dear Ms. Mears,

The undersigned (ACLI, PPIA, and NASVA) appreciate the opportunity to comment on the exposure referred to above that was released for comment by the Valuation of Securities Task Force (VOSTF) on December 14<sup>th</sup>, 2022.

The undersigned are supportive of the referred to proposed amendment.

\*\*\*\*\*

We stand ready to work collaboratively with the Task Force and SVO on this and other matters in the future.

Sincerely,

A handwritten signature in black ink that reads 'Mike Monahan'.

Mike Monahan  
Senior Director, Accounting Policy

**Tracey Lindsey**  
Tracey Lindsey  
NASVA

**John Petchler**  
John Petchler  
on behalf of PPIA  
Board of Director



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## MEMORANDUM

TO: Carrie Mears, Chair, Valuation of Securities (E) Task Force  
Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)  
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Non-substantive technical amendment to the Purposes and Procedures Manual clarifying the corresponding NAIC Designation Category for NAIC 5GI

DATE: November 15, 2022

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**Summary** – At the 2021 Fall National Meeting the Task Force adopted a non-substantive technical amendment to the PL Securities section in Part Three of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office (Purposes and Procedures Manual)* which clarified that an NAIC 5GI Designation is the equivalent of an NAIC 5.B Designation Category. The SVO has identified other places in the *Purposes and Procedures Manual* where the 5GI.B Designation Category is not currently specified and proposes a non-substantive technical amendment to make the changes shown below in **red** (additions **underlined** and deletions with **~~strikethrough~~**).

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**PART TWO**  
**OPERATIONAL AND ADMINISTRATIVE INSTRUCTIONS**  
**APPLICABLE TO THE SVO**

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**COMPILATION AND PUBLICATION OF THE SVO LIST OF INVESTMENT SECURITIES**

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**RMBS/CMBS Modeled Securities Process**

7. RMBS and CMBS that are deemed to be subject to financial modeling are retained in the RMBS/CMBS Modeled Process. RMBS and CMBS that are deemed ineligible for financial modeling but that have been assigned credit ratings by NAIC CRPs migrate to the Filing Exempt Securities Process. RMBS and CMBS that are deemed ineligible for financial modeling and that have also not been assigned credit ratings by NAIC CRPs may be reported by the insurer in the **5GI NAIC General Interrogatory** with an NAIC 5GI and an NAIC Designation Category of 5.B GI.

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**PART THREE**  
**SVO PROCEDURES AND METHODOLOGY FOR PRODUCTION**  
**OF NAIC DESIGNATIONS**

**PRODUCTION OF NAIC DESIGNATIONS**

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**NAIC DESIGNATIONS RELATED TO SPECIAL REPORTING INSTRUCTION**

27. An insurance company that self-assigns a 5.B GI must attest that securities receiving this designation meet all required qualifications by completing the appropriate general interrogatory in the statutory financial statements. If documentation necessary for the SVO to perform a full credit analysis for a security does not exist or if an NAIC CRP credit rating for an FE or PL security is not available, but the issuer is not current on contractual interest and principal payments, and/or if the insurer does not have an actual expectation of ultimate payment of all contracted interest and principal, the insurance company is required to self-assign this security an NAIC 6\*.
28. NAIC 6\* is assigned by an insurer to an obligation in lieu of reporting the obligation with appropriate documentation in instances in which appropriate documentation does not exist, but the requirements for an insurance company to assign a 5.B GI are not met.
29. Securities with NAIC 5.B GI Designations Categories are deemed to possess the credit characteristics of securities assigned an NAIC 5.B Designation Category. A security assigned an NAIC 5.B GI Designation Category incurs the regulatory treatment associated with an NAIC 5.B Designation Category.
30. Securities an insurance company previously assigned as NAIC 5.B GI are permitted to subsequently receive this NAIC 6\* Designation Category if the requirements for an NAIC 5.B GI Designation Category continue to be met.
31. Securities with NAIC 6\* Designations are deemed to possess the credit characteristics of securities assigned an NAIC 6 Designation. Therefore, a security assigned an NAIC 6\* Designation incurs the regulatory treatment associated with an NAIC 6 Designation.
32. Securities that are residual tranches or interests, as defined in *SSAP 43R – Loan Backed and Structured Securities*, shall be reported on Schedule BA - Other Long-Term Invested Assets, without an NAIC Designation and are ineligible to be assigned an NAIC 5.B GI Designation Category or NAIC 6\* Designation.

**NOTE REGARDING RESIDUAL TRanches OR INTERESTS:** For 2021 year-end reporting only, residual tranches or interests previously reported on Schedule D-1: Long-Term Bonds shall be permitted to be reported on Schedule D-1 with an NAIC 6\* Designation, however an NAIC 5GI is not permitted.

**NOTE:** The GI after the quality indicator 5.B refers to General Interrogatory and distinguishes NAIC 5.B GI from an NAIC 5.B Designation Category. The asterisk (\*) after the quality indicator 6 distinguishes the NAIC 6\* Designation from an NAIC 6 Designation.

**REGULATORY TRANSACTIONS**

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**Status of Regulatory Transactions**

290. A Regulatory Transaction is not eligible for:
- Assignment of an NAIC Designation by the SVO;
  - The filing exemption process for publicly rated securities;
  - The private letter rating component of the filing exemption or for use of the PLGI designation symbol;
  - Self-assignment by an insurer of the administrative symbol Z under the 120-rule;
  - Self-reporting by an insurer on the general interrogatory for securities eligible for filing exemption but for which no NAIC CRP credit rating is available (i.e., 5.B GI) and
  - Inclusion in the SVO List of Investment Securities or any other NAIC electronic system or processes maintained for operations for the VOS/TF





**Steve Clayburn, FSA, MAAA**  
Senior Actuary, Health Insurance & Reinsurance  
[steveclayburn@acli.com](mailto:steveclayburn@acli.com)

January 9, 2023

Ms. Carrie Mears, Chair  
Valuation of Securities (E) Task Force  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

Via email: [ctherriault@naic.org](mailto:ctherriault@naic.org) and [dgenaorosado@naic.org](mailto:dgenaorosado@naic.org)

**Re: Re-Exposure Amendment to Part Four of the Purposes and Procedures Manual (“P&P Manual”) of the NAIC Investment Analysis Office to Include Collateralized Loan Obligations (“CLO”)**

Dear Ms. Mears:

ACLI appreciates the opportunity to provide comments on the Valuation of Securities Task Force's (VoSTF) re-exposure to update Part Four of the P&P Manual to include CLOs. We have the following ask for clarification with the newly written paragraph 24.

In the “Use of the Financial Modeling for Year-End Reporting for CLO, RMBS, and CMBS”, new paragraph 24, the following is the rewrite from the previous exposure:

24. Beginning with year-end **2024** ~~2023~~ for CLOs, probability weighted net present values will be produced **under NAIC staff supervision by SSG using its financial model** ~~by SSG~~ with defined analytical inputs selected by the SSG. SSG will model CLO investments and evaluate all tranche level losses across all debt and equity tranches under a series of calibrated and weighted collateral stress scenarios to assign NAIC Designations **Categories** for a specific CLO tranche ~~is~~ **will be as** determined by the NAIC. ~~Designation Intrinsic Price Mapping by SSG.~~

NOTE: Please refer to SSAP No. 43R—Loan-Backed and Structured Securities for guidance on all accounting and related reporting issues.

**NOTE: Effective as of January 1, 2024, SSG will financially model CLOs.**

Currently the paragraph starts by stating “beginning with year-end 2024 for CLOs”; however, the second note states “effective as of January 1, 2024, SSG will financially model CLOs”. This has raised the questions as what is the intent of the note and how will this work? In addition, can one explain how to understand the “year-end 2024” reference? If the SSG will provide designations for all CLOs starting January 1, 2024 (although not necessarily done for RMBS/CMBS), how are

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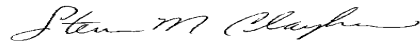
The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

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insurers expected to provide ratings/designations for CLO tranches for 2024 quarterly financial statements? If SSG cannot provide credit designations for all CLOs beginning Q1 2024, this raises the question which rating categories are eligible for insurers to complete their 2024 quarterly financial statements.

Thank you for the opportunity to continue to participate and comment on this issue. We look forward to future discussions and continued collaboration with the NAIC on this important initiative.

Sincerely,



Steve Clayburn

cc: Mike Monahan, ACLI  
Paul Graham, ACLI



TO: Carrie Mears, Chair, Valuation of Securities (E) Task Force  
Members of the Valuation of Securities (E) Task Force

FROM: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau  
Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)  
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)

RE: Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office  
(the "P&P Manual") to Include Collateralized Loan Obligations (CLO) as a Financially Model  
Security in Part Four

DATE: September 16, 2022 (**Updated: December 20, 2022**)

**Summary** – A collateralized loan obligation (CLO) is type of structured security backed by a pool of debt, typically corporate loans with low credit ratings. An insurer that purchases every tranche of a CLO holds the exact same investment risk as if it had directly purchased the entire pool of loans backing the CLO. The aggregate risk-based capital (RBC) factor for owning all of the CLO tranches should be the same as that required for owning all of the underlying loan collateral. If it is less, it means there is risk-based capital (RBC) arbitrage. As noted in the Investment Analysis Office’s (IAO) memo of May 25, 2022, “Risk Assessment of Structured Securities – CLOs”, it is currently possible to materially (and artificially) reduce C1 capital requirements just by securitizing a pool of assets.

**Recommendation** – The Investment Analysis Office recommends the Task Force assign the Structured Securities Group (SSG) the responsibility of financially modeling CLO investments. SSG can model CLO investments and evaluate all tranche level losses across all debt and equity tranches under a series of calibrated and weighted collateral stress scenarios to assign NAIC Designations that create equivalency between securitization and direct holdings, thereby eliminating RBC arbitrage.

The Task Force sent a referral to the Capital Adequacy (E) Task Force (CATF) and its Risk-Based Capital Investment Risk and Evaluation (E) Working Group (RBCIREWG) requesting those groups consider adding two new RBC factors. These recommended new RBC factors would account for the tail risk in any structured finance tranche. Staff also recommends adding NAIC Designation Categories (e.g. 6.A, 6.B and 6.C) with possible interim RBC factors of 30%, 75% and 100%, respectively, until those groups can further study structured securities. Staff request approval to draft a Blanks proposal for the new NAIC Designation Categories.

**Proposed Amendment** - The proposed text changes to P&P Manual are shown below with additions in red underline, deletions in ~~red strikethrough~~ as it would appear in the 2022 P&P Manual format. Changes made on December 20, 2022 are highlighted in **yellow**.

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**PART ONE**

**POLICIES OF THE NAIC VALUATION OF SECURITIES (E) TASK  
FORCE**



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<p style="text-align: center;"><b>POLICIES APPLICABLE TO FILING EXEMPT (FE) SECURITIES AND PRIVATE LETTER (PL) RATING SECURITIES</b></p>
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### **Filing Exemption**

82. Bonds, within the scope of SSAP No. 26R and SSAP No. 43R (excluding **CLO** RMBS and CMBS subject to financial modeling) and Preferred Stock within scope of SSAP No. 32, that have been assigned an Eligible NAIC CRP Rating, are exempt from filing with the SVO (FE securities) with the exception of Bonds and or Preferred Stock explicitly excluded in this Manual.

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**PART TWO**  
**OPERATIONAL AND ADMINISTRATIVE INSTRUCTIONS**  
**APPLICABLE TO THE SVO**



## COMPILATION AND PUBLICATION OF THE SVO LIST OF INVESTMENT SECURITIES

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### Directive

3. On a quarterly basis, the SVO shall:
  - Compile a list of Investment Securities from each of the data files defined as VOS Process, Filing Exempt Securities Process, **CLO/RMBS/CMBS Modeled Securities Process**, U.S. Treasury Process and the Exempt U.S. Government Securities Process (each an SVO Sub-List bearing the name of the corresponding Process).

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### **CLO/RMBS/CMBS Modeled Securities Process**

6. **Collateralized Loan Obligations (CLO)**, Residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS) are Investment Securities, reported by an insurance company to the NAIC and subsequently added by NAIC staff to the **CLO/RMBS/CMBS Modeled Securities Process**, where on an annual basis and for purposes of the annual surveillance they are evaluated for eligibility to be financially modeled.
7. **CLO/RMBS** and CMBS that are deemed to be subject to financial modeling are retained in the **CLO/RMBS/CMBS Modeled Process**. **CLO**, RMBS and CMBS that are deemed ineligible for financial modeling but that have been assigned credit ratings by NAIC CRPs migrate to the Filing Exempt Securities Process. **CLO**, RMBS and CMBS that are deemed ineligible for financial modeling and that have also not been assigned credit ratings by NAIC CRPs may be reported by the insurer in the **5GI General Interrogatory**.
8. Insurance companies shall not file Regulatory Transactions as eligible for the **CLO/RMBS/CMBS Modeled Securities Process**, and the NAIC staff shall not add a Regulatory Transaction to the **CLO/RMBS/CMBS Modeled Securities Process**.

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## **NAIC POLICY ON THE USE OF CREDIT RATINGS OF NRSROS**

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**NOTE:** See “Coordination Between the Statutory Accounting Principles Working Group and the Valuation of Securities Task Force, “Use of Credit Ratings of NRSROs in NAIC Processes” and “Policies Applicable to the Filing Exemption (FE) Process” in Part One; “Definition – Credit Ratings Eligible for Translation to NAIC Designations in this “NAIC Policy on the Use of Credit Ratings of NRSROs”; “Procedure Applicable to Filing Exempt (FE) Securities and Private Letter (PL) Rating Securities” in Part Three; and “Filing Exemption Status of **CLO**, RMBS and CMBS” in Part Four, which excludes **CLO**, RMBS and CMBS from the use of **NRSRO** credit ratings for NAIC regulatory processes.





**PART THREE**  
**SVO PROCEDURES AND METHODOLOGY FOR PRODUCTION**  
**OF NAIC DESIGNATIONS**



## **PROCEDURE APPLICABLE TO FILING EXEMPT (FE) SECURITIES AND PRIVATE LETTER (PL) RATING SECURITIES**

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**NOTE:** See “Use of Credit Ratings of NRSROs in NAIC Processes” and “Coordination Between the Statutory Accounting Principles Working Group and the Valuation of Securities Task Force” (especially “NAIC Designations Do Not Communicate Statutory Accounting or Reporting” and “Policies Applicable to the Filing Exemption (FE) Process”) in Part One; “NAIC Policy on the Use of Credit Ratings of NRSROs” (especially “Definition – Credit Ratings Eligible for Translation to NAIC Designations”) in Part Two (the definition excludes the use of NAIC CRP credit ratings assigned to a security type where the NAIC has determined that the security type is not eligible to be reported on Schedule D or the it is not appropriate for NRSRO credit ratings to be used to determine the regulatory treatment of the security or asset, as specified in this Manual); and “Filing Exemption Status of **CLO**, RMBS and CMBS” in Part Four (excluding **CLO**, RMBS and CMBS from the use of credit ratings for NAIC regulatory processes).

<b>FE SECURITIES</b>
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### **Filing Exemption**

3. Bonds, within the scope of SSAP No. 26R and SSAP No. 43R (excluding **CLO**, RMBS and CMBS subject to financial modeling) and Preferred Stock within scope of SSAP No. 32, that have been assigned an Eligible NAIC CRP Rating, as described in this Manual, are exempt from filing with the SVO (FE securities) with the exception of Bonds and/or Preferred Stock explicitly excluded below.



**PART FOUR**  
**THE NAIC STRUCTURED SECURITIES GROUP**



## DEFINITIONS

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1. The following terms used in this Part Four have the meaning ascribed to them below.
  - **ABS** stands for asset-backed securities and means structured securities backed by consumer obligations originated in the United States.
  - **CLO** stands for collateralized loan obligation and means structured securities backed by a pool of debt, typically corporate loans with low credit ratings. The loans are managed by a collateral manager which bundles the initial loans (for example, generally 150 or more) together and then actively manages the portfolio -- buying and selling loans. To fund the purchase of new debt, the CLO manager sells various tranches of the CLO to outside investors, such as which could include insurers. Each tranche differs based on the order-priority in which the investors will be paid when the underlying loan payments are made. As a result, they also differ with respect to the risk associated with the investment since investors who are in lower tranches paid last have a higher risk of default from the underlying loans. To compensate for the risk, the interest coupon payments on the subordinate tranches are higher. Investors who are in higher tranches paid out first have lower overall risk, but they receive smaller interest coupon payments, as a result.
  - **CMBS** stands for commercial mortgage-backed securities and means structured securities backed by commercial real estate mortgage loans originated in the United States. The definition of CMBS may refer to securitizations backed by commercial mortgages, respectively, originated outside of the United States if and to the extent that the vendor selected by the NAIC to conduct the financial modeling: (a) has the necessary information about the commercial mortgage and commercial mortgage loans originated outside of the United States to fully model the resulting securities; and (b) can adapt the modeling process to account for any structural peculiarities associated with the jurisdiction in which the mortgage was originated.
  - **Initial Information** means the documentation required to be filed with an Initial Filing of an CLO, RMBS or a CMBS CUSIP, pursuant to the section below and pertaining to Loan Information, Reps and Warranty Information and Structure and Formation Information for the transaction, where:



- *Loan Information* For RMBS and CMBS, means a review of the loan files by a third party to assess the sufficiency of legal title and other related issues. For middle market loans in CLOs, means a review consistent with the guidance in Part Three of this manual for General Corporate and Municipal Methodology for Independent Credit Quality Assessment. This requirement will generally not apply to broadly syndicated bank loans.
- *Reps and Warranty Information* means the actual representation and warranties in effect for the securitization given by the mortgage originator(s) to the Trust pertaining to loan origination processes and standards, compliance with applicable law, loan documentation and the process governing put backs of defective mortgages back to the originator(s). Rep and Warranty information will generally not be applicable or required in the case of CLOs.
- *Structure and Formation Information* means the waterfall, as described in the definition of Ongoing Information, information and documentation in the form of legal opinions and documentation governing the formation of the securitization and its entities relative to issues such as bankruptcy remoteness, true sale characterization, the legal standards and procedures governing the securitization and other similar issues. In each case, as applicable to the relevant asset class in question.
- **Intrinsic Price** is an output of financial modeling, defined as ‘1 – weighted average of discounted principal loss’ expressed as a percentage, reflecting the credit risk of the security.
- **Legacy Security**, for the purposes of this section shall mean any RMBS and any CMBS that closed prior to January 1, 2013.
- **Official Price Grids** means and refers to those generated by the SSG and provided to an insurance company or insurance companies that own the security for regulatory reporting purposes.



- **Ongoing Information** differs based on the asset class of the security being reviewed. In general, Ongoing Information can consist of: (a) tranche level data; such as principal balance, factors, principal and interest due and paid, interest shortfalls, allocated realized losses, appraisal reductions and other similar information typically provided by the trustee in periodic reports for the specific tranche; (b) trust level data, such as aggregate interest and principal and other payments received, balances and payments to non-tranche accounts, aggregate pool performance data and other similar information; (c) loan level performance information (where such information is not otherwise available - for example, broadly syndicated loans - it will generally not require such information); and (d) a computerized model of rules that govern the order and priority of the distribution of cash from the collateral pool (i.e., the “waterfall”) to the holders of the certificates/securities—provided in the format and modeling package used by the NAIC financial modeling vendor.
- **Original Source**, with respect to a specific set of data, means the Trustee, Servicer or similar entity that is contractually obligated under the agreement governing the RMBS or CMBS to generate and maintain the relevant data and information in accordance with standards specified in applicable agreements or an authorized re-distributor of the same.
- **NAIC Designation Intrinsic Price Mapping** is the mapping of the Intrinsic Price to a single NAIC Designation and Designation Category employing the midpoints between each adjoining AVR RBC charges (pre-tax). The midpoints are directly used as the minimum Intrinsic Prices (weighted average loss points) for corresponding NAIC Designations and Designation Categories.
- **Price Grids** means and refers to CUSIP-specific price matrices containing six price breakpoints; i.e., each price corresponding to a specific NAIC Designation category. Each breakpoint on a Price Grid is the price point that tips the NAIC Designation for the RMBS CUSIP into the next NAIC Designation (credit quality/credit risk) category. The plural is used because two Price Grids are generated for any CUSIP. This reflects the difference in RBC for those insurance companies that maintain an asset valuation reserve and for those insurance companies that do not.



- **Re-REMIC** is a securitization backed by: (a) otherwise eligible RMBS from one or two transactions; or (b) otherwise eligible CMBS from one or two transactions at closing. Re-REMICs cannot acquire any Underlying Securities after closing.
- **RMBS** stands for residential mortgage-backed securities and means structured securities backed by non-agency residential mortgages originated in the United States, where the collateral consists of loans pertaining to non-multi-family homes. That includes prime, subprime and Alt-A mortgages, as well as home-equity loans, home-equity lines of credit and Re-REMICs of the above. Excluded from this definition is agency RMBS, where the mortgages are guaranteed by federal and federally sponsored agencies such as the Government National Mortgage Association (GNMA), Federal National Mortgage Association (FNMA) or Federal Home Loan Mortgage Corporation (FHLMC) and loans against manufactured or mobile homes or collateralized debt obligations backed by RMBS. The exclusion covers bonds issued and guaranteed by, or only guaranteed by, the respective agency. Also not included are loans guaranteed by the U.S. Department of Veteran Affairs or the U.S. Department of Agriculture's Rural Development Housing and Community Facilities Programs. The definition of RMBS may refer to securitizations backed by residential mortgages, respectively, originated outside of the United States if and to the extent that the vendor selected by the NAIC to conduct the financial modeling: (a) has the necessary information about the residential mortgage and residential mortgage loans originated outside of the United States to fully model the resulting securities; and (b) can adapt the modeling process to account for any structural peculiarities associated with the jurisdiction in which the mortgage was originated.
- **Underlying Security** means the RMBS or CMBS backing a Re-REMIC. A Re-REMIC cannot be an Underlying Security.

**NOTE:** The definitions of **CLO**, RMBS and CMBS reflect limitations associated with the financial modeling process, NAIC credit rating provider (CRP) internal naming conventions and SSG processes, as more fully discussed below and may, therefore, be subject to a narrower or a broader reading in any reporting period. Please call the SSG with any concerns or questions about the scope of the definitions for a given reporting period. Also note:



- It is possible that the scope of the CLO, RMBS and CMBS definitions may be broadened because the financial modeling vendors indicate other collateral or waterfall structures can be modeled.
- NAIC CRPs may adopt different internal conventions with respect to what market or asset segments are within their rated populations of CLO, RMBS, CMBS or ABS. This could affect the application of the adopted NAIC methodology or require the NAIC to select which naming process it wishes to adopt.
- It is possible that the SSG will acquire analytical assessment capabilities that permit the assessment of existing, additional or different structured securities that cannot now be modeled or that are not currently rated.





## ADMINISTRATIVE AND OPERATIONAL MATTERS

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### Certain Administrative Symbols

2. The following administrative symbols are used in the Valuation of Securities (VOS) Products to identify RMBS and CMBS that the NAIC vendor has confirmed will be subject to the financial modeling methodology and application of Price Grids described in this Part.
  - **FMR** – Indicates that the specific CUSIP identifies a Legacy Security RMBS that is subject to the financial modeling methodology and the application of Price Grids to determine a NAIC Designation and Designation Category.
  - **FMC** – Indicates that the specific CUSIP identifies a Legacy Security CMBS that is subject to the financial modeling methodology and the application of Price Grids to determine a NAIC Designation and Designation Category
  - Non-Legacy RMBS and CMBS subject to the financial modeling methodology would be assigned an NAIC Designation and Designation Category by the SSG without an administrative symbol.
  - **CLO** subject to the financial modeling methodology would be assigned an NAIC Designation and Designation Category by the SSG without an administrative symbol.

**NOTE:** The administrative symbols **FMR** and **FMC** are related to symbols that insurers are required to use in the financial statement reporting process. Under applicable financial statement reporting rules, an insurer uses the symbol **FM** as a suffix to identify Legacy Security modeled RMBS and CMBS CUSIPs. The symbol **FM** is inserted by the insurer in the financial statement as a suffix following the NAIC Designation Category for Legacy Security RMBS and CMBS; (e.g., **2.B FM**), and for **CLO** and Non-Legacy RMBS and CMBS it would be left blank (e.g. **3.C**).

The use of these administrative symbols in the VOS Product means the insurer should not use the filing exempt process for the security so identified.



### Quarterly Reporting of RMBS and CMBS

3. To determine the NAIC Designation to be used for quarterly financial statement reporting for a **CLO**, RMBS or CMBS purchased subsequent to the annual surveillance described in this Part, the insurer uses the prior year-end modeling data for that CUSIP (which can be obtained from the NAIC) and follows the instructions in contained under the heading “Use of Net Present Value and Carrying Value for Financially Modelled Legacy Security RMBS and CMBS” or “Use of Intrinsic Price for Financially Modelled non-Legacy Security RMBS and CMBS” below, subject to, and in accordance with, *SSAP No. 43R—Loan-Backed and Structured Securities*.



## FILING EXEMPTIONS

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### Limited Filing Exemption for RMBS and CMBS

4. **CLO, RMBS and CMBS that Can be Financially Modeled** – CLO, RMBS and CMBS that can be financially modeled are exempt from filing with the SVO. NAIC Designations for CLO, RMBS and CMBS that can be financially modeled are determined by application of the methodology discussed in this Part, not by the use of credit ratings of CRPs.
5. **CLO, RMBS and CMBS securities that Cannot be Financially Modeled**
  - **But Are Rated by a CRP** – CLO, RMBS and CMBS that cannot be financially modeled but that are rated by a CRP are exempt from filing with the SSG. The NAIC Designations for these CLO, RMBS and CMBS are determined by application of the filing exemption procedures discussed in this Manual.
  - **But Are Not Rated by a CRP** – CLO, RMBS and CMBS that cannot be financially modeled and that are not rated by a CRP are not filing exempt and must be filed with the SSG or follow the procedures, as discussed below in this Part.

### Filing Exemption for ABS

6. ABS rated by a CRP are exempt from filing with the SSG.

### Review of Decisions of the SSG

7. Analytical decisions made through the application of financial modeling are not subject to the appeal process. In the absence of an appeal, the SSG shall provide whatever clarification as to the results of financial modeling is possible to any insurer who requests it and owns the security, provided that it is not unduly burdensome for the SSG to do so. Any decision made by the SSG that results in the assignment of an NAIC Designation and does not involve financial modeling methodology, whether developed by the SSG on its own or in collaboration with the SVO, is subject to the appeal process.



## **REQUIRED DATA AND DOCUMENTS FOR TRANSACTIONS SUBMITTED TO THE SSG**

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8. The policy statement set forth in this section shall be applicable generally to any transaction filed with the SSG for an analytical assessment, including, but not limited to, a Price Grid or for assignment of an NAIC Designation. Any filing with the SSG is deemed to be incomplete unless the insurer has provided the information, documentation, and data in quantity and quality sufficient to permit the SSG to conduct an analysis of the creditworthiness of the issuer and the terms of the security to determine the requested analytical value. It is the obligation of the reporting insurance company to provide the SSG with all necessary information. It is the responsibility of the SSG to determine whether the information provided is sufficient and reliable for its purposes and to communicate informational deficiencies to the reporting insurance company.

### **Documentation Standards**

9. In order for an insurer-owned CLO, RMBS or CMBS to be eligible for the year-end modeling process, conducted pursuant to this section below, the analysis must be based on information, documentation and data of the utmost integrity. A Legacy Security must meet the Ongoing Information requirements. A CLO, RMBS, CMBS or Re-REMIC that is not a Legacy Security must meet the Initial Information and Ongoing Information requirements. For the purposes of determining a Re-REMIC's status as a Legacy Security, the closing date of the Re-REMIC (not the Underlying Security) shall be used. The SSG may, in its sole discretion, determine that the Initial Information and/or Ongoing Information is not sufficient and/or not reliable to permit the CLO, RMBS or CMBS CUSIP to be eligible for financial modeling. If the SSG determines that the Initial Information and/or Ongoing Information is not sufficient and/or not reliable to permit the CLO, RMBS or CMBS CUSIP to be eligible for financial modeling, it will communicate this decision to the insurer and invite a dialogue to ascertain whether alternative information is available that would be deemed sufficient and/or reliable by the SSG.

### **Initial Information Requirements**

10. A CLO, RMBS or CMBS meets the Initial Information Requirements if the security meets one of the following three conditions:



- **RTAS** – The RMBS or CMBS was assigned a preliminary price grid or designation as described in this Part;
- **Initial Sufficiency Filing** – The **CLO**, RMBS or CMBS was reviewed by SSG through an Initial Sufficiency Filing; or
- **Safe Harbor** – The **CLO**, RMBS or CMBS meets the Safe Harbor requirements.

### Initial Sufficiency Information Filing

11. An insurance company may file Initial Sufficiency Information with the SSG for the purpose of obtaining a determination that a **CLO**, RMBS or CMBS CUSIP is eligible for financial modeling under the annual surveillance process discussed below. Initial Sufficiency Information is only filed once for any given **CLO**, RMBS or CMBS. Reporting insurance companies are solely responsible for providing the SSG with Initial Information. A determination by the SSG that a given **CLO**, RMBS or CMBS CUSIP is eligible for financial modeling after an Initial Sufficiency Filing assessment is subject to the further and continuing obligation that the SSG obtain or the insurer provide the SSG with updated Ongoing Information close to the date of the annual surveillance.
12. **Required Documents for Initial Sufficiency Filing** – An insurer that owns a **CLO**, RMBS or a CMBS for which Initial Information is not publicly available shall provide the SSG with the following documentation.
13. **CLO** – Unless otherwise specified by the SSG in a Modeling Alert, as further described below, an Initial Filing for a CLO consists of submission of Initial Information and Ongoing Information in the form of the following documentation, as may be appropriate:
  - **Pooling and Servicing Agreement Indenture** or similar
  - **Prospectus, Offering Memorandum or similar; Accountant’s comfort letter, if obtained in connection with such transaction.**
  - If applicable, ISDA Schedules and Confirmations or similar
  - Legal opinions given in connection with the transaction
  - Any other documents referenced by the above



- ~~Third-Party Due diligence scope document and raw results. If less than 100% due diligence, detailed description of the loan selection process.~~
- ~~If applicable, loan purchase agreements or similar.~~
- ~~Loan Tape~~
- All available eligible CRP ratings for underlying loan portfolio.
- For each unrated underlying loans, the Prospectus, Offering Memorandum or similar; 3-years of audited financial statements for the issuing entity.

14. **RMBS** – Unless otherwise specified by the SSG in a Modeling Alert, as further described below, an Initial Filing for an RMBS consists of submission of Initial Information and Ongoing Information in the form of the following documentation:

- Pooling and Servicing Agreement or similar
- Prospectus, Offering Memorandum or similar; Accountant’s comfort letter
- If applicable, ISDA Schedules and Confirmations or similar
- Legal opinions given in connection with the transaction
- Any other documents referenced by the above
- Third-Party Due diligence scope document and raw results. If less than 100% due diligence, detailed description of the loan selection process
- If applicable, loan purchase agreements or similar. Loan Tape

15. **CMBS** – Unless otherwise specified by the SSG in a Modeling Alert, as further described below, an Initial Filing for a CMBS consists of submission of Initial Information and Ongoing Information in the form of the following documentation:

- Pooling and Servicing Agreement or similar
- Prospectus, Offering Memorandum or similar; Accountant’s comfort letter
- If applicable, ISDA Schedules and Confirmations or similar
- Legal opinion given in connection with the transaction
- Any other documents referenced in the above
- Asset Summaries



- Loan Tape
- Loan documents, including reliable information about the terms of the transaction; including, but not limited to, financial covenants, events of default, legal remedies and other information about financial, contractual or legal aspects of the transaction in form and substance consistent with industry best practices for CMBS issuance.
- In certain cases, additional documents below will enable the SSG to verify and validate initial underwriting information of the property securing the CMBS. These documents may be required in form and substance consistent with best practices for typical CMBS issuance.
- Historical operating statements and borrower's budget
- Underwriter's analysis of stabilized cash flow with footnotes of assumptions used
- Property type specific, rent roll information
- Appraisals and other data from recognized industry market sources
- Independent engineering report (Property Condition Assessment)
- Environmental Site Assessment (ESA) – Phase I/Phase II
- Documentation related to seismic, flood and windstorm risks
- Franchise agreements and ground leases, if applicable
- Management agreements

### **SSG Modeling Alerts**

16. The SSG shall at all times have discretion to determine that differences in the structure, governing law, waterfall structure or any other aspect of a securitization or a class of securitization requires that insurance companies provide Initial Information and/or Ongoing Information additional to or different from that identified in this Part. The SSG shall communicate such additional or different documentation requirements to insurers by publishing a Modeling Alert on the NAIC website and scheduling a meeting of the VOS/TF to ensure public dissemination of the decision.



### Safe Harbor

17. Safe Harbor options serve as proxies for the Initial Sufficiency filing. The options reflect publicly available information that a third party has analyzed the Initial Information. Because the structured securities market is quite dynamic, the list of Safe Harbor options may change frequently, with notice and opportunity for comment, as described in this section. A CLO, RMBS or CMBS meets the Initial Information requirement if:

- At least two Section 17(g)-7 reports issued by different CRPs are publicly available; or
- A security that is publicly registered under the federal Securities Act of 1933.

### Ongoing Information Requirements

18. A CLO, RMBS or CMBS meets the Ongoing Information Requirements if Ongoing Information is available to the SSG and the relevant third-party vendor from an Original Source. The SSG, in its sole discretion and in consultation with the relevant third-party vendor, may determine that the Ongoing Information is not sufficient or reliable to permit a given CLO, RMBS or CMBS CUSIP to be financially modeled. However, in making such a determination, the SSG shall take into account reasonable market practices and standards.

### Special Rules for Certain Re-REMICs

19. Re-REMICs are generally simple restructurings of RMBS or CMBS. An Initial Sufficiency Filing for a Re-REMIC (a) which is not a Legacy Security itself but (b) where each Underlying Security is a Legacy Security shall not require submission of information regarding the Underlying Securities. In most cases, a prospectus for the Re-REMIC will be sufficient. If the SSG determines that additional information about the Re-REMIC structure or formation is required, it will communicate this decision to the insurer and invite a dialogue to ascertain whether additional information is available that would be deemed sufficient by the SSG.





## ANALYTICAL ASSIGNMENTS

### ANNUAL SURVEILLANCE OF CLO, RMBS AND CMBS – MODELED AND NON-MODELED SECURITIES

#### Scope

20. This section explains the financial modeling methodology applicable to all CLO, RMBS and CMBS (defined above) securitizations, the book/adjusted carrying value methodology applicable to a modeled Legacy Security, the NAIC Designation Intrinsic Price Mapping applicable to a modeled non-Legacy Security, and non-modeled securities subject to SSAP No. 43R—*Loan-Backed and Structured Securities*. Please refer to SSAP No. 43R for a description of securities subject to its provisions. The VOS/TF does not formulate policy or administrative procedures for statutory accounting guidance. Reporting insurance companies are responsible for determining whether a security is subject to SSAP No. 43R and applying the appropriate guidance.

#### Important Limitation on the Definitions of RMBS and CMBS

21. The definitions of CLO, RMBS and CMBS above are intended solely to permit the SSG to communicate with financial modeling vendors, insurance company investors who own CLO, RMBS and CMBS subject to financial modeling and/or the book/adjusted carrying value methodology and their investment advisors to facilitate the performance by the SSG of the financial modeling methodology described below. The definitions contained in this section are not intended for use and should not be used as accounting or statutory statement reporting instructions or guidance.

**NOTE:** Please refer to SSAP No. 43R—*Loan-Backed and Structured Securities* for applicable accounting guidance and reporting instructions.

### ANALYTICAL PROCEDURES APPLICABLE TO CLO, RMBS AND CMBS SECURITIZATIONS SUBJECT TO FINANCIAL MODELING METHODOLOGY

#### Filing Exemption Status of RMBS and CMBS

22. CLO, RMBS and CMBS are not eligible for filing exemption because credit ratings of CRPs are no longer used to set risk-based capital (RBC) for CLO, RMBS or CMBS. However, CLO, RMBS and CMBS are not submitted to the SSG.



### Use of Financial Modeling for Year-End Reporting for CLO, RMBS and CMBS

23. Beginning with year-end 2009 for RMBS, and 2010 for CMBS, probability weighted net present values will be produced under NAIC staff supervision by an NAIC-selected vendor using its financial model with defined analytical inputs selected by the SSG. The vendor will provide the SSG with a Intrinsic Price and/or a range of net present values for each RMBS or CMBS corresponding to each NAIC Designation category. The NAIC Designation for a specific Legacy Security RMBS or CMBS is determined by the insurance company, based on book/adjusted carrying value ranges, and the NAIC Designation for a specific non-Legacy Security RMBS or CMBS is determined by the NAIC Designation Intrinsic Price Mapping by SSG.
24. Beginning with year-end 2024 2023 for CLOs, probability weighted net present values will be produced under NAIC staff supervision by SSG using its financial model by SSG with defined analytical inputs selected by the SSG. SSG will model CLO investments and evaluate all tranche level losses across all debt and equity tranches under a series of calibrated and weighted collateral stress scenarios to assign NAIC Designations Categories for a specific CLO tranche is will be as determined by the NAIC. Designation Intrinsic Price Mapping by SSG.

**NOTE:** Please refer to *SSAP No. 43R—Loan-Backed and Structured Securities* for guidance on all accounting and related reporting issues.

**NOTE:** Effective as of January 1, 2024, SSG will financially model CLOs.

### Analytical Procedures for CLO, RMBS and CMBS

25. The SSG shall develop and implement all necessary processes to coordinate the engagement by the NAIC of a vendor who will perform loan-level analysis of insurer-owned CLO, RMBS and CMBS using the vendor's proprietary models.

<b>CLO, RMBS AND CMBS SUBJECT TO FINANCIAL MODELING</b>
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### Setting Microeconomic Assumptions and Stress Scenarios

26. Not later than September of each year, the SSG shall begin working with the vendor to identify the assumptions, stress scenarios and probabilities (hereafter model criteria) the SSG intends to use at year-end to run the vendor's financial model.



**The Financial Modeling Process**

27. Information about the financial modeling process can be found at [www.naic.org/structured\\_securities/index\\_structured\\_securities.htm](http://www.naic.org/structured_securities/index_structured_securities.htm).

**Use of Net Present Value and Carrying Value for Financially Modeled Legacy Security RMBS and CMBS**

28. For each modeled Legacy Security RMBS and CMBS, the financial model determines the net present value at which the expected loss equals the midpoint between the RBC charges for each NAIC Designation; i.e., each price point, if exceeded, changes the NAIC Designation. Net present value is the net present value of principal losses, discounted using the security’s coupon rate (adjusted in case of original issue discount securities to book yield at original issue and in case of floating rate securities, discounted using LIBOR curve + Origination spread). Because of the difference in RBC charge, the deliverable is five values for each RMBS and CMBS security for companies required to maintain an asset valuation reserve (AVR) and five values for companies not required to maintain an AVR. This is illustrated in the chart below.

**RBC charge / NAIC designation (pre-tax)**

P&C	RBC	Midpoint
1	0.3%	0.65%
2	1.0%	1.50%
3	2.0%	3.25%
4	4.5%	7.25%
5	10.0%	20.00%
6	30.0%	
Life	RBC	Midpoint
1	0.4%	0.85%
2	1.3%	2.95%
3	4.6%	7.30%
4	10.0%	16.50%
5	23.0%	26.50%
6	30.0%	



29. The NAIC Designation and NAIC Designation Category for a given modeled Legacy Security RMBS or CMBS CUSIP owned by a given insurance company depends on the insurer’s book/adjusted carrying value of each RMBS or CMBS, whether that carrying value, in accordance with *SSAP No. 43R—Loan-Backed and Structured Securities*, paragraphs 25 through 26a, is the amortized cost or fair value, and where the book/adjusted carrying value matches the price ranges provided in the model output for each NAIC Designation and the mapped NAIC Designation Category, reflected in the table below, to be used for reporting an NAIC Designation Category until new prices ranges are developed to reflect the full range of new Risk Based Capital factors adopted for each NAIC Designation Category; except that a modeled Legacy Security RMBS or CMBS tranche that has no expected loss under any of the selected modeling scenarios would be assigned an **NAIC 1 Designation** and **NAIC 1.A Designation Category** regardless of the insurer’s book/adjusted carrying value.

**NOTE:** Please refer to the detailed instructions provided in SSAP No. 43R.

NAIC Designation Determined by Modeled Price Ranges	Mapped NAIC Designation Category
1	1.D
2	2.B
3	3.B
4	4.B
5	5.B
6	6

**Use of Intrinsic Price for Financially Modeled CLO and non-Legacy Security RMBS and CMBS**

30. The NAIC Designation and NAIC Designation Category for a given modeled CLO and non-Legacy Security RMBS or CMBS CUSIP owned by a given insurance is assigned by SSG and **does not** depend on the insurer’s book/adjusted carrying value of each CLO, RMBS or CMBS. The NAIC Designation and Designation Category assigned will be determined by applying the Intrinsic Price to the NAIC Designation Intrinsic Price Mapping, as defined in this Part.



**Securities Not Modeled by the SSG and Not Rated by an NAIC CRP or Designated by the SVO**

31. Securities subject to *SSAP No. 43R—Loan-Backed and Structured Securities* that cannot be modeled by the SSG and are not rated by an NAIC CRP or designated by the SVO are either: (a) assigned the NAIC administrative symbol **ND** (not designated), requiring subsequent filing with the SVO; or (b) assigned the NAIC Designation for Special Reporting Instruction [i.e., an **NAIC 5GI**, NAIC Designation Category **NAIC 5.B GI** or **NAIC 6\*** (six-star)].



## **MORTGAGE REFERENCED SECURITIES**

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### **Definition**

32. A Mortgage Referenced Security has the following characteristics: A Mortgage Referenced Security’s coupon and/or principal payments are linked, in whole or in part, to prices of, or payment streams from, real estate, index or indices related to real estate, or assets deriving their value from instruments related to real estate, including, but not limited to, mortgage loans.

### **Not Filing Exempt**

33. A Mortgage Referenced Security is not eligible for filing exemption but is subject to the filing requirement.

### **NAIC Risk Assessment**

34. In determining the NAIC Designation of a Mortgage Referenced Security, the SSG may use the financial modeling methodology discussed in this Part, adjusted (if and as necessary) to the specific reporting and accounting requirements applicable to Mortgage Referenced Securities.

### **Quarterly Reporting for Mortgage Reference Securities**

35. To determine the NAIC Designation to be used for quarterly financial statement reporting for a Mortgage Reference Security purchased subsequent to the annual surveillance described in this Part, the insurer uses the prior year-end modeling data for that CUSIP (which can be obtained from the NAIC) until the annual surveillance data is published for the current year. For a Mortgage Reference Security that is not in the prior year-end modeling data for that CUSIP, the insurer may follow the instructions in Part Two of this manual for the assignment of the SVO Administrative Symbol “Z” provided the insurer owned security meets the criteria for a security that is in transition in reporting or filing status.

**NOTE:** Please refer to SSAP No. 26R and SSAP No. 43R for the definition of and guidance on Structured Notes and Mortgage Referenced Securities. Please also refer to Part Three of this Manual for guidance about the filing exempt status of Structured Notes.



## **GROUND LEASE FINANCING TRANSACTIONS**

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### **Definition**

36. Ground Lease Financing (GLF) transactions are defined and explained in “Ground Lease Financing Transactions” in Part Three of this Manual.

### **SSG Role and Process**

37. On occasion, the SVO may refer a GLF transaction to the SVO for financial modeling of the GLF space leases or business operation, as applicable, in accordance with the process set forth in “Ground Lease Financing Transactions” in Part Three of this Manual. Following an SVO referral the SSG and SVO will maintain open communication related to requests for additional data, analytical questions and analytical conclusions. Any GLF transaction NAIC Designation will be assigned by the SVO.



## **THE RTAS – EMERGING INVESTMENT VEHICLE**

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### **Purpose**

38. Price grids and/or NAIC Designation and Designation Categories are generated for the exclusive use of insurance companies and the NAIC regulatory community. Insurance companies use official Prices Grids and/or NAIC Designations and Designation Categories by following the instructions in *SSAP No. 43R—Loan-Backed and Structured Securities* to derive a final NAIC Designation for the **CLO**, RMBS or CMBS, which they use to derive the RBC applicable for the **CLO**, RMBS or CMBS.

**NOTE:** Please refer to SSAP No. 43R for a full explanation of the applicable procedure.

### **Extension of Authority**

39. The Regulatory Treatment Assessment Service – Emerging Investment Vehicle procedure is extended to the SSG, and the SSG is authorized to determine probable regulatory treatment for **CLO**, RMBS and CMBS pursuant to this Part or for other securities, where, in the opinion of the SSG, financial modeling methodology would yield the necessary analytical insight to determine probable regulatory treatment or otherwise enable the SSG to make recommendations to the VOS/TF as to regulatory treatment for a security.

### **Interpretation**

40. To facilitate this purpose, wherever in the Regulatory Treatment Assessment Service – Emerging Investment Vehicle procedure reference is made to the SVO, it shall be read to also refer to and apply to the SSG, adjusting for differences in the operational or methodological context. The Regulatory Treatment Assessment Service – Emerging Investment Vehicle procedure shall also be read as authority for collaboration between SVO and SSG staff functions so as to encompass RTAS assignments that require the use of SVO financial, corporate, municipal, legal, and structural analysis and related methodologies, as well as of financial modeling methodologies.





### Translation of Preliminary into Official Price Grids and/or NAIC Designations and Designation Categories

41. Price Grids and/or Designations and Designation Categories (“PGD”) generated by the SSG pursuant to an RTAS are preliminary within the meaning of that term as used in the Regulatory Treatment Assessment Service – Emerging Investment Vehicle procedure and accordingly cannot be used for official NAIC regulatory purposes. Preliminary NAIC Designations are translated into official NAIC Designations by the SVO when an insurance company purchases and files the security and the SVO conducts an official assessment. However, this Manual does not require the filing of CLO, RMBS and CMBS subject to financial modeling methodology with the SSG. It is, therefore, necessary to specify a procedure for the translation of preliminary Price Grids and/or Designations and Designation Categories (“Preliminary PGD”) into official PGD that can be used for NAIC regulatory purposes. Preliminary PGDs generated by the SSG become an official PGD within the meaning of this section when an insurance company has purchased the security for which the PGD was generated and reported that security for quarterly reporting purposes using the SSG generated PGD. A PGD for a security reported by an insurance company for quarterly reporting is effective until the SSG conducts the next annual surveillance pursuant to this Part at which the time the PGD generated by the SSG at year-end shall be the official PGDs for that security.

<https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2022/2022-12 - Fall National Meeting/02-CLOs Part Four/2022-004.12b - PP Amend to Add CLO to Part Four v2.docx>

**FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE**

Financial Regulation Standards and Accreditation (F) Committee March 22, 2023, Minutes ..... 10-2

Memorandum from the Statutory Accounting Principles (E) Working Group Regarding Financial Regulation Standards – As of March 2023 *Accounting Practices and Procedures Manual* (Attachment One)..... 10-4

Memorandum from the Blanks (E) Working Group Regarding Items Impacting Current Accreditation Standard (Attachment Two) ..... 10-9

Memorandum from the Capital Adequacy (E) Task Force Regarding Accreditation Standards – Changes to the RBC Formulas and Instructions for Health, Life, and P/C (Attachment Three) ..... 10-13

Memorandum from the Financial Examiners Handbook (E) Technical Group Regarding Consideration for Financial Accreditation Standards 2023 *Financial Condition Examiners Handbook* (Attachment Four) ..... 10-15

Memorandum from the Valuation of Securities (E) Task Force Regarding Report of the Valuation of Securities (E) Task Force (Attachment Five) ..... 10-17

Memorandum from the Life Actuarial (A) Task Force Regarding Financial Regulation Standards – As of March 2023 *Valuation Manual* (Attachment Six) ..... 10-22

Draft: 3/28/23

Financial Regulation Standards and Accreditation (F) Committee  
Louisville, Kentucky  
March 22, 2023

The Financial Regulation Standards and Accreditation (F) Committee met in Louisville, KY, March 22, 2023. The following Committee members participated: Lori K. Wing-Heier, Chair (AK); Vicki Schmidt, Co-Vice Chair (KS); Sharon P. Clark, Co-Vice Chair (KY); Alan McClain (AR); Andrew N. Mais (CT); Gary D. Anderson (MA); Mike Causey (NC); Jon Godfread represented by Matt Fischer (ND); Eric Dunning (NE); Andrew R. Stolfi (OR); Elizabeth Kelleher Dwyer represented by Ted Hurley (RI); Larry D. Deiter (SD); Scott A. White (VA); and Jeff Rude (WY).

1. Adopted its 2022 Fall National Meeting Minutes

Commissioner Schmidt made a motion, seconded by Commissioner Mais, to adopt the Committee's Dec. 13, 2022, minutes (see *NAIC Proceedings – Fall 2022, Financial Regulation Standards and Accreditation (F) Committee*). The motion passed unanimously.

Director Wing-Heier said the Committee met March 21 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 vote to award continued accreditation to Nebraska, Virginia, and West Virginia.

2. Adopted Revisions Made During 2022 to NAIC Publications Referenced in the Accreditation Standards

Director Wing-Heier said there are several NAIC publications currently included in the accreditation standards by reference. At each Spring National Meeting, the Committee is to review revisions made to these publications in the prior year. Each of the applicable groups that developed revisions to the publications in 2022 have provided the Committee with a memorandum discussing the revisions, and they indicated whether the revisions should be considered significant or insignificant for accreditation purposes. This included the following publications: the *Accounting Practices and Procedures Manual (AP&P Manual)* (Attachment One); the *Annual and Quarterly Statement Blanks and Instructions* (Attachment Two); *Risk-Based Capital (RBC) Formulas and Instructions for Life and Property/Casualty (P/C) Insurers* (Attachment Three); the *Financial Condition Examiners Handbook* (Handbook) (Attachment Four); the *Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual)* (Attachment Five); and the *Valuation Manual* (Attachment Six). The working group or task force responsible for each of these publications has deemed their 2022 changes as insignificant to the accreditation process.

Commissioner Clark made a motion, seconded by Commissioner White, to adopt the revisions deemed insignificant to each of the publications immediately by reference to the accreditation standards. The motion passed unanimously.

3. Discussed Comments Received on Exposure of 2020 Revisions to Model #440 and Model #450

At the 2021 Summer National Meeting, the Committee exposed proposed changes to the Accreditation Program to incorporate the 2020 revisions to the *Insurance Holding Company System Regulatory Act (#440)* and *Insurance Holding Company Model Regulation with Reporting Forms and Instructions (#450)* for a one-year public comment period ending Dec. 31, 2022.

The changes include the incorporation of the group capital calculation (GCC) and liquidity stress test (LST) requirements as significant elements for the Part A accreditation standards for insurance holding company systems. It is important to note that the proposed elements would allow commissioners to grant exemptions to the GCC to groups meeting the standards set out in Section 21A and Section 21B of Model #450, without the requirement to file at least once. During the 12-month exposure period, two comment letters were received. The first is from the National Risk Retention Association (NRRA), and the second is from the NAIC's Risk Retention Group (E) Task Force. Both comment letters discuss the applicability of the GCC requirements to risk retention groups (RRGs), noting that few groups are likely to be impacted. However, both letters stress the importance of allowing the commissioner to exempt an RRG from the GCC reporting requirements, when appropriate, to avoid placing an unnecessary burden on groups where such a filing would not provide added benefit. A final vote on the proposed additions to the Part A accreditation standards is scheduled for the 2023 Summer National Meeting.

#### 4. Voted to Remove Model #822 as an Accreditation Standard

At the 2022 Fall National Meeting, the Committee discussed a question that came up about significant elements in the Part A Liabilities and Reserves accreditation standard that require sections of the *Actuarial Opinion and Memorandum Regulation* (#822) to be adopted. The question raised was whether the requirements in Model #822 are duplicative of requirements in the *Valuation Manual*, which became an accreditation requirement when principle-based reserves was implemented in 2020. As a result of those discussions, the Committee sent a referral to the Life Actuarial (A) Task Force asking whether Model #822 was redundant with the requirements outlined in the *Valuation Manual*. The Task Force's analysis showed that Model #822 is now redundant with the requirements outlined in the *Valuation Manual*. As such, the Task Force recommends that Model #822 be removed as an accreditation standard. Please note that this should not be construed as a requirement that states rescind their versions of Model #822, only that adoption of the *Valuation Manual* is the new accreditation standard for life insurance and annuity actuarial opinion and memorandum requirements.

Commissioner Mais made a motion, seconded by Commissioner Anderson, to remove Model #822 as an accreditation standard. The motion passed unanimously.

Having no further business, the Financial Regulation Standards and Accreditation (F) Committee adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/F CMTE/2023Spring



### MEMORANDUM

TO: Commissioner Lori K. Wing-Heier, (AK), Chair, Financial Regulations Standards and Accreditation (F) Committee  
 Commissioner Vicki Schmidt, (KS), Co-Vice Chair, Financial Regulations Standards and Accreditation (F) Committee  
 Commissioner Sharon P. Clark, (KY), Co-Vice Chair, Financial Regulations Standards and Accreditation (F) Committee

FROM: Dale Bruggeman (OH), Chair, Statutory Accounting Principles (E) Working Group  
 Kevin Clark (IA), Vice Chair, Statutory Accounting Principles (E) Working Group

DATE: February 27, 2023

RE: Financial Regulation Standards – As of March 2023 *Accounting Practices and Procedures Manual*

In 2001, the Financial Regulation Standards and Accreditation (F) Committee approved a motion to adopt the *Accounting Practices and Procedures Manual – Effective January 1, 2001, Version 1999* (AP&P Manual) as an accreditation standard. The intention of this memorandum is to update the Committee on changes the Statutory Accounting Principles (E) Working Group has made to the AP&P Manual in 2022 up to the 2023 date of submission for publication. This memo is to provide the customary annual update regarding changes to the AP&P Manual.

Attachment A to this memo includes a detailed listing of the changes made to the AP&P Manual in 2022. On behalf of the Working Group, it is our opinion that none of these items, either individually or collectively, should be considered “significant” as defined by the financial solvency accreditation standards.

As outlined in the *NAIC Policy Statement on Maintenance of Statutory Accounting Principles* (SAP Policy Statement), modifications will be made to the *AP&P Manual* each year. As such, it will be reprinted with an “as of” date associated with it. For example, the next printing of the AP&P Manual, which encompasses the attached modifications, will be titled *Accounting Practices and Procedures Manual – as of March 2023*. This process allows for an efficient way to update the AP&P Manual and virtually guarantees that users have the latest version. Reprints and updates are necessary because of the evolutionary nature of accounting—in both the statutory accounting principles and the generally accepted accounting principles arenas—and are positive for users of the AP&P Manual.

The Working Group sincerely requests that the Committee consider the items listed in Attachment A as “insignificant” changes to the AP&P Manual. We will continue to notify the Committee of any changes to the AP&P Manual and to advise if, in our opinion, those changes are “significant” by financial solvency accreditation standards.

cc Bailey Henning, Sara Franson, Sherry Shull, Robin Marcotte, Julie Gann, Jake Stultz, Wil Oden and Jason Farr

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Attachment A

**Summary of Changes to the  
As of March 2022 Accounting Practices and Procedures Manual  
included in the As of March 2023 Manual**

The following summarizes changes made to the *As of March 2022 Accounting Practices and Procedures Manual* (Manual) and shown in the As of March 2023 version.

**Section 1** summarizes revisions that result in a new SSAP or new SAP concept to statutory accounting principles. Revisions that introduce original or modified accounting principles can be reflected in an existing or new SSAP. When revisions that result in a new SAP concept are made to an existing SSAP, the effective date is identified in the Status section, New SSAPs and new SAP concepts that revise existing SSAPs are commonly accompanied by a corresponding issue paper that reflects the tracked revisions for historical purposes. If language in an existing SSAP is superseded, that language is shaded and the new or revised SSAP is referenced. Completely superseded SSAPs and nullified interpretations are included in Appendix H.

**Section 2** summarizes revisions that clarify existing statutory accounting principles. These revisions are characterized as language clarifications which do not modify the original intent of a SSAP, or changes to reference material. Such revisions are depicted by underlines (new language) and strikethroughs (removed language) and will not be tracked in subsequent manuals. Revisions that clarify existing statutory accounting principles are effective when adopted unless a specific effective date is noted.

**Section 3** summarizes revisions to the Manual appendices.

1. Revisions that Resulted in a New SSAP or New SAP Concept – Statutory Accounting Principles		
Section	Reference	Description
<i>There were no revisions that resulted in a new SSAP or new SAP concept.</i>		
2. Revisions that Resulted in a SAP Clarification – Statutory Accounting Principles		
Section	Reference	Description
Preamble	2022-01	Revisions incorporate updates from <i>FASB Concepts Statement No. 8, Conceptual Framework for Financial Reporting—Chapter 4, Elements of Financial Statements</i> , which updates the definition of an asset.
How to Use This Manual; Summary of Changes; Preamble	2021-26EP 2021-14	Revisions to replace the term “substantive” with “new SSAP” or “new SAP concept” and to replace the term “nonsubstantive” with “SAP clarification” on a primarily prospective basis.
SSAP No. 4	2022-01	Revisions update the definition of an asset based on updates from <i>FASB Concepts Statement No. 8, Conceptual Framework for Financial Reporting—Chapter 4, Elements of Financial Statements</i> .
SSAP No. 19	2021-25	Revisions clarify that leasehold improvements shall be immediately expensed upon lease termination unless limited exceptions are met.



## Attachment A

SSAP No. 22R	2021-29	Revisions reject <i>ASU 2021-05, Leases (Topic 842), Lessors—Certain Leases with Variable Lease Payments</i> for statutory accounting.
	2022-05	Revisions reject <i>ASU 2021-09, Leases Discount Rate for Lessees That Are Not Public Business Entities</i> for statutory accounting.
SSAP No. 24	2022-04	Revisions incorporate disclosures from <i>ASU 2021-10, Government Assistance, Disclosures by Business Entities about Government Assistance</i> regarding terms and provisions of assistance received.
SSAP No. 25	2021-21	Revisions clarify reporting of related party transactions and incorporate new investment schedule reporting requirements to identify investments that involve related parties.
	2022-13	Revisions identify foreign open-end investment funds as a fund in which ownership percentage is not deemed to reflect control unless the entity has the power to direct the underlying company.
SSAP No. 36	2022-10	Revisions reject <i>ASU 2022-02, Troubled Debt Restructurings and Vintage Disclosures</i> and identify that retained guidance reflects superseded U.S. GAAP.
SSAP No. 43R	2021-21	Revisions clarify reporting of related party transactions and incorporate new investment schedule reporting requirements to identify investments that involve related parties.
	2021-23	Revisions update the summarized financial modeling guidance and refers users to the <i>Purposes and Procedures Manual of the NAIC Investment Analysis Office</i> for the detailed financial modeling guidance.
SSAP No. 47	2022-07	Revisions reject <i>ASU 2021-08, Business Combinations, Accounting for Contract Assets and Contract Liabilities from Contracts with Customers</i> for statutory accounting.
SSAP No. 48	2022-02	Revisions clarify that the audit of an entity utilizing the U.S. tax basis equity valuation exception shall occur at the investee level.
SSAP No. 61R	2021-31	Revisions clarify and, in some cases, remove certain disclosures for life and health reinsurance contracts. Clarifications also address the information in the audited report.
SSAP No. 68	2021-28	Revisions reject <i>ASU 2021-03, Intangibles – Goodwill and Other (Topic 350) – Accounting Alternative for Evaluating Triggering Events</i> for statutory accounting.
	2022-07	Revisions reject <i>ASU 2021-08, Business Combinations, Accounting for Contract Assets and Contract Liabilities from Contracts with Customers</i> for statutory accounting and note that rejection does not impact the determination of U.S. GAAP book value of an acquired entity.
SSAP No. 72	2021-27	Revisions incorporate guidance related to the accounting for the changes in fair value when exchanging equity-classified written call options, while rejecting <i>ASU 2021-04</i> for statutory accounting.
SSAP No. 73	2021-25	Revisions clarify that leasehold improvements shall be immediately expensed upon lease termination unless limited exceptions are met.



Attachment A

SSAP No. 86	2021-20	Revisions result with a new Exhibit A, replacing both Exhibit A and Exhibit B of <i>SSAP No. 86—Derivatives</i> that adopts with modification U.S. GAAP guidance in determining hedge effectiveness, and measurement guidance for excluded components.
	2022-09	Revisions adopt with modification derivative guidance from <i>ASU 2017-12, Derivatives and Hedging</i> and <i>ASU 2022-01, Fair Value Hedging – Portfolio Layer</i> to incorporate the portfolio layer method and partial-term hedges for statutory accounting.
SSAP No. 97	2022-13	Revisions identify foreign open-end investment funds as a fund in which ownership percentage is not deemed to reflect control unless the entity has the power to direct the underlying company.
SSAP No.104R	2022-06	Revisions incorporate the practical expedient from <i>ASU 2021-07, Compensation – Stock Compensation, Determining the Current Price of an Underlying Share for Equity-Classified Share-Based Awards</i> for the current price input, a required component for option-pricing models utilized in determining fair value for share-based payments.
SSAP No. 108	2021-18	Revisions ensure consistency with the <i>Valuation Manual</i> , Section 21, by updating references to the “standard” scenario.
<b>3. Revisions to the Appendices</b>		
<b>Section</b>	<b>Reference</b>	<b>Description</b>
Appendix A		<i>No revisions impacting this appendix were adopted in 2022.</i>
Appendix B	2022-08 INT 22-01	New <i>INT 22-01—Freddie Mac When-Issued K-Deal (WI Trust) Certificates</i> clarifies that investments in the Freddie Mac “When Issued K-Deal” (WI) Program are in scope of <i>SSAP No. 43R—Loan-Backed and Structured Securities</i> from the date of initial acquisition.
	INT 22-02	<i>INT 22-02: Third Quarter 2022 through First Quarter 2023 Reporting of the Inflation Reduction Act – Corporate Alternative Minimum Tax</i> provides an exception that does not require entities to assess the statutory valuation allowance and deferred tax asset impacts or tax estimates related to Inflation Reduction Act CAMT for third quarter 2022 through first quarter 2023. It also provides subsequent event exceptions and disclosures.
Appendix C	AG 44	Revised <i>Actuarial Guideline XLIV—Group Term Life Waiver of Premium Disabled Life Reserves</i> provides for the use of the 2023 GTLW Mortality and Recovery Valuation Tables for individuals disabled on or after January 1, 2023.
	AG 53	New <i>Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves</i> provides uniform guidance and clarification of requirements for the appropriate support of certain assumptions for asset adequacy analysis.
Appendix D	Rejected as Not Applicable to Statutory Accounting:	
	2021-30	<i>ASU 2021-06, Amendments to SEC Paragraphs in Topic 205, Topic 942 and Topic 94</i>





## Attachment A

Appendix E	2022-01	<i>Issue Paper No. 166—Updates to the Definition of an Asset</i> documents revisions to <i>SSAP No. 4—Assets and Nonadmitted Assets</i> to incorporate updates from <i>FASB Concepts Statement No. 8, Conceptual Framework for Financial Reporting—Chapter 4, Elements of Financial Statements</i> , which updates the definition of an asset.
Appendix F	2021-26EP 2021-14	Revisions to replace the term “substantive” with “new SSAP” or “new SAP concept” and to replace the term “nonsubstantive” with “SAP clarification” on a primarily prospective basis.
Appendix G		<i>No revisions impacting this appendix were adopted in 2022.</i>
Appendix H		<i>No revisions impacting this appendix were adopted in 2022.</i>

**MEMORANDUM**

TO: Lori K. Wing-Heier, Chair  
Financial Regulation Standards & Accreditation (F) Committee

FROM: Pat Gosselin, Chair  
Blanks (E) Working Group

DATE: January 4, 2023

RE: Items Impacting Current Accreditation Standard

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Please find attached a list of items adopted by the Blanks (E) Working Group during 2022. The Blanks Working Group adopts numerous changes to the Annual Statement Blanks and Instructions each year. Most of the changes are made to clarify current requirements or are considered enhancements to existing reporting. The changes adopted in 2022 do not represent a substantive change to any reporting requirements.

I am planning to be present when the Financial Regulation Standards & Accreditation (F) Committee meets in the event any member of the committee wishes to discuss these issues.

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### Changes to blanks and instructions adopted during 2022

1. Add a footnote to Exhibit 7 in the Life/Fraternal statement and the Health Statement (Life Supplement) to capture amount of Federal Home Loan Bank (FHLB) Funding Agreements reported in columns 1 through 6 of the exhibit (2021-16 SAPWG). (2021-15BWG) Effective Dec. 31, 2022.
2. For Note 9 – Income Taxes, remove the 9C illustration instructions for the DTA and DTL components which states that “reporting entities should disclose those items included as “Other” (Lines 2a13, 2e4, 3a5 and 3b3) as additional lines for those items greater than 5% in the printed/PDF filing document”, as the illustration is not set up to accommodate variable lines. Add formulas for calculation of total and subtotal on the illustration for 9C. For Note 15 – Leases, modify the illustrations to add a “Thereafter” line and add a formula for “Total” line. (2021-16BWG) Effective Dec. 31, 2022.
3. Modify the Analysis of Operations by Lines of Business in the Health Blank to include all of health lines of business included in the Life/Fraternal Analysis of Operations by Lines of Business – Accident and Health. Add instructions for the new columns and adjust the column references. Add the Health Blank Analysis of Operations by Lines of Business as a supplement to the Life/Fraternal Blank with the appropriate instructions and crosschecks. Add crosscheck to the Health Blank Analysis of Operations by Lines of Business to the Life/Fraternal Analysis of Operations by Lines of Business – Accident and Health instructions. (2021-17BWG) Effective Dec. 31, 2023.
4. Add columns and lines to U&I (Parts 1, 2, 2A, 2B, and 2D) and the Exhibit of Premiums, Enrollment and Utilization in the annual statement bring the lines of business reporting in line with Life/Fraternal and Property. Add columns and lines to the Exhibit of Premiums, Enrollment and Utilization and U&I Analysis of Claims Unpaid quarterly pages. The appropriate adjustments to the instructions are also being made. (2021-19BWG) Effective Dec. 31, 2022.
5. Starting at Line 72 of the Life/Fraternal Five-Year Historical add or delete lines that do not pull in the specific lines of business reported on the Life/Fraternal Analysis of Operations by Lines of Business detail pages for life (individual and group), annuities (individual and group), and A&H for Line 33 of those pages. (2021-20BWG) Effective Dec. 31, 2023.
6. Add instruction to the Investment Schedules General Instructions to exclude non-rated residual tranches or interests from being reported as bonds on Schedule D, Part 1 and add lines to Schedule BA for the reporting of those investments (2021-15 SAPWG). (2021-21BWG) Effective Dec. 31, 2022.
7. Add a new reporting requirement in the investment schedules for investment transactions with related parties. In addition to capturing direct loans in related parties, it will also capture information involving securitizations (or other similar investments) where the related party is a sponsor/originator, along with whether the underlying investment is in a related party. (2021-22BWG Modified) Effective Dec. 31, 2022.
8. Added a group of lines for Residual Tranches or Interests in the Asset Valuation Reserve Equity and Other Invested Asset Component blank and renumber lines below them. Modify instructions as appropriate for the added lines. (2021-23BWG) Effective Dec. 31, 2022.
9. Add new questions to General Interrogatories Part 1 asking if the reporting entity accepts cryptocurrency for payment of premiums, which cryptocurrencies are accepted, and whether they are held for investment or immediately converted to U.S. dollars (2021-24 SAPWG). (2022-01BWG) Effective Dec. 31, 2022.



10. Add four new electronic-only columns to Schedule D, Part 6, Section 1, for Prior Year Book/Adjusted Carrying Value (BACV) (Column 16), Prior Year Nonadmitted Amount (Column 17), Prior Year Sub-2 Verified Value (Column 18), and Prior Year VISION Filing Number (Column 19) (2021-22 SAPWG). (2022-02BWG) Effective Dec. 31, 2022.
11. Split Line 5 of the Quarterly Part 1 – Loss Experience and Part 2 – Direct Premiums Written into Line 5.1 – Commercial multiple peril (non-liability portion) and Line 5.2 – Commercial multiple peril (liability portion). (2022-03BWG) Effective Jan. 1, 2023.
12. Add a new supplement to capture premium and loss data for Annual Statement Line 17.1, 17.2, and 17.3 of the Exhibit of Premiums and Losses (State Page) – Other Liability by more granular lines of business. (2022-04BWG) Effective Dec. 2023.
13. Add line numbers to the status data points in the Life/Fraternal, Health, and Property/Casualty (P/C) Schedule T footnote. (2022-05BWG Modified) Effective Dec. 31, 2022.
14. Revise the Health Annual Statement Test language in the annual statement instructions. (2022-06BWG Modified) Effective Dec. 31, 2022.
15. Modify the Health Actuarial Opinion Instructions. Add definitions of “actuarial asset” and “actuarial liability.” Modify Section 4 – Identification, Section 5 – Scope, and Section 7 – Opinion to clarify that the actuary’s opinion covers actuarial assets as well as actuarial liabilities. Modify Section 9 to clarify that the guidance related to the type of opinion rendered by an appointed actuary covers both actuarial assets and actuarial liabilities. (2022-07BWG) Effective Dec. 31, 2022.
16. Modify the instructions in Section 1, Section 3, and Section 8 of the P/C Actuarial Opinion Instructions to reflect the changes adopted by the Actuarial Opinion (C) Working Group. (2022-08BWG) Effective Dec. 31, 2022.
17. Changes to the Life/Fraternal VM-20, Requirements for Principle Based Reserves for Life Products, Reserves Supplement blank Part 2, and adding a Question 3, a disclosure of the year that the Life Principle-Based Reserving (PBR) Exemption was actively filed, and a confirmation of the eligibility criteria in the case of ongoing exemptions. Also, correct references to a state “granting” an exemption, since this is often not the case (e.g., the exemption may be allowed). For the VM-20 Reserves Supplement Instructions, add instructions for the new disclosure item, Question 3. Correct the references to a state “granting” an exemption. For the Supplemental Exhibits and Schedules Interrogatories (Quarterly Statement), for Question 8, add instructions on how to respond if the company is utilizing the ongoing exemption. The same instructions can also be found in the Valuation Manual, Section II, Subsection 1G(1). (2022-09BWG) Effective Dec. 31, 2022.
18. Add instructions to Schedule T, State pages and the Accident and Health (A&H) Policy Experience Exhibit to clarify guidance for reporting premium adjustments by jurisdiction. (2022-10BWG) Effective Dec. 31, 2022.
19. Update the Life/Fraternal Blank Asset Valuation Reserve (AVR) factors to correspond with the adopted Risk-Based Capital (RBC) factors for the expanded bond designation categories. (2022-11BWG Modified) Effective Dec. 31, 2022.
20. Combine the Health Analysis of Operations by Lines of Business Supplement page and the Health Care Receivable Supplement pages (Exhibits 3 and 3A) into one supplement filing set for Health Blank pages filed as a supplement by Life/Fraternal companies. (2022-12BWG) Effective Dec. 31, 2023.



21. Modify Five-Year Historical Data questions 68 and 69 to reference group comprehensive and modify questions 70 and 71 to reflect inclusion of all health lines of business other than group comprehensive. Crosschecks for these questions are being modified accordingly. (2022-13 BWG Modified) Effective Dec. 31, 2022.
22. Modify the Life Insurance (State Page) to include the line of business detail reported on the Analysis of Operations by Lines of Business pages. Adds definitions for life and annuity products to the lines of business definitions in the health appendix. (2022-19BWG Modified) Effective Dec. 31, 2023.



## MEMORANDUM

TO: Lori K. Wing-Heier, Chair, Financial Regulation Standards and Accreditation (F) Committee

FROM: Tom Botsko, Chair, Capital Adequacy (E) Task Force and Property and Casualty Risk-Based Capital (E) Working Group

DATE: February 1, 2023

RE: Accreditation Standards – Changes to the RBC Formulas and Instructions for Health, Life, and P/C

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Attached please find a brief description of changes to the 2022 risk-based capital (RBC) reports, including an overview and instructions, for health, life, and property/casualty (P/C). These changes were adopted by the Capital Adequacy (E) Task Force and the Executive (EX) Committee and Plenary in 2022. The significance of these changes was viewed as it relates to the overall RBC standard.

***No changes to the RBC formulas or instructions were deemed to be significant for health, life, or P/C.***

Any questions can be directed to NAIC staff:  
 P/C – Eva Yeung  
 Life – Dave Fleming  
 Health – Crystal Brown

### Health RBC Formula

Not Significant      Added benchmarking guidelines to the underwriting risk instructions for investment income.

### Life RBC Formula

Not Significant      Added an instruction to address changes made to Schedule BA and the asset valuation reserve (AVR) to isolate the reporting of residual tranches.

Not Significant      Made structural changes to LR025, Life Insurance, to expand the categorization of policies with instructional and factor changes.



**P/C RBC Formula**

Not Significant	Included the Karen Clark & Company (KCC) catastrophe model as one of the approved third-party commercial vendor catastrophe models.
Not Significant	Incorporated wildfire peril as one of the catastrophe risk perils for informational-purposes only in the Rcat component.
Not Significant	For companies qualifying for exemption under PR027INT C(10), did not require to report PR027C Lines 1 through 10.
Not Significant	Removed the embedded 2% operational risk contained in the R3 credit risk component.
Not Significant	Removed the trend test for the information-only footnote in PR033.
Not Significant	Updated the Line 1 industry average development factors in PR017 and PR018.



## MEMORANDUM

TO: Financial Regulation Standards and Accreditation (F) Committee

FROM: Susan Bernard (CA), Chair, Financial Examiners Handbook (E) Technical Group  
John Litweiler (WI), Vice-Chair, Financial Examiners Handbook (E) Technical Group

DATE: Feb. 3, 2023

RE: Consideration for Financial Accreditation Standards  
*2023 Financial Condition Examiners Handbook*

The *Accreditation Program Manual* (Manual) includes Review Team Guidelines to be used for financial examinations performed using the risk-focused surveillance approach that is found in the NAIC *Financial Condition Examiners Handbook* (Handbook). This memorandum is to update the Financial Regulation Standards and Accreditation (F) Committee (FRSAC) on changes the Financial Examiners Handbook (E) Technical Group has made to the Handbook in 2022.

Modifications are made to the Handbook each year, and a new edition is available annually. This process allows for an efficient way to update the Handbook and ensures that users have the latest version. The Technical Group made several changes to the Handbook in 2022, all of which it considers non-significant; i.e., having no impact on accreditation guidance.

During 2022, the Technical Group made the following changes:

### **Non-Significant Changes to the Handbook:**

- Revisions to incorporate elements and topics of the Common Framework for the Supervision of Internationally Active Insurance Groups (IAIGs) throughout the Handbook. Additional considerations for IAIGs were included throughout the following:
  - Narrative guidance in Sections 1-1, 1-3, 1-11 and 2-1.
  - Repositories: Capital and Surplus, Investments, Reinsurance Assuming, Reinsurance Ceding, Reserves/Claims Handling (Health), Reserves/Claims Handling (Life), Reserves/Claims Handling (P/C), and Underwriting.
  - Exhibits: Exhibit E – Audit Review Procedures, Exhibit M – Understanding the Corporate Governance Structure, Exhibit Y – Exam Interviews and Exhibit AA – Summary Review Memorandum.
  
- Revisions to enhance regulatory guidance in the following areas:
  - Terrorism Reinsurance: Additional guidance was added regarding Terrorism Reinsurance that was previously included in the Solvency Monitoring Risk Alert, which includes the background of the

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Terrorism Risk Insurance Act (TRIA) and possible procedures for regulators to consider when assessing an insurer's solvency.

- Affiliated Relationships: Guidance was added to emphasize the importance of understanding and evaluating affiliated relationships in monitoring the services provided by and receivable balances due from key agents and producers. Potential procedures were added to the Underwriting Repository for examiners to consider regarding risks surrounding affiliated relationships.
  - Start-Up Insurers: Guidance was added to help evaluate the reasonableness of a start-up insurer's business plan, projections and strategy, and level of funding needed to meet targets. Possible procedures were added to the Capital and Surplus Repository to help the exam team address the reasonableness of the aforementioned areas.
- Revisions to Exhibit E helped to clarify that Audit Awareness Letters should be received when there has been a change in auditor.
  - Revisions to the Capital and Surplus Repository to align the recently added ORSA procedures to the work conducted in evaluating risks related to an insurer's capital and surplus.
  - Revisions to the Investments Repository and the Reserves/Claims Handling (Life) Repository help to provide additional guidance and potential procedures to assist examiners in evaluating related party investment holdings and asset adequacy of complex investments.
  - Revised guidance related to information technology (IT) in the following areas:
    - Additional guidance was added in Section 1-3 to describe a new process for communicating and addressing prospective IT risks. Exhibit C, Part Three (IT Review Summary Memo) was also updated to include a new subsection that details this process and includes an additional column in the IT findings chart where examiners can recommend ongoing monitoring.
    - Guidance was added for monitoring companies that heavily outsource IT functions and cross references to applicable procedures within Exhibit C Part Two (IT Work Program).

The Technical Group will continue to notify the FRSAC of any changes to the Handbook and advise if, in our opinion, these changes are "significant" by accreditation expectations.



## MEMORANDUM

**TO:** Financial Regulation Standards and Accreditation (F) Committee

**FROM:** Carrie Mears (IA), Chair Valuation of Securities (E) Task Force  
Charles Therriault, Director, NAIC Securities Valuation Office

**CC:** Dan Daveline, Director, NAIC Financial Regulatory Services  
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office

**DATE:** February 13, 2023

**RE:** Report of the Valuation of Securities (E) Task Force

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**A. Purpose** – This report is presented to assist the Financial Regulation Standards and Accreditation (F) Committee to determine if amendments to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* adopted by the Valuation of Securities (E) Task Force in 2022 require corresponding changes in either the Financial Regulation Standards (defined below) or state laws or regulations adopted in conformity with Part A: Laws and Regulations of the Financial Regulation Standards.

**B. Financial Regulation Standards** – The NAIC Policy Statement on Financial Regulation Standards (SFRS) in the *2023 Accreditation Program Manual* consists of four parts: Part A identifies laws and regulations deemed necessary to financial solvency regulation;<sup>1</sup> Part B identifies regulatory practices and procedures that supplement and support enforcement of the financial solvency laws and regulations discussed in Part A;<sup>2</sup> Part C contains three standards related to an insurance department’s organizational and personnel policies; and Part D focuses on Organization, licensing and change of control of domestic insurers. This report is concerned with the financial solvency standards in Part A. Those standards relevant to this report are shown immediately below and can be characterized as NAIC model legislation, codified NAIC guidance (i.e., *the Accounting Practices and Procedures Manual*): analytical work product of the NAIC staff (including the NAIC Investment Analysis Office) and state laws and regulations that contain substantially the same standards as NAIC model legislation or guidance. A review indicates that the work product of the NAIC Investment Analysis Office is directly or indirectly incorporated into the following Part A standards. For example:

- Standard 5 requires that insurer owned securities be valued in accordance with the standards promulgated by the NAIC Investment Analysis Office;<sup>3</sup>

- Standard 2, the *Risk-Based Capital (RBC) for Insurers Model Act* (#312)<sup>4</sup> assigns RBC factors for securities based on their credit risk as measured by NAIC Designations;
- Standard 3, the *Accounting Practices and Procedures Manual*<sup>5</sup> uses NAIC Designations produced by the SVO or SSG, or by insurers through the filing exempt process and or Price Grids produced by the SSG to identify valuation rules applicable to an investment and the reserved capital amount the insurer must report;
- Standard 8, pertaining to state investment regulations often incorporate NAIC mechanisms that relate asset allocations to credit risk expressed in the form of NAIC Designations;<sup>6</sup> and
- Standard 10, the *Credit for Reinsurance Model Act* (#785)<sup>7</sup> identifies insurer owned securities compiled by the SVO into a List of Investment Securities published quarterly in the NAIC AVS + Plus product, and letters of credits issued by the institutions on the NAIC Qualified U.S. Financial Institutions List administered by the SVO, as eligible for use as collateral in reinsurance transactions.

**C. Investment Analysis Office Standards Identified in the *Purposes and Procedures Manual*** – All SVO and SSG standards related to the assessment of credit risk in insurer owned securities, identification of additional non-payment risk in securities, classification of certain assets as bonds or as bond-like for reporting purposes, the valuation of insurer owned securities, and other activities conducted by the SVO or the SSG in support of state insurance regulatory objectives, are determined and promulgated by the Valuation of Securities (E) Task Force and published in the *Purposes and Procedures Manual*. In 2022, the *Purposes and Procedures Manual* was revised once, in December, with all policies, analytical procedures and instructions adopted during 2022 effective for year-end financial reporting. Amendments to the *Purposes and Procedures Manual* would automatically be reflected in the SFRS if any or all of the SFRS Standards identified in paragraph A of this memorandum have been adopted by an accredited state or incorporated by reference into the laws or regulations of an accredited state. For example, amendments to the *Purposes and Procedures Manual* would be directly incorporated by reference if the laws or regulations of an accredited state refer to or incorporate Standard 5 on valuation. Amendments to the *Purposes and Procedures Manual* would be indirectly incorporated by reference if the law or regulations of a state refers to or incorporates any other Standard that itself uses NAIC Designations or other analytical products of the Investment Analysis Office as a component; for example, Standard 2 in the case of RBC and/or Standard 3 in the case of statutory accounting.

**D. Conclusion** – In our opinion, reasoning as discussed above, amendments to the *Purposes and Procedures Manual* adopted by the Valuation of Securities (E) Task Force in 2022 can be characterized as maintenance items consistent with the existing regulatory framework and automatically incorporated into the Part A Standards identified above. The amendments identified in Attachments One did not create processes or practices external to the *Purposes and Procedures Manual* or other NAIC model legislation, guidance or analysis of NAIC staff that would suggest the need to consider an amendment to NAIC model legislation or guidance or legislative action on the part of an accredited state.

We hope this is responsive to the issues and concerns before the Committee.

**Attachment One****RECENT CHANGES TO THE PURPOSES AND PROCEDURES MANUAL***Published in the December 31, 2022 Publication*

- **Adopted updates to permit un-guaranteed and unrated subsidiary obligors in WCFI transaction, with SVO discretion to notch** – the Task Force directs the SVO to rely upon the NAIC Designation or NAIC CRP Rating equivalent of the obligor, subsidiary or affiliate’s parent entity if the obligor, subsidiary or affiliate does not have an NAIC CRP Rating and the SVO cannot assign an NAIC Designation to it. The Task Force authorizes the SVO, based on its analytical judgement and in its sole discretion, to notch such NAIC Designation down or decline to assign an NAIC Designation.

*The Valuation of Securities (E) Task Force adopted this amendment on Apr. 5, 2022*

- **Adopted updates clarifying the SVO’s role regarding accounting and reporting determinations** – these changes clarify, in accordance with Part One, that the SVO can assign NAIC Designations to investments which it does not think are eligible for Schedule D or BA reporting so long as it has the methodology to do so. The SVO, however, would have the authority, at its discretion, to notify the appropriate regulators of any investments which, in its opinion, would not or might not be eligible for reporting on Schedules D or BA. The SVO would also maintain its authority to offer its accounting and reporting opinion, when requested to do so, as part of its Regulatory Treatment Analysis Service, it being understood that such opinions would not be authoritative and might not reflect the opinion of the relevant state regulator.

*The Valuation of Securities (E) Task Force adopted this amendment on Aug. 11, 2022*

- **Adopted updates to the definition of Principal Protected Securities (PPS)** – PPS typically have both a principal protected component and a performance component whose payments originate from, or are determined by, non-fixed income like sources and, therefore, pose the risk of non-fixed income like cashflows. Additional transaction examples were included for demonstrative purposes only, to highlight the intent behind the principle-based PPS definition and the core regulatory concern (that there are Other Non-payments Risks associated with PPSs beyond the contractually promised payments that may not be reflected in a CRP rating) but are not intended to encompass all possible PPS variants. Each of these examples meets the definition of a PPS. Any design that circumvents the definition, and related examples, through technical means but which in substance achieves the same ends or poses the same risk, shall be deemed a PPS.

*The Valuation of Securities (E) Task Force adopted this amendment on Aug. 11, 2022*

- **Adopted updates to Part Four to reflect a consistent reference to “NAIC Designation Category” and the additional price points needed to determine them.** – the changes reflect the adoption of new Risk Based Capital (RBC) factors for each NAIC Designation Category in 2021 by the Capital Adequacy (E) Task Force and its parent, the Financial Condition (E) Committee. These technical updates reflect a consistent reference to “NAIC designation Category” and the nineteen price points needed to determine them using the new RBC factors.

***The Valuation of Securities (E) Task Force adopted this amendment on Aug. 11, 2022***

- **Adopted updates to Part One and Part Three to reflect changes adopted by the Statutory Accounting Principles (E) Working Group to SSAP No. 25 – Affiliates and Other Related Parties and SSAP No. 43 – Loan-Backed and Structured Securities for Subsidiary, Controlled and Affiliated (SCA) and Related Party Investments.** – the changes in section for Subsidiary, Controlled and Affiliated (SCA) and Related Party Debt or Preferred Stock Investments clarifies that it includes non-control relationships. Additionally, the amendment divides SCA and related party investments into two categories: (1) those with direct or indirect credit risk exposure to the SCA or related party, which are not filing exempt, and (2) those with no direct or indirect credit exposure to the SCA or related party, which are filing exempt. Transactions in category (1) could include structures in which the non-issuer underlying credit exposure would qualify as a related party pursuant to paragraph 4.a. in SSAP No. 43R – Loan-Backed and Structured Securities. Transactions in category (2) are captured by a new defined term called Related Party Filing Exempt Investments which would mean any investment (i) issued by an SCA or related party special purpose entity (SPE) which itself is not an obligor or ultimate source of the investment repayment, or (ii) issued as part of a structure in which the originator, sponsor, manager, servicer, other influential transaction party is an affiliate or related party of the reporting insurance company. SCA and Related Party Filing Exempt Investments would be eligible for filing exemption unless otherwise ineligible (for reasons other than their affiliate or related party status). The P&P Manual also clarifies that state insurance regulators are permitted, as specified in Part One of the P&P, to require an insurance company to file what would otherwise be an SCA and Related Party Filing Exempt Investment for analysis and/or assignment of an NAIC Designation only by the SVO, thereby making it ineligible for filing exemption in the future.

***The Valuation of Securities (E) Task Force adopted this amendment on Dec. 14, 2022***

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**END NOTES**

<sup>1</sup> “...The purpose of the Part A: Laws and Regulations standards are to assure that an accredited state has sufficient authority to regulate the solvency of its multi-state domestic insurance industry in an effective manner. ... A state may demonstrate compliance with a Part A standard through a law, a regulation, an established practice, which implements the general authority granted to the state or any combination of laws, regulations or practices, which achieves the objective of the standard ...” Accreditation Program Manual. “...For those standards included in the Part A ... where the term “substantially similar” is included, a state must have a law, regulation, administrative practice or a combination of the above that addresses the significant elements included in the NAIC model laws or regulations. ... Accreditation Interlineations (Substantially Similar)”

<sup>2</sup> “...Part B sets out standards required to ensure adequate solvency regulation of multi-state insurers ... In addition to a domestic state’s examination and analysis activities, other checks and balances exist in the regulatory environment. These include ... analyses by NAIC’s staff, ... and to some extent the evaluation by private rating agencies...” Accreditation Program Manual

<sup>3</sup> The SFRS requires that securities owned by insurance companies be valued in accordance with standards promulgated by the NAIC’s Capital Markets and Investment Analysis Office approved by VOS TF while other invested assets should be valued in accordance with procedures promulgated by the Financial Condition (E) Committee. The Investment Analysis Office refers to two independent staff functions: i.e., that of the SVO and that of the NAIC Structured Securities Group (SSG). The SSG was formally established as an NAIC staff function in 2013 and assumes responsibility for the conduct of the year-end financial surveillance of insurer owned residential mortgage backed securities (RMBS) and commercial mortgage backed securities (CMBS), conducted by

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the SVO since 2009. The SSG is also presumptively the segment of NAIC professional staff that would lead assessment of structured finance products generally.

The financial modeling process administered by the SSG generates intrinsic price values (referred to Price Grids) for legacy RMBS and CMBS and NAIC Designations for non-legacy RMBS and CMBS. These standards are contained in Part Four of the Purposes and Procedures Manual. Price Grids are used by insurers to generate NAIC Designations in accordance with procedures specified in Statement of Statutory Accounting Principles (SSAP) No. 43R *Loan Backed and Structured Securities* of the NAIC Accounting Practices and Procedures Manual. Accordingly, to the extent that the NAIC Accounting Practices and Procedures Manual are incorporated by reference in any standard, Price Grids and NAIC Designations derived by reference to them would also be incorporated.

<sup>4</sup> The SFRS requires the adoption of the *Risk Based Capital (RBC) for Insurers Model Act* (#312) or a substantially similar law or regulation. RBC factors are tied to NAIC designations assigned by the SVO or in certain cases, for example in the case of Mortgage Referenced Securities, by the SSG; NAIC Designations assigned by insurance companies pursuant to the filing exempt rule contained in the Purposes and Procedures Manual or NAIC Designations derived by insurance companies for RMBS and CMBS from Price Grids produced by the SSG pursuant to SSAP No. 43R. “...*This standard does not articulate a threshold level for minimum capital and surplus required for insurers to transact business ... Risk-based capital will, however, effectively require minimums when adopted by states.*” Accreditation Interlineations - [Financial Regulation Standards](#)

<sup>5</sup> The SFRS requires the use of the codified version of the *Accounting Practices and Procedures Manual*. Valuation procedures applicable to long-term invested assets are determined by the nature of the insurer (life or property/casualty) and the NAIC designation assigned to the security by the SVO or SSG; NAIC Designations assigned by insurance companies pursuant to the filing exempt rule contained in the Purposes and Procedures Manual or NAIC Designations derived by insurance companies for RMBS and CMBS from Price Grids produced by the SSG pursuant to SSAP No. 43R. “...*To satisfy this standard, ... specific adoption of the NAIC Annual Statement Blank, NAIC Annual Statement Instructions, and the NAIC Accounting Practices and Procedures Manual [is required]...Accreditation Interlineations - Financial Regulation Standards*”

<sup>6</sup> The SFRS requires a diversified investment portfolio. Although the Investment of Insurers Model Act (Defined Limits or Defined Standards) is not specifically identified, portions of one or the other model acts have been adopted by many of the states and these relate specific asset allocations to NAIC designations provided by the SVO or in some cases by the SSG; NAIC Designations assigned by insurance companies pursuant to the filing exempt rule contained in the *Purposes and Procedures Manual* or NAIC Designations derived by insurance companies for RMBS and CMBS from Price grids produced by the SSG pursuant to SSAP No., 43R. “... *This standard ... [will require] that statutes, together with related regulations and administrative practices, provide adequate basis ... to prevent, or correct, undue concentration of investment by type and issue and unreasonable mismatching of maturities of assets and liabilities. The standard is not interpreted to require an investment statute that automatically leads to a fully diversified portfolio of investments.*” [Accreditation Interlineations - Financial Regulation Standards](#)

The *NAIC Investment of Insurers Model Act (Defined Limits Version)* (# 280) imposes a 3% limit on the amount an insurer can invest in a single person (the threshold diversification limit) and also imposes a percentage limit on total investments of a defined credit quality, expressed by reference to NAIC Designation categories (the threshold credit quality limit). An additional percentage limit is then assigned to specific asset categories, which may or may not be subject to adjustment with the two threshold requirements. The limits identified in the Model Act are what would guide portfolio allocation decisions. Once made the insurer would shift to monitoring changes in the portfolio and rebalancing the allocations accordingly. Assuming a process for the identification of concentrations caused by indirect exposures, the insurer would aggregate such exposures with similar risks across all activities.

<sup>7</sup> The SFRS requires the adoption of the *Credit for Reinsurance Model Act* (#785), *Credit for Reinsurance Model Regulation* (#786) and *Life and Health Reinsurance Agreement Model Regulation* (#791) or substantially similar laws. The SVO maintains a list of banks that meet defined eligibility criteria to issue letters of credit in support of reinsurance obligations or that are eligible to serve as trustees under various arrangements required by state insurance law.



## MEMORANDUM

**TO:** Director Lori K. Wing-Heier (AK), Chair, Financial Regulations Standards and Accreditation (F) Committee, Commissioner Vicki Schmidt, (KS), Co-Vice Chair, Financial Regulations Standards and Accreditation (F) Committee and Commissioner Sharon P. Clark, (KY), Co-Vice Chair, Financial Regulations Standards and Accreditation (F) Committee

**FROM:** Rachel Hemphill (TX), Chair, Life Actuarial (A) Task Force, Craig Chupp (VA), Vice Chair, Life Actuarial (A) Task Force

**DATE:** March 1, 2023

**RE:** Financial Regulation Standards – As of March 2023 *Valuation Manual*

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In 2017, the Financial Regulation Standards and Accreditation (F) Committee approved a motion to adopt the *Valuation Manual – Effective January 1, 2020* as an accreditation standard. The intention of this memorandum is to update the Committee on changes the Life Actuarial (A) Task Force made to the Valuation Manual in 2022. The changes were adopted by the Executive (EX) Committee and Plenary at the 2022 Summer Meeting.

Attachment A to this memo includes a detailed listing of the changes made to the Valuation Manual in 2022. Of the 2022 Valuation Manual amendments, 2020-12 warrants additional notice due to the potential for increases to reserve requirements for life insurance and annuity companies with certain hedging practices. The other 2022 Valuation Manual amendments could be characterized as clarifications, additional guidance, updates to the basis used in prescribed assumption tables, or requests for additional documentation. In light of the considerations above and on behalf of the Task Force, it is our opinion that none of these items, either individually or collectively, should be considered “significant” as defined by the financial solvency accreditation standards.

As outlined in the Valuation Manual, amendments will be adopted annually by the Executive (EX) Committee and Plenary at each NAIC Summer Meeting. As such, the Valuation Manual will be reposted with an effective date of January 1 of the year following Executive Committee and Plenary adoption. For example, the current Valuation Manual, which encompasses the attached modifications, is titled the *2023 Edition - Valuation Manual*. This process allows for an efficient way to update the Valuation Manual and ensures that users have the latest version.

The Task Force sincerely requests that the Committee consider the items listed in Attachment A as “insignificant” changes to the Valuation Manual. We will continue to notify the Committee of any changes to the Valuation Manual and to advise if, in our opinion, those changes are “significant” by financial solvency accreditation standards.

## Attachment A

LATF VM Amendment	Valuation Manual Reference	Valuation Manual Amendment Proposal Descriptions	LATF Adoption Date
2020-12	VM-01, VM-20, VM-21, VM-31	Create consistency between CDHS determination in VM-20 and VM-21. Revise hedge modeling to only require CDHS if modeling future hedging reduces the reserves under VM-20 or TAR under VM-21.	6/9/22
2021-11	VM-21, section 12 and various others	Add a section for other assumptions requirement in VM-21 which covers general guidance and requirements for assumptions, and expense assumptions.	2/3/22
2021-12	VM-21 Section 6.B.3.a, VM-21 Section 6.B.6.a, VM-21 Section 6.B.6.b, VM-21 Section 6.C.4, VM-21 Section 6.C.10, VM-21 Section 6.C.11	Correct CSMP reference and clarify requirements for VA contracts with no minimum guaranteed benefits in Additional Standard Projection Amount in VM-21 Section 6.C. These three prescribed assumptions are Partial Withdrawal, Account Value Depletion, and Other Voluntary Contract Termination.	11/18/21
2021-13	VM-20 Sect. 9.C.6.e, VM-20 Sect. 9.C.7, VM-31 Sect. 3.D.3.o.	It has been observed that adding the prescribed mortality margins for some Life/LTC combination products cause modeled reserves to decrease rather than increase.	11/4/21
2022-01	VM-20 Section 8.C.18	Clarifying the Valuation Manual treatment of the pre-reinsurance ceded reserve and the reserve credit for retrocessions	3/10/22
2022-02	VM-31	Revise language and add an explicit cross-reference to the VM-21 section since it has further details on how to demonstrate compliance	3/31/22
2022-03	VM-20, VM-21, VM-31	General cleanup, including updating cross-references, better consistency between VM-20 and VM-21, where reasonable, and making clarifying edits.	3/31/22
2022-04	VM-20 Section 9.F.8, App 2.F, App 2.G	LIBOR transition to the Secured Overnight Financing Rate (SOFR) - Updated VM-20 prescribed swap spreads guidance to facilitate the LIBOR transition to SOFR.	6/30/22
2022-05	VM-51 App 1, App 4	Add dividend plan code & Covid-19 indicator; change field identifier; correct Appendix 1 reference.	5/12/22

The individual amendment proposals reside on the Industry tab on the NAIC website and are accessible by following the link below:

[LATF Adopted Amendments for the 2023 VM.](#)



**INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE**

International Insurance Relations (G) Committee March 22, 2023, Minutes ..... 11-2  
 International Insurance Relations (G) Committee Feb. 3, 2023, Minutes (Attachment One)..... 11-6  
     NAIC Comments on the Individual Insurer Monitoring (IIM) Assessment Methodology  
     (Attachment One-A)..... 11-7  
 International Insurance Relations (G) Committee Jan. 4, 2023, Minutes (Attachment Two) ..... 11-10  
     NAIC Comments on the International Association of Insurance Supervisors (IAIS) Public  
     Consultation on the Issue Paper on Insurance Sector Operational Resilience  
     (Attachment Two-A) ..... 11-11

Draft: 4/3/23

International Insurance Relations (G) Committee  
Louisville, Kentucky  
March 22, 2023

The International Insurance Relations (G) Committee met in Louisville, KY, March 22, 2023. The following Committee members participated: Gary D. Anderson, Chair (MA); Eric Dunning, Vice Chair (NE); Lori K. Wing-Heier (AK); Ricardo Lara (CA); Andrew N. Mais (CT); Gordon I. Ito (HI); Dean L. Cameron (ID); Doug Ommen (IA); Dana Popish Severinghaus (IL); Vicki Schmidt (KS); James J. Donelon (LA); Kathleen A. Birrane (MD); Anita G. Fox (MI); Troy Downing (MT); and Marlene Caride (NJ).

1. Adopted its Feb. 3, 2023; Jan. 4, 2023; and 2022 Fall National Meeting Minutes

The Committee met Feb. 3, 2023, and Jan. 4, 2023. During these meetings, the Committee took the following action: 1) discussed NAIC comments on the International Association of Insurance Supervisors' (IAIS') public consultation on the review of its individual insurer monitoring (IIM) assessment methodology; and 2) discussed NAIC comments on the IAIS' *Issues Paper on Insurance Sector Operational Resilience*.

Commissioner Mais made a motion, seconded by Commissioner Caride, to adopt the Committee's Feb. 3, 2023 (Attachment One), Jan. 4, 2023 (Attachment Two), and Dec. 13, 2022 (*see NAIC Proceedings – Fall 2022, International Insurance Relations (G) Committee*) minutes. The motion passed unanimously.

2. Heard an Update on International Activities Related to Addressing Protection Gaps

Commissioner Anderson spotlighted international activities related to addressing protection gaps and mentioned the recent creation of the Protection Gaps Task Force (PGTF) at the IAIS. He noted that Director Cameron serves as a member of the PGTF, with California represented as a member as well. He said that the primary work of the PGTF will initially be focused on surveying members, and eventually stakeholders, on protection gaps related to natural catastrophes. This survey will ultimately lead to a report to be released by year-end.

David Snyder (American Property Casualty Insurance Association—APCIA) and Dennis Burke (Reinsurance Association of America—RAA) presented a recent report published by the Global Federation of Insurance Associations (GFIA). Titled *Global Protection Gaps and Recommendations for Bridging Them*, the report examines the drivers of the most relevant protection gaps and provides an overview of the wide range of potential levers that could help reduce each of the gaps.

Snyder reviewed the roles that various groups play in addressing protection gaps and highlighted the report's four primary risk categories that drive the gaps: 1) natural catastrophes (natcats); 2) cyber; 3) pensions; and 4) health. Burke spoke to the natcat risks as defined in the paper and recommended that committee members provide the report to their relevant staff who cover the topic. Snyder and Burke noted that certain protection gaps, such as health, may be more present in some countries versus others, based on the respective insurance markets in place.

Snyder listed the main recommendations of the report, noting education and consumer risk literacy are of key importance to tackling wide protection gaps. He noted that with respect to natcats, better building codes and inspections are recommended, as well as the involvement of more private-public partnerships. Burke noted that market differences exist globally and that open markets will help alleviate the spreading of risk. On cyber risk, recommendations included: 1) promoting an improved cyber-resilience landscape; 2) focusing on critical infrastructure; 3) creating a cyber-incident reporting framework to understand major incidents; and 4) the

furthered use of aggregate modeling. Finally, they noted that jurisdictions should be mindful of not creating barriers for insurers in addressing protection gaps and allowing risk-based capital (RBC) models to be used.

Commissioner Anderson emphasized that both domestic and international activities to address protection gaps are important for state insurance regulators and the larger insurance sector. He asked the presenters about the process GFIA undertook to highlight the four topics and if there were others on the list. Snyder responded by saying that a cross-section of members from many jurisdictions around the world participated in the drafting of the report and noted that there were no other topics on the agenda.

Director Cameron inquired about access and affordability and whether it is a lack of understanding of risk rather than access to funding mechanisms. He acknowledged that the report addresses what regulators and governments can do. However, he asked if there is any discussion that addresses industry action. Snyder and Burke noted that the paper is, to a lesser extent, focused on the risk-takers of the world, i.e., insurers and insurance sellers. They did note that a combination of recommendations is aimed at different groups and that the industry as a whole should look at potential ways to fill protection gaps together, such as parametric insurance and microinsurance in less developed nations.

Commissioner Lara asked the speakers how global insurers are incentivizing risk reduction and not just the pricing of the risk. Snyder noted that GFIA aims to provide more information on risk mitigation from around the world, which will be circulated once available. He concluded by saying that the work being undertaken by GFIA is a strong signal of the desire to work with regulators to address the top-priority issue of protection gaps.

### 3. Heard an Update on Activities of the IAIS

Commissioner Anderson gave an update on IAIS activities and its key 2023 projects and priorities. He began with a review of the IAIS committee meetings that took place earlier in the month. On the insurance capital standard (ICS), he commended the recent approval of the final criteria to assess whether the aggregation method (AM) provides comparable outcomes to the ICS. Commissioner Anderson noted that this marks an important milestone for the global insurance sector and represents years of work by supervisors to fulfill the Financial Stability Board's (FSB's) charge to develop a comprehensive, group-wide supervisory and regulatory framework for internationally active insurance groups (IAIGs), including a quantitative capital standard. He mentioned that the IAIS is entering the fourth year of the five-year monitoring period for the ICS and that specifications for both the ICS and AM data collections will be released at the end of April, with data due to the IAIS of August 31.

Next, Commissioner Anderson applauded the FSB's endorsement of the IAIS holistic framework for systemic risk in the insurance sector and the discontinuation of the process to designate global systemically important insurers (G-SIIs). He noted that the FSB's decision was based in part on the targeted jurisdictional assessment (TJA) of the holistic framework, which took place over the course of 2021 and 2022.

Commissioner Anderson highlighted some of the ongoing work being undertaken by forums and other groups within the IAIS, including:

- The Financial Inclusion Forum, which is discussing updating the 2012 IAIS Application Paper on Regulation and Supervision Supporting Inclusive Insurance Markets.
- The Fintech Forum and its continuing review of artificial intelligence (AI) and machine learning (ML) guidance from supervisory authorities and explore the need for the IAIS to develop global guidance for the insurance sector.
- The Climate Risk Steering Group's upcoming public consultation that covers the addition of new text to the IAIS Insurance Core Principles Introduction, work related to climate risk and governance, and the IAIS' plans to address climate more broadly.

Commissioner Anderson concluded by mentioning the IAIS Operational Resilience Task Force will be finalizing an issues paper on operational resilience in the insurance sector, and the Resolution Working Group recently issued a public consultation on an application paper on policyholder protection schemes. He said that the Committee will be meeting April 13 to consider any NAIC comments on the application paper.

#### 4. Heard an Update on International Activities

##### A. International Activities

Director Dunning reported on upcoming regional supervisory cooperation activities. The European Union (EU)-U.S. Insurance Dialogue Project has been working within three working groups this year: 1) climate risk financial oversight, including climate risk disclosures, supervisory reporting, and other financial surveillance; 2) climate risk and resilience, including innovative technology, pre-disaster mitigation, adaptation efforts, and modeling; and 3) innovation and technology, including big data, AI, and supervisory technology as a regulatory tool. He noted the project's upcoming public stakeholder event to be held June 16 in Seattle, WA.

Director Dunning then spoke about the NAIC's International Fellows program and noted the application period is currently open for the spring 2023 virtual session. He encouraged Committee members to notify NAIC staff if their insurance departments would be willing to host a fellow this fall for the in-person session.

Director Dunning spotlighted NAIC participation in recent international events, including the Bermuda Risk Summit 2023, held March 6–8, where Director Lindley-Myers and Director Wing-Heier addressed the NAIC's upcoming priorities for the year, as well as the importance of regulatory collaboration. He also noted the Geneva Association's Program on Regulation and Supervision (PROGRES) that was held March 9–10, where Commissioner Mais participated on a panel on the interplay between health and insurance regulation, and Commissioner Anderson participated on a panel on the ICS.

##### B. OECD

Director Dunning reported on work at the Organization for Economic Co-operation and Development (OECD) conducted by the NAIC along with its federal colleagues from the U.S. Department of Commerce (DOC), Federal Insurance Office (FIO), and Department of Labor (DOL). He said that since the 2022 Fall National Meeting, work has continued on a variety of topics, including enhancing the contribution of insurance climate adaptation, as well as digitalization to encourage policyholder risk reduction. Lastly, he noted an upcoming OECD roundtable event in India hosted in conjunction with India's insurance regulator and the Asian Development Bank Institute (ADBI) scheduled for May 24–25 and the next OECD Insurance and Private Pensions Committee meeting scheduled for June 26–27 in Paris, France.

##### C. SIF

Director Dunning reported that the Sustainable Insurance Forum (SIF) is continuing its work on two work streams: 1) identifying the potential role of insurance supervisors in the net-zero transition; and 2) how to best leverage existing practices from around the globe to help jurisdictions address access and affordability issues to help close the coverage gap within their own jurisdictions. The next meeting is expected to take place in the second quarter of 2023.

## 5. Discussed Other Matters

Commissioner Anderson noted two upcoming events: 1) the NAIC's International Insurance Forum scheduled for May 18–19, in Washington, DC; and 2) the IAIS 2023 Global Seminar scheduled for June 15–16, in Seattle, WA, which will be hosted by the NAIC.

In his closing remarks, Commissioner Anderson gave special thanks to NAIC CEO Michael F. Consedine, who will be resigning from his position in April 2023. Commissioner Anderson highlighted Consedine's commitment to the U.S. perspective at the global insurance regulatory stage and his consistent push for the NAIC's participation in a variety of international forums, associations, and events.

Having no further business, the International Insurance Relations (G) Committee adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/G CMTE/National Meetings/2023/Louisville-Spring National Meeting

Draft: 2/13/23

International Insurance Relations (G) Committee  
Virtual Meeting  
February 3, 2023

The International Insurance Relations (G) Committee met Feb. 3, 2023. The following Committee members participated: Gary D. Anderson, Chair (MA); Eric Dunning, Vice Chair (NE); Lori K. Wing-Heier (AK); Ricardo Lara represented by Susan Bernard (CA); Andrew N. Mais represented by William Arfanis (CT); Dean L. Cameron (ID); Doug Ommen (IA); Dana Popish Severinghaus (IL); Vicki Schmidt (KS); James J. Donelon (LA); Kathleen A. Birrane (MD); Anita G. Fox (MI); Troy Downing (MT); and Marlene Caride (NJ).

1. Discussed NAIC Comments on the IAIS Public Consultation on the Review of the IIM Assessment Methodology

Commissioner Anderson explained that the International Association of Insurance Supervisors (IAIS) is conducting a public consultation on the review of its Individual Insurer Monitoring (IIM) Assessment Methodology, which is one component of the IAIS's Global Monitoring Exercise (GME). He reviewed the GME as a key element of the Holistic Framework adopted by the IAIS in November 2019 to support the IAIS mission of effective and globally consistent supervision in order to protect policyholders and contribute to global financial stability. He noted that the objective of the public consultation is to seek input on the review of the IIM Assessment Methodology for the next three-year cycle of application, and the triannual review of the IIM helps to ensure that the Holistic Framework for systemic risk in insurance remains up to date as risks and the sector continue to evolve. He said the NAIC's initial draft comments are based on an internal review of the IIM consultation document, and they were circulated in advance of the call, but no input was received from state insurance regulators or interested parties.

Ryan Workman (NAIC) gave an overview of the NAIC's comments on the public consultation and summarized the draft answers to a variety of the consultation questions. The NAIC comments address potential changes to the IIM scoring indicators, including refinements to Level 3 assets, cross-border reinsurance, the derivatives and the short-term funding indicators, and removal the financial guarantee indicator. Workman explained that the draft comments recommend that the insurer pool selection criteria contain language providing for an inflation adjustment of the dollar threshold on a periodic basis. He concluded by noting that the last comment recommends that the IAIS Global Insurance Market Report (GIMAR) should be more concise going forward.

Stephen Broadie (American Property Casualty Insurance Association—APCIA) provided a review of comments to be submitted by the APCIA on the public consultation. He noted three areas of focus for the comments: 1) a misplaced focus on cross-border reinsurance that should be better directed at identifying concentration risk; 2) the abundance of liquidity risk measures that exist and how they should be limited in number to one or two; and 3) general comments on how the IAIS should reduce additional data requests to items that are not publicly available and are directly relevant to identifying systemic risk.

Commissioner Caride made a motion, seconded by Director Cameron, to approve the submission of the NAIC comments on the review of the IIM Assessment Methodology (Attachment One-A). The motion passed unanimously.

Having no further business, the International Insurance Relations (G) Committee adjourned.

G Cmte Minutes 020323



NAIC Comments Submitted Feb. 3, 2023

## IAIS public consultation on the review of the Individual Insurer Monitoring (IIM) Assessment Methodology

### Consultation Questions

#### 2.1 IIM scoring indicators

##### 2.1.2 *Enhancing the monitoring of level 3 assets*

###### Questions:

- Which (underlying) data rows would be necessary to monitor the different types of level 3 assets?
  - If possible, also provide the technical specifications for these rows
- Which (underlying) data rows would be necessary to monitor illiquid/difficult to value assets held at historical cost or valued using other non-fair value methods?
  - If possible, also provide the technical specifications for these rows
- Which other refinements could be made to the level 3 assets indicator?

###### Answer:

Refinement of Level 3 assets does not seem necessary because Level 3 assets have been readily publicly available (other otherwise has proxies). The NAIC suggests more time needs to be spent on data validation, rather than collecting more data, to be more efficient at analyzing firm and jurisdictional differences of Level 3 assets.

##### 2.1.3 *Enhancing the monitoring of (cross-border) reinsurance*

###### Questions:

- Which (underlying) data rows would be necessary to better capture (1) cross-border reinsurance exposures (ceded and assumed) and (2) the concentration risk of cross-border reinsurance in certain insurers or jurisdictions?
  - If possible, also provide the technical specifications for these rows
- Which potential reinsurance ancillary indicator could be developed?
  - If possible, also provide the data rows and technical specifications
- Which other refinements could be made to better capture reinsurance exposures under the intra-financial assets and liabilities indicators?
- If possible, also provide the technical specifications for these rows.

###### Answer:

The NAIC agrees with the proposed enhancements -- asking jurisdictions where premiums and risk is ceded could assist in better capturing concentration of exposures.



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#### **2.1.4 Refining the derivatives indicator**

##### **Questions:**

- Which (underlying) data rows would be necessary to monitor the different types of derivatives?
  - If possible, also provide the technical specifications for these rows
- Which other variables could be looked at to monitor derivatives exposures and their potential 'outward' risk, in addition to gross notional amounts?
- What is your assessment of the difference in systemic risk between the risk from OTC derivatives that are centrally cleared vs derivatives that are bilaterally settled?
- Should the hedging leverage in derivatives and repo exposures be monitored?
  - If yes, how?

##### **Answer:**

The existing derivatives data seems adequate. With respect to other variables and hedging leverage, the impact of margin calls may be a useful additional indicator of risk. Centrally cleared derivatives are typically considered less risky than bilaterally settled.

#### **2.1.5 Refining the short-term funding indicator**

##### **Question:**

- Which (underlying) data rows would be necessary to monitor the potential outward risk of short-term funding?
  - If possible, also provide the technical specifications for these rows
- Which other refinements could be made to the short-term funding indicator?

##### **Answer:**

The NAIC agrees with the existing assessment methodology, so no changes are necessary.

#### **2.1.6 Removal of the financial guarantees indicator**

**Question:** Do you have any feedback on the removal of financial guarantees as an indicator?

##### **Answer:**

The NAIC is in favor of removing the financial guarantee indicator.

#### **2.1.7 Any other feedback on any of the indicators and the IIM data template**

##### **Question:**

- Do you have any other feedback on any of the indicators?
- What is your view of the overall granularity of the IIM data template (Annex 1)?

##### **Answer:**

No comments.





NAIC Comments Submitted Feb. 3, 2023

## 2.2 Indicator weighting

**Question:** Do you have any feedback on the updated indicator weighting?

**Answer:**

The NAIC agrees with the updated indicator weighting to reflect omission of the financial guarantee indicator.

## 2.3 Insurer Pool selection criteria

**Question:** Do you have any feedback on the Insurer Pool selection criteria?

**Answer:**

The NAIC recommends that the insurer pool selection criteria contain language providing for an inflation adjustment of the dollar threshold on a periodic basis.

## 2.4 Reporting to participating insurers and the public

### *2.4.1 Reporting to participating insurers: Participating Insurer Reports (PIRs)*

**Question:** Do you have any feedback on the Participating Insurer Reports?

**Answer:**

No comments.

### *2.4.2 Reporting to the public: Global Insurance Market Report (GIMAR)*

**Question:** Do you have any feedback on the Global Insurance Market Report (GIMAR)?

**Answer:**

The NAIC recommends that the GIMAR should be more concise.

Draft: 1/17/23

International Insurance Relations (G) Committee  
Virtual Meeting  
January 4, 2023

The International Insurance Relations (G) Committee met Jan. 4, 2023. The following Committee members participated: Gary D. Anderson, Chair (MA); Eric Dunning, Vice Chair (NE); Andrew N. Mais represented by William Arfanis (CT); Doug Ommen (IA); Dana Popish Severinghaus represented by Susan Berry (IL); James J. Donelon (LA); Kathleen A. Birrane (MD); Anita G. Fox represented by Judy Weaver (MI); Marlene Caride (NJ); and Michael Wise (SC).

1. Discussed NAIC Comments on the IAIS Public Consultation on the Issue Paper on Insurance Sector Operational Resilience

Commissioner Anderson explained that the International Association of Insurance Supervisors' (IAIS's) public consultation on its Issue Paper on Insurance Sector Operational Resilience was a result of work done by the IAIS Operational Resilience Task Force. He noted that the issue paper: 1) identifies issues affecting operational resilience in the insurance sector, specifically those related to cyber resilience, third-party outsourcing, and business continuity management; and 2) provides examples of how supervisors are approaching these developments while considering lessons learned during the COVID-19 pandemic. He said the NAIC's initial draft comments on the issue paper that were circulated in advance of the call for review were drafted upon internal review by NAIC staff and members of the Cybersecurity (H) Working Group.

Ryan Workman (NAIC) gave an overview of the NAIC's comments on the public consultation, noting that many were editorial in nature, and he provided more of an explanation of the comments on areas for further clarification and suggestions for additional context to strengthen certain concepts that were being discussed. He summarized the draft answers to three consultation questions, which touched on the priorities of observations set out in the paper, the potential future focus of the IAIS, and the value of cross-border information sharing.

Commissioner Donelon made a motion, seconded by Acting Director Wise, to approve the submission of the NAIC comments on the Issue Paper on Insurance Sector Operational Resilience consultation document (Attachment Two-A). The motion passed unanimously.

Having no further business, the International Insurance Relations (G) Committee adjourned.

G Cmte Minutes 010423



**NAIC Comments Submitted Jan. 13, 2023**

# **Questions for Consultation on Issues Paper on Insurance Sector Operational Resilience**

Thank you for your interest in the public consultation on the Issues Paper on Insurance Sector Operational Resilience. The Consultation Tool is available on the IAIS website.

**Please do not submit this document to the IAIS. All responses to the Consultation Document must be made via the [Consultation Tool](#) to enable those responses to be considered.**



NAIC Comments Submitted Jan. 13, 2023

## Consultation questions

1	<p>General comments on the Issues Paper</p> <p>The paper introduces new terms that may not be familiar to some readers. Suggest adding a glossary to the beginning of the paper.</p> <p>“Business Continuity Management” (BCM) is a concept mentioned throughout the paper and in some places, “Business Continuity Planning” (BCP) is used as an interchangeable term. Suggest defining these two terms in a glossary and also clarifying in the paper (see comments for paragraphs 35 and 80) the difference between the two. Presumably BCM encompasses BCP.</p> <p>There are numerous inconsistencies in the use of the Oxford comma (a.k.a. serial comma) throughout the document. For example, paragraphs 25 and 29 omit it, while paragraphs 2 and 24 employ it.</p>
2	General comments on Section 1 Introduction
3	General comments on Section 1.1 Objectives and Scope
4	<p>Comment on Paragraph 1</p> <p>In the second bullet, add “IT” before “Third-party outsourcing” as this is way the topic is framed throughout the paper and especially in the heading for Section 3.4</p>
5	Comment on Paragraph 2
6	<p>Comment on Paragraph 3</p> <p>Suggest the following edit to this paragraph. Based on the preceding text, the area of expertise of the stakeholders is implied.</p> <p>The information in this paper is informed by a review of the IAIS Insurance Core Principles (ICPs), a stocktake of existing publications by Standard Setting Bodies (SSBs) with relevance to operational resilience, direct engagement – including roundtables – held with <b>operational resilience</b> experts external to the IAIS membership, and information shared on supervisory practices among insurance supervisors.</p>
7	General comments on Section 1.2 Relevance of operational resilience to the insurance sector
8	<p>Comment on Paragraph 4</p> <p>Suggest the following edit to the second sentence to improve flow:</p> <p><del>Thus,</del> The concept of operational resilience is not new, though recognition of the importance of adapting supervisory regimes to account for the growing reliance by insurers on digital systems is more recent.</p>



## NAIC Comments Submitted Jan. 13, 2023

9	<p>Comment on Paragraph 5</p> <p>It might strengthen this paragraph to have similar statistics on cyber-attacks between 2019 and 2020, if available, to give some pre-pandemic context. Also, this paragraph is a bit disjointed; there is a number in February and a number in late April, but then goes to the percent increase in May and June compared to March and April. Since the number for March isn't given anywhere, it is hard to know what kind of increase it is over March.</p> <p>For consistency with the use of percent signs elsewhere within the document, suggest replacing “per cent” with a percent sign.</p> <p>Replace “cyber attacks” with “cyber-attacks” for consistency with the other eight occurrences of this word throughout the document.</p>
10	Comment on Paragraph 6
11	Comment on Paragraph 7
12	Comment on Paragraph 8
13	Comment on Paragraph 9
14	Comment on Paragraph 10
15	Comment on Paragraph 11
16	General comments on Section 1.3 Issues Paper structure
17	Comment on Paragraph 12
18	Comment on Paragraph 13
19	<p>Comment on Paragraph 14</p> <p>Replace both occurrences of “cyber attacks” with “cyber-attacks” for consistency with the other eight occurrences of this word throughout the document.</p>
20	<p>Comment on Paragraph 15</p> <p>Suggest the following edit to the first sentence to improve flow:</p> <p>The risks posed <del>to insurers</del> by a third-party outsourcing partner for IT-related functions are similar across many industries, including the insurance industry.</p> <p>In this paragraph, consider adding a bit more context around “concentration risk” as the concept is being introduced here.</p>
21	<p>Comment on Paragraph 16</p> <p>Suggest the following edit to the last sentence; removing “business continuity” eliminates a redundancy and also broadens this statement a bit.</p>



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	<p>However, a critical piece of moving to hybrid and remote work environments is understanding and proactively managing the <del>business continuity</del> risks that arise from an increased attack surface, and reliance on technology and outsourcing of critical IT services.</p>
22	Comment on Paragraph 17
23	General comments on Section 2 Applicability of ICPs to operational resilience
24	Comment on Paragraph 18
25	Comment on Paragraph 19
26	<p>Comment on Paragraph 20</p> <p>Suggest the following edit to the second sentence; modifier not needed.</p> <p>“All of which promote <del>sound</del> operational risk management more generally, while respecting issues of proportionality.”</p>
27	<p>Comment on Paragraph 21</p> <p>The ICPs typically use “sound” in referring to an insurer’s management, governance, etc., but not when describing supervision.</p> <p>The ICPs identified as supporting the <del>sound</del> supervision and <del>sound</del> management of operational resilience in the insurance sector include:</p>
28	<p>Comment on Paragraph 22</p> <p>Similar to paragraph 20, the modifier is not really needed here.</p> <p>The ICPs have clear interactions with operational resilience and support the <del>sound</del> management of an insurer’s operational risks.</p>
29	Comment on Paragraph 23
30	<p>Comment on Paragraph 24</p> <p>Similar to paragraph 21, delete the modifier in this context.</p> <p>The review of ICPs also revealed a number of examples of areas where further discussions or considerations for developing supporting materials could advance the <del>sound</del>-supervision of cyber resilience, IT third-party outsourcing, and BCM as critical elements of operational risk management (which are considered among those elements outlined in section 4).</p>
31	General comments on Section 3 Key issues and supervisory approaches
32	Comment on Paragraph 25



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33	Comment on Paragraph 26
34	<p>Comment on Paragraph 27</p> <p>Suggest the following edit to the last sentence to improve clarity:</p> <p>This is particularly important for insurers, in respect of any confidential or personal <b>customer</b> data that is shared with third-party service providers.</p> <p>Inclusion of the word “legacy” in the second sentence implies that all on-premises IT infrastructure is ipso facto obsolete, unable to be updated, nonconforming to security standards, inherently vulnerable, unsupported, unscalable, etc. This simply should not be presumed. The use of advancing technologies could provide cyber security benefit as compared to in-house technology infrastructure and systems, whether legacy or not.</p> <p>The use of advancing technologies, such as the cloud, could provide efficiencies and improvements in cyber security as compared to <del>in-house legacy on-premises</del> technology infrastructure and systems.</p>
35	Comment on Paragraph 28
36	<p>Comment on Paragraph 29</p> <p>See general comments above and for paragraph 80 – BCP is introduced here without explaining its relationship to BCM. It is also used somewhat interchangeably with BCM. Recommend adding a sentence clarifying the difference between BCM and BCP in this paragraph.</p>
37	General comments on Section 3.1 Governance and Board accountability
38	Comment on Paragraph 30
39	Comment on Paragraph 31
40	<p>Comment on Paragraph 32</p> <p>The document mentions sound operational resilience, sound practices, sound operational risk management, sound governance, sound management, sound supervision etc., but the word appears misplaced in the following sentence. It should be moved as follows.</p> <p>Recognising that operational disruptions can have widespread impacts across an organisation, the provision of appropriate training across relevant groups within an organisation could facilitate the <del>sound</del> implementation of <del>an a sound</del> operational resilience framework.</p>
41	<p>Comment on Paragraph 33</p> <p>Suggest the following edit to the first sentence to eliminate redundancy:</p>



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	The absence of a framework for identifying – and analysing the impact of – severe but plausible short, medium and long-term risks <del>to operational resilience</del> can limit the chances of successfully enhancing the insurer’s overall <del>operational</del> resilience.
42	Comment on Paragraph 34
43	General Comments on Section 3.1.1 Lessons learnt from the pandemic
44	Comment on Paragraph 35
45	Comment on Paragraph 36
46	General comments on 3.1.2 Supervisory approaches
47	<p>Comment on Paragraph 37</p> <p>Replace “oversight over” with “oversight of” in the first sentence to eliminate the nearly redundant alliteration.</p> <p>Many supervisory authorities currently seek assurance that insurers have sound governance frameworks and adequate Board and Senior Management oversight <del>over</del> of resilience measures, as well as strategies to mitigate risks associated with operational disruption.</p> <p>Additionally, just having and documenting processes isn’t enough, so recommend adding a bullet regarding the importance of regularly reviewing/updating processes.</p>
48	<p>General Comments on Section 3.2 Information collection and sharing among supervisors, public/private collaboration</p> <p>Recommend shortening this section name for clarity and consistency with other section titles:</p> <p><b>3.2 Information collection and sharing <del>among supervisors, public/private collaboration</del></b></p>
49	Comment on Paragraph 38
50	<p>Comment on Paragraph 39</p> <p>Regarding supervisor and insurer engagement, it seems that in most cases the appropriate engagement is between the supervisor and insurer management (not the board), though the board of course should have a clear understanding of the insurer’s operational resilience framework (this is mentioned elsewhere in the paper).</p> <p>To gather this information, some supervisors proactively engage with an entity’s <del>Board and</del> Senior Management to understand the effectiveness of an entity’s operational resilience framework.</p>





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51	<p>Comment on Paragraph 40</p> <p>Last sentence, beginning and end quotes should be consistent:</p> <p>As the International Monetary Fund (IMF) has noted “[a]ttackers show a degree of agility in cooperation across borders that authorities find difficult to match.”<sup>11</sup></p>
52	General comment on Section 3.2.1 Lessons learnt from the pandemic
53	Comment on Paragraph 41
54	General comments on Section 3.2.2 Supervisory approaches
55	Comment on Paragraph 42
56	Comment on Paragraph 43
57	<p>Comment on Paragraph 44</p> <p>The seventh bullet point references operational <i>resiliency</i>, rather than operational <i>resilience</i>, which appears 79 times throughout the document.</p> <p>Reports on training delivered in relation to operational <del>resiliency</del> <i>resilience</i> best practices, and in particular on expectations, and roles and responsibilities during periods of sub-optimal functioning;</p>
58	<p>Comment on Paragraph 45</p> <p>Consider adding “consumer” to the second bullet point as follows:</p> <p>Concerns on data protection and <del>consumer</del> privacy laws that limit or prevent the sharing of information beyond an entity or jurisdiction</p> <p>Further, consider adding an additional bullet as an additional barrier:</p> <ul style="list-style-type: none"> <li><del>Hesitancy of insurer to share information with supervisor because of concerns the information could be used against them, could lead to additional scrutiny of their controls, or that doing so could cause legal risks;</del></li> </ul>
59	General Comments on Section 3.3 Cyber resilience
60	<p>Comment on Paragraph 46</p> <p>We may be further away from the pandemic once this paper is published, so recommend deleting “has” in the first sentence. Also in the first sentence, there should be a comma after “technologies” to separate the two independent clauses.</p> <p>The insurance sector is heavily dependent on the use of digital technologies, and this reliance <del>has</del> only accelerated during the pandemic as entities transitioned to remote working.</p>

Public

Public Consultation on Issues Paper on Insurance Sector Operational Resilience

13 October 2022 – 6 January 2023



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61	Comment on Paragraph 47
62	Comment on Paragraph 48
63	Comment on Paragraph 49
64	Comment on Paragraph 50
65	Comment on Paragraph 51
66	Comment on Paragraph 52
67	Comment on Paragraph 53
68	<p>Comment on Paragraph 54</p> <p>For this paragraph and heading, it might be more appropriate to refer to “consistent approach” rather than “standardized metrics” to be less prescriptive. The use of “consistent approach” is also more outcomes focused.</p> <p><b>Lack of <del>standardised metries</del> consistent approach</b></p> <p>Having a consistent/<del>standardised</del> approach to assess insurers’ cyber resilience can be helpful especially when insurers are engaging third-party service providers that operate cross jurisdiction (eg cloud).</p>
69	<p>Comment on Paragraph 55</p> <p>Punctuation is inconsistent. An en dash follows Availability in the first bullet point, while a simple hyphen follows RTO and RPO in the second and third bullet points. All should be en dash characters to maintain consistency with the remainder of the document.</p> <p>Recovery Time Objective (RTO) – defined by the entity...</p> <p>Recovery Point Objective (RPO) – defined by the entity...</p>
70	Comment on Paragraph 56
71	Comment on Paragraph 57
72	<p>Comment on Paragraph 58</p> <p>Recommend the following edit to avoid using duplicating word choice:</p> <p>One consequence of skills shortages is that the advancement of supervisory frameworks over cyber resilience may lag behind the <del>advancement</del> growing sophistication of cyber-attacks.</p>
73	General Comments on Section 3.3.1 Lessons learnt from the pandemic



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74	Comment on Paragraph 59
75	General Comments on Section 3.3.2 Supervisory approaches
76	<p>Comment on Paragraph 60</p> <p>First sentence of the “Tabletop Exercises” example:</p> <p>Working with US state and federal supervisors, law enforcement agencies, and other officials, under the auspices of the Treasury Department’s “Hamilton” programme, the National Association of Insurance Commissioners (NAIC) facilitates tabletop exercises with insurers and supervisors to explore cyber incident response and recovery<del>back</del>.</p> <p>For consistency of the British English spelling used throughout the document, consider changing “programs” to “programmes” in the second sentence under Tabletop Exercises.</p> <p>This aims to enhance cyber response <del>programs</del> programmes of insurers and supervisors by discussing key methods supporting pre-emptive and/or reactive responses to potential threats.</p>
77	<p>Comment on Paragraph 61</p> <p>The first bullet point requires two corrections, as follows:</p> <p>Self-assessment Questionnaires – involves <del>entity’s entities</del> performing self-assessments of the quality of their cyber resilience framework, the responses to which provide a snapshot of the <del>entity’s entities’</del> cyber resilience capabilities and vulnerabilities.</p> <p>Suggest the Vulnerability Assessments bullet point be expanded to indicate that these tools are automated scans that check for exploitable known vulnerabilities and culminate in a report on risk exposure.</p> <p>Suggest changing “Cyber incident reporting” to “Cyber Incident Reporting” for case consistency with other titles throughout the document.</p> <p>Suggest changing “Scenario-Based Testing” to “Scenario-based Testing”, for case consistency with other hyphenated titles throughout the document.</p>
78	<p>Comment on Section 3.4 IT third-party outsourcing</p> <p>Suggest additional clarification in this section regarding what is considered a critical and important IT service. As mentioned in paragraph 68, third-party provider risk goes beyond just those that provide IT services.</p>
79	<p>Comment on Paragraph 62</p> <p>Comment on Paragraph 62</p>



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	<p>The last sentence ends awkwardly with two terms that mean essentially the same thing. Recommend striking some text to remove the redundancy. Additionally, “third party” should be hyphenated because it is used as an adjective rather than a noun.</p> <p>However, an area where both supervisory requirements and financial institutions' risk management processes remain less advanced is the identification and management of concentration risks associated with the provision of critical IT services to firms by third-party <del>and-outsourced</del> service providers.</p>
80	Comment on Paragraph 63
81	Comment on Paragraph 64
82	Comment on Paragraph 65
83	Comment on Paragraph 66
84	Comment on Paragraph 67
85	<p>Comment on Paragraph 68</p> <p>Suggest the following edits:</p> <p>Other examples of third-party services often used by insurers that may present concentration risks include processes for annuities, payroll <del>and benefits</del> administration, <del>investment management</del>, claims processing and resolving customer queries.</p>
86	Comment on Section 3.4.1 Lessons learned from the pandemic
87	Comment on Paragraph 69
88	Comment on Paragraph 70
89	<p>Comment on Paragraph 71</p> <p>The contractual relationship is not at issue, so suggest identifying the third parties as simply <i>providers</i>:</p> <p>This was associated with entities having in place numerous arrangements in the same geographic area, resulting in a dependence on one or a few <del>sub-contractors providers</del> in that area for the delivery of services.</p>
90	Comment on Section 3.4.2 Supervisory approaches
91	Comment on Paragraph 72
92	Comment on Paragraph 73
93	Comment on Paragraph 74
94	Comment on Paragraph 75
95	Comment on Paragraph 76



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96	Comment on Paragraph 77
97	General Comments on Section 3.5 Business continuity management
98	<p>Comment on Paragraph 78</p> <p>Suggest using a different word for the following sentence, as to not limit it to only speed:</p> <p>An operational disruption, <del>slowdown</del> degradation or interruption in the activities of an insurer or any of its service providers could jeopardise its ability to meet its commitments to its insureds and other partners.</p>
99	Comment on Paragraph 79
100	<p>Comment on Paragraph 80</p> <p>Second sentence, similar to the first comments and comments for paragraph 35, recommend adding some additional context around “BCP” or at least referencing an earlier explanation.</p>
101	Comment on Paragraph 81
102	<p>Comment on Paragraph 82</p> <p>Second sentence, since the IAIS may follow up on some of these considerations, suggest noting that here:</p> <p>The following aspects of BCM are identified as challenges that could benefit from further analysis by the IAIS and/or cooperation amongst supervisory authorities:</p>
103	Comment on Paragraph 83
104	<p>Comment on Paragraph 84</p> <p>Suggest adding the parenthetical reference “(BIA)” following “Business Impact Analysis.”</p> <p>Also, suggest the following addition to include an example of another area that could be contemplated in a BCP.</p> <p>For example, the need to consider availability in BCPs could be extended to consider the consequences of loss of confidentiality and integrity of information for important business services when business impact analysis (BIA) and risk assessment are performed (information security / cyber preparedness could be integrated into broader BCP and enterprise risk management [ERM]), or how the insurer would handle the loss of a significant number of employees.</p>
105	Comment on Paragraph 85



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	<p>If the BIA parenthetical reference is added to paragraph 84, then suggest changing the last sentence accordingly. Additionally, the last sentence of the paragraph should be singular.</p> <p>Continuity assumptions that proved inadequate during the pandemic have led to a review of the criticality of some existing processes and the adoption of different time frames (eg immediate, short, medium and long term) in many operational continuity strategies, depending on the results of their <del>business impact analysis</del> BIA and the needs and resources of each insurers.</p>
106	<p>Comment on Paragraph 86</p> <p>First and second sentences, recommend the following edits. We can already observe that remote work is more permanent. Also, it should be clarified that any additional expenses for remote work are likely attributed to IT security, as remote work in general is often cheaper for organizations.</p> <p>Although hybrid work arrangements <del>might have</del> become more permanent features, in practice remote working policies may vary significantly. Some institutions may consider arrangements that limit the amount of time staff can work from home to avoid additional expenses on IT security.</p>
107	Comment on Paragraph 87
108	General Comments on Section 3.5.1 Lessons learnt from the pandemic
109	<p>Comment on Paragraph 88</p> <p>Recommend replacing “cyberattacks” with “cyber-attacks” in the last bullet point for consistency with the other eight occurrences of this word throughout the document.</p> <p>It was often seen that third parties had the capability of offering technology solutions that are more secure, resilient, and flexible than financial institutions’ own existing technology solutions, which sometimes rely on legacy systems.</p> <p>The third bullet point is cumbersome but can possibly be repaired by striking one word.</p> <p>Growing customer expectations in relation to the time to recovery and level of recovery, and in terms of effective communication from insurers – ie when a disruption occurs, progress in recovering, <del>and</del> mitigation measures to ensure they can still get serviced, and notification of when services are restored;</p>
110	Comment on Paragraph 89
111	General Comments on Section 3.5.2 Supervisory approaches
112	Comment on Paragraph 90
113	General Comments on Section 4 Summary of observations and potential future areas of IAIS focus



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114	Comment on Paragraph 91
115	Comment on Paragraph 92
116	Comment on Paragraph 93
117	Comment on Paragraph 94
118	Comment on Paragraph 95
119	<p>Comment on Paragraph 96</p> <p>Revision to the first sentence to address a typo:</p> <p>Based on the observations outlined in section 3.4 4, areas that may benefit from further consideration include:</p> <p>In the fourth bullet point, the last sentence identifies small and medium-sized entities but neither qualifies nor quantifies those terms. Accordingly, recommend modifying as follows to denote all but the largest insurers:</p> <p>However, it is recognised that these are complex and costly tools, in particular for <del>small and medium-sized</del> smaller entities.</p>
120	Comment on Paragraph 97
121	<p>Comment on Paragraph 98</p> <p>First bullet, suggest edit to reflect that the sector is already integrating BCM into other risk management functions:</p> <p>How the sector is approaching evolutions in BCM best practices, in particular in relation to the need to <b>continue</b> to integrate BCM with other relevant risk management functions to remove silos and ensure that BCM frameworks consider the implications of disruptions stemming from cyber and IT third-party outsourcing risks;</p>
122	<p>Consultation Question 1: Do you have views on the relative priority of the observations set out in section 4? Please indicate your preferred prioritisation and any relevant explanations.</p> <p>In our view, cyber incident reporting and concentration risk (as outlined under “IT third-party outsourcing) are key areas that could benefit from additional IAIS discussion. These are areas require supervisory coordination on jurisdictional and global levels and also have implications beyond the insurance sector.</p>
123	<p>Consultation question 2: Are there additional observations for potential future IAIS focus that you view as important to address with respect to insurance sector operational resilience, and which have not been identified in this Issues Paper?</p> <p>If the third-party provider management discussed in this Issues Paper is strictly related to IT services, additional discussion on third-party vendor management as a whole could be useful. If, for instance, a company’s producer suffers a cyber-attack or data</p>

Public

Public Consultation on Issues Paper on Insurance Sector Operational Resilience

13 October 2022 – 6 January 2023



NAIC Comments Submitted Jan. 13, 2023

	<p>breach or isn't able to resume business in a timely manner after a disaster, that impacts the company's operations, as well. Also, as touched on in Annex 1, there is very little consideration that has been given to fourth-party risks to date.</p> <p>Another item that was touched on briefly but wasn't mentioned as a potential future area of focus is the need to be able to attract and retain talent with expertise in cybersecurity. Training existing staff is a good response, but there has to be existing staff that is interested and there has to be someone or some way to train them. After the training, there still needs to be a way to retain them. Cybersecurity experts are at a premium and although large insurers have the money to pay them, small and mid-sized companies and regulatory agencies don't have the budget.</p>
124	<p>Consultation Question 3: Do you find value in the IAIS facilitating cross-border information sharing to collect information to facilitate a dialogue on operational resilience exposures and best practices? Would you be willing to participate?</p> <p>We think there is value in this assuming it is folded into an existing IAIS forum, such as the revamped Supervisory Forum. It might also be required for such information sharing that participants are signatories to the MMoU. Depending on the forum, we might be interested in participating.</p>



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

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Draft: 4/6/23

Innovation, Cybersecurity, and Technology (H) Committee  
Louisville, KY  
March 22, 2023

The Innovation, Cybersecurity, and Technology (H) Committee met in Louisville, KY, March 22, 2023. The following Committee members participated: Kathleen A. Birrane, Chair (MD); Michael Conway, Co-Vice Chair, and Jason Lapham (CO); Doug Ommen, Co-Vice Chair (IA); John F. King (GA); Gordon I. Ito and Lance Hirano (HI); Dana Popish Severinghaus (IL); Chlora Lindley-Myers represented by Cynthia Amann (MO); Troy Downing (MT); Jon Godfread and Chris Aufenthie (ND); Adrienne A. Harris represented by John Finston (NY); Judith L. French (OH); Carter Lawrence (TN); Kevin Gaffney (VT); and Mike Kreidler and Molly Nollette (WA). Also participating were: Lori K. Wing-Heier (AK); George Bradner (CT); Weston Trexler (ID); Amy L. Beard (IN); Sandra Darby (ME); Grace Arnold (MN); Angela Hatchell (NC); Jennifer A. Catechis (NM); Elizabeth Kelleher Dwyer (RI); and Katie Johnson (VA).

1. Adopted its 2022 Fall National Meeting Minutes

Director French made a motion, seconded by Commissioner Godfread, to adopt the Committee's Dec. 13, 2022, minutes (*see NAIC Proceedings – Fall 2022, Innovation, Cybersecurity, and Technology (H) Committee*). The motion passed unanimously.

2. Adopted the Reports of its Working Groups

A. Big Data and Artificial Intelligence (H) Working Group

Superintendent Dwyer said the Big Data and Artificial Intelligence (H) Working Group met March 22 at the Spring National Meeting.

Related to the Working Group's survey efforts, Superintendent Dwyer reported that the home insurance survey is complete, with the Working Group now shifting to the analysis phase of the project. A public report is to be provided to the public at the Summer National Meeting.

Superintendent Dwyer reminded attendees that the private passenger auto (PPA) insurance survey report is already available on the Working Group's website.

Lastly, related to the survey work, the artificial intelligence (AI)/machine learning (ML) life insurance survey is scheduled to be distributed by the end of March. The requesting states intend to issue a public report by the Fall National Meeting.

The Working Group's third-party vendor workstream has three deliverables this year.

First, using the results of the survey work, the workstream will develop a library of third-party vendors operating in the PPA market, home market, and life market. The library will be completed for both the PPA and home markets by the Summer National Meeting. The library for the life market will be delivered by the Fall National Meeting. The second deliverable of this workstream is to develop a regulator-only tool for states to share information about third-party vendors' activities, similar to what the NAIC has developed for states to share information about the review of property/casualty (P/C) rating models. This tool will be available by the end of April. The final deliverable is a set of model and data regulatory questions, which state insurance regulators may use to ask about models and data used by insurance companies. A revised draft of the questions should be circulated by the end of April. Those in the industry have submitted comments raising the following issues: 1) the

document should be principle-based; 2) the document should be more limited in scope to encourage state insurance regulators to focus on higher-risk AI models; 3) questions should be prioritized to recognize the importance of model governance; 4) there are questions about assumptions of law that are not based in law; 5) there are concerns about redundancy with financial examinations and the potential burdens on smaller companies and smaller AI providers; and 6) the document needs to clarify the intended use of the questions.

The third workstream under the Working Group will evaluate tools and resources for monitoring the industry's use of data and AI/ML. This workstream will create a library of tools, metrics, and resources available to the insurance industry for managing AI/ML activity by the Summer National Meeting. The workstream may then pursue a more formal assessment of the strengths and weaknesses of these tools.

The final Working Group workstream, which is addressing the development of a regulatory framework for AI/ML, has not been active due to work on the AI Interpretive Bulletin, which will address regulatory expectations for the use of AI by insurers, as well as regulatory oversight and examination considerations. Related to the final workstream, Commissioner Beard said that the state insurance regulators have started leaning toward the idea of an independent data set, which could help in testing for bias. The work would progress with the assistance of Dorothy L. Andrews (Center for Insurance Policy and Research—CIPR) and the CIPR. Birny Birnbaum (Center for Economic Justice—CEJ) asked who would be responsible for the development of an independent data set and how the project came about. Commissioner Birrane said that the project cannot be elaborated on because, at this point, state insurance regulators have just started to brainstorm the possibilities of the project.

#### B. Cybersecurity (H) Working Group

Amann said the Cybersecurity (H) Working Group's most significant project is the planned cybersecurity response plan. The Working Group has volunteers and has drafted an outline document that the volunteers will now meet to expand on. The response plan will serve as an aid to states responding to cybersecurity events occurring at regulated entities. Additionally, the Working Group, as part of its efforts to monitor federal cybersecurity developments, will be having discussions about cloud service providers that insurers are using, whether state insurance regulators should have that data, and how they would go about getting that data. Third, the Working Group will send a referral to the Information Technology (IT) Examination (E) Working Group, asking it to consider updating its guidance based on recent releases by the Cybersecurity and Infrastructure Security Agency (CISA). The Cybersecurity (H) Working Group will also continue to support NAIC training initiatives. Lastly, the Working Group will also be working with NAIC staff to receive presentations from cyber risk analytic vendors so that state insurance regulators can consider if the tools would be useful to them as regulatory tools.

#### C. E-Commerce (H) Working Group

Director French said that the E-Commerce (H) Working Group has now exposed its state laws surveys/framework with comments due by March 23. The framework was developed based on survey work completed in 2022, which included questions on state laws, questions on actions taken in the wake of the COVID-19 pandemic, and a business impact survey.

Following the receipt of the comments, the Working Group plans to meet to further discuss the framework comments received and to consider the next steps required to meet the demands of the Working Group's 2023 charges.

#### D. Innovation in Technology and Regulation (H) Working Group

Commissioner Conway said the Innovation in Technology and Regulation (H) Working Group plans to meet in April to develop a supotech regulator forum that would allow state insurance regulators to share insights on current innovations and technologies being explored among the regulatory community. The regulators will also look at developing an insurtech forum that would allow regulators to have confidential one-on-one discussions with insurers and third parties about innovation and technologies that insurers and third parties are using, as well as the regulations and barriers that may exist. The Working Group will also continue to monitor the developments of the Innovation, Cybersecurity, and Technology (ICT) Hub to ensure insights shared among the state insurance regulator community can be widely and easily distributed. The Working Group will continue to monitor industry trends, including consideration of training for regulators, which may lead to referrals to other working groups or committees.

#### E. Privacy Protections (H) Working Group

Johnson said that on Feb. 1, the Privacy Protections (H) Working Group exposed a draft of the new *Insurance Consumer Privacy Protection Model Law (#674)* for a 60-day public comment period ending April 3. In the interim, the Working Group has met in regulator-to-regulator sessions on March 15 and Jan. 23. The Working Group met directly with companies on Feb. 16, March 1, 2, March 9, March 14, and March 19, with additional meetings scheduled for April 5, April 6, April 11, April 12, and April 13. The Working Group is also planning open meetings following the comment period beginning April 18 and an interim in-person meeting in Kansas City, MO, in June. The Working Group also met March 21 during the Spring National Meeting, during which it adopted its 2022 Fall National Meeting minutes, heard updates from Jennifer Neuerburg (NAIC) on state privacy legislation, heard updates from Shana Oppenheim (NAIC) on federal privacy legislation, and adopted its 2023 work plan. Commissioner Birrane commended the Working Group for its process thus far, noting that it has been rigorous and transparent.

Commissioner Godfreed made a motion, seconded by Deputy Superintendent Finston, to adopt the reports of the Big Data and Artificial Intelligence (H) Working Group (Attachment One), the Cybersecurity (H) Working Group (Attachment Two), the E-Commerce (H) Working Group, the Innovation in Technology and Regulation (H) Working Group, and the Privacy Protections (H) Working Group (Attachment Three). The motion passed unanimously.

#### 3. Received an Update from the Collaboration Forum on Algorithmic Bias on the Development of a Model Bulletin Providing Regulatory Guidance Respecting the Use of Big Data/AI-Driven Decisional Systems by Insurers

Commissioner Birrane started the discussion by revisiting past discussions on the bulletin at the 2022 Fall National Meeting. Commissioner Birrane stated that bulletin work is a member-driven activity with a consensus that the framework developed should be principles-based and not prescriptive. The membership also has a consensus that the framework should focus on governance requirements and the establishment of protocols that rely on external and objective standards. The membership has also agreed that validations should be a part of the requirements but with recognition of the practical difficulties and limitations associated with testing. With respect to third parties, the preference among the membership was that responsibility be placed on licensees to conduct appropriate diligence with respect to third-party data and model vendors and to hold licensees responsible as opposed to attempting to directly regulate unlicensed third parties at this time.

Since the 2022 Fall National Meeting, state insurance regulators have started drafting the four sections of the bulletin among drafting groups. There is an introductory section with the leaders of that group: Director Popish Severinghaus, Commissioner Andrew R. Stolfi (OR), and Commissioner Nathan Houdek (WI). There is also a definitional section, of which the leaders are Commissioner Conway and Commissioner Gaffney. There is a section

focused on regulatory expectations, which is the largest section of the bulletin. This section's leaders are Commissioner Beard, Commissioner Birrane, Superintendent Dwyer, and Deputy Superintendent Finston. The final section of the bulletin is focused on regulatory oversight and examination based on the articulated standards. The leaders of that section are Commissioner Arnold, Commissioner Trinidad Navarro (DE), Commissioner Ommen, Commissioner Jon Pike (UT), and Director Wing-Heier.

Commissioner Birrane said she hopes to have a public exposure draft by the Summer National Meeting.

#### 4. Heard a Report on the Colorado Proposed Algorithm and Predictive Model Governance Regulation

Commissioner Conway introduced Lapham, who provided an update on the Colorado proposed regulation. Lapham stated that the regulation under consideration is based on Senate Bill (S.B.) 21-169, which is designed to protect Colorado insurance consumers from insurance practices that result in unfair discrimination due to the use of predictive model AI tools. It applies broadly to insurers that use external consumer data and information sources (ECDIS), as well as the algorithms and predictive models that use ECDIS. The law requires that the Colorado Division of Insurance engages in stakeholder outreach for each type of insurance, with the Division initiating this process in February 2022. The Division has initially focused on life insurance underwriting and has held six stakeholder meetings thus far. Additionally, the Division completed a survey of 10 life insurers. In the process of stakeholder outreach, the Division has discovered that there is a wide range of insurer preparedness related to governance and risk management around AI tools. The Division bifurcated its approach to addressing the required risk management framework and testing components contemplated by S.B. 21-169 through two regulations.

The draft risk management framework regulation has three sections. The sections address governance framework expectations, documentation requirements, and a reporting requirement. The Division is in the process of digesting and synthesizing comments received and will adjust the regulations as appropriate with the intention of exposing a revised draft for additional comment. Commissioner Conway added that there has been an inaccurate view that once the Division notices the regulation, the discussion or opportunity for input is over. Commissioner Conway said this is not true. The Division continues to look forward to input regarding S.B. 21-169.

Birnbaum asked how many insurers will be submitting the annual reporting on their use of ECDIS, to which Lapham responded he does not have an answer apart from saying that as many carriers as are subject to the regulation. Commissioner Conway noted that the Division has not done a comprehensive survey of the companies to which the regulation will apply, so the Division is currently unable to provide an estimate apart from anticipating there will be a robust number of companies submitting the required information. Birnbaum followed up by saying that the reason for his inquiry is that, on the resources, the Division will need to review the insurance company reporting in a timely manner. Commissioner Conway said that is an issue that industry members have raised as well, and it will be one the Division is going to be cognizant of, as there is no point in requiring the testing or getting the required report if the Division cannot use it in a meaningful way.

#### 5. Heard a Presentation on the Use of Block Chain Methodology for Data Calls

Commissioner Godfreed led a presentation on a North Dakota project to use blockchain technology for data calls. The reason for the data call initiative is to address several issues with data. The data available is often delayed, but the legislature meets on a biannual basis, with the data provided often being out of date. However, the North Dakota Insurance Department wants all policy decisions to be data-driven, noting that bad data can lead to bad public policy. Additionally, the data often available is usually higher in level than is needed to address the questions posed. The data-gathering process is often delayed as the Department tries to refine the questions being asked, which can lead to legislation not advancing or legislation advancing without the data needed. Data calls are often for a single point in time and are not easy to repeat. Lastly, Commissioner Godfreed noted that the data does not provide meaningful value to companies.

To address this problem, the Department undertook a pilot with one goal of the data call being to help answer the question regarding uninsured motorists, which is a frequent issue in every session of the legislature. The second goal was to test the data-gathering process/technology. Some industry estimates suggest the figure is as high as 20%, while others say it is as high as 7%, and the data available right now is likely 24 months old.

The Department gathered data by asking the North Dakota Department of Transportation (DOT) to provide the registers of vehicles in the state and relied on the 10 personal auto insurance companies with the most business in the state to provide data on the vehicles they insure in North Dakota.

Commissioner Godfread then described the mechanics of the technology, which, at a high level, can be explained as a highly secure, highly complex spreadsheet of information. The Department posted its list of vehicles registered in North Dakota. Carriers input their insured vehicle identification numbers (VINs) into a node created for each individual company. Information was then compared. No information ever left the nodes and thus stayed in the custody, control, and care of each company the entire time. This is different from a traditional data call, in which the data would have been copied and given to a third party or regulator, which raises a security issue consideration.

The Department ran into resistance, which required an extensive explanation of the technology and safeguards in place. However, once data was received, the Department found that among the 10 participating carriers, 46% of vehicles registered in North Dakota can be as insured in the top 10 auto carriers. The figure appears low, but Commissioner Godfread reminded the Committee that the data call only included 10 carriers and only focused on personal auto and that some companies provided information on recreational and farm auto VINs. Other vehicle types (e.g., motorcycles, classics, and recreational vehicles [RVs]) may also not be accounted for.

What the Department also found was that this data call was easy to repeat, with the first call going out on Feb. 10 and a repeat data call going out on March 10. The data call also allowed the Department to provide information back to carriers—for instance, that 21% of the VINs insured were not registered in the state. A final data call is expected on April 10. This data process could also be repeated to ask for more granular data as long as a data standard is set up, which sounds simple but has proved to be difficult. Still, because of the speed of the process and the information the process yielded, Commissioner Godfread considered the project a success.

Deputy Superintendent Finston asked if the Department ever took possession of the data. Aufenthie responded that the Department only received aggregated results based on the question posed. Godfread restated that the intent of the project was to prove that functionality was viable. Aufenthie noted that the American Association of Insurance Services (AAIS) created nodes for each individual company, and each company uploaded information into its node, but the nodes remained in their possession.

Commissioner Gaffney noted that this effort is very timely, as states are in legislative session, so this technology may be beneficial from an efficiency and data security standard. Commissioner Gaffney asked what expertise would be needed to complete the project or if the expertise was provided by the vendor. Commissioner Godfread remarked that the resources/costs were not substantial but that the key hurdle was generating willingness to embark on the project as it required many discussions with stakeholders, especially if departments of insurance (DOIs) continue with parallel data tracking mechanisms while the blockchain technology continues to be validated for data call usage. Commissioner Godfread noted that smaller companies did find the project beneficial in that they were able to access meaningful data that was gathered as part of the project. Commissioner Godfread further noted that while there may be a cost associated with the technology, it is negligible compared to the cost associated with the current data-gathering processes.

Darby, Statistical Data (C) Working Group chair, noted that the Working Group had been looking at blockchain technology/OpenIDL technology for a similar project and asked if there was a cost figure per company or if figures

were able to compare costs between smaller and larger companies. Aufenthie noted that there was zero cost to the companies participating in the process. However, he said that he was unsure about cost to the vendor and expects the cost would go down as an increasing number of companies participate in the process. Darby also asked about the security of the data in the node. Aufenthie noted that the program was permission-based, which helped avoid security issues. The companies were able to see and understand the information that would be shared, which required some upfront discussion about the technology, but the fact that the information stays with the company the entire time means it is more secure than the current process. Under the current process for data calls, data is transmitted to a third party, which is less secure. Additionally, DOIs are able to limit access to the data to only the data fields that are truly needed for the information-gathering exercise.

Bradner noted that in their own experience with OpenIDL, the initial setup can be time-consuming, but it can be easily repeated once set up. Bradner hopes that state insurance regulators can continue to build data-gathering capabilities leveraging OpenIDL technology.

Hirano asked how, if the Department did not ever have the data locally, it was able to determine that farm and recreational vehicles were included in the data set. Commissioner Godfread noted that as companies were uploading information, they informed the Department about what was being uploaded. Therefore, this determination did not come out through the blockchain analysis phase of the project but instead was identified in the early discussions before data was uploaded.

Commissioner Birrane asked how long the project took to get started. Aufenthie stated that the project started in June 2022 with the hopes of getting done by the end of the year, but the project took a long time to get started, specifically with getting companies comfortable with the technology. The Department started the discussions with a day-long summit to talk about the technology and intent of the project, which was beneficial, but the companies still raised many questions as the project moved along.

Commissioner Birrane asked what the North Dakota Insurance Department sees as the challenge going forward. Commissioner Godfread said that a data standard is the largest obstacle. Working with VINs was manageable, but as the complexity of the data call increases, so will the complexity of the data standards. Therefore, asking for very specific information may prove to be difficult.

Birnbaum thanked North Dakota for its willingness to engage in the data call pilot project. Birnbaum asked about resource requirements for the DOIs to continue with the data calls. Aufenthie said the resource requirements are minimal because most of the work of the project comes in the setup. Asking for a data refresh, as anticipated in April, will take one minute to complete. Aufenthie noted that this project resulted in no additional staffing needs and no cost to the state. Birnbaum then asked how difficult it would be to expand the data call project to include zip codes and then produce the same uninsured data by zip code. Aufenthie said it would not be difficult to expand the data call as such but would require upfront work with the vendor to ensure the coding is updated. Aufenthie noted, however, that adding ZIP codes could introduce privacy issues that would need to be considered.

Tony Cotto (National Association of Mutual Insurance Companies—NAMIC), thanked North Dakota for the process undertaken, including involving the trades, as it helped build comfort with the project. Cotto also noted that while answering the uninsured motorist problem was not the true intent of the data call, it is still an important issue for states to consider. Cotto noted that the Insurance Industry Committee on Motor Vehicle Administration (IICMVA) is also looking at blockchain technology, specifically regarding motor vehicle authentication.

Robin Wescott (AAIS) thanked Aufenthie for his work on the project and noted that cost is difficult to determine, even for the current data-gathering process, but noted that the blockchain project might yield efficiencies. Wescott also noted that the technology this was built upon is the hyper ledger fabric through the Linux Foundation, which is an open software solution. Wescott encouraged the industry to look at open-source solutions, not just proprietary ones. This technology could affect the statistical reporting process, perhaps even removing the need for statistical agents. Wescott said the AAIS supports this because its goal is to make data easier to access.

Having no further business, the Innovation, Cybersecurity, and Technology (H) Committee adjourned.

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Big Data and Artificial Intelligence (H) Working Group  
Louisville, Kentucky  
March 22, 2023

The Big Data and Artificial Intelligence (H) Working Group of the Innovation, Cybersecurity, and Technology (H) Committee met in Louisville, KY, March 22, 2023. The following Working Group members participated: Elizabeth Kelleher Dwyer, Chair (RI); Amy L. Beard, Co-Vice Chair, represented by Victoria Hastings (IN); Doug Ommen, Co-Vice Chair (IA); Kevin Gaffney, Co-Vice Chair (VT); Sarah Bailey (AK); Mark Fowler (AL); Peg Brown and Jason Lapham (CO); George Bradner and Wanchin Chou (CT); Michelle Brewer (FL); Shannon Hohl (ID); Erica Weyhenmeyer (IL); Abigail Gall (KY); Tom Travis (LA); Jackie Horigan (MA); Kory Boone (MD); Timothy N. Schott and Sandra Darby (ME); Karen Dennis (MI); Grace Arnold (MN); Cynthia Amann (MO); Robert Croom (NC); Chris Aufenthie, John Arnold, and Colton Schulz (ND); Connie Van Slyke and Martin Swanson (NE); Christian Citarella (NH); TK Keen (OR); Shannen Logue (PA); Ryan Basnett (SC); Travis Jordan (SD); Stephanie Cope (TN); Leah Gillum (TX); Tanji J. Northrup (UT); Eric Lowe and Katie Johnson (VA); Molly Nollette (WA); Nathan Houdek and Lauren Van Buren (WI); and Erin K. Hunter (WV). Also participating were: John F. King (GA); Troy Downing (MT); and Matt Gendron (RI).

1. Adopted its 2022 Fall National Meeting Minutes

Commissioner Gaffney made a motion, seconded by Cope, to adopt the Working Group's Dec. 13, 2022, minutes (see *NAIC Proceedings – Fall 2022, Innovation, Cybersecurity, and Technology (H) Committee, Attachment Two*). The motion passed unanimously.

2. Received an Update on the AI/ML Surveys

Commissioner Gaffney said the purpose of the home survey is to gain a better understanding of the industry's use of big data, artificial intelligence (AI), and machine learning (ML), as well as what governance, risk management, and controls are being put in place in developing and managing those activities. The survey also seeks to gather information that may inform the development of guidance or a potential regulatory framework that would support the insurance industry's use of big data and AI/ML in accordance with the expectations outlined in the NAIC's AI Principles. As previously reported to the Working Group, the formal examination call letter was sent to 194 companies. Any company licensed to write home insurance in one of the 10 Requesting States that also had at least \$50 million in national home insurance premiums for 2020 was required to complete the survey.

Commissioner Gaffney said survey responses were due by Dec. 15, 2022. The Requesting States were still awaiting responses from eight companies as of March 1. A final request was sent to these companies on March 3 with a response deadline of March 24. Once the survey is closed on March 24, NAIC staff will begin working with the Requesting States to produce a public report, similar to the Private Passenger Auto (PPA) Report. As with the PPA Report, the confidentiality of individual company responses will be protected. The Requesting States will present a public report to the Working Group at the Summer National Meeting.

Commissioner Gaffney said a group of 14 states continued to develop the life insurance survey with the goal of collecting information to understand how life insurance companies are deploying AI/ML in the following operational areas: 1) pricing and underwriting; 2) marketing; and 3) loss prevention. Like the PPA survey and the home survey, the goal of the life insurance survey is to learn directly from the industry about what is happening in this space to get a sense of the current level of risk and exposure associated with their use of AI/ML and how the industry is managing or mitigating that risk. The following criteria were used to identify

which companies should receive the survey: 1) a company with more than \$250 million in premiums on all individual policies in 2021; 2) a term writer that has issued policies on more than 10,000 lives; or 3) a specifically selected InsurTech company. Using these criteria, the 14 Requesting States, which will collect the survey information under their examination authority, will issue a formal examination call letter to a total of 192 life insurance companies.

An informational letter should be sent to the 192 companies on March 31. Coinciding with the issuance of this letter, the NAIC will go live with the AI/ML life insurance survey weblink, which will include the survey template, survey filing guidance and definitions, and a frequently asked questions (FAQ) document. Concurrently, each company will receive a survey link and can begin to input their answers into the Qualtrics survey tool even before the official call letter is sent. Commissioner Gaffney said each company scheduled to receive the survey should have designated one contact to receive the survey link, and they can forward it to anyone in their company who has the information needed for the survey. The tool allows multiple people in a company to input answers and saves the most up-to-date information input into the survey.

Commissioner Gaffney said the formal examination call letter is scheduled to be issued on May 1, and companies will have until May 31 to respond to the survey. The Requesting States hope this timeline will help accommodate those companies also filing Market Conduct Annual Statement (MCAS) data due April 30.

Superintendent Dwyer reminded everyone that the PPA public report is posted on the Working Group's web page, and she is not aware of any comments on or concerns about this report.

### 3. Discussed Draft Model and Data Regulatory Questions

Commissioner Ommen said the subject matter experts (SMEs) assembled for Workstream #2 were asked last year by the Working Group to provide recommendations for: 1) the feasibility of a library of third-party data and model vendors with AI-known applications in the business of insurance; and 2) an appropriate regulatory framework for monitoring and overseeing the industry's use of third-party data and model vendors. In accordance with the second charge of the Working Group, the state insurance regulators on Workstream #2 exposed for discussion draft questions that state insurance regulators might ask about data and models used by insurance companies, regardless of whether the data or model is developed internally or obtained from external sources. These questions were meant to be a starting point for discussion, and there needs to be further work.

Commissioner Ommen provided a summary of the document. The first section, titled "Main General Questions," includes a list of suggested questions to obtain a high-level understanding of a model or data being used. The second section, titled "Detailed and Technical Questions," expands on the first section by including additional questions to obtain a more in-depth understanding of the model or data. The questions are subdivided into three categories within each of these first two sections. The first category contains questions to ask a company about a model, whether the company is an insurer or a third party. The second category contains questions to ask an insurer about its implementation of a third-party model. The third category contains questions about the purchase of third-party data. Finally, the third section in the document contains definitions of key terms used throughout the document. Commissioner Ommen said he is not satisfied with the definitions, which are meant as "placeholder" definitions.

Commissioner Ommen said the SMEs of Workstream #2 had a call on March 8 and began discussing the following policy issues raised in the comment letters: 1) the document should be principle-based; 2) the document should be more limited in scope to encourage state insurance regulator use for "higher-risk" AI models; 3) questions should be prioritized to recognize the importance of model governance; 4) there are concerns that questions contain assumptions of law that are not based in law; 5) there are concerns regarding redundancy with financial

examinations; 6) there are concerns with the potential burden on smaller companies and small AI providers; and 7) clarification of the intended use of questions by state insurance regulators is needed. He said a smaller group of the Workstream SMEs will review the comments and hope to present a revised draft for public comment by the end of May.

Birny Birnbaum (Center for Economic Justice—CEJ) said insurers use data models through the insurance life cycle, including marketing, underwriting, pricing, antifraud, and claim settlements. He said state insurance regulators have a responsibility to ensure that rates are not excessive, inadequate, or unfairly discriminatory, and he said the document should identify regulatory authorities and responsibilities. He said state insurance regulators can best fulfill their responsibilities by analyzing the outcomes of data models rather than asking questions to understand how an insurer developed a data model. He said state insurance regulators do not have the resources to review and analyze insurers' narrative responses, and state insurance regulators should collect additional data from insurers to ensure that model outcomes comply with state laws rather than focusing on an insurer's process of model development.

David Leifer (American Council of Life Insurers—ACLI) said the scope of information to be collected is overly broad, especially regarding third-party vendors and the ability of insurers to produce proprietary information from third-party vendors. David F. Snyder (American Property Casualty Insurance Association—APCIA) also said the questions should be grounded in existing state laws. He said the definitions need to be revised. He also encouraged additional coordination of this work with other workstreams across the NAIC, such as the Accelerated Underwriting (A) Working Group and the Innovation, Cybersecurity, and Technology (H) Committee's work on the AI model bulletin.

Andrew Pauley (National Association of Mutual Insurance Companies—NAMIC) said NAMIC has concerns with the questions not being based on state regulatory requirements. He said the definitions need to be revised, and he encouraged this work to be coordinated with other NAIC workstreams. He suggested that the state insurance regulators focus on a principle-based approach, and he questioned why all information would be requested at once. He also expressed concern regarding the protection of confidential proprietary information that might be provided.

Scott Harrison (American InsurTech Council—AITC) suggested a risk-based approach, and he voiced concern that the scope of questions would create a disproportionate burden on smaller companies. He suggested that state insurance regulators should focus on only those AI models that affect consumers or a company's financial solvency since companies use models that do not have regulatory implications. He also expressed concerns regarding the protection of confidential information, especially the protection of proprietary information.

Snyder said the creation of a uniform set of questions is helpful, but the scope and detail of the questions are very broad. He said there are concerns with the definitions, and he suggested that state insurance regulators should consider the risk, scale, and complexity of a company when asking about its AI models. He urged that testing not be included in the document due to the complicated nature of AI model testing. He said it is not clear what standard is being tested and how much is too much of a relationship to a protected class. Snyder also said confidentiality protections are important, and the disclosure of propriety models of third-party vendors can be very complicated. Finally, Snyder encouraged everyone to remember that the use of AI models makes it possible for the industry to provide better services to consumers.

Bob Ridgeway (America's Health Insurance Plans—AHIP) said any use of these questions should be under examination authority to protect the confidentiality of responses. He said insurers are familiar with submitting confidential information to state insurance regulators, but third-party vendors are not comfortable with sharing proprietary information. He said third-party vendors might not have any appropriate recourse if a governmental

agency is the source of propriety information being shared with the public. He said the scope of the questions would require insurers to share a voluminous amount of information, and he suggested that higher-level information be collected first. This would make it easier for companies to respond and for state insurance regulators to review the information.

Peter Kochenburger (University of Connecticut School of Law) said state insurance regulators should not look at these issues only through the application of existing state laws. State insurance regulators should be setting expectations, and if needed, they can amend existing laws and regulations to address the use of AI in the insurance industry.

Superintendent Dwyer said the Innovation, Cybersecurity, and Technology (H) Committee is coordinating the AI work across the NAIC, including the activities of Workstreams #3 and #4. Workstream #3 is charged with evaluating tools and resources for monitoring the industry's use of data and AI/ML, and Workstream #4 is focusing on the broader regulatory framework and governance.

Having no further business, the Big Data and Artificial Intelligence (H) Working Group adjourned.

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Draft: 4/6/23

Cybersecurity (H) Working Group  
Virtual Meeting (*in lieu of meeting at the 2023 Spring National Meeting*)  
March 7, 2023

The Cybersecurity (H) Working Group of the Innovation, Cybersecurity, and Technology (H) Committee met March 7, 2023. The following Working Group members participated: Cynthia Amann, Co-Chair (MO); C.J. Metcalf, Co-Vice Chair (IL); Michael Peterson, Co-Vice Chair (VA); Julia Jette (AK); Damon Diederich (CA); Wanchin Chou (CT); Tim Li (DE); Shane Mead (KS); Matt Kilgallen (GA); Daniel Mathis (IA); Alexander Borkowski (MD); T.J. Patton (MN); Jake Martin (MI); Troy Smith (MT); Colton Schulz and Chris Aufenthie (ND); Martin Swanson (NE); David Bettencourt (NH); Justin Herrings (NY); Matt Walsh (OH); John Haworth (WA); and Rebecca Rebholz (WI).

1. Adopted its 2022 Fall National Meeting Minutes

Haworth made a motion, seconded by Schulz, to adopt the Working Group's Nov. 15, 2022, minutes (*see NAIC Proceedings – Fall 2022, Innovation, Cybersecurity, and Technology (H) Committee, Attachment Three*). The motion passed unanimously.

2. Discussed its Work Plan for 2023

Amann summarized the Working Group's work plan for 2023 (Attachment Two-A) The work plan contains four components, called workstreams, building from the results of the Working Group's survey to state insurance regulators in 2022.

The first item on the work plan is to develop a cybersecurity response plan. The subject matter expert (SME) group leads for this workstream are Amann and Peterson. The outline for the response plan includes 12 topics to date:

- Introduction
- Communication with other states/federal regulators
- Initial notification by domestic
- Meetings (initial and follow-up meetings if necessary)
- Communication with the firm handling the incident
- Organizational security
- Risk assessment
- Audits
- Communications with consumers
- Summary of regulator tools
- Coordination of communication
- Information-gathering template

A drafting group is being formed, and drafting will begin following the Spring National Meeting.

The second item on the work plan is for the Working Group to send a referral to the Information Technology (IT) Examination (E) Working Group asking it to consider updating its cybersecurity guidance (Attachment Two-B).

The third item on the work plan is for the Working Group to continue to support NAIC training initiatives. This workstream will identify cybersecurity subject matters. The Working Group will work with NAIC staff, state insurance regulators, and the insurance industry to identify warranted training. Any work considered by this workstream requires coordination with the Innovation, Cybersecurity, and Technology (H) Committee to avoid duplications of effort.

The fourth item on the work plan is for the Working Group to continue to monitor cybersecurity trends among regulated entities and among federal and international bodies. State insurance regulators will receive relevant updates regarding cybersecurity trends, work being completed by related working groups, state efforts to adopt the *Insurance Data Security Model Law* (#668), and relevant work happening at the federal and international levels.

Amann concluded by asking states to consider volunteering and contacting NAIC staff with their specific interest in supporting components of the work plan. Romero noted that workstream one, the cybersecurity response plan, is the workstream most likely to need assistance. Romero acknowledged past willingness to aid from Connecticut and North Dakota.

Haworth asked if the Working Group would meet in regulator-to-regulator session to discuss cybersecurity events. Amann said there may be a case for regulator-only sessions for some of the issues the Working Group will be addressing. Romero indicated that if there is a specific subject matter related to an examination or another confidential matter, a regulator-only meeting would be a possibility.

### 3. Heard an Overview of the Treasury Department's Report Titled *The Financial Services Sector's Adoption of Cloud Services*

Ethan Sonnichsen (NAIC) provided an overview of the U.S. Department of Treasury's (Treasury Department's) *The Report on the Financial Services Sector's Adoption of Cloud Services*, which was released on Feb. 8. The report discusses the benefits and challenges of the financial services sector's increasing adoption of cloud services technology. It also makes several recommendations for financial service providers and the regulatory community.

The report summarizes some of the benefits, including scalability, cost savings, and the security of the information technology infrastructure. In the financial services sector, there is a concentration among a small number of cloud service providers. Risks may involve a significant system failure or data breach at a large cloud service provider, which may have substantial implications for the financial services sector and the customers they serve. Many financial services institutions additionally expressed concerns regarding a cloud service provider's (CSP's) cybersecurity vulnerabilities. Currently, there is a lack of data in the financial regulatory community regarding the number of providers and the types of services provided at CSPs.

The report addressed concerns from institutions regarding the lack of transparency of reporting, as several of the institutions surveyed noted they do not receive information regarding incidents, outages, or other problems at the CSP that would affect the institution's system or its customer's access to information.

The report highlights a talent gap at financial services firms, including training expertise and the ability to determine which services to transition to a cloud infrastructure. The talent gap is the most pressing issue for smaller institutions.

The report also notes there is exposure to potential operational incidents at CSPs. Many financial services institutions additionally expressed concerns regarding CSPs' cybersecurity vulnerabilities or a service failure. Financial service regulators need more data regarding a financial institution's exposures.

Additionally, the report addresses the global regulatory requirements and how those may create challenges for firms wishing to migrate to a cloud service. There are regulatory differences around the world, making it difficult for a large global financial institution wanting to transition to the cloud. Some countries have restrictive data policies requiring data to be housed locally, whereas the U.S. is less restrictive regarding data flows.

Likewise, the report addresses concerns regarding market concentration. First, the market is concentrated among a small number of CSPs; third-parties may also use the same CSP. This concentration means an incident has a better chance of spreading throughout the financial system. Market concentration exists across banking, securities, and insurance markets. There is also a need to close significant data gaps regarding a financial institution's use of a CSP to better understand its risk exposure.

The report asks financial institutions to think about building a communication plan with its CSP, establishing a risk management framework to prioritize which systems will move to the cloud, whether there are backups and controls to execute them, and to introduce performance metrics showing the financial institution is receiving some economic value by transitioning to the cloud.

A cloud services steering group will be created in the next year or so to focus closer on domestic collaboration among financial regulators regarding cloud services. The steering group will consider writing best practices for cloud adoption and cloud contracts to provide some standardization. Interagency collaboration and coordination will be important. The steering group will also examine the data gap regarding CSP usage and determine what the financial regulators need to know regarding the reliance at a CSP.

The steering group will also look at protocols for incident response and engaging on international standards as the international standard setting groups, as well as fostering some industry discussions to obtain a direct account of what is happening in the financial services sector as cloud standards are adopted.

Amann asked the Working Group to consider the data state insurance regulators need, why they need it, and what the data will disclose regarding an insurer's use of cloud service providers. She asked the Working Group to also think about how this data is best obtained, whether the data is confidential data, unidentified data, group data, individual insurer data, how frequently the data needs to be collected, and if there are exemptions.

Peterson said that he believes the Treasury Department intends to remain active on this topic. He suggested that state insurance regulators could take the initiative to create a solution that works for both insurers and state insurance regulators. Peterson proposed that state insurance regulators use the systems summary grid, a tool in the *Financial Condition Examiners Handbook*, to help gather information on insurers' industry-wide use of cloud service providers. He suggested that a regulator-only filing submission could be beneficial as a new annual filing and would help regulators from a macroprudential perspective of an insurers' cloud service usage. There would be logistics to work through, including whether template standardization is necessary. Peterson asked the Working Group to consider whether this is a viable path forward to help state insurance regulators gather cloud service provider information.

Romero restated the proposal regarding whether regulators could use the systems summary grid to streamline the transmission of information on an insurer's use of cloud service providers, including whether data is needed and how frequently data needs to be submitted. Amann emphasized the need for insurers' input on this proposal. Romero indicated that given the time left for the meeting, the Working Group could solicit industry input on this proposal via e-mail following the meeting. Upon receiving the insurer's input, the Working Group could reconvene to continue the discussion.

#### 4. Discussed a Referral to the IT Examination (E) Working Group.

Amann said that because of the discussion last year with the Cybersecurity and Infrastructure Security Agency (CISA), the Working Group will be asking the IT Examination (E) Working Group to consider updating its cybersecurity-related guidance based on the CISA cybersecurity performance goals. Romero indicated that the Working Group has a charge to monitor and not to update cybersecurity guidance. Therefore, the referral sends the matter to the Working Group, having authority over cybersecurity guidance.

The Working Group's referral acknowledges there may be resources apart from the CISA cybersecurity performance goals. Updated guidance could help ensure the addressing of cybersecurity-related risks.

Brian de Vallance (Center for Internet Security—CIS) stated that cybersecurity is an important topic for state insurance regulators to consider and that the CIS supports updating the guidance as cyber defense has evolved. He noted that the CIS would be available to assist state insurance regulators as they continue to study this project.

#### 5. Discussed the Outline for the Incident Response Plan

Amann stated that the Working Group's charge of creating an incident response plan builds on the Model #668 and would aid the states in requesting information from insurers that have experienced a cybersecurity event.

Amann indicated that insurers' input benefits this project, specifically in addressing the type of information that would be available. Romero indicated that in following up with states regarding the state insurance regulators' needs, the survey identified the demand for a tool assisting states in responding to cybersecurity events among regulated entities. Such a tool would help guide states in the communication and information-gathering responsibilities of the department of insurance (DOI). The tool would enhance a state's ability to act as a lead state in a cybersecurity event and minimize state inquiries to regulated entities.

States could tailor the tool to suit their individual needs. Romero suggested the Working Group form a drafting group to advance the tool's planning and suggested creating an information-gathering template and the value therein from an insurer's perspective.

Peter Kochenburger (University of Connecticut School of Law) said consumer representatives might also provide valuable input to ensure consumer notifications are included in the response plan. Schulz suggested that the workstream leverage insights from past NAIC cybersecurity tabletop exercises to assist with this project.

#### 6. Discussed Other Matters

Skyler Gunther (NAIC) said that the NAIC would lead an effort to facilitate vendor presentations from Security Scorecard and Bitsight to provide information to state insurance regulators regarding cyber-risk analytic capabilities. Herring indicated that the New York Department of Financial Services (DFS) has been using Security Scorecard and may provide beneficial information in the Working Group's consideration of these tools. Romero indicated that after the vendor meetings, the state insurance regulators would reconvene to consider the usefulness of these tools.

Having no further business, the Cybersecurity (H) Working Group adjourned.

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**The Cybersecurity (H) Working Group 2023 Workplan:**

## Working Group Charges:

- A. Monitor cybersecurity trends such as vulnerabilities, risk management, governance practices and breaches with the potential to affect the insurance industry.
- B. Interact with and support state insurance departments responding to insurance industry cybersecurity events.
- C. Promote communication across state insurance departments regarding cybersecurity risks and events.
- D. Oversee the development of a regulatory cybersecurity response guidance document to assist state insurance regulators in the investigation of insurance cyber events.
- E. Monitor federal and international activities on efforts to manage and evaluate cybersecurity risk.
- F. Coordinate NAIC committee cybersecurity work including cybersecurity guidance developed by the Market Conduct Examination Guidelines (D) Working Group and the Information Technology Examination (E) Working Group.
- G. Advise on the development of cybersecurity training for state insurance regulators.
- H. Work with the Center for Insurance Policy and Research (CIPR) to analyze publicly available cybersecurity related information.
- I. Support the states with implementation efforts related to the adoption of *Insurance Data Security Model Law* (#668).

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- Workstream 1: Cybersecurity Response Plan

Subject Matter Expert Group Lead: Cindy Amann/Michael Peterson

Summary: Regulators will develop an optional guide to assist states in responding to cybersecurity events among their regulated entities. The project will include, but is not limited to:

- A Review of existing regulator cybersecurity response plans
- Drafting an outline of main topics to be included in the cybersecurity response plan to ensure the necessary topics are incorporated into the response plan
- Drafting a response plan
- Creating a reporting template to aid states in collecting information in the wake of a cybersecurity event

Timeline: Completed by 2023

Related Charges: This project would fall under charges B, C, and D.

Considerations: Regulators should consider:

- Whether the response plan should include a reporting template
- Whether the publication should be a public or regulator only resource

- Workstream 2: Referral to the Information Technology (IT) Examination (E) Working Group (ITEWG)

Subject Matter Expert Group Lead: N/A

Summary: Referral should be sent by Summer NM, but the actual underlying project may last until 2024 depending on the approach chosen by ITEWG

- Update the Financial Examination Handbook to strengthen and update guidance for financial examiners to draw on more focus on cyber during an exam.

Related Charges: This project would fall under charge E.

Considerations: The Working Group needs to recognize that there is overlapping membership between the ITEWG and the Cybersecurity (H) Working Group, limiting the Working Group's resources.

- Workstream 3: Training

Summary: The Working Group could work with NAIC staff, regulators, and industry to identify cybersecurity subject matter that warrant training. The Working Group would oversee the development of training.

The Working Group could also work with D/E committee groups to aid in the identification of relevant certifications/credentials that Departments of Insurance could use to help in developing subject matter expertise.

Timeline: The working group could develop an initial plan by the Summer National Meeting and thereafter, the work would transition to an ongoing project.

Related Charges: This project falls primarily under charge F, but the training material may relate to other charges.

Considerations: While there are many topics that may warrant training, resource limitations will make it important to prioritize training requests considering the significance/prevalence/complexity of said subject matter.

H Committee and other related groups may also undertake related efforts. Work should be coordinated to avoid duplication of effort.

- Workstream 4: Monitoring

Subject Matter Expert Group Lead: Wendy Erdly

Summary: The Working Group has several charges that relate to monitoring and coordination. At rotating meetings, regulators could receive updates from NAIC staff or regulators:

- Cybersecurity trends
  - Industry may also assist in the identification of relevant trends
- The relevant work done at the Market Conduct Examination Guidelines (D) Working Group and the Information Technology Examination (E) Working Group
- State efforts to implement/adopt the *Insurance Data Security Model Law* (#668)
- The relevant work done at federal and/or international level

Timeline: The working group should consider engaging in some monitoring effort on an annual basis, but otherwise, there is no expiration or timeline for this work.

Related Charges: This project would fall under charges A, C, and D.

Considerations: With each item discussed, it would be relevant to consider whether the Working Group should take action. Actions would be determined based on the situation. It's most likely that federal/international work would lead to such action/responses.

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**MEMORANDUM**

TO: Jerry Ehlers, Chair, Information Technology (IT) Examination (E) Working Group  
Ber Vang, Vice-Chair, Information Technology (IT) Examination (E) Working Group

FROM: Cindy Amann, Co-Chair, Cybersecurity (H) Working Group  
Wendy Erdly, Co-Chair, Cybersecurity (H) Working Group  
CJ Metcalf, Co-Vice-Chair, Cybersecurity (H) Working Group  
Michael Peterson, Co-Vice-Chair, Cybersecurity (H) Working Group

DATE: March 7, 2023

RE: Cybersecurity Procedures

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The Cybersecurity (H) Working Group has several charges that call on the working group to monitor industry trends and to coordinate our work with the IT Examination (E) Working Group. Those include:

- A. Monitor cybersecurity trends such as vulnerabilities, risk management, governance practices, and breaches with the potential to affect the insurance industry.
- E. Monitor federal and international activities on cybersecurity engaging on efforts to manage and evaluate cybersecurity risk.
- F. 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.

In keeping with those charges, the Cybersecurity (H) Working Group met with the Executive Director from the Cybersecurity and Infrastructure Security Agency (CISA), Brandon Wales, who provided an update on his agency's work. As part of the update, Mr. Wales mentioned his agency's work to develop and publish a "Cross-Sector Baseline Cybersecurity Performance Goals (CPGs)". Per CISA's website, "the CPGs are a prioritized subset of IT and operational technology (OT) cybersecurity practices that critical infrastructure owners and operators can implement to meaningfully reduce the likelihood and impact of known risks and adversary techniques."

More importantly, these CPG's the Cybersecurity (H) Working Group is suggesting this publication to the IT Examination (E) Working Group as it may represent an opportunity to update the cybersecurity related guidance contained within the *Financial Condition Examiners Handbook* (Handbook). While the guidance in the Handbook has long served regulators as an effective tool to investigate a myriad of risks, cybersecurity included, this tool or other resources may represent an opportunity to ensure the work program appropriately prioritizes cybersecurity related considerations.

Therefore, the Cybersecurity (H) Working Group asks the IT Examination (E) Working Group to consider the following:

- Whether the existing guidance would benefit from an update to better prioritize cybersecurity risks.
- If so, whether the CPGs or a different resource (i.e., NIST, CIS, etc.) would aid in a project to update cybersecurity guidance.
  - For instance, the CIS listing of security controls includes a tiering that may make that a useful tool that allows regulators to distinguish relevant controls from key controls.
- Whether any international developments could prove beneficial as a resource towards this project (i.e., Issues Paper under development by the Operational Resilience Task Force).

This is potentially a substantial project, but one that could enhance the regulatory ability to investigate cybersecurity risks. An update may also identify specific procedures that are less relevant as the focus of investigations prioritizes cybersecurity over the review of IT general controls. Upon a quick review by one of our Working Group volunteers, we found substantial overlap between the CPGs and the existing Handbook work program. However, the IT Examination (E) Working Group may find that the CPGs more clearly or simply articulate the controls that are needed to directly address cybersecurity risks. There may also be procedures that while still relevant could be de-emphasized or investigated via inquiry to better allow for cybersecurity to remain a core focus.

The Cybersecurity (H) Working Group acknowledges less ambitious ideas may also be appropriate but stands ready to support the work of the IT Examination (E) Working Group in whatever approach to this project and study is chosen.

Please work with our NAIC support staff, Miguel Romero and Sara Robben to keep our group updated on your progress and decisions.

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Draft: 4/6/23

Privacy Protections (H) Working Group  
Louisville, Kentucky  
March 22, 2023

The Privacy Protections (H) Working Group of the Innovation, Technology, and Cybersecurity (H) Committee met March 22, 2023. The following Working Group members participated: Katie C. Johnson, Chair (VA); Cynthia Amann, Co-Vice Chair (MO); Chris Aufenthie, Co-Vice Chair (ND); Catherine O'Neil (AZ); LeAnn Crow (KS); Kathleen Birrane Alexander Borkowski (MD); Robert Wake (ME); T. J. Patton (MN); Jo LeDuc (MO); Martin Swanson (NE); Gary Jones (PA); Patricia Smock (RI); Frank Marnell (SD); Amy Garcia (TX); Don Beatty (VA); Todd Dixon (WA); and Rachel Cissne Carabell, Tim Cornelius, and Lauren U. Van Buren (WI). Also participating were Peg Brown (CO); Victoria Hastings (IN); John Arnold (ND); and Travis Jordan (SD).

1. Adopted its 2022 Fall National Meeting Minutes

Ms. Johnson said the Working Group met Dec. 12, 2022.

The Working Group also met Feb. 16, 2023, and Mar. 15, 2023, in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss next steps for the Working Group.

Ms. Amann made a motion, seconded by Mr. Aufenthie, to adopt the Working Group's Dec. 12, 2022 (*see NAIC Proceedings – Fall 2022, Innovation, Technology, and Cybersecurity (H) Committee, Attachment xx*). The motion passed unanimously.

2. Heard an Update on Federal and State Privacy Legislation

Ms. Neuerburg said there had been a lot of activity since the Fall National Meeting in December, but that she was going to try to keep her update brief because she knew a lot of people were waiting to comment on the exposure draft. Ms. Neuerburg said there are currently around 50 bills under consideration across 21 states.

She said the Iowa legislature passed a consumer data privacy bill on Mar. 15, 2023, that is similar to Utah's privacy law and that is business friendly. While the bill is pending the governor's signature, she said Iowa would become the sixth state to pass a comprehensive data privacy bill. Ms. Neuerburg said Hawaii and Indiana are considering bills that are similar to the Virginia Consumer Data Protection Act. She said there are also bills being considered in New Jersey, Montana, and Oklahoma, just to name a few.

Ms. Neuerburg said charts tracking the legislation will be posted on the NAIC's Privacy Protections Working Group webpage if anyone wants to read more about these bills. She said the NAIC Legal team will continue to follow state data privacy legislation and will provide updates at future Working Group meetings.

Ms. Oppenheim said there had been a lot of activity on the federal side. In the House Financial Services Committee, she said Chair Patrick McHenry's financial data privacy bill, the data privacy bill of 2023, H.R. 165, has passed out of committee along party lines. Ms. Oppenheim said it would revamp existing data privacy protections for consumers by providing a preemptive ceiling and floor in an attempt to create a uniform federal standard. For enforcement by the functional regulators, the current bill provides a new deletion right for consumers and allows consumers to stop the collection and disclosure of their data among other provisions. She said Representative

Waters and other Democrats have been critical of the exemption because it would hinder a state's ability to, "Act as a laboratory for innovation while establishing what they see to be a weak federal standard.

Ms. Oppenheim said the House energy and Commerce Subcommittee on innovation, technology, and commerce across the hall also recently held a hearing like a hearing for a federal national standard on data privacy. She said this follows up on the work from the last Congress when the House Energy and Commerce Committee leaders and then senior commerce ranking member, Senator Wicker, compromised on the American Data Privacy Protection Act. Ms. Oppenheim said Chairwoman Senator Cantwell did not sign though the bill passed the House Energy and Commerce Committee and was being considered for the Omnibus bill but it was ultimately not included. She said this preemptive bill would create a national standard and safeguards for personal information collected by companies, including protections intended to address potentially discriminatory impacts of algorithms. Ms. Oppenheim said we expect this to be reintroduced in some form, so we expect federal action to be ongoing.

### 3. Considered its Updated 2023 Work Plan

Ms. Johnson gave an overview of the updated Work Plan dated Mar. 13, 2023. She said the Work Plan is posted on the Working Group's Webpage and indicates that the Exposure Draft of the new model was distributed on Feb. 1, for a two-month comments period that ends Apr. 3, 2023. Ms. Johnson said the revised Work Plan extends the date of which the model will be sent to the Innovation, Cybersecurity, and Technology (H) Committee to the 2023 Fall National Meeting. She said the Working Group did that because it had received so many comments from interested parties and the Working Group wanted to give everyone enough time to consider those comments.

Ms. Johnson said the revised workplan lists Apr. 18 as the date that bi-weekly Working Group meetings will resume to discuss comments received in open meetings. She asked that all parties come prepared to roll up their sleeves and get to work on refining the wording in the draft exposure model.

Ms. Johnson said a two-day, in-person Interim Working Group Meeting is also being planned for June in Kansas City to work through the more complex issues identified in the model using transparent collaborations to address those issues in a way that makes the model workable for regulators, industry, and consumers. She said many of the more complex issues have already been identified by the drafting group in private meetings with volunteer companies. Ms. Johnson thanked the companies that had stepped forward to discuss these complex issues. She said many of the industry trade associations and consumer representatives were included in those who volunteered. She said the Working Group was very grateful for their help and appreciated their help.

### 4. Received and Discussed Comments on the Exposure Draft of the New Consumer Privacy Protections Model Law (#674)

Ms. Johnson said the Working Group would hear preliminary comments from interested parties on the exposure draft of the new Privacy Protections Model Law (#674) in advance of the 60-day public comment period ending April 3.

Dr. Harold M. Ting (Healthcare Consumer Advocate and NAIC Consumer Representative) said he was also a Senior Health Insurance Information Program-SHIIP counselor who has counseled over 400 people who qualify for Medicare and Medicaid. He said the comments he submitted in more detail in writing on the new model draft #674 expressed his very strong support for it and suggested a few changes. Dr. Ting said since getting involved in this Working Group, he had become more aware of how personal information is captured and misused. He said whenever he goes to a new website now, he tries to minimize the data that can be stored and utilized. He also tried to read the entire privacy policy to understand how to exercise that option; however, he said sometimes it

takes too much time and sometimes, he is given no choice if he wants to use the site. Dr. Ting said he experienced abuse of his personal data daily; he has had his credit card information stolen; he gets so many unwanted marketing emails that the emails he wants to see get lost in a sea of unwanted emails; and he said the worst of it is that it seems to be occurring more frequently. He said he gets phishing emails and texts disguised as urgent messages from companies he uses trying to steal his personal information. Dr. Ting said in addition to that, he cannot escape losing his information as it is being shared by his phone, his TV, his car, and his appliances through the Internet of Things-IoT in this environment. He said he wished the federal government would do more to protect his personal information but that it was unlikely because Google and Meta base their business upon it.

Dr. Ting said now is the time for insurance regulators to pass fair consumer data privacy legislation for the insurance industry because the key players in this realm are not taking any action. He said he was pleased to see that the draft model #674 establishes clear standards for protecting consumer privacy in the areas of transparency and data minimization; use limitations by review and correction; and requiring third party service providers to meet the same privacy standards as licensees and accountability. Recognizing that not all states and territories will adopt this model, he said he hoped that many insurance companies and licensees will adopt these privacy protections anyway. By doing so, Dr. Ting said companies are likely to meet the requirements of the states where they do business. He said there are six reasons why consumer data privacy standards are needed and three revisions that he recommends. He said claims that standards are not needed because consumers are not complaining is totally invalid because consumers have no way of knowing that their data is being used or how it is being shared with others for their use. Dr. Ting said privacy protections must be the default of privacy protection policies should always be the default of non-disclosure. He said it is well documented that most consumers do not read entire privacy policies and that it is not realistic to expect them to do so nor to expect them to understand what's in them because privacy policies are notoriously long and complex. Moreover, Dr. Ting said companies use dark patterns that manipulate consumers into permitting greater use of their data than the consumer had intended.

Dr. Ting said Health Insurance Portability and Accountability Act-HIPAA standards should apply to all personal information. Dr. Ting said when HIPAA was enacted, it stated that personal health information was more sensitive and needed more protection than personal financial information; however, time has proven that to be false as personal financial information has been used fraudulently to significantly harm millions of Americans. He said the same standards should apply to third party service providers as for insurance providers and licensees because the risk of abuse to personal information is the same for both groups. Dr. Ting said because most states do not have regulatory authority over third party service providers, it is even more important that the model include these providers in its privacy protections standards through their contracts with insurance carriers that are regulated by state insurance departments. He said data minimization is essential because it is impossible to totally prevent data breaches and that over the past 5 years, insurance companies as diverse as Prudential Financial, John Hancock, Allstate and State Farm have each reported multiple data breaches and major third-party providers have reported breaches by BlueCross Blue Shield healthcare group, a medical imaging group, a professional health care collection agency, and Verisk Analytics - one of the world's largest data aggregators.

Dr. Ting said last month in Congress, the Electronic Privacy Information Center agreed that all companies should limit their data collection to only what is reasonably necessary and appropriate to provide or maintain a product or service requested by an individual. He said that is exactly what we see in the draft of model #674 and that compliance with it is the key. Dr. Ting said model #674 will only be effective if it has meaningful penalties for serious non-compliance because there is no practical way for state insurance regulators to adequately monitor thousands of licensees and third-party service providers. He said there are 3 specific recommendations:



- Article 3, Section 7, should also require disclosure of consumer reporting agencies used and to the extent they use their third-party services to obtain and share consumers' personal information;
- Article 5, Section 14, should be revised and it should not be optional because consumers should have the ability to obtain detailed reasons for insurance companies' adverse underwriting decisions immediately and not be required to provide a written request to the company to get those details;
- Data security and privacy are inextricably connected so data security requirements such as those in NAIC Model #668 need to be added to this model so third-party service providers and licensees that have access to consumer data are held to the same standards as the insurance companies they contract with.

Ms. Johnson said a joint trade group also submitted comments in advance of the comments deadline that are included in the materials posted on the website for this meeting. She asked if anyone would like to provide comments on the draft model.

Kristin Abbott, American Council of Life Insurers (ACLI) said companies and people need standards for privacy protections but do not need an overly prescriptive model. To avoid friction and unnecessary new barriers, she said the key is prior consent for marketing because requiring it would hurt underserved markets; prohibit joint marketing; increase costs and premiums; harm small to mid-size companies; restrict research; and limit actuarial services. Ms. Abbott said overseas processing is difficult to track and putting privacy restrictions on them would harm international insurers would result in decreased services for customers which is why the General Data Privacy Regulation-GDPR doesn't even require this. She said the 90-day deletion requirement needs to be removed from the model as most companies with Legacy Systems will not be able to accommodate this standard. Ms. Abbott said the new notice and oversight requirements in the model would increase implementation costs because insurers use personal information to provide products to meet their needs.

Robert Ridgeway, Americas Health Insurance Plans (AHIP) said he was speaking on behalf of both HIPAA-compliant and non-HIPAA-compliant companies. He said the companies he represents like the new timetable and the schedule of future meetings, including the Interim, in-person meeting being planned. Mr. Ridgeway said the Working Group's plan to handle low-hanging fruit in the form of less complex privacy issues during calls would be very productive. He said the partial exemption for HIPAA issues should be made a complete exemption via safe harbor for HIPAA-compliant companies. Mr. Ridgeway said the operative sections should be what companies need to do or not do; and should not pertain to activities that are already covered by HIPAA so companies are not trying to wade through duplicate obligations. He said for other non-HIPAA-compliant companies, the pinch points are: 1) private right of action where verbiage the same as model #668 would be a good choice; and 2) whether the sharing of personal data overseas should be considered as a privacy or cybersecurity issue.

Chris Peterson, Joint Health Coalition, said he agreed with Mr. Ridgeway that the partial safe harbor for HIPAA should be a full safe harbor incorporating oversight of third-party contracts including business associates.

Shelby Shoensee, American Property Casualty Insurance Association (APCIA) said that several members have met with the Drafting Group; want an in-person interim meeting; will be submitting written comments; and will be actively engaged in the collaboration process. She said their primary concerns are: 1) the overseas data privacy requirement because many of the companies operate on a global basis that relies on the data market; 2) the marketing and research limitations as that would prevent joint marketing; 3) third party oversight, which is a contractual issue so a delayed effective date (like the risk-based approach in the Insurance Data Security Act-IDSA model) for implementation is imperative; 4) the private right of action; 5) the new notice requirements; and 6) the inconsistent language about actuarial studies.

5. Discussed Other Matters

Ms. Johnson reminded attendees about the Working Group's Two-Day, In-Person, Interim Meeting tentatively scheduled for June 4-6, in Kansas City, Missouri.

Having no further business, the Privacy Protections (H) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/H Committee/2023\_Spring/WG-Privacy/Privacy-WG-Minutes032123

**NAIC/CONSUMER LIAISON COMMITTEE**

NAIC/Consumer Liaison Committee March 21, 2023, Minutes..... 13-2  
NAIC/American Indian and Alaska Native Liaison Committee March 25, 2023, Minutes  
(Attachment One) ..... 13-8

Draft: 4/6/23

NAIC/Consumer Liaison Committee  
Louisville, Kentucky  
March 21, 2023

The NAIC/Consumer Liaison Committee met in Louisville, KY, March 21, 2023. The following Liaison Committee members participated: Andrew R. Stolfi, Chair (OR); Grace Arnold, Vice Chair (MN); Lori K. Wing-Heier represented by Sharon Comstock (AK); Mark Fowler (AL); Alan McClain (AR); Andrew N. Mais represented by Kurt Swan (CT); Michael Conway (CO); Trinidad Navarro (DE); Michael Yaworsky (FL); Doug Ommen represented by Sonya Sellmeyer (IA); Dean L. Cameron represented by Shannon Hohl (ID); Vicki Schmidt (KS); Kathleen A. Birrane represented by Nour Benchaaboun (MD); Anita G. Fox represented by Renee Campbell (MI); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Chaney represented by Ryan Blakeney (MS); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by John Arnold (ND); Eric Dunning represented by Martin Swanson (NE); Chris Nicolopoulos represented by David Bettencourt (NH); Scott Kipper represented by Dave Cassetty (NV); Adrienne A. Harris represented by John Finston (NY); Judith L. French represented by Jana Jarrett (OH); Michael Humphreys (PA); Jon Pike represented by Shelley Wiseman (UT); Scott A. White represented by Don Beatty (VA); Mike Kreidler (WA); and Allan L. McVey (WV).

1. Adopted its 2022 Fall National Meeting Minutes

Commissioner Arnold made a motion, seconded by Beatty, to adopt the Committee's Dec. 12, 2022, minutes (see *NAIC Proceedings – Fall 2022, NAIC/Consumer Liaison Committee*). The motion passed unanimously.

2. Heard Opening Remarks

Commissioner Stolfi said the NAIC Consumer Participation Board of Trustees met March 21 to discuss Michael Delong's (Consumer Federation of America—CFA) request that the NAIC review the use of telematics in auto insurance. The Property and Casualty Insurance (C) Committee is reviewing this request under its existing charges. The Board reviewed the 2023 budget for the Consumer Participation Program and discussed potential changes to the Consumer Representative applications for 2024.

3. Heard a Presentation from RIPIN, ACS CAN, and CHIR on Barriers to Enrollment

Shamus Durac (Rhode Island Parent Information Network—RIPIN) said Medicaid eligibility is determined at the time of application, during regulator redeterminations, and when a Medicaid agency receives new eligibility information. At the beginning of the COVID-19 public health emergency (PHE), redeterminations were paused, and Medicaid terminations were prohibited. Durac said these protections end on March 31, 2023, and states have 12 months to initiate Redeterminations for all current Medicaid enrollees.

Durac said redeterminations are expected to result in as many as 15 million Americans losing Medicaid coverage. Medicaid renewals can take place *ex parte* when Medicaid can verify income and all other eligibility information. If Medicaid does not have all necessary information, consumers must go through the full renewal process, which requires consumers to provide information and documentation to demonstrate continuing eligibility for Medicaid.

Anna Schwamlein Howard (American Cancer Society Cancer Action Network—ACS CAN) said state insurance regulators should work with their Medicaid counterparts to coordinate the notices Medicaid will be sending to consumers. Schwamlein Howard encouraged state insurance regulators to reach out to health plans so they are prepared for an influx of enrollees and remind health insurers of the requirement to comply with network adequacy requirements. Schwamlein Howard said state insurance regulators should reach out to consumers to

explain changes to Medicaid provisions, provide consumer notices in multiple languages, and be vigilantly watching for fraudulent activity, which may occur during the Medicaid unwinding. For states with state-based exchanges, Schwamlein Howard said states can extend open enrollment past 60 days.

Maanasa Kona (Georgetown University Center on Health Insurance Reforms—CHIR) said federal continuity of care protections apply to patients with serious conditions, including consumers undergoing treatment, such as those who are pregnant or terminally ill. Kona said the protections are available for up to 90 days for the duration of the patient’s treatment and that 29 states offer similar protections to enrollees who lose access to an in-network provider. These protections are limited since they are triggered when a provider leaves a network. Only 13 jurisdictions extend their continuity of care protections when consumers transition from Medicaid to a new plan. At the same time, the protections vary by state. Kona said that state insurance regulators should extend continuity of care protections to consumers transitioning to new plans, require pro-rating of deductibles and out-of-pocket maximums, and require insurance companies to honor prior authorizations for care.

Bettencourt asked how to engage with provider groups to encourage enrollment in Medicaid. Kona said state insurance regulators are encouraged to reach out to providers to ensure they have the necessary information to communicate with consumers.

3. Heard a Presentation from the HCFA, LLS, Consumers’ Checkbook, and the HIV+Hepatitis Policy Institute on “Obstacles to Medically Necessary Care – Part 1: Delays and Red Tape Due to Prior Authorization”

Carl Schmid (HIV+Hepatitis Policy Institute) referenced multiple situations in which consumers had problems accessing necessary prescription drugs due to a lack of authorization by health insurers. Schmid said 17%, or 48 million consumers, experience denied prescription coverages, and very few consumers appeal a denial. Schmid said African Americans and Hispanic Americans were much more affected by the privatization of step therapy. Schmid said prescription drugs that prevent HIV should not require preauthorization by an insurer and that some companies’ preauthorization requirements for long-term HIV treatment are very difficult to meet.

Lucy Culp (Leukemia & Lymphoma Society—LLS) said her organization has seen blood cancer patients struggling with accessing medically necessary care prescribed by their providers. Culp said LLS partnered with Manatt to identify barriers to care and solutions.

Eric Ellsworth (Consumers’ Checkbook/Center for the Study of Services—Consumers’ Checkbook) said the claims adjudication system, with most claims being adjudicated automatically, contributes to the access to care problem. Ellsworth said the medical necessity rules and coding rules are all different between insurance carriers, and it is almost impossible for a health provider or patient to determine what the rules and codes mean. This leads to confusion on why claims and charges are denied. In addition to code-based claims, the utilization management system is unclear and disjointed. Ellsworth said the appeals rate is very low because consumers are not aware of their options for appeal.

Ellsworth said state insurance regulators should work to standardize the different rules and codes across all insurers. Ellsworth said the federal Centers for Medicare & Medicaid Services (CMS) has a rule on interoperability in prior authorization, which addresses patient access, provider access to claims for patients, payer-to-payer guidance, prior authorization rules, and reporting requirements regarding prior authorizations. Ellsworth said the proposed effective date is Jan. 1, 2026, and does not supersede more stringent state laws.

Ashley Blackburn (Health Care for All—HCFA) talked about a proposal in Massachusetts, which is facing an extreme workforce shortage. Blackburn said there is a prior authorization work group that has been developing standardized pre-authorization forms. The current proposal is focused on improving access to and continuity to care by prohibiting prior authorization for generic medications and medications and treatment with low denial

rates, low variation in utilization, or an evidence base to treat chronic illness. The second goal of the Massachusetts bill is to promote transparency and fairness by requiring public data from insurers related to approvals, denials, appeals, and wait times. The third goal of the Massachusetts bill is to improve timely access to care and administrative efficiency, which requires a 24-hour response time for urgent care.

Culp outlined the following recommendations for state insurance regulators: 1) monitor implementation and compliance with the federal interoperability rule; 2) utilize existing authority to monitor carrier conduct; 3) support efforts to improve access and continuity of care; 4) increase public transparency around utilization management; 5) require the use of standard forms and electronic processing; and 6) require standardization in documentation and publication of medical necessity criteria.

#### 4. Heard a Presentation from the NWLC and the NHeLP on “Obstacles to Medically Necessary Care – Refusal of Care and Network Adequacy”

Dorianne Mason (National Women’s Law Center—NWLC) said health care refusals are when consumers are denied medically necessary care. Wayne Turner (National Health Law Program—NHeLP) said individual providers may deny care due to personal or religious objections, and religiously affiliated health care systems may deny care as a matter of policy. Turner said providers may also fail to inform patients of the full array of services and treatment options.

Mason said standards of care are made up of a patchwork of state and federal laws, and through this patchwork, a consumer’s care may be driven by a hospital or individual health care provider’s beliefs rather than what is best for the patient’s health. Mason said refusals of care force patients to delay or forgo necessary care. This is particularly true and dangerous for patients who have limited options for care. Mason said the refusals of care cause the most harm to people of color, people with limited financial resources, young people, LGBTQ individuals, and people seeking gender-affirming care.

Turner said the Center for American Progress (CAP) said 15% of transgender individuals were refused gender-affirming care, and 20% of transgender people of color reported that a provider refused to see them due to the provider’s religious beliefs or the state religious tenets of the healthcare facility. Turner said people who are turned away from care suffer pain and humiliation. Turner said some of the refusals of care violate federal non-discrimination laws. Turner said end-of-life care directives may not be followed due to ethical and religious directives of religiously affiliated healthcare systems. Turner said religiously affiliated providers also dominate some healthcare markets.

Mason said the expansion of Catholic health care has had a disproportionate effect on the sexual and reproductive health care available to women of color, especially with regard to miscarriage management.

Mason and Turner provided the following recommendations for state insurance regulators: 1) prioritize patient access in federal and state rulemaking; 2) conduct state assessments on access to service to identify coverage gaps; 3) include healthcare refusal as part of network adequacy reviews; 4) require transparency for exclusions from coverage; and 5) consider refusals when reviewing health plan/provider mergers and acquisitions.

#### 5. Heard a Presentation Calling Attention to the Dilemma of Current Assumption Policy Illustrations

Richard Weber (Life Insurance Consumer Advocacy Center—LICAC) said current policy illustrations cannot reflect the long-term likelihood of a policy sustaining its ultimate use as a needed death benefit. Weber said the NAIC *Life Insurance Illustrations Model Regulation* (#582) has a stated purpose to protect consumers and foster consumer education. The goal of Model #582 is to ensure that illustrations do not mislead purchasers of life insurance and to make illustrations more understandable.

Weber said the total death benefits in the U.S. is \$21 trillion, with \$14 trillion being term/group life insurance policies. Weber said all universal life insurance policies are designed to combine term life insurance and cash value. Over time, the cash value replaces the term life insurance element, which makes the policy affordable over time. Weber said the cash accumulation will fluctuate over time, and this is not apparent through the use of a current policy illustration. Weber said policy illustrations are not projections. Weber said the main difference in universal life insurance policies is how universal life credits its cash value. Weber said the original universal life insurance policy was a cash accumulation policy with a minimum guaranteed crediting rate (general account). Weber said the variable universal life insurance policy is a cash accumulation policy in a brokerage account with market-driven ups and downs (security). Weber said there is also an indexed universal life insurance policy where cash accumulation is based on an external index.

Weber provided some simple graphic views of variable universal life policies and said an illustration showing a \$5,900 annual premium with an illustrated rate of return of 10% had only an 8% probability of success of actually covering a policyholder until age 100. Weber said consumers should buy policies based on the probability of success rather than the lowest premium. Weber said a policy with a constant illustrated rate of return of 4.4% would need an annual premium of \$16,500 to reach a 99% probability of success.

Weber suggested insurance companies and agents should discuss the probability of success based on annual premiums and the implied constant illustration rate. Weber said this would provide consumers with a better understanding of what they are purchasing. Weber recommended the NAIC reopen Model #582 to address indexed universal life products, no-lapse guarantees, and variable universal life insurance products.

6. Heard a Presentation from the CEJ on “Dark Patterns in Digital Communications: Addressing the Perils of Moving from Paper to Digital Consumer Interactions”

Birny Birnbaum (Center for Economic Justice—CEJ) said dark patterns are user interface techniques that benefit an online service by leading consumers into making decisions they might not otherwise make. Some dark patterns deceive consumers, while others exploit cognitive biases or shortcuts to manipulate or coerce them into choices that are not in their best interests. Birnbaum said dark patterns are a specific type of choice architecture in website and app design that interfere with user autonomy and choice. Dark patterns modify the presentation of choices available to users or manipulate the flow of information so that users make selections that they would not otherwise have chosen—to their own detriment and to the benefit of the website or app provider. Dark patterns include imposing asymmetric burdens to achieve competing choices, restricting the choices available at the same time (or at all), and hiding information or presenting information deceptively.

From Jamie Liguri published in “Shining a Light on Dark Patterns,” Birnbaum listed the following types of dark patterns:

- Nagging: Repeated requests to do something the firm prefers.
- Confirm shaming: Choice framed in a way that makes it seem dishonorable or stupid.
- Forced Action: Requiring opt-out of optional services, manipulative extraction of personal information and information about other users.
- Social Proof: False/misleading notices that others are purchasing or offering testimonials.
- Roach Motel: Asymmetry between signing up and canceling.
- Price Comparison Prevention: Difficulty in understanding and comparing prices.
- Hidden Information/Aesthetic Manipulation: Important information visually obscured.

From the European Consumer Organization’s (BEUC’s) “Fast Track to Surveillance,” Birnbaum quoted the following: “During this signup process, which involves consumers taking important decisions about how Google will process their personal data, the tech giant uses a combination of deceptive design, unclear language,

misleading choices, and missing information. With only one step ('express personalization'), the consumer activates all the account settings that feed Google's surveillance activities. Google does not provide consumers with the option to turn all settings 'off' in one step. If consumers want to try to protect their privacy, it requires 'manual personalization': five steps with ten clicks and grappling with information that is unclear, incomplete, and misleading. Consider the consent for use of cookies on most websites. In almost every case, one click is required to accept all cookies. If you want to avoid sharing your personal information, it requires many clicks."

Birnbaum provided some examples of state regulation of dark patterns in California, Connecticut, Colorado, the Federal Trade Commission (FTC), and the Consumer Financial Protection Bureau (CFPB). Birnbaum said it is critical for state insurance regulators to understand and address dark patterns. Insurance regulatory disclosures are based on and designed for paper, not digital interfaces. Paper disclosures are static. Digital disclosures are dynamic and change based on the consumer, the method of consumer interaction, and the choices of the consumer during the process. There has been a massive and rapid increase in digital interactions in place of paper or face-to-face interactions between consumers and insurers.

Birnbaum provided the following recommendations for the Market Regulation and Consumer Affairs (D) Committee:

- Train analysts and examiners to recognize dark patterns and manipulative digital design.
- Compile resources on manipulative digital design.
- Review existing disclosure requirements. Do they make sense for a digital interface and protect against dark patterns?
- Update guidance in regulations as needed—not just revisions in disclosures and disclosure requirements but articulating dark patterns as an unfair and deceptive trade practice.
- Develop relevant methods of regulatory review and update the *Market Regulation Handbook*.

In response to Commissioner Stolfi's question of when a website design becomes a dark pattern, Birnbaum said a website design becomes a dark pattern when the website obscures a choice for a consumer. For example, Birnbaum said a person can purchase travel insurance with one click but cannot revoke a purchase with one click. This is an example of an asymmetric approach.

#### 7. Heard a Presentation from the AEPI on "Aftermarket Parts: Imitation Often is Not Equal"

Erica Eversman (Automotive Education & Policy Institute—AEPI) said an aftermarket part is any part that is not factory-installed. An imitation or generic part is any part that was made for use in the repair of a vehicle that is not sanctioned or authorized by the automobile manufacturer. Eversman said the NAIC's *After Market Parts Model Regulation* (#891) applies to only external sheet metal and plastic parts. Eversman said the evolution of arguments in favor of the use of imitation parts include the following: 1) the parts are purely cosmetic; 2) the parts are identical to the automaker parts; and 3) the parts are made by the same manufacturer as the automaker parts. Because of these arguments, Ford Motor Company successfully sued parts makers and distributors for design patent infringement.

Eversman said the claims that aftermarket parts and imitation parts are of the same likeness, kind, and quality as factory-installed parts are not accurate. Eversman said aftermarket parts and imitation parts are not made of the same steel type, weight, and specifications. Eversman said automakers routinely void and restrict auto warranties for any portion of a vehicle on which an insurance claim is paid. In addition, Eversman said an automobile conditions report will note the use of imitation parts if a vehicle repair has been made, which reduces the value of the vehicle.



Eversman said the Certified Automotive Parts Association (CAPA) was funded by the insurance industry. However, Eversman said CAPA routinely decertifies parts. At the same time, Eversman said there is no entity responsible for providing consumer notifications about decertification, and the National Highway Traffic Safety Administration (NHTSA) does not have the authority to recall parts.

Eversman provided the following recommendations:

- Establish a charge under the Property and Casualty Insurance (C) Committee to revisit what an aftermarket part is.
- Establish a concrete definition and criteria for determining proper use in insured/consumer repairs.
- Require auto insurers to establish and publish recall methodology for decertified or defective imitation parts.
- Establish a mechanism for insureds/consumers to obtain replacement parts and installation.
- Mandate payment for replacement parts and installation.

Having no further business, the NAIC/Consumer Liaison Committee adjourned.

SharePoint/NAIC Support Staff Hub/Committees/Consumer/Consumer\_03 Min\_Final

Draft: 4/10/23

NAIC/American Indian and Alaska Native Liaison Committee  
Louisville, Kentucky  
March 25, 2023

The NAIC/American Indian and Alaska Native Liaison Committee met in Louisville, KY, March 25, 2023. The following Liaison Committee members participated: Glen Mulready, Chair (OK); Trinidad Navarro, Vice Chair (DE); Lori K. Wing-Heier (AK); Dean L. Cameron represented by Shannon Hohl (ID); Grace Arnold represented by Peter Brickwedde (MN); Chlora Lindley-Myers represented by Jo LeDuc (MO); Troy Downing (MT); Mike Causey represented by Tracy Biehn (NC); Jennifer A. Catechis (NM); Andrew R. Stolfi represented by TK Keen and Eric Cutter (OR); Larry D. Deiter represented by Tony Dorschner (SD); Jon Pike represented by Tanji J. Northrup and Brian Hiller (UT); Mike Kreidler (WA); Nathan Houdek represented Sarah Smith (WI); and Jeff Rude (WY). Also participating were: John Arnold (ND); and Patrick Smock (RI).

1. Adopted its 2022 Fall National Meeting Minutes

Commissioner Navarro made a motion, seconded by Brickwedde, to adopt the Committee's Dec. 14, 2022, minutes (see *NAIC Proceedings – Fall 2022, NAIC/Consumer Liaison Committee, Attachment Two*). The motion passed unanimously.

2. Adopted the Results of its Member Survey and Discussed its Next Steps for 2023

Commissioner Mulready gave an overview of the responses received to the Committee's survey of Members regarding topics to be discussed in 2023. He thanked the Members who responded to the survey with their recommendations for agenda topics for the Liaison Committee to discuss this year. Commissioner Mulready said the responses to the survey were included in the meeting packet for Members at the head table. He said the topics included: tribal issues with the federal Affordable Care Act (ACA); property/casualty (P/C) insurance; large agencies selling to tribal members; the Tribal Association of Insurance Commissioners (TAIC); Sovereign Nations Health Consortium (SNHC); and conducting an interim meeting. Commissioner Mulready said he met with leaders from the SNHC in his office two weeks ago. He also discussed the Committee's next steps for the rest of the year.

3. Heard a Presentation from Blue Cross and Blue Shield of Oklahoma on the Risk Adjustment Treatment of Tribal Enrollees

Commissioner Mulready introduced Lucinda Myers (Blue Cross and Blue Shield of Oklahoma) and J.T. Petherick (Blue Cross and Blue Shield of Oklahoma) as the speakers for this presentation.

Commissioner Mulready said their presentation was titled "ACA Risk Adjustment Treatment of Tribal Enrollees: Barrier to Tribal Member Enrollment and Investments in Tribal Health and Health Equity." This presentation is important because it highlights the inequities of the federal Centers for Medicare & Medicaid Services (CMS) risk assessment process, especially relative to underserved tribal communities due to the lack of tribal investment opportunities.

Petherick said he appreciates the aims of the Committee going forward and that this presentation is just an introduction to future work with the Oklahoma Department of Insurance (DOI) regarding their boots-on-the-ground approach.

Myers said her office serves as a resource for building partnerships to improve health care to the underserved communities. She said she has done liaison work for more than eight years and that she has helped more than 36,000 people since 2012 with the Mobile Assistance Center helping her to become a trusted provider and to create a custom network. Myers said when tribes and insurers work together, care is better.

Petherick said Blue Cross and Blue Shield of Oklahoma does all it can to increase coverage opportunities as evidenced by its 10<sup>th</sup> anniversary on the Tribal Liaison Council. He said their relationship began in 2014 with the federal Affordable Care Act (ACA) and that, initially, the company did not know how risk-sharing and zero premium would work, particularly as a health care 501 (c) group. He described how slides based on the cost-sharing reduction (CSR) demand factors and induced demand factors (IDF) accuracy 2021 risk adjustment paper showed how the inequities of federal risk assessments served as barriers to tribal member enrollments and investments in tribal health. Petherick said insurers should not be penalized for the disparities in health in American Indian and Alaska Native communities. He said the modeling results suggest using the Platinum plan rather than the Silver plan as illustrated by his example of recalibrated CSR factors. Mr. Petherick said it is used for services through Medicare outside of Indian Health Services.

Director Wing-Heier said that this has been a problem in Alaska for many years because they have only two carriers, and the CMS has not responded to them on this issue.

Josh Goldberg (Blue Cross and Blue Shield of Oklahoma), said he has been meeting with the CMS about the report, but it was not ready in time to meet the CMS deadline. He said, however, that they plan to continue the process and to discuss the report with the CMS.

Hiller asked if any state would be willing to take this on; there was no response.

Commissioner Mulready said he has had conversations with the CMS on this issue as well, and it needs to be addressed by this Liaison Committee. He said the Platinum product reduces the administrative process and is geared toward larger tribes with self-funded group plans, so employers and employees of tribes love it.

Having no further business, the NAIC/American Indian and Alaska Native Liaison Committee adjourned.

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