NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Fall Volume I

2024 Proceedings of the

National Association of Insurance Commissioners

2024 Fall National Meeting
November 16–19, 2024

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Denver, Colorado

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

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

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

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

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

Legal
Comprehensive collection of NAIC model laws, regulations and guidelines; state laws on insurance topics; and other regulatory guidance on taxation and consumer privacy.

Market Regulation
Regulatory and industry guidance on market-related issues, including antifraud, product filing requirements, producer licensing and market analysis.

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

I. Name

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

II. Duration

The period of duration of the NAIC is perpetual.

III. Registered Office and Agent

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

IV. Authority to Issue Stock

The NAIC shall have no authority to issue capital stock.

V. Incorporators

The name and address of the incorporator are as follows:

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

VI. Purpose

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

(a) Protect the public interest, promote competitive markets and facilitate the fair and equitable treatment of insurance consumers.

(b) Promote, in the public interest, the reliability, solvency and financial solidity of insurance institutions.

(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

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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).

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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.

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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

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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 shallbe 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, accessto 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.

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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 tothe 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 shallbe 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 forremoval 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 allspecial 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 completeshis 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,

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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 ofIncorporation 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 ata 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

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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 responsibilityfor 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.

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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) periodicallymonitor 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 reportcontaining the current budget and expenditures which the Secretary-Treasurer shall present to theExecutive 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) reviewthe 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 orinsular 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

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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 ofmembers 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; competitionin 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.

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(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 shallhave 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 Forceshall 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 ExecutiveCommittee 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 membersnotice 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

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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 leaveless 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, subjectto 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

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voting inspectors. The voting inspectors shall distribute, collect, count and/orverify 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 appointanother 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 subjectto 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-specificitem, Government Relations Leadership Council, or International Insurance Relations LeadershipGroup, or any respective subcommittees.

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

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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 suchmeeting.

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 meetingand 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 grammaticalerrors 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 theExecutive 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

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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.

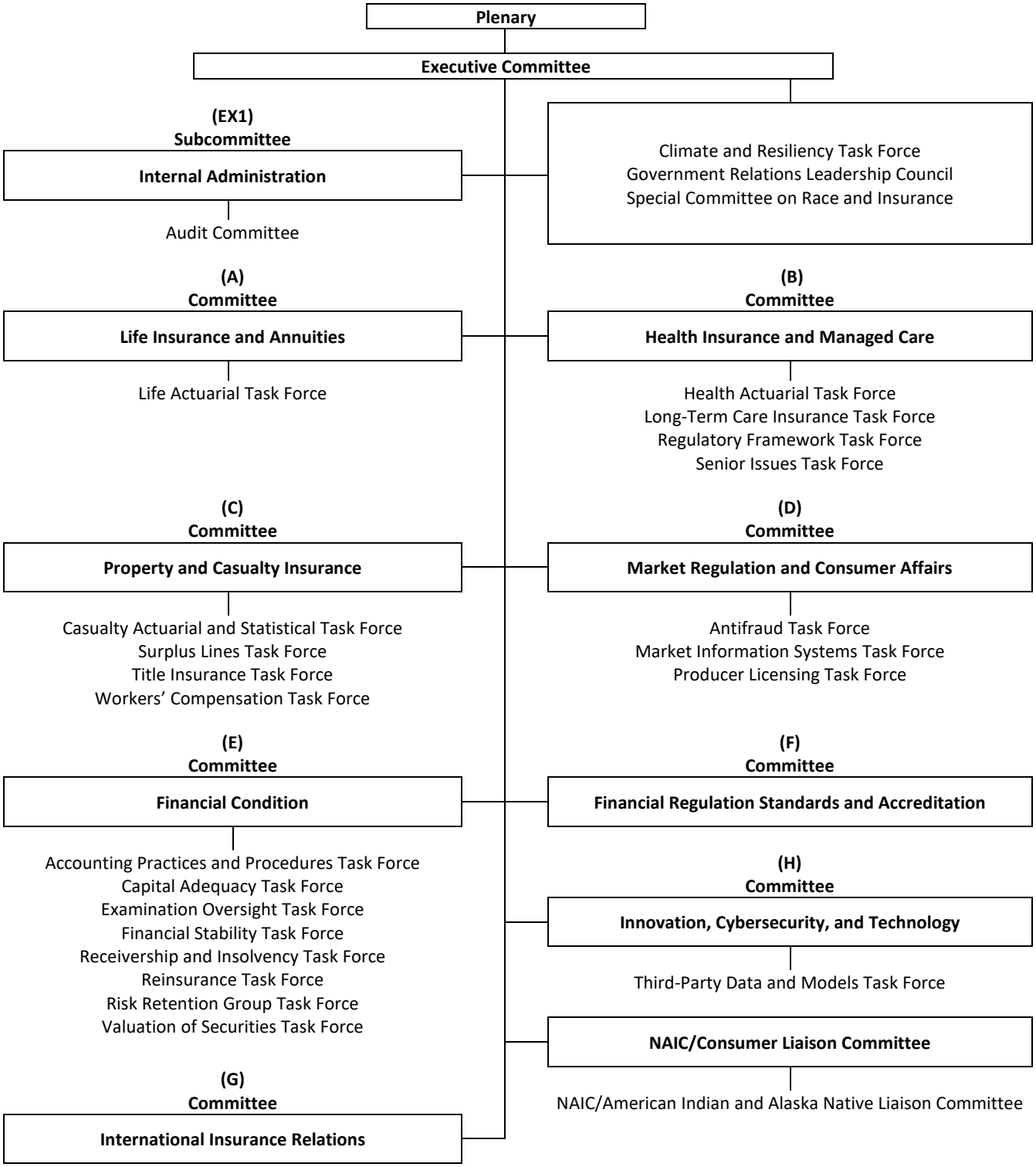
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[NOTE: (Effective Jan. 1, 1996, conference call meetings are included in the application of the policy statement, by action of the NAIC on June 4, 1995). This policy statement was originally adopted by the NAIC membership during the 1994 Fall National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

Revisions Adopted by the NAIC Membership, April 1, 2014

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2024 COMMITTEE AND TASK FORCE STRUCTURE



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APPOINTED AND DISBANDED
Current and Previous Year

APPOINTED SINCE JANUARY 2024	Effective Date	NAIC Support Staff
Public Adjuster Licensing (D) Working Group	12/03/2023	Tim Mullen
Third-Party Data and Models (H) Task Force	11/16/2023	Kris DeFrain

RENAMED SINCE JANUARY 2024	Effective Date	NAIC Support Staff
Long-Term Care Insurance (B) Task Force (f.k.a. Long-Term Care Insurance (EX) Task Force)	12/04/2023	Jane Koenigsman
Pharmaceutical Benefit Management Regulatory Issues (B) Working Group (f.k.a. Pharmacy Benefit Manager Regulatory Issues (B) Subgroup	07/26/2024	Jolie Matthews
Technology, Innovation, and InsurTech (H) Working Group (f.k.a. Innovation in Technology and Regulation (H) Working Group)	11/16/2023	Libby Crews

DISBANDED SINCE JANUARY 2024	Effective Date	NAIC Support Staff

DISBANDED IN 2023	Effective Date	NAIC Support Staff
Index-Linked Variable Annuity (A) Subgroup	08/16/2023	Jim Stinson
Long-Term Care Pricing (B) Subgroup	03/25/2023	Eric King
Long-Term Care Valuation (B) Subgroup	03/25/2023	Eric King
Mortgage Guaranty Insurance (E) Working Group	12/04/2023	Andy Daleo
Receiver's Handbook (E) Subgroup	12/04/2023	Sherry Flippo
Restructuring Mechanisms (E) Subgroup	03/25/2023	Robin Marcotte

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2024 MEMBERS BY ZONE

Northeast Zone

Trinidad Navarro, Chair	Delaware
Kevin Gaffney, Vice Chair	Vermont
Michael Humphreys, Secretary	Pennsylvania
Andrew N. Mais	Connecticut
Karima M. Woods	District of Columbia
Robert L. Carey	Maine
Marie Grant	Maryland
Michael T. Caljouw	Massachusetts
D.J. Bettencourt	New Hampshire
Justin Zimmerman	New Jersey
Adrienne A. Harris	New York
Elizabeth Kelleher Dwyer	Rhode Island

Southeast Zone

Carter Lawrence, Chair	Tennessee
Sharon P. Clark, Vice Chair	Kentucky
Alan McClain, Secretary	Arkansas
Mark Fowler	Alabama
Michael Yaworsky	Florida
John F. King	Georgia
Timothy J. Temple	Louisiana
Mike Chaney	Mississippi
Mike Causey	North Carolina
Alexander S. Adams Vega	Puerto Rico
Michael Wise	South Carolina
Tregenza A. Roach	U.S. Virgin Islands
Scott A. White	Virginia
Allan L. McVey	West Virginia

Midwest Zone

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Vicki Schmidt, Vice Chair	Kansas
Eric Dunning, Secretary	Nebraska
Ann Gillespie	Illinois
Holly W. Lambert	Indiana
Doug Ommen	Iowa
Grace Arnold	Minnesota
Chlora Lindley-Myers	Missouri
Jon Godfread	North Dakota
Judith L. French	Ohio
Glen Mulready	Oklahoma
Larry D. Deiter	South Dakota
Nathan Houdek	Wisconsin

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Lori K. Wing-Heier	Alaska
Peni Itula Sapini Teo	American Samoa
Barbara D. Richardson	Arizona
Ricardo Lara	California
Michelle B. Santos	Guam
Gordon I. Ito	Hawaii
Dean L. Cameron	Idaho
Troy Downing	Montana
Remedio C. Mafnas	N. Mariana Islands
Scott Kipper	Nevada
Alice T. Kane	New Mexico
Jon Pike	Utah
Mike Kreidler	Washington
Jeff Rude	Wyoming

Updated October 30, 2024

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2024 EXECUTIVE (EX) COMMITTEE

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Jon Godfread, President-Elect	North Dakota
Scott A. White, Vice President	Virginia
Elizabeth Kelleher Dwyer, Secretary-Treasurer	Rhode Island
Most Recent Past President:	
Chlora Lindley-Myers	Missouri

Northeast Zone

Trinidad Navarro, Chair	Delaware
Kevin Gaffney, Vice Chair	Vermont
Michael Humphreys, Secretary	Pennsylvania

Southeast Zone

Carter Lawrence, Chair	Tennessee
Sharon P. Clark, Vice Chair	Kentucky
Alan McClain, Secretary	Arkansas

Midwest Zone

Anita G. Fox, Chair	Michigan
Vicki Schmidt, Vice Chair	Kansas
Eric Dunning, Secretary	Nebraska

Western Zone

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Cassie Brown, Secretary	Texas

NAIC Support Staff: Andrew J. Beal/Kay Noonan

Updated April 8, 2024

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Peni Itula Sapini Teo	American Samoa
Barbara D. Richardson	Arizona
Alan McClain	Arkansas
Michael Conway	Colorado
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Gordon I. Ito	Hawaii
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Doug Ommen	Iowa
Vicki Schmidt	Kansas
Sharon P. Clark	Kentucky
Timothy J. Temple	Louisiana
Robert L. Carey	Maine
Marie Grant	Maryland
Michael T. Caljouw	Massachusetts
Anita G. Fox	Michigan
Grace Arnold	Minnesota
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Eric Dunning	Nebraska
Scott Kipper	Nevada
D.J. Bettencourt	New Hampshire
Justin Zimmerman	New Jersey
Alice T. Kane	New Mexico
Adrienne A. Harris	New York
Mike Causey	North Carolina
Jon Godfread	North Dakota
Judith L. French	Ohio
Glen Mulready	Oklahoma
Michael Humphreys	Pennsylvania
Alexander S. Adams Vega	Puerto Rico
Elizabeth Kelleher Dwyer	Rhode Island
Michael Wise	South Carolina
Tregenza A. Roach	U.S. Virgin Islands
Kevin Gaffney	Vermont
Scott A. White	Virginia
Mike Kreidler	Washington
Nathan Houdek	Wisconsin

NAIC Support Staff: Aaron Brandenburg/Libby Crews

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John F. King	Georgia
Doug Ommen	Iowa
Chlora Lindley-Myers	Missouri
Troy Downing	Montana
Glen Mulready	Oklahoma
Elizabeth Kelleher Dwyer	Rhode Island
Jon Pike	Utah
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Scott A. White	Virginia
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Peni Itula Sapini Teo	American Samoa	Justin Zimmerman	New Jersey
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Alan McClain	Arkansas	Judith L. French	Ohio
Ricardo Lara	California	Glen Mulready	Oklahoma
Michael Conway	Colorado	Andrew R. Stolfi	Oregon
Karima M. Woods	District of Columbia	Michael Humphreys	Pennsylvania
Ann Gillespie	Illinois	Michael Wise	South Carolina
Holly W. Lambert	Indiana	Cassie Brown	Texas
Doug Ommen	Iowa	Kevin Gaffney	Vermont
Sharon P. Clark	Kentucky	Mike Kreidler	Washington
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NAIC Support Staff: Andrew J. Beal/Kay Noonan

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Andrew R. Stolfi	Oregon
Elizabeth Kelleher Dwyer	Rhode Island
Kevin Gaffney	Vermont
Scott A. White	Virginia

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

AUDIT COMMITTEE

of the Internal Administration (EX1) Subcommittee

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Eric Dunning	Nebraska
Scott Kipper	Nevada
Jon Godfread	North Dakota
Andrew R. Stolfi	Oregon
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Carter Lawrence	Tennessee
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NAIC Support Staff: Jim Woody

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Barbara D. Richardson	Arizona
Karima M. Woods	District of Columbia
Grace Arnold	Minnesota
Remedio C. Mafnas	N. Mariana Islands
Justin Zimmerman	New Jersey
Adrienne A. Harris	New York
Glen Mulready	Oklahoma
Elizabeth Kelleher Dwyer	Rhode Island
Scott A. White	Virginia
Nathan Houdek	Wisconsin

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of the Life Insurance and Annuities (A) Committee

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Jason Lapham	Colorado
Russ Gibson	Iowa
Cynthia Amann	Missouri
Maggie Reinert/Megan VanAusdall	Nebraska
Ross Hartley	North Dakota
Daniel Bradford	Ohio
Matt Gendron	Rhode Island
David Hippen	Washington

NAIC Support Staff: Jennifer R. Cook

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Peni Itula Sapini Teo	American Samoa
Ricardo Lara	California
Andrew N. Mais	Connecticut
Ann Gillespie	Illinois
Holly W. Lambert	Indiana
Doug Ommen	Iowa
Vicki Schmidt	Kansas
Robert L. Carey	Maine
Grace Arnold	Minnesota
Chlora Lindley-Myers	Missouri
Eric Dunning	Nebraska
D.J. Bettencourt	New Hampshire
Justin Zimmerman	New Jersey
Adrienne A. Harris	New York
Judith L. French	Ohio
Glen Mulready	Oklahoma
Michael Humphreys	Pennsylvania
Jon Pike	Utah

NAIC Support Staff: Scott O'Neal/Jennifer Frasier

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Experience Reporting (A) Subgroup

of the Life Actuarial (A) Task Force

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

NAIC Support Staff: Angela McNabb

Generator of Economic Scenarios (GOES) (E/A) Subgroup

of the Life Risk-Based Capital (E) Working Group and Life Actuarial (A) Task Force

Mike Yanacheak, Chair	Iowa
Peter Weber, Vice Chair	Ohio
Ted Chang	California
Wanchin Chou	Connecticut
Philip Barlow	District of Columbia
Scott Shover	Indiana
Ben Slutsker	Minnesota
William Leung	Missouri
Seong-min Eom	New Jersey
Bill Carmello	New York
Rachel Hemphill	Texas
Craig Chupp	Virginia

NAIC Support Staff: Scott O'Neal

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Indexed Universal Life (IUL) Illustration (A) Subgroup

of the Life Actuarial (A) Task Force

Fred Andersen, Chair	Minnesota
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Matt Cheung	Illinois
Scott Shover	Indiana
Mike Yanacheak	Iowa
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

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
Ben Slutsker	Minnesota
Bill Carmello	New York
Peter Weber	Ohio
Rachel Hemphill	Texas
Tomasz Serbinowski	Utah

NAIC Support Staff: Dave Fleming

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Valuation Manual (VM)-22 (A) Subgroup

of the Life Actuarial (A) Task Force

Ben Slutsker, Chair	Minnesota
Elaine Lam, Vice Chair	California
Lei Rao-Knight	Connecticut
Matt Cheung	Illinois
Mike Yanacheak	Iowa
Nicole Boyd	Kansas
William Leung	Missouri
Seong-min Eom	New Jersey
Bill Carmello	New York
Rachel Hemphill	Texas
Tomasz Serbinowski	Utah
Craig Chupp	Virginia

NAIC Support Staff: Amy Fitzpatrick/Scott O'Neal

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 Brlow	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/Jane Ren

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John F. King	Georgia
Dean L. Cameron	Idaho
Marie Grant	Maryland
D.J. Bettencourt	New Hampshire
Alice T. Kane	New Mexico
Andrew R. Stolfi	Oregon
Michael Humphreys	Pennsylvania
Alexander S. Adams Vega	Puerto Rico
Jon Pike	Utah
Mike Kreidler	Washington
Allan L. McVey	West Virginia

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

Consumer Information (B) Subgroup

of the Health Insurance and Managed Care (B) Committee

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T.J. Patton, Vice Chair	Minnesota
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John F. King	Atlanta 30334
Guam Commissioner	
Michelle B. Santos	Barrigada 96913
Hawaii Commissioner	
Gordon I. Ito	Honolulu 96813
Idaho Director	
Dean L. Cameron	Boise 83720
Illinois Acting Director	
Ann Gillespie	Springfield 62767
Indiana Commissioner	
Holly W. Lambert	Indianapolis 46204
Iowa Commissioner	
Doug Ommen	Des Moines 50319
Kansas Commissioner	
Vicki Schmidt	Topeka 66612
Kentucky Commissioner	
Sharon P. Clark	Frankfort 40601
Louisiana Commissioner	
Timothy J. Temple	Baton Rouge 70802
Maine Superintendent	
Robert L. Carey	Augusta 04333
Maryland Acting Commissioner	
Marie Grant	Baltimore 21202
Massachusetts Commissioner	
Michael T. Caljouw	Boston 02118
Michigan Director	
Anita G. Fox	Lansing 48933
Minnesota Commissioner	
Grace Arnold	St. Paul 55101
Mississippi Commissioner	
Mike Chaney	Jackson 39201
Missouri Director	
Chlora Lindley-Myers	Jefferson City 65101
Montana Commissioner/State Auditor	
Troy Downing	Helena 59601
Nebraska Director	
Eric Dunning	Lincoln 68501
Nevada Commissioner	
Scott Kipper	Carson City 89706
New Hampshire Commissioner	
D.J. Bettencourt	Concord 03301
New Jersey Acting Commissioner	
Justin Zimmerman	Trenton 08625
New Mexico Superintendent	
Alice T. Kane	Santa Fe 87501
New York Superintendent	
Adrienne A. Harris	New York 10004
North Carolina Commissioner	
Mike Causey	Raleigh 27603
North Dakota Commissioner	
Jon Godfread	Bismarck 58505
N. Mariana Islands Secretary of Commerce	
Remedio C. Mafnas	Saipan 96950
Ohio Director	
Judith L. French	Columbus 43215
Oklahoma Commissioner	
Glen Mulready	Oklahoma City 73112
Oregon Commissioner	
Andrew R. Stolfi	Salem 97301
Pennsylvania Commissioner	
Michael Humphreys	Harrisburg 17120
Puerto Rico Commissioner	
Alexander S. Adams Vega	Guaynabo 00968
Rhode Island Superintendent	
Elizabeth Kelleher Dwyer	Cranston 02920
South Carolina Director	
Michael Wise	Columbia 29201
South Dakota Director	
Larry D. Deiter	Pierre 57501
Tennessee Commissioner	
Carter Lawrence	Nashville 37243
Texas Commissioner	
Cassie Brown	Austin 78701
Utah Commissioner	
Jon Pike	Salt Lake City 84114
Vermont Commissioner	
Kevin Gaffney	Montpelier 05620
Virgin Islands Lt. Governor/Commissioner	
Tregenza A. Roach	St. Thomas 00802
Virginia Commissioner	
Scott A. White	Richmond 23219
Washington Commissioner	
Mike Kreidler	Olympia 98504
West Virginia Commissioner	
Allan L. McVey	Charleston 25301
Wisconsin Commissioner	
Nathan Houdek	Madison 53703
Wyoming Commissioner	
Jeff Rude	Cheyenne 82002

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
ALABAMA—*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 (*Appointed Sept. 15, 2008; Reappointed Jan. 17, 2011; Reappointed November 2017*)	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 (*Died Nov. 13, 2021*)	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* (*Died Nov. 30, 1944*)	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* (*Died Nov. 30, 1944*)	9/30/1923	10/1/1927	4	0
Commissioner of Insurance	Frank N. Julian* (*Died Nov. 30, 1944*)	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.

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
ALABAMA—*Continued*					
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
ALASKA—*Appointed, at the pleasure of the Commissioner of Commerce, Community, and Economic Development*					
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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
ALASKA—*Continued*					
Surveyor-General/Secretary	William L. Distin	8/7/1897	10/18/1913	16	2
AMERICAN SAMOA—*Appointed, at the pleasure of the Governor*					
Insurance Commissioner	Peni 'Ben' Itula Sapini Teo	2/15/2022		incumbent	
Acting Insurance Commissioner	Elizabeth S. Perri	8/5/2021	2/14/2022	0	6
Insurance Commissioner	Peni 'Ben' Itula 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	*Position Vacant*	2/1/2013	11/24/2013	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
ARIZONA—*Appointed, at the pleasure of the Governor, with the consent of the Arizona State Senate*					
Director, Department of Insurance & Financial Institutions (DIFI)	Barbara D. Richardson	8/30/2024		incumbent	
Cabinet Executive Officer, DIFI	Barbara D. Richardson	9/25/2023	8/30/2024	0	1
Director, DIFI	Barbara D. Richardson	3/6/2023	9/24/2023	0	6
Acting Director, DIFI	Shane W. Foster	1/13/2023	3/5/2023	0	2
Director, DIFI	*Position Vacant*	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

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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
ARIZONA—*Continued*					
Insurance Director	Chris Herstam	1/1/1994	8/1/1996	2	7
Insurance Director	Susan Gallinger	5/1/1988	12/31/1993	5	7
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
ARKANSAS—*Appointed, at the pleasure of the Governor, with the advice and consent of the Senate*					
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. 'Bob' 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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
ARKANSAS—*Continued*					
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
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 (*Died June 20, 1913*)	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 (*Died Nov. 29, 1887*)	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
CALIFORNIA—*Elected; 4-year term (not to exceed two 4-year terms)*					
Insurance Commissioner	Ricardo Lara *(Elected Nov. 6, 2018; Re-elected Nov. 8, 2022)*	1/7/2019		incumbent	
Insurance Commissioner	David E. 'Dave' Jones *(Elected Nov. 2, 2010; Re-elected Nov. 4, 2014)*	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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
CALIFORNIA—*Continued*					
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
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
COLORADO—*Appointed, at the pleasure of the Governor; subject to confirmation by the Senate*					
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	*Position Vacant*	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	7/1/1989	10/1/1989	0	3
Insurance Commissioner	John Kezer	2/5/1985	7/1/1989	4	5
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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
Superintendent of Insurance	Charles W. Crouter	6/1/1901	6/1/1903	2	0
COLORADO—*Continued*					
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
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
CONNECTICUT—*Appointed, at the pleasure of the Governor with the advice and consent of either house of the General Assembly; 4-year term*					
Insurance Commissioner	Andrew N. 'Andy' Mais* (*Reappointed Jan. 4, 2023*)	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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
Acting Insurance Commissioner	John S. Seymour	3/3/1893	4/11/1893	0	1
CONNECTICUT—*Continued*					
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
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
DELAWARE—*Elected; 4-Year Term*					
Insurance Commissioner	Trinidad Navarro *(Elected Nov. 8, 2016; Re-elected Nov. 3, 2020; Re-elected Nov. 5, 2024)*	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 (*Died July 24, 1922*)	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 (*Died Feb. 27, 1885*)	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
DISTRICT OF COLUMBIA—*Appointed, at the pleasure of the Mayor; confirmed by the Council of District Columbia*					
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

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STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
Interim Commissioner, DISB	Chester A. McPherson	11/15/2013	4/20/2014	0	5
DISTRICT OF COLUMBIA—*Continued*					
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
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 (*Died Oct. 21, 2020*)	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 (*Died Nov. 7, 1978*)	11/24/1973	11/7/1978	4	10
Acting Superintendent of Insurance	Maximilian 'Max' Wallach (*Died Nov. 7, 1978*)	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 (*Died July 22, 1939*)	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 (*Died July 23, 1910*)	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 (*Died May 21, 1887*)	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

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FLORIDA—*Appointed, at the Pleasure of the Financial Services Commission*					
Insurance Commissioner	Michael Yaworsky	3/13/2023		incumbent	
Interim Insurance Commissioner	Michael Yaworsky	2/10/2023	2/13/2023	0	1
Insurance Commissioner	*Position Vacant*	12/29/2022	2/9/2023	0	2
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* (*Died April 8, 2024*)	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* (*Died Jan. 24, 1965*)	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* (*Died Sept. 26, 1928*)	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 (*Died Dec. 24, 1891*)	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
FLORIDA (Department of Financial Services)—*Elected; 4-Year Term*					
Chief Financial Officer	Jimmy T. Patronis, Jr. (*Appointed June 25, 2017; Elected Nov. 6, 2018; Re-elected Nov. 8, 2022*)	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
GEORGIA—*Elected; 4-Year Term*					
Insurance Commissioner	John F. King *(Appointed June 12, 2019; Elected Nov. 8, 2022)*	7/1/2019		incumbent	
Insurance Commissioner	*Position Vacant*	5/17/2019	6/30/2019	0	1
Insurance Commissioner	Jim Beck (*Suspended May 16, 2019*)	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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	EG DATE	ND DATE	RS SERVED	OS SERVED
Ins. Commissioner/Comptroller General	Johnnie L. Caldwell*	1/12/1971	11/1/1985	14	0
GEORGIA—*Continued*					
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
Ins. Commissioner/Comptroller General	Homer C. Parker (*Died June 22, 1946*)	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 (*Died June 3, 1940*)	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 (*Died Sept. 13, 1929*)	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
GUAM—*Appointed, at the pleasure of the Governor*					
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

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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
GUAM—*Continued*					
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
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 (*Died March 26, 1979*)	3/6/1961	1/1/1964	2	10
Director of Finance/Insurance Commissioner	Richard F. 'Dick' Taitano (*Died Jan. 4, 1997*)	6/8/1959	3/6/1961	0	9
HAWAII—*Appointed, at the pleasure of the Director of Commerce and Consumer Affairs; approved by the Governor*					
Insurance Commissioner	Gordon I. Ito	12/16/2022		incumbent	
Insurance Commissioner	Colin M. Hayashida (*Died Feb. 28, 2023*)	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 (Died April 6, 2024)	3/1/1999	11/1/2002	3	8
Insurance Commissioner	Rey Graulty	2/4/1997	3/1/1999	2	1
Insurance Commissioner	Wayne C. Metcalf (Died April 6, 2024)	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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
HAWAII—*Continued*					
Insurance Commissioner	A. J. Campbell	1/1/1907	7/1/1909	2	6
Insurance Commissioner	A. N. Keooikai	1/1/1903	1/1/1907	4	0
IDAHO—*Appointed; 4-year term, subject to earlier removal by the Governor*					
Insurance Director	Dean L. Cameron (*Reappointed March 19, 2019; Reappointed January 6, 2023*)	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
ILLINOIS—*Appointed, at the Pleasure of the Governor*					
Acting Insurance Director	Ann Gillespie	4/15/2024		incumbent	
Insurance Director	Dana Popish Severinghaus (*Reappointed Feb. 3, 2023*)	2/22/2022	4/14/2024	2	2
Acting Insurance Director	Dana Popish Severinghaus	1/19/2021	2/22/2022	1	1

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
ILLINOIS—*Continued*					
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
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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
ILLINOIS—*Continued*					
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. Vredenburgh	5/2/1903	1/1/1907	3	8
Insurance Superintendent	Henry Yates (*Died May 1, 1903*)	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

INDIANA—*Appointed, at the Pleasure of the Governor*					
Insurance Commissioner	Holly W. Lambert	10/16/2024		incumbent	
Insurance Commissioner	Amy L. Beard	6/2/2021	10/15/2024	3	4
Insurance Commissioner	Stephen W. 'Steve' Robertson	10/13/2010	6/1/2021	10	8
Acting Insurance Commissioner	Stephen W. 'Steve' Robertson **NOTE**: 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 (*Died Sept. 6, 2010*)	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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
INDIANA—*Continued*					
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
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
IOWA—*Appointed, at the Pleasure of the Governor; 4-Year Term*					
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. 'Bill' 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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
IOWA—*Continued*					
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
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
KANSAS—*Elected; 4-Year Term*					
Insurance Commissioner	Vicki Schmidt *(Elected Nov. 6, 2018* *Re-elected Nov. 8, 2022)*	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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
KENTUCKY—*Appointed, at the Pleasure of the Governor*					
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
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. Koetters	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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
KENTUCKY—*Continued*					
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
LOUISIANA—*Elected; 4-Year Term*					
Insurance Commissioner	Timothy J. 'Tim' Temple (*Elected Oct. 14, 2023*)	1/8/2024		incumbent	
Insurance Commissioner	James J. 'Jim' Donelon* *(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)*	2/15/2006	1/8/2024	17	10
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 (*Died March 9, 1915*)	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	*No Record in NAIC Proceedings*	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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
Secretary of State	*No Record in NAIC Proceedings*	4/16/1872	8/27/1878	6	4
LOUISIANA—*Continued*					
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
MAINE—*Appointed; 5-Year Term*					
Acting Insurance Superintendent	Robert L. 'Bob' Carey	2/27/2024		incumbent	
Acting Insurance Superintendent	Timothy N. Schott	4/1/2022	2/27/2024	1	10
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
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 miliary 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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
MARYLAND—*Appointed, at the Pleasure of the Governor; 4-Year Term*					
Acting Insurance Commissioner	Marie L. Grant	10/1/2024		incumbent	
Interim Insurance Commissioner	Joy Y. Hatchette	7/1/2024	9/30/2024	0	3
Insurance Commissioner	Kathleen A. Birrane	5/18/2020	6/30/2024	4	1
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
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	5/1/989	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 (*Died Aug. 17, 1952*)	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 (*Died Feb. 8, 1929*)	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* (*Died Nov. 8, 1910*)	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 *(Died Sept. 20, 1889)*	2/1/1877	9/20/1889	12	7

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
MARYLAND—*Continued*					
Insurance Commissioner	John M. Miller	4/29/1876	1/31/1877	0	9
Insurance Commissioner	*Position Vacant*	1/31/1876	4/29/1876	0	3
Insurance Commissioner	Charles A. Wailes (*Died Jan. 31, 1876*)	1/1/1872	1/31/1876	4	1
Chief Clerk of the Treasury and Superintendent of Insurance	Charles A. Wailes *(Died Jan. 31, 1876)*	5/24/1871	1/1/1872	0	7
MASSACHUSETTS—*Appointed, at the Discretion of the Governor*					
Insurance Commissioner	Michael T. Caljouw	10/30/2024		incumbent	
Acting Insurance Commissioner	Kevin P. Beagan	6/10/2024	10/29/2024	0	4
Acting Insurance Commissioner	Rachel M. Davison	4/15/2024	6/7/2024	0	2
Insurance Commissioner	Gary D. Anderson	10/31/2017	4/14/2024	6	6
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
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

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STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
MICHIGAN—*Appointed, at the Pleasure of the Governor; 4-Year Term*					
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
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 D. 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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
MICHIGAN—*Continued*					
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
MINNESOTA—*Appointed, at the Pleasure of the Governor; Confirmed by the Senate*					
Commissioner of Commerce	Grace Arnold (*Reappointed Jan. 2, 2023; Confirmed Feb. 16, 2023*)	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
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	*Position Vacant*	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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
MINNESOTA—*Continued*					
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
MISSISSIPPI—*Elected; 4-Year Term*					
Commissioner of Insurance	Michael J. 'Mike' Chaney *(Elected Nov. 6, 2007; Re-elected Nov. 8, 2011; Re-elected Nov. 3, 2015; Re-elected Nov. 5, 2019; Re-elected Nov. 7, 2023)*	1/10/2008		incumbent	
Commissioner of Insurance	George Dale	1/1/1976	1/10/2008	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* (*Died Jan. 29, 1944*)	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 (*Died June 18, 1935*)	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
MISSOURI—*Appointed, at the Pleasure of the Governor; Confirmed by the Senate*					
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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
MISSOURI—*Continued*					
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. 'Lew' 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
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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
MISSOURI—*Continued*					
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
MONTANA—*Elected; 4-Year Term*					
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
Cmsr. of Securities and Insurance / State Auditor	John Morrison (*Elected Nov. 7, 2000; Re-elected Nov. 2, 2004*)	1/1/2001	1/5/2009	8	0
Cmsr. of Insurance/State Auditor	Mark D. O'Keefe (*Elected Nov. 3, 1992; Re-elected Nov. 5, 1996*)	1/4/1993	1/1/2001	8	0
Cmsr. of Insurance/State Auditor	Andrea M. 'Andy' Bennett (*Elected Nov. 6, 1984 Re-elected Nov. 8, 1988*)	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 (*Died May 12, 1962*)	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 (*Died June 23, 1917*)	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
NEBRASKA—*Appointed, at the Pleasure of the Governor*					
Director of Insurance	Eric Dunning (*Appointed April 19, 2021; Reappointed Jan. 5, 2023*)	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 (*Died Oct. 9, 2007*)	1/7/1999	10/9/2007	8	9
Director of Insurance	Timothy J. Hall	1/3/1998	1/7/1999	1	0

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
NEBRASKA—*Continued*					
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
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 Wallichs	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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
NEVADA—*Appointed, at the Pleasure of the Director of the Department of Business and Industry*					
Insurance Commissioner	Scott J. Kipper	2/27/2023		Incumbent	
Interim Insurance Commissioner	Nick Stosic	1/6/2023	2/26/2023	0	1
Insurance Commissioner	*Position Vacant*	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
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* (*Died April 21, 1965*)	4/1/1951	4/21/1965	14	1
Deputy Controller	Paul A. Hammel* (*Died April 21, 1965*)	1/1/1951	4/1/1951	0	3
State Comptroller	Jerome P. 'Jerry' Donovan	12/1/1947	1/1/1951	3	5
State Comptroller	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
NEW HAMPSHIRE—*Appointed, 5-Year Term; Nominated by the Governor; Approved by the Executive Council*					
Insurance Commissioner	David J. 'D.J.' Bettencourt	9/20/2023		incumbent	
Acting Insurance Commissioner	David J. 'D.J.' Bettencourt	7/5/2023	9/20/2023	0	2
Insurance Commissioner	Christopher R. 'Chris' Nicolopoulos	2/19/2020	7/4/2023	3	5
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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
NEW HAMPSHIRE—*Continued*					
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 (*Died Sept. 6, 1937*)	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 (*Died May 8, 1923*)	4/2/1919	5/8/1923	4	1
Insurance Commissioner	Rufus N. Elwell (*Died Feb. 9, 1919*)	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* *(Died Sept. 19, 1905)*	9/25/1890	9/19/1905	15	0
Insurance Commissioner	Henry H. Huse	3/14/1888	9/7/1890	2	6
Insurance Commissioner	Oliver Pillsbury* (*Died Feb. 21, 1888*)	5/24/1871	2/21/1888	16	9
NEW JERSEY—*Appointed, at the Pleasure of the Governor, with the Advice and Consent of the Senate*					
Cmsr. of Banking and Ins.	Justin Zimmerman	11/4/2024		incumbent	
Acting Cmsr. of Banking and Ins.	Justin Zimmerman	6/27/2023	11/4/2024	1	5
Cmsr. of Banking and Insurance	Marlene Caride	6/27/2018	6/26/2023	5	0
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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
NEW JERSEY—*Continued*					
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
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. (*Died Feb. 11, 1923*)	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	*No Record in Proceedings* (Represented by Actuary David P. Fackler)	9/20/1881	8/20/1890	8	11
Secretary of State	Henry C. Kelsey	5/24/1871	4/1/1881	9	11
NEW MEXICO—*Appointed, by the Insurance Nominating Committee; 4-Year Term*					
Superintendent of Insurance	Alice T. Kane	6/12/2023		incumbent	
Interim Superintendent of Insurance	Jennifer A. Catechis	1/21/2023	6/11/2023	0	5
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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
NEW MEXICO—*Continued*					
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
Superintendent of Insurance	John H. Sloan	1/19/1906	3/19/1907	1	2
Superintendent of Insurance	Pedro Perea (*Died Jan. 11, 1906*)	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

NEW YORK—*Appointed, at the Pleasure of the Governor*					
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. Lawsky	10/3/2011	6/17/2015	3	8
Superintendent of Insurance	James J. 'Jim' Wrynn	9/11/2009	10/3/2011	2	1
Acting Superintendent of Insurance	James J. 'Jim' 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

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STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
NEW YORK—*Continued*					
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 (*Died Sept. 11, 2001*)	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
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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
NEW YORK—*Continued*					
Superintendent of Insurance	George W. Miller*	5/24/1871	5/12/1872	1	0
NORTH CAROLINA—*Elected; 4-Year Term*					
Commissioner of Insurance	Mike Causey *(Elected Nov. 8, 2016; Re-elected Nov. 3, 2020; Re-elected Nov. 5, 2024)*	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
Secretary of State	*No Record in Proceedings* (Represented by Special Delegate William H. Finch)	10/1/1871	1/1/1873	1	3
NORTH DAKOTA—*Elected; 4-Year Term*					
Commissioner of Insurance	Jon Godfread* *(Elected Nov. 8, 2016; Re-elected Nov. 3, 2020 Re-elected Nov. 5, 2024)*	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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
Commissioner of Insurance	Ferdinand 'Ferd' Leutz	1/1/1901	12/31/1904	4	0
NORTH DAKOTA—*Continued*					
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
NORTHERN MARIANA ISLANDS—*Appointed, Concurrent with Current Governor*					
Secretary of Commerce	Remedio C. 'Remy' Mafnas	8/8/2024		Incumbent	
Acting Secretary of Commerce	Remedio C. 'Remy' Mafnas	5/10/2024	8/8/2024	0	3
Acting Secretary of Commerce	Francisco D. 'Frank' Cabrera	3/20/2024	5/9/2024	0	2
Acting Secretary of Commerce	Remedio C. 'Remy' Mafnas	11/13/2023	3/19/2024	0	4
Acting Secretary of Commerce	Francisco D. 'Frank' Cabrera	4/26/2023	11/12/23	0	7
Acting Secretary of Commerce	Joseph Rios Jr.	2/1/2023	4/25/2023	0	2
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
OHIO—*Appointed, at the Pleasure of the Governor; Confirmed by the Senate*					
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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
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
OHIO—*Continued*					
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
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
OKLAHOMA—*Elected; 4-Year Term*					
Insurance Commissioner	Glen Mulready (*Elected Nov. 6, 2018; Re-elected Nov. 8, 2022*)	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	*Position Vacant*	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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
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
OKLAHOMA—*Continued*					
Insurance Commissioner	Donald F. Dickey	7/21/1946	6/1/1954	7	11
Insurance Commissioner	Jess G. Read* (*Died July 20, 1946*)	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
OREGON—*Appointed, Indefinite*					
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
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 *(exp. 1/1/2003)*	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 Guilfoy	10/1/1993	12/1/1993	0	2
Insurance Commissioner	Gary Weeks	3/1/1991	10/1/1993	2	7
Acting Insurance Commissioner	Geoff Guilfoy	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

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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
OREGON—*Continued*					
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
PENNSYLVANIA—*Appointed, by the Governor with the Advice and Consent of the Senate*					
Insurance Commissioner	Michael M. 'Mike' Humphreys	6/26/2023		incumbent	
Acting Insurance Commissioner	Michael M. 'Mike' Humphreys	2/26/2022	6/26/2023	1	4
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
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

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STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
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
PENNSYLVANIA—*Continued*					
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 (*Died July 23, 1942*)	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 (*Died Feb. 4, 1934*)	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
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

PUERTO RICO—*Appointed, Indefinite*					
Commissioner of Insurance	Alexander S. Adams Vega	12/20/2021		incumbent	
Commissioner of Insurance	*Position Vacant*	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

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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
PUERTO RICO—*Continued*					
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 (*Died June 13, 1957*)	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
RHODE ISLAND—*Appointed, at the Discretion of the Director of Business Regulation*					
Director, Department of Business Regulation (DBR)	Elizabeth 'Beth' Kelleher Dwyer	5/16/2023		incumbent	
Superintendent of Banking and Insurance	Elizabeth 'Beth' Kelleher Dwyer	1/11/2016	5/16/2023	7	4
Deputy Director/Superintendent of Banking and Insurance	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. Petrarca	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
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 (*Died Dec. 21, 1916*)	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

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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
SOUTH CAROLINA—*Appointed, by the Governor upon the Advice and Consent of the Senate*					
Director of Insurance	Michael Wise (*Appointed April 26, 2023; Confirmed May 11, 2023)*	5/11/2023		incumbent	
Acting Director of Insurance	Michael Wise	4/16/2022	5/11/2023	1	1
Director of Insurance	Raymond G. 'Ray' Farmer* (*Appointed Nov. 12, 2012; Confirmed Feb. 14, 2013; Reappointed Dec. 12, 2018*)	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 (*Appointed Jan. 20, 2011; Confirmed Feb. 3, 2011*)	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
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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
SOUTH CAROLINA—*Continued*					
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
SOUTH DAKOTA—*Appointed, at the Pleasure of the Secretary of the Department of Labor and Regulation*					
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
Acting Director of Insurance	Jeff Stingley	5/13/1987	7/6/1987	0	2
Director of Insurance	Susan L. Walker	8/30/1983	5/13/1987	3	8
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 (*Died Nov. 15, 1960*)	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 (*Died May 23, 1944*)	3/1/1940	5/23/1944	4	3
Commissioner of Insurance	P. J. Dunn	7/1/1937	3/1/1940	2	8
Commissioner of Insurance	William J. 'Bill' Dawson (*Died Nov. 15, 1960*)	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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
SOUTH DAKOTA—*Continued*					
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
TENNESSEE—*Appointed, at the Discretion of the Governor*					
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 (*Died Nov. 27, 1952*)	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
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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
TENNESSEE—*Continued*					
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
TEXAS—*Appointed; 2-Year Term*					
Insurance Commissioner	Cassandra J. 'Cassie' Brown (*Reappointed Feb. 3, 2023*)	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	*Position Vacant*	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	Thomas J. '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
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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
TEXAS—*Continued*					
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 Rosenburg	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
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
UTAH—*Appointed, at the Pleasure of the Governor; Confirmed by the Senate*					
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

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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
UTAH—*Continued*					
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
VERMONT—*Appointed, Biennially by the Governor with the Advice and Consent of the Senate*					
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
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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
VERMONT—*Continued*					
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
U.S. VIRGIN ISLANDS—*Elected; 4-Year Term*					
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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
U.S. VIRGIN ISLANDS—*Continued*					
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
VIRGINIA—*Appointed, at the Pleasure of the State Corporation Commission*					
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	
Auditor of Public Accounts	*Research Proceedings*	4/1/1872	1879	7	
Special Delegate for Auditor	Edward M. Alfriend	10/18/1871	4/1/1872	0	6
WASHINGTON—*Elected; 4-Year Term*					
Insurance Commissioner	Mike Kreidler *(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)*	1/10/2001		incumbent	

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
WASHINGTON—*Continued*					
Insurance Commissioner	Deborah M. Senn (*Elected Nov. 3, 1992*; *Re-elected Nov. 5, 1996*)	1/13/1993	1/10/2001	8	0
Insurance Commissioner	Richard G. 'Dick' Marquardt (*Elected Nov. 2, 1976*; *Re-elected Nov. 4, 1980*; *Re-elected Nov. 6, 1984*; *Re-elected Nov. 8, 1988*)	1/12/1977	1/13/1993	16	0
Insurance Commissioner	Karl V. Herrmann (*Elected Nov. 5, 1968; Re-elected Nov. 7, 1972*)	1/15/1969	1/12/1977	8	0
Insurance Commissioner	Lee I. Kueckelhan* (*Elected Nov. 8, 1960; Re-elected Nov. 3, 1964*)	1/1/1961	1/15/1969	8	0
Insurance Commissioner	William A. Sullivan* (*Elected Nov. 8, 1932; Re-elected Nov. 3, 1936; Re-elected Nov. 5, 1940; Re-elected Nov. 7, 1944; Re-elected Nov. 2, 1948; Re-elected Nov. 4, 1952; Re-elected Nov. 6, 1956*)	1/11/1933	1/1/1961	28	0
Insurance Commissioner	Herbert O. Fishback* (*Elected Nov. 5, 1912; Re-elected Nov. 7, 1916; Re-elected Nov. 2, 1920; Re-elected Nov. 4, 1924: Re-elected Nov. 6, 1928*)	1/13/1913	1/11/1933	20	0
Insurance Commissioner	John H. Schively (*Elected Nov. 3, 1908*)	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
WEST VIRGINIA—*Appointed, at the Pleasure of the Governor*					
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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
WEST VIRGINIA—*Continued*					
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
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
WISCONSIN—*Appointed, at the Pleasure of the Governor*					
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	*Position Vacant*	1/1/1993	3/7/1993	0	2
Insurance Commissioner	Robert D. 'Bob' 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. 'Bob' 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

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Insurance Commissioner	Platt Whitman*	4/10/1919	7/17/1923	4	3
WISCONSIN—*Continued*					
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
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
WYOMING—*Appointed, at the Pleasure of the Governor*					
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

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

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
State Auditor	Mortimer N. Grant	7/10/1890	11/8/1890	0	4
WYOMING—*Continued*					
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: 10/30/2024

https://naiconline.sharepoint.com/teams/memberservicesexecutive/shared documents/commissioner/tenure/_tenure_list_master.docx

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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.

Mtg	Date	Meeting Site	President	Vice-President	Secretary / Secretary-Treasurer
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[1]	Samuel H. Cross, RI[1]	Jacob A. McEwen, OH[1]
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[2]
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[3]	Stephen W. Carr, ME[3]	Frederick L. 'Fred' Cutting, MA
28	9/7–8/1897	Old Point Comfort, VA	Stephen W. Carr, ME[4]	Stephen W. Carr, ME[4]	John J. Brinkerhoff, IL[5]
29	9/1898	Milwaukee, WI	Stephen W. Carr, ME	William A. Fricke, WI	John J. Brinkerhoff, IL[6]
30	9/1899	Detroit, MI	Edward T. Orear, MO[7]	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[8]	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[9]	Harry R. Cunningham, MT
43	7/1912	Spokane, WA	Fred W. Potter, IL	Frank H. Hardison, MA	Fitz Hugh McMaster, SC[10]
44	7/1913	Burlington, VT	Frank H. Hardison, MA	1st James R. Young, NC 2nd Willard Done, UT	Fitz Hugh McMaster, SC
45	9/1914	Asheville, NC	James R. Young, NC	1st Willard Done, UT[11] 2nd John S. Darst, WV	Fitz Hugh McMaster, SC
46	9/1915	Del Monte, CA	John S. Darst, WV	1st Burton Mansfield, CT 2nd John T. Winship, MI	Fitz Hugh McMaster, SC
47	9/1916	Richmond, VA	Burton Mansfield, CT	1st John T. Winship, MI 2nd W. C. Taylor, ND	Fitz Hugh McMaster, SC
48	8/1917	St. Paul, MN	Jesse S. Phillips, NY	1st John T. Winship, MI 2nd Emory H. English, IA	Fitz Hugh McMaster, SC
49	9/1918	Denver, CO	Michael J. 'Mike' Cleary, WI[12]	1st Robert J. Merrill, NH[12] 2nd Walter K. Chorn, MO[12]	Joseph L. Button, VA[13]
50	9/1919	Hartford, CT	Claude W. Fairchild, CO	1st Joseph G. Brown, VT 2nd Frank H. Ellsworth, MI	Joseph L. Button, VA
51	9/1920	Beverly Hills, CA	Joseph G. Brown, VT	1st Frank H. Ellsworth, MI 2nd Alfred L. Harty, MO[14]	Joseph L. Button, VA
52	9/1921	Louisville, KY	Alfred L. Harty, MO[15]	1st Thomas B. Donaldson, PA[15] 2nd Platt Whitman, WI[15]	Joseph L. Button, VA
53	9/1922	Swampscott, MA	Thomas B. Donaldson, PA	1st Platt Whitman, WI 2nd Herbert. O. Fishback, WA	Joseph L. Button, VA
54	8/1923	Minneapolis, MN	Herbert O. Fishback, WA[16]	1st. John C. Luning, FL[16] 2nd John C. Luning, FL[16]	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

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Mtg	Date	Meeting Site	President	Vice-President	Secretary / Secretary-Treasurer
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[17]	1st T. M. Henry, MA 2nd Thomas M. Baldwin, Jr., DC	Joseph L. Button, VA
58	9/1927	Cincinnati, OH	Albert S. Caldwell, TN[18]	1st James A. Beha, NY[18] 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[19]	1st Clarence C. Wysong, IN[19] 2nd Jess G. Read, OK[19]	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[20]
62	9/1931	Portland, OR	Jess G. Read, OK[21]	1st Charles D. Livingston, MI[21] 2nd William A. Tarver, TX [21]	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[22]	1st Daniel C. 'Dan' Boney, NC[22] 2nd George S. Van Schaick, NY[22]	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[23] 2nd Merton L. Brown, MA[23]	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[24]	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[25]	Jess G. Read, OK
78	6/1947	Atlantic City, NJ	Robert E. Dineen, NY	Seth B. Thompson, OR	Nellis P. Parkinson, IL[26]
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[27]	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[28]
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[29]	Sam N. Beery, CO[29]	J. Edwin Larson, FL
Reg.	11/30-12/4/1959	Miami Beach, FL	Paul A. Hammel, NV	Sam N. Beery, CO	Alfred N. Premo, CT
91	5/30–6/3/1960	San Francisco, CA	Paul A. Hammel, NV	Sam N. Beery, CO	Alfred N. Premo, CT
Reg.	11/28-12/2/1960	New York, NY	Sam N. Beery, CO	T. Nelson Parker, VA	Alfred N. Premo, CT
92	6/5–9/1961	Philadelphia, PA	Sam N. Beery, CO	T. Nelson Parker, VA	Alfred N. Premo, CT
Reg.	12/4–8/1961	Dallas, TX	T. Nelson Parker, VA	Rufus D. Hayes, LA	Harvey G. Combs, AR
93	6/18–22/1962	Montreal, Canada	T. Nelson Parker, VA	Rufus D. Hayes, LA	Harvey G. Combs, AR
Reg.	12/3–7/1962	Chicago, IL	Rufus D. Hayes, LA	Joseph S. Gerber, IL	Harvey G. Combs, AR
94	6/17–21/1963	Seattle, WA	Rufus D. Hayes, LA	Joseph S. Gerber, IL[30]	Harvey G. Combs, AR
Reg.	12/2–6/1963	Phoenix, AZ	Lee I. Kueckelhan, WA	Cyrus E. Magnusson, MN	Ralph F. Apodaca, NM
95	6/8–12/1964	Minneapolis, MN	Lee I. Kueckelhan, WA	Cyrus E. Magnusson, MN	Ralph F. Apodaca, NM
Reg.	11/30-12/4/1964	Las Vegas, NV	Cyrus E. Magnusson, MN	William E. Timmons, IA	Ralph F. Apodaca, NM
96	6/7–11/1965	New York, NY	Cyrus E. Magnusson, MN	William E. Timmons, IA	Ralph F. Apodaca, NM
Reg.	11/29-12/3/1965	Miami Beach, FL	William E. Timmons, IA	Frank J. Barrett, NE	Ralph F. Apodaca, NM
97	6/19–24/1966	Richmond, VA	William E. Timmons, IA	Frank J. Barrett, NE	Ralph F. Apodaca, NM
Reg.	12/4–9/1966	Dallas, TX	Frank J. Barrett, NE	James L. Bentley, GA	Ralph F. Apodaca, NM
98	6/11–16/1967	Boston, MA	Frank J. Barrett, NE	James L. Bentley, GA	Ralph F. Apodaca, NM
Reg.	12/3–8/1967	Honolulu, HI	James L. Bentley, GA	Charles R. Howell, NJ	Ralph F. Apodaca, NM
99	6/16–21/1968	Portland, OR	James L. Bentley, GA	Charles R. Howell, NJ	Ralph F. Apodaca, NM
Reg.	12/1–6/1968	Los Angeles, CA	Charles R. Howell, NJ[31]	Ned Price, TX	Ralph F. Apodaca, NM

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Mtg	Date	Meeting Site	President	Vice-President	Secretary / Secretary-Treasurer
100	6/16–20/1969	Philadelphia, PA	Ned Price, TX	Richard E. 'Dick' Stewart, NY	Ralph F. Apodaca, NM
Reg.	12/1–5/1969	New Orleans, LA	Ned Price, TX	Richard E. 'Dick' Stewart, NY	Ralph F. Apodaca, NM
101	6/15–19/1970	Cleveland, OH	Ned Price, TX	Richard E. 'Dick' Stewart, NY	Ralph F. Apodaca, NM
Reg.	12/14–18/1970	Chicago, IL	Richard E. 'Dick' Stewart, NY[32]	Lorne R. Worthington, IA	Ralph F. Apodaca, NM
102	6/14–18/1971	New York, NY	Lorne R. Worthington, IA	Richards D. 'Dick' Barger, CA	Ralph F. Apodaca, NM
Reg.	11/28-12/3/1971	Miami Beach, FL	Richards D. 'Dick' Barger, CA	Russell E. Van Hooser, MI	Ralph F. Apodaca, NM
103	6/12–16/1972	Denver, CO	Richards D. 'Dick' Barger, CA	Russell E. Van Hooser, MI	Ralph F. Apodaca, NM
Reg.	12/3–8/1972	Atlanta, GA	Russell E. Van Hooser, MI	W. Fletcher Bell, KS	Ralph F. Apodaca, NM
104	6/4–8/1973	Washington, DC	Russell E. Van Hooser, MI	W. Fletcher Bell, KS	Ralph F. Apodaca, NM
Reg.	12/2–7/1973	Las Vegas, NV	W. Fletcher Bell, KS	Johnnie L. Caldwell, GA	Ralph F. Apodaca, NM
105	6/2–7/1974	San Francisco, CA	W. Fletcher Bell, KS	Johnnie L. Caldwell, GA	Ralph F. Apodaca, NM
Reg.	12/1–6/1974	Mexico City, Mexico	Johnnie L. Caldwell, GA[33]	Kenneth E. 'Ken' DeShetler, OH[34]	Ralph F. Apodaca, NM
106	6/8–12/1975	Seattle, WA	William H. Huff III, IA[34]	Richard L. 'Dick' Rottman, NV	Ralph F. Apodaca, NM
Reg.	12/7–11/1975	San Juan, PR	William H. Huff III, IA	Richard L. 'Dick' Rottman, NV	Ralph F. Apodaca, NM
107	6/7–11/1976	New Orleans, LA	Richard L. 'Dick' Rottman, NV	Lester L. Rawls, OR	Ralph F. Apodaca, NM
Reg.	12/6–10/1976	Phoenix, AZ	Richard L. 'Dick' Rottman, NV	Lester L. Rawls, OR	Ralph F. Apodaca, NM
108	6/5–10/1977	Minneapolis, MN	Lester L. Rawls, OR	Harold B. McGuffey, KY	Elmer V. Omholt, MT
Reg.	12/4–9/1977	Miami Beach, FL	Lester L. Rawls, OR	Harold B. McGuffey, KY	Elmer V. Omholt, MT
109	6/11–16/1978	Washington, DC	Harold B. McGuffey, KY	H. Peter 'Pete' Hudson, IN	Elmer V. Omholt, MT
Reg.	12/3–8/1978	Las Vegas, NV	Harold B. McGuffey, KY	H. Peter 'Pete' Hudson, IN	Elmer V. Omholt, MT
110	6/3–8/1979	Chicago, IL	H. Peter 'Pete' Hudson, IN	Wesley J. Kinder, CA	Elmer V. Omholt, MT
Reg.	12/2–7/1979	Los Angeles, CA	H. Peter 'Pete' Hudson, IN[35]	Wesley J. Kinder, CA	Elmer V. Omholt, MT
111	6/15–20/1980	Denver, CO	Wesley J. Kinder, CA	William H. L. Woodyard III, AR	Elmer V. Omholt, MT
Reg.	11/30-12/5/1980	New York, NY	Wesley J. Kinder, CA	William H. L. Woodyard III, AR	Elmer V. Omholt, MT
112	6/7–12/1981	Detroit, MI	William H. L. Woodyard, AR	John W. Lindsay, SC[36]	Elmer V. Omholt, MT
Reg.	12/13–18/1981	New Orleans, LA	William H. L. Woodyard, AR	Johnnie L. Caldwell, GA[36]	Elmer V. Omholt, MT
113	6/6–11/1982	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	11/28-12/3/1982	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	6/12–17/1983	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	12/4–9/1983	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	6/3–8/1984	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	12/9–14/1984	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. 'Jo' Driscoll, OR	Elmer V. Omholt, MT
119	6/9–14/1985	Kansas City, MO	Bruce W. Foudree, IA	Josephine M. 'Jo' Driscoll, OR	Elmer V. Omholt, MT
Zone	9/1985	Syracuse, NY	Bruce W. Foudree, IA	Josephine M. 'Jo' Driscoll, OR	Elmer V. Omholt, MT
120	12/8–12/1985	Reno, NV	Bruce W. Foudree, IA	Josephine M. 'Jo' 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	6/8–12/1986	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	12/7–11/1986	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	6/21–26/1987	Chicago, IL	Edward J. Muhl, MD	John E. Washburn, IL	W. Fletcher Bell, KS
Zone	9/13–16/1987	Pittsburgh, PA	Edward J. Muhl, MD	John E. Washburn, IL	W. Fletcher Bell, KS
124	12/6–11/1987	Phoenix, AZ	Edward J. Muhl, MD	John E. Washburn, IL	W. Fletcher Bell, KS
Zone	3/13–15/1988	Santa Fe, NM	John E. Washburn, IL	David A. Gates, NV	W. Fletcher Bell, KS
125	6/12–17/1988	New York, NY	John E. Washburn, IL	David A. Gates, NV	W. Fletcher Bell, KS
Zone	9/18-20/1988	Mackinac Island, MI	John E. Washburn, IL	David A. Gates, NV	W. Fletcher Bell, KS
126	12/11–16/1988	New Orleans, LA	John E. Washburn, IL	David A. Gates, NV	W. Fletcher Bell, KS
Zone	3/19-21/1989	Little Rock, AR	David A. Gates, NV	Earl R. Pomeroy, ND	W. Fletcher Bell, KS
127	6/4–8/1989	Cincinnati, OH	David A. Gates, NV	Earl R. Pomeroy, ND	W. Fletcher Bell, KS
Zone	9/10–12/1989	Wilmington, DE	David A. Gates, NV	Earl R. Pomeroy, ND	W. Fletcher Bell, KS
128	12/3–7/1989	Las Vegas, NV	David A. Gates, NV	Earl R. Pomeroy, ND	W. Fletcher Bell, KS
Zone	3/25–27/1990	Salt Lake City, UT	Earl R. Pomeroy, ND	James E. 'Jim' Long, NC	W. Fletcher Bell, KS
129	6/3–7/1990	Baltimore, MD	Earl R. Pomeroy, ND	James E. 'Jim' Long, NC	W. Fletcher Bell, KS
Zone	9/8–11/1990	Kansas City, MO	Earl R. Pomeroy, ND	James E. 'Jim' Long, NC	W. Fletcher Bell, KS
130	12/2–6/1990	Louisville, KY	Earl R. Pomeroy, ND	James E. 'Jim' Long, NC	W. Fletcher Bell, KS
Zone	4/13-16/1991	Charleston, WV	James E. 'Jim' Long, NC	William H. 'Bill' McCartney, NE	Robin Campaniano, HI
131	6/9–13/1991	Indianapolis, IN	James E. 'Jim' Long, NC	William H. 'Bill' McCartney, NE	Robin Campaniano, HI
Zone	9/14–17/1991	Pittsburgh, PA	James E. 'Jim' Long, NC	William H. 'Bill' McCartney, NE	Robin Campaniano, HI
132	12/9–12/1991	Houston, TX	James E. 'Jim' Long, NC	William H. 'Bill' McCartney, NE	Robin Campaniano, HI
Zone	3/28–31/1992	Seattle, WA	William H. 'Bill' McCartney, NE	Steven T. Foster, VA	David J. Walsh, AK
133	6/7–11/1992	Washington, DC	William H. 'Bill' McCartney, NE	Steven T. Foster, VA	David J. Walsh, AK
Zone	9/20–22/1992	Cincinnati, OH	William H. 'Bill' McCartney, NE	Steven T. Foster, VA	David J. Walsh, AK
134	12/6–9/1992	Atlanta, GA	William H. 'Bill' McCartney, NE	Steven T. Foster, VA	David J. Walsh, AK
Zone	3/7–9/1993	Nashville, TN	Steven T. Foster, VA	David J. Walsh, AK	David J. Lyons, IA
135	6/20–23/1993	Chicago, IL	Steven T. Foster, VA	David J. Walsh, AK	David J. Lyons, IA
136	9/19–21/1993	Boston, MA	Steven T. Foster, VA	David J. Walsh, AK	David J. Lyons, IA
137	12/5–8/1993	Honolulu, HI	Steven T. Foster, VA	David J. Walsh, AK	David J. Lyons, IA
138	3/6–8/1994	Denver, CO	David J. Walsh, AK	David J. Lyons, IA	Catherine J. Weatherford, OK
139	6/12–15/1994	Baltimore, MD	David J. Walsh, AK	David J. Lyons, IA[37]	Catherine J. Weatherford, OK

Mtg	Date	Meeting Site	President	Vice-President	Secretary / Secretary-Treasurer
140	9/18–20/1994	Minneapolis, MN	David J. Walsh, AK	Lee Douglass, AR[37]	Catherine J. Weatherford, OK
141	12/4–7/1994	New Orleans, LA	David J. Walsh, AK	Lee Douglass, AR	Catherine J. Weatherford, OK
142	3/12–14/1995	Miami, FL	Lee Douglass, AR	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI
143	6/4–7/1995	St. Louis, MO	Lee Douglass, AR	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI
144	9/10–12/1995	Philadelphia, PA	Lee Douglass, AR	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI
145	12/2–6/1995	San Antonio, TX	Lee Douglass, AR	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI
146	3/23–27/1996	Detroit, MI	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND
147	6/1–5/1996	New York, NY	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND
148	9/28–10/2/1996	Anchorage, AK	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND
149	12/14–18/1996	Atlanta, GA	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND
150	3/15–19/1997	Orlando, FL	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND	George M. Reider Jr., CT
151	6/7–11/1997	Chicago, IL	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND	George M. Reider Jr., CT
152	9/22/1997	Washington, DC	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND	George M. Reider Jr., CT
153	12/6–9/1997	Seattle, WA	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND	George M. Reider Jr., CT
154	3/14–18/1998	Salt Lake City, UT	Glenn Pomeroy, ND	George M. Reider Jr., CT	George Nichols, III, KY
155	6/20–24/1998	Boston, MA	Glenn Pomeroy, ND	George M. Reider Jr., CT	George Nichols, III, KY
156	9/12–16/1998	New York, NY	Glenn Pomeroy, ND	George M. Reider Jr., CT	George Nichols, III, KY
157	12/5–9/1998	Orlando, FL	Glenn Pomeroy, ND	George M. Reider Jr., CT	George Nichols, III, KY
158	3/6–10/1999	Washington, DC	George M. Reider Jr., CT	George Nichols, III, KY	Kathleen Sebelius, KS
159	6/5–9/1999	Kansas City, MO	George M. Reider Jr., CT	George Nichols, III, KY	Kathleen Sebelius, KS
160	10/2–6/1999	Atlanta, GA	George M. Reider Jr., CT	George Nichols, III, KY	Kathleen Sebelius, KS
161	12/4–8/1999	San Francisco, CA	George M. Reider Jr., CT	George Nichols, III, KY	Kathleen Sebelius, KS
162	3/11–15/2000	Chicago, IL	George Nichols, III, KY	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA
163	6/10–14/2000	Orlando, FL	George Nichols, III, KY	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA
164	9/9–13/2000	Dallas, TX	George Nichols, III, KY	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA
165	12/2–5/2000	Boston, MA	George Nichols, III, KY	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA
166	3/24–27/2001	Nashville, TN	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR
167	6/9–12/2001	New Orleans, LA	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR
N/A	9/2001	Mtg. canceled [38]	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR
168	12/8–11/2001	Chicago, IL	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR
169	3/16–19/2002	Reno, NV	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR	Nathanial S. 'Nat' Shapo, IL
170	6/8–11/2002	Philadelphia, PA	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR	Nathanial S. 'Nat' Shapo, IL
171	9/9–12/2002	New Orleans, LA	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR	Nathanial S. 'Nat' Shapo, IL
172	12/7–10/2002	San Diego, CA	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR	Nathanial S. 'Nat' Shapo, IL
173	3/8–11/2003	Atlanta, GA	J. Michael 'Mike' Pickens, AR	Ernst N. 'Ernie' Csiszar, SC	Joel S. Ario, OR
174	6/21–24/2003	New York, NY	J. Michael 'Mike' Pickens, AR	Ernst N. 'Ernie' Csiszar, SC	Joel S. Ario, OR
175	9/13–16/2003	Chicago, IL	J. Michael 'Mike' Pickens, AR	Ernst N. 'Ernie' Csiszar, SC	Joel S. Ario, OR
176	12/6–9/2003	Anaheim, CA	J. Michael 'Mike' Pickens, AR	Ernst N. 'Ernie' Csiszar, SC	Joel S. Ario, OR
177	3/13–16/2004	New York, NY	Ernst N. 'Ernie' Csiszar, SC	James A. 'Jim' Poolman, ND	Joel S. Ario, OR
178	6/13–16/2004	San Francisco, CA	Ernst N. 'Ernie' Csiszar, SC[39]	James A. 'Jim' Poolman, ND	Joel S. Ario, OR
179	9/11–14/2004	Anchorage, AK	M. Diane Koken, PA[39]	Joel S. Ario, OR[39]	Alessandro A. 'Al' Iuppa, ME[39]
180	12/4–7/2004	New Orleans, LA [40]	M. Diane Koken, PA	Joel S. Ario, OR	Alessandro A. 'Al' Iuppa, ME

Mtg	Date	Meeting Site	President	President-Elect	Vice President	Secretary-Treasurer
181	3/12–15/2005	Salt Lake City, UT	M. Diane Koken, PA	Alessandro A. 'Al' Iuppa, ME	Joel S. Ario, OR	Sandra K. 'Sandy' Praeger, KS
182	6/11–14/2005	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 [41]	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 [42]
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 [42]
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 [43]
N/A	8/2011	Mtg. canceled [44]	Susan E. Voss, IA	Kevin M. McCarty, FL	James J. Donelon, LA	Adam Hamm, ND [43]
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 [45]	Sharon P. Clark, KY
214	3/28–31/2015	Phoenix, AZ	Monica J. Lindeen, MT	John M. Huff, MO [45]	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 [46]	Theodore K. 'Ted' Nickel, WI
217	4/3–6/2016	New Orleans, LA	John M. Huff, MO	Theodore K. 'Ted' Nickel, WI [46]	Julie Mix McPeak, TN [46]	Eric A. Cioppa, ME [46]
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 [47]
221	8/6–9/2017	Philadelphia, PA	Theodore K. 'Ted' Nickel, WI	Julie Mix McPeak, TN	Eric A. Cioppa, ME	Raymond G. Farmer, SC [47]
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 [48]
226	4/6–9/2019	Orlando, FL	Eric A. Cioppa, ME	Raymond G. Farmer, SC	David Altmaier, FL [48]	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 [49]	Raymond G. Farmer, SC	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO
229	7/27–8/14/2020	Virtual meeting [50]	Raymond G. Farmer, SC	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO
230	12/3–9/2020	Virtual meeting [51]	Raymond G. Farmer, SC	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO
231	4/7–14/2021	Virtual meeting [52]	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO	Andrew N. Mais, CT
232	8/13–17/2021	Columbus, OH [53]	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO	Andrew N. Mais, CT
233	12/13–16/2021	San Diego, CA [54]	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
238	8/12–16/2023	Seattle, WA	Chlora Lindley-Myers, MO	Andrew N. Mais, CT	Jon Godfread, ND	Scott A. White, VA
239	11/30-12/4/2023	Orlando, FL	Chlora Lindley-Myers, MO	Andrew N. Mais, CT	Jon Godfread, ND	Scott A. White, VA
240	3/15–18/2024	Phoenix, AZ	Andrew N. Mais, CT	Jon Godfread, ND	Scott A. White, VA	Elizabeth Kelleher Dwyer, RI
241	8/12–15/2024	Chicago, IL	Andrew N. Mais, CT	Jon Godfread, ND	Scott A. White, VA	Elizabeth Kelleher Dwyer, RI
242	11/16–11/19/2024	Denver, CO	Andrew N. Mais, CT	Jon Godfread, ND	Scott A. White, VA	Elizabeth Kelleher Dwyer, RI

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.

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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 on 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

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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.

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

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

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

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

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

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

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

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.

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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: 11/19/2024

https://naiconline.sharepoint.com/teams/MemberServicesExecutive/Shared Documents/Commissioner/Meeting_Officer_Record/08-Meeting_Officer_Record.docx

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NAIC MODEL LAWS, REGULATIONS, AND GUIDELINES

The following is a listing of NAIC model laws, regulations, and guidelines referenced in the *Proceedings* of the 2024 Summer National Meeting.

Health Insurance Reserves Model Regulation (#10)
9-739, 9-750, 9-758, 9-792

Health Benefit Plan Network Access and Adequacy Model Act (#74)
3-113

Coordination of Benefits Model Regulation (#120)
3-83, 3-89, 6-27, 6-179

Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170)
2-6, 3-5, 3-11, 3-113, 4-3, 6-3, 6-167, 6-221

Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)
2-2, 2-6, 2-7, 3-3, 3-5, 3-11, 3-113, 4-3, 6-3, 6-164, 6-167, 6-216, 6-218, 6-221

Uniform Individual Accident and Sickness Policy Provision Law (UPPL) (#180)
3-89, 6-36, 6-188

Annual Financial Reporting Model Regulation (#205)
3-49, 9-14, 9-77, 9-78

Managing General Agents Act (#225)
9-677, 9-842, 9-843, 9-845

Public Adjuster Licensing Model Act (#228)
2-2, 2-12, 2-14, 3-3, 3-11, 4-4, 8-2, 8-3

Charitable Gift Annuities Model Act (#240)
5-5

Annuity Disclosure Model Regulation (#245)
5-10, 8-20, 8-22

Variable Life Insurance Model (#270)
8-27

Suitability in Annuity Transactions Model Regulation (#275)
1-5, 3-22, 5-13, 5-14, 8-20, 8-22

Disclosure of Material Transactions Model Act (#285)
9-841, 9-843, 9-844

Risk-Based Capital (RBC) for Health Organizations Model Act (#315)
9-741

Business Transacted with Producer Controlled Property/Casualty Insurer Act (#325)
9-841

Insurance Holding Company System Regulatory Act (#440)
3-49, 3-118, 9-14, 9-86, 9-169, 9-426, 9-489, 9-496, 9-513

Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)
3-49, 3-118, 9-14

Risk Management and Own Risk and Solvency Assessment Model Act (#505)
3-49, 9-14

Property and Casualty Insurance Guaranty Association Model Act (#540)
4-20, 9-103

Military Sales Practices Model Regulation (#568)
8-22

Advertisements of Life Insurance and Annuities Model Regulation (#570)
8-18, 8-22, 8-30

Life Insurance Disclosure Model Regulation (#580)
8-20, 8-22, 8-27, 8-30

Life Insurance Illustrations Model Regulation (#582)
3-24, 5-12, 5-74, 8-18, 8-22, 8-27, 8-30

Universal Life Insurance Model Regulation (#585)
8-27, 8-28

Life Insurance Model Regulation (#585)
8-19

Mortgage Guaranty Insurance Model Act (#630)
4-20

Travel Insurance Model Act (#632)
8-7, 8-81

Pet Insurance Model Act (#633)
4-20, 8-7, 8-80

Long-Term Care Insurance Model Act (#640)
3-31, 3-95, 8-22, 9-758, 9-792

Long-Term Care Insurance Model Regulation (#641)
3-30

Limited Long-Term Care Insurance Model Act (#642)
3-95, 6-42, 6-193

Limited Long-Term Care Insurance Model Regulation (#643)
3-95, 6-42, 6-193

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
3-75, 3-103, 6-19, 6-48, 6-171, 6-200, 13-7

Insurance Data Security Model Law (#668)
3-66, 3-68, 9-685, 9-686, 9-894, 12-16, 12-31, 12-38, 12-40

NAIC Insurance Information and Privacy Protection Model Act (#670)
3-66, 12-38

Privacy of Consumer Financial and Health Information Regulation (#745)
2-2, 2-23, 3-3, 3-12, 3-66, 4-6, 12-3, 12-14, 12-38

Property and Casualty Actuarial Opinion Model Law (#745)
7-113

Credit for Reinsurance Model Law (#785)
3-60

Credit for Reinsurance Model Regulation (#786)
3-60

Term and Universal Life Insurance Reserve Financing Model Regulation (#787)
3-60

Reinsurance Intermediary Model Act (#790)
9-841, 9-843, 9-845

Life and Health Reinsurance Agreements Model Regulation (#791)
9-759

Actuarial Opinion and Memorandum Regulation (#822)
9-739

Nonadmitted Insurance Model Act (#870)
4-20, 7-149, 7-151

Unfair Trade Practices Act (#880)
3-66, 4-20, 8-19, 8-22, 8-30, 12-38

NAIC 2024 Fall National Meeting
Denver, CO

OPENING SESSION
November 17, 2024

CALL TO ORDER *Andrew N. Mais, NAIC President*

It is my privilege to welcome you to the 242nd session of the National Association of Insurance Commissioners, which will now come to order. We are honored you could join us for our final national meeting of 2024, and we are especially grateful to those among our more than 2,800 in-person and virtual registrants who are attending a national meeting for the first time. Your participation, your voice, and your interest play a vital role in the NAIC and state insurance regulators' work to protect consumers and support a stable and robust marketplace.

We'll start with a little bit of trivia to kick things off. I'm going to go back to 1889. The NAIC's 20th "national convention," as our gatherings were called back then, marked the organization's first meeting in Denver. And here's where it gets to be really fun. The NAIC President at the time? Orsamus R. Fyler, Insurance Commissioner from the great state of … Connecticut!

I want to read a short excerpt from his presidential address here. He said, "It should be our high aim and purpose to contribute to the valuable store of knowledge already possessed, secure the passage of desirable insurance laws, encourage and promote sound insurance institutions, place our seal of disapprobation on all mere schemes and shams of insurance intended to swindle the public, and in general to so conduct the affairs of our office as to inspire confidence in the public in official supervision."

Now, these days, that might not fit on a bumper sticker, but it certainly does sound like a good insurance regulation policy to me all these years later.

INTRODUCTION OF HEAD TABLE *Andrew N. Mais, NAIC President*

I want to start by introducing the members of our head table. Please hold your applause until I have announced each name. Starting on my far right:

Honorable Michael Conway, Meeting Host and Colorado Division of Insurance Commissioner
Gary Anderson, NAIC CEO
Honorable Chlora Lindley-Myers, NAIC Immediate Past President and Missouri Commerce and Insurance Director
Honorable Jon Godfread, NAIC President-Elect and North Dakota Insurance Commissioner
Honorable Scott White, NAIC Vice President and Virginia Insurance Commissioner
Honorable Elizabeth Kelleher Dwyer, NAIC Secretary-Treasurer and Rhode Island Department of Business Regulation Director
Honorable Dean Cameron, NAIC Past President and Idaho Department of Insurance Director

Please join me in welcoming the Members of our NAIC Fall National Meeting head table.

WELCOME TO SPECIAL GUESTS *Andrew N. Mais, NAIC President*

We're also pleased to welcome our special guests to the Fall National Meeting. Thank you to the federal officials, the state officials, and the international regulators who are joining us here today.

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INTRODUCTION OF NEW MEMBERS *Andrew N. Mais, NAIC President*

We also have a short video recognizing the Members who have taken office since our last national meeting.

[New member video plays]

Can we get one more round of applause to welcome our newest Members to the NAIC?

COMMISSIONER KREIDLER RECOGNITION *Andrew N. Mais, NAIC President*

As we say hello to our new Members, we are also preparing to say goodbye to our longest-serving Insurance Commissioner, Washington's Mike Kreidler. Mike will be leaving office following six consecutive terms of service, a total of 24 years.

Commissioner Kreidler has long been a leading voice on climate issues, including in his work at the NAIC, where he co-founded and chaired the NAIC's Climate Risk and Resilience Working Group for almost two decades. He also served as co-vice chair of the Climate Risk and Resilience Task Force. He led the successful 2009 effort to require insurers to publicly disclose how they address climate change in the NAIC *Climate Risk Disclosure Survey*, and that covers approximately 85% of the U.S. market.

Among his numerous other accomplishments, Mike directed his office to become a founding member of the United Nation's (UN's) Sustainable Insurance Forum (SIF), a network of insurance supervisors and regulators working together to strengthen their response to relevant sustainability challenges. Since 2016, Commissioner Kreidler has held an annual "Climate Summit Series," which convenes the insurance industry, policymakers, academics, scientists, and public and private risk and emergency managers to discuss climate risk and mitigation practices. And, in 2020, InsuranceERM named him an industry leader on climate change.

In addition to his time at the Office of the Insurance Commissioner, Commissioner Kreidler also represented Washingtonians for 16 years as a state representative and state senator, and he was also elected to the U.S. Congress. He did not just serve the state; he served his country. He retired as a lieutenant colonel in the U.S. Army Reserve after more than 20 years of active and reserve service.

Mike, thank you for your decades of service to state insurance regulation and for your passionate leadership on climate and other top priorities. We wish you all the best.

INTRODUCTION OF HOST COMMISSIONER *Andrew N. Mais, NAIC President*

I now have the honor of introducing our host, my good friend, the Colorado Division of Insurance (DOI) Commissioner Michael Conway, who will do his best to make up for his state not being Connecticut.

Prior to being confirmed as Insurance Commissioner by the Colorado State Senate in January 2019 after serving as interim commissioner for a year, Commissioner Conway worked to protect consumers and ensure a fair, level regulatory environment as the division's deputy commissioner for consumer and compliance services. From 2010 to 2016, he was an assistant attorney general for the Colorado State Attorney General's Office. He has also advocated for Coloradans regarding homelessness prevention, housing rights, evictions, and subsidized housing as an attorney for Colorado Legal Services.

Please welcome Commissioner Conway.

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HOST COMMISSIONER'S REMARKS *Colorado Commissioner Michael Conway*

It is my absolute pleasure to welcome everyone to Denver for the NAIC's 2024 Fall National Meeting. I'd like to thank everyone who is making this edition of our national meeting possible. That includes all of the NAIC staff, who seemingly work endlessly to make sure our meetings go off without a hitch. And that gratitude also extends to the staff here at the Gaylord Rockies. It also certainly extends to the Colorado DOI team, who, while having the impossible task of putting up with me, did a fantastic job of helping the NAIC put this meeting together.

When people come to Denver, it's quite often the case that they complain about how far the Denver airport is from the city. I'm happy to note that we fixed that issue by just having the conference at the airport. But there is a lot more to Colorado than just our airport. Every fall, we celebrate Colorado's annual tarantula migration—when the large, furry spiders come out of their burrows and roam the southern parts of our state. And of course, what kind of event would be complete without a festival? So, next year, come on back to La Junta, Colorado, along the New Mexico border for their annual Tarantula Fest.

We also hold our Pueblo Chile and Frijoles Festival every year in September. So, if you time it just right, you can come out for the festival to learn why our Pueblo green chile is so far superior to the New Mexico Hatch green chile and then stay to hang out with the spiders.

And, of course, Colorado is best known for our world-class mountains. Whether you want to see some of the best wildlife in the country or experience some of the best fishing in the country, hike a 14er or experience the best skiing and snowboarding in the world, our mountains are America's playground year-round.

So, I encourage you to find the time to get out and enjoy the greatness that is Colorado. Visit the world's best concert venue, Red Rocks Amphitheatre, or take time to trek up into the spectacular majesty of the Rocky Mountain National Park. But you didn't come here just to experience all of the wonders that Colorado has to offer. You came to talk about our collective favorite topic—insurance.

When I became Colorado's Insurance Commissioner, there were numerous health insurance issues that occupied most of my time. But we fixed everything about health insurance in Colorado—at least for the next two months—so now much more of my time, like many of you, is absorbed by the challenges in the homeowners insurance market. But regardless of the challenges that are upon us at any given moment in our markets, it's when we are facing challenging times that the NAIC is at its best. We may not always agree on what the perfect solution may be for a particular problem. But whether we are tackling a global pandemic or grappling with the dawn of artificial intelligence (AI), our strength derives from the fact that we always do everything in our power to protect the insurance markets in our great states and territories. And I know that regardless of the challenges in front of us today, that will continue to be the case.

To close, I want to thank President Mais for his leadership over the last year. You've done an exceptional job leading this organization, Andy. And I am extremely thankful for the work and commitment you've shown. Of course, Andy is preparing to hand the reins of the NAIC off to Commissioner Godfread. Some of my best friends in the world are sitting around this table right now or have sat around it in the past. Much to Jon's chagrin, I count him among that group. So, all I have to say to you, my friend, is—please don't screw it up.

Thank you for coming out to our great city, and again, welcome to Colorado.

TRANSITION REMARKS *Andrew N. Mais, NAIC President*

Thank you, Commissioner Conway, for sharing the Centennial State with us for a few days. Although, as mentioned, we're a little way from Denver proper, but I hope you all will have time to check out the city and more

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of our beautiful, scenic surroundings. It is no wonder the state is also known as Colorful Colorado. It's a beautiful place. While we're here, let's see as much of it as we can.

NAIC AWARD FOR EXCELLENCE IN REGULATORY SUPPORT *Andrew N. Mais, NAIC President*

For those of you who regularly attend NAIC meetings, you might be familiar with the Robert Dineen Award we present each fall. That award is designed to honor a staff member of an insurance department who has made an outstanding contribution to the state-based system of insurance regulation and who exhibits an attitude and performs activities fostering the advancement of the insurance regulatory profession.

And, at times, there may be recipients of the Raymond G. Farmer Award, which is given at the NAIC President's discretion and honors NAIC Members who have shown exemplary leadership and who have contributed to advancing the NAIC's mission.

This year, we would like to also announce a long-overdue recognition to honor an internal NAIC colleague who has shown exemplary leadership, served for a sustained length, and significantly contributed to advancing the mission of the NAIC in the support of its membership.

The Members of the National Association of Insurance Commissioners extend their heartfelt appreciation to the NAIC's chief operating officer and chief legal officer, Andy Beal, for his leadership and vision in support of an efficient, market-oriented system of insurance regulation and for his leadership to position NAIC operations for success for years to come.

Andy joined the NAIC in 1999 after retiring as a veteran of the United States Marine Corps. During his early years with the NAIC, Andy served as general counsel from 2000 through July 2006, then as deputy executive vice president and chief legal officer from 2006 through February of 2009. As Andy settled into his leadership roles, he increased his understanding of how state-based regulation operates while serving as a steady and trusted member of staff support for commissioners and state insurance department personnel. In February 2009, Andy was promoted to chief operating officer and chief legal officer. In addition to all that, during his tenure, Andy served as acting chief executive officer in 2012–2013, again in 2016–2017, and most recently from March 2023–April 2024.

Andy, we are grateful for your friendship, your integrity, and your dedication to all our success. And for these reasons and many more, we thank you for your distinguished service. With respect and admiration from your fellow NAIC Members and staff, we are proud to present you with the first NAIC Award for Excellence in Regulatory Support.

We all know that no man is an island. We get things done right through support, and for many of us, that support comes from our family. Peggy Beal, will you join us here with your husband? We thank you for sharing your husband with us as we work to make a difference in the insurance industry.

2024 ROBERT DINEEN AWARDS *Andrew N. Mais, NAIC President*

Now, as I mentioned, at each Fall National Meeting, we announce our Robert Dineen Award recipients. This award was established in June 1989 to honor the founder of the NAIC's Support and Services Office. This is one way we say thank you to our state staff for all their support and their commitment to helping consumers, advancing state insurance regulation no matter how long or complicated the task.

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Our staffs all know, sometimes you are the first call or email. Sometimes the last. But, always, you're there, and it is thanks to you that consumers can be heard, can know they have an ally who is looking out for them, and can have greater peace of mind in some of life's most challenging and frightening moments.

Today, there are two individuals we particularly want to recognize, and I am glad they can be here in person. After I call your name, please come to the head table to receive your award. We will take a quick photo, but I would also ask our recipients and their Insurance Commissioners to join us up front at the conclusion of the opening session for additional photos.

Our first Robert Dineen Award this year goes to Matt Gendron.

Matt joined the Rhode Island Department of Business Regulation in 2015 as an entry-level legal counsel. During his time at the department, where he currently oversees the Market Conduct Division, he's earned a reputation as a dedicated and certainly passionate regulator who is always volunteering to take on more responsibility and who attacks the most challenging issues with hard work, enthusiasm, and dedication. At the NAIC, Matt has been a valuable member of so many working groups and task forces, including the Big Data and Artificial Intelligence (H) Working Group, Restructuring Mechanisms (E) Working Group, Pet Insurance (C) Working Group, and more.

Among his accomplishments, he worked for several years to draft the pet insurance and travel insurance model acts and then worked to implement annual statements or standardize data requests (SDRs) for them with various market conduct working groups. He also assisted in drafting the best interest updates to the *Suitability in Annuity Transactions Model Regulation* (#275) and has helped interpret that regulation as the working group has drafted several rounds of FAQs.

And, if that's not enough, along the way, he has earned designations including LOMA's Fellow, Life Management Institute, and the NAIC's Professional in Insurance Regulation (PIR) designation. Congratulations, Matt.

Now we move to our second 2024 Robert Dineen Award recipient, John Rehagen. John has worn many hats at the Missouri Department of Commerce and Insurance (DCI), where he started in 2003 as a financial analyst. In the 21 years since, he's also been a financial examiner, captive program manager, and deputy division director. And, in 2014, he became the division director of company regulation. In 2017, he served as acting department director until Director Lindley-Myers was appointed. He serves as both a member and Director Lindley-Myers' representative on numerous NAIC working groups related to solvency monitoring, group supervision, reinsurance, captives, and international matters, and he acts as chair of the Reinsurance (E) Task Force on the director's behalf.

One of John's most notable contributions to the Missouri DCI has been the transformation of his division's processes and procedures. John encourages open communication among his team, resolves problems and issues quickly and efficiently, and has established a stellar reputation as both a leader in the department and a knowledgeable regulator, nationally and internationally. My privilege and my pleasure. Congratulations, John.

Please join me in another round of applause for both awardees.

OPENING SESSION SPEECH *Andrew N. Mais, NAIC President*

During this season, our thoughts especially turn toward who and what make us thankful and grateful. And I'm particularly reminded of such things as I prepare to wrap up my time as NAIC President.

Shortly after I started my term this year, I challenged us all, but especially myself, to "Mind the Gap" in 2024. As state insurance regulators, we know the importance of making sure as many people as possible have the proper insurance coverage. And no one is in a better position to help than we are. The coverage gap is always on our

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minds, as closing it is a core part of our mission, but placing extra emphasis on this message has allowed for greater discussion and strategizing and for even more focused efforts.

Already in this session, we have had some special moments of thanks. There will be more to come. Truthfully, if we went through the whole list, we would be here quite a long time. But as I look back over the past year, I want to be sure that my fellow Insurance Commissioners, their teams, and the NAIC staff know how thankful I am for your incredibly hard work to mind the gap.

In your day-to-day responsibilities, on social media, in the press, at sold-out standing-room-only events, and more, you have spread the word and tackled the issues with creativity, passion, and diligence. Nowhere is this more evident, perhaps, than when dealing with natural disasters, as we have had to do this year. Before, during, and after, you engage, support, and equip. Though there is much about nature we cannot predict with absolute certainty, we can be sure of the basic principles of mitigation and preparation to strengthen protection and resilience.

As we confront shared as well as the unique challenges in our individual states on this front, the NAIC is supporting our state departments of insurance (DOIs) in creating and expanding mitigation programs. The NAIC's Center for Insurance Policy and Research (CIPR) is working with several states, including my own, to develop—we're all working to develop—mitigation programs for perils such as wind, hail, wildfire, and flood. Through the CIPR, state insurance regulators have greater resources available to assist in planning, developing, implementing, and maintaining viable mitigation programs. Several states are utilizing the CIPR resources to address new risk reduction and consumer protection efforts on a large scale. And these mitigation efforts are helping to reduce risks and guard more homes, which will ultimately help close the gap by expanding access to more insurance options. This work provides a great example of the coordination and collaboration required to successfully mind and close protection gaps.

You hear those words a lot at the NAIC: "coordination" and "collaboration." That's because such an approach helps set our system apart. Regardless of background or belief, here we are, around the same table, dedicated to the same result. That is not so easy to find nowadays. Working together—and the back and forth that comes from thoughtful debate—strengthens the end product, and it strengthens us, too. We gain new insights. We see broader perspectives. That means greater and more diverse representation.

This year, collaboration resulted in the first-ever National Climate Resilience Strategy for Insurance. It's also gained us ground in addressing financial transparency around investments through the Framework for Regulation of Insurer Investments. And state insurance regulators, working together through the Macroprudential (E) Working Group under the NAIC's Financial Condition (E) Committee, have been making great progress on addressing the list of 13 regulatory considerations for solvency monitoring. Some of the work has been completed, while other projects remain ongoing or may lend themselves to continuous ongoing monitoring in the future. All this work has resulted in significant progress and enhancements for our regulatory system, mostly around investments and affiliated transactions.

The release of the Cybersecurity Event Response Plan (CERP) by the NAIC's Cybersecurity (H) Working Group earlier this year marked another achievement, one that supports regulators with responding to a cybersecurity event at a regulated entity. And that Working Group is not done yet with the work. It keeps learning and expects to enhance the document as it continues to hear from subject matter experts (SMEs).

On the health insurance front, this year, as stated in our strategic priorities, we modified Model #880, the *Unfair Trade Practices Act*, to grant states regulatory power over lead generators. And thanks to the persistence of state insurance regulators making their voices heard, federal regulators finalized a rule earlier this year stepping up their oversight of Medicare Advantage plan marketing, and they have also heightened scrutiny to protect

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consumers in the federal exchange from unauthorized health-plan switches and enrollments. Still, as always, to best protect consumers, we continue to call for regulatory authority over the Medicare Advantage market to be returned to the states.

Of course, our collaborative philosophy extends to our involvement not only beyond our state lines but also our country's borders, as minding the gap is a global issue. To date in 2024, we have participated in more than 40 outreach calls, bilateral meetings, and events held by international organizations. And that is without factoring in the numerous meetings hosted by the IAIS, the International Association of Insurance Supervisors.

One of the bright spots, one of the highlights of my year, always comes each year when our International Fellows program offers us a chance to introduce insurance supervisors from around the world to our state-based system. Just a few days ago, we wrapped up our fall in-person session, which drew eight regulators from the Bahamas, Bermuda, Saudi Arabia, Taiwan, and Thailand. And as part of that program, insurance departments in the District of Columbia, Missouri, Nebraska, Ohio, and Rhode Island, as well as my own state of Connecticut, hosted these regulators for five weeks to provide firsthand insight into how states approach financial regulation, market conduct, licensing, and many other aspects of insurance regulation.

My department was proud to work with Nitipha Changlum from Thailand's Office of the Insurance Commission, who shared her own insights from more than seven years in the field as she learned from us. It is a two-way street. We learn as much as we share, and that is why I would encourage any states that have not taken advantage of this unique opportunity to talk to the NAIC about hosting an International Fellow in the future.

Now, without a doubt, one of our longest-running and most involved collaboration efforts internationally has been the development of a group capital standard for internationally active insurance groups (IAIGs). The idea for that was to provide insurance regulators with meaningful and reliable information about the solvency risks presented by and to the IAIGs. And this project has been underway at the IAIS for more than a decade.

Now, I can happily say that state insurance regulators and the NAIC welcome the successful conclusion of the IAIS process, which has determined that the U.S. aggregation method (AM) provides a basis for implementation in the United States of the insurance capital standard (ICS) to produce comparable outcomes.

The comparability assessment—and I know there are so many in the industry, as well as regulators who participated; thank you to everyone who participated in this long and sometimes arduous struggle—has been a multiyear robust, technical process examining the two approaches to group capital adequacy. The AM was developed as a more appropriate approach for the U.S. insurance market and supervisory regime, and it ensures that policyholders are protected and that the insurance products on which U.S. consumers rely are available.

Now, the finalization of the ICS and conclusion of the AM comparability assessment will be officially affirmed during the IAIS' upcoming meetings in Cape Town, and it is a major milestone for the IAIS. It reflects the commitment of the international insurance supervisory community to moving forward together and the importance of having appropriate jurisdictional flexibility.

Reaching this milestone is also a testament to the resolve of insurance supervisors to collaborate on setting standards that protect policyholders and enhance global financial stability. As work transitions into implementation, the NAIC will work domestically on its approach to the AM as the U.S. implementation of the ICS. Collaboration and coordination will continue with our international counterparts as they adapt the ICS to their respective jurisdictional approaches and as the IAIS works on developing an appropriate implementation assessment framework.

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Internally, we continue working together on our three-year *State Connected* strategic plan, which is headed into its final year. One of our key completed initiatives under that plan has been the launch of a new member portal for regulators—NAIC Connect. It's a centralized hub for more effective communication and collaboration between Members and insurance department colleagues.

We're also in the final steps of launching the modernized System for Electronic Rates & Forms Filing (SERFF) platform, and it will be launched with the Interstate Insurance Product Regulation Commission (Compact) filings.

Finally, as I review this, I have to say congratulations are in store for the insurance departments in Massachusetts and New York, the U.S. Virgin Islands, and Connecticut. It's out of alphabetical order, but I had to save the best for last. But I'm proud to announce that the NAIC's Financial Regulation Standards and Accreditation (F) Committee just voted to reaccredit those jurisdictions for the next five years after a thorough, independent review.

These few examples I've listed today are just that: It's a snapshot of the good work that has taken place this year to protect consumers; support secure, stable, and healthy markets; and mind the gap. The year is almost over, but our work is far from done. This week, we will build on our efforts from 2024 and help set the stage for 2025, with collaboration once again the featured element. We know the challenges, but if we look around this room, I believe we will see the solution: each of us, from government, to industry, to interested parties, with unique talents, views, and resources, demonstrating what is possible when we work together.

As proud guardians of the exemplary tradition of state insurance regulation, we have all worked together, each contributing in our own way to our North Star: consumer protection. And that should give all of us—here in this room and around this nation—a lot to be thankful for. I know I have a lot to be thankful for, and I want to thank you one more time. I thank the officers for their support, their sage advice … and the occasional eye roll.

I want to thank the NAIC staff, top to bottom, in every area who went out of their way to make this whirlwind of a year tolerable at worst and so often enjoyable, even when I would wake up in some strange hotel room not knowing which city I was in. Thank you. As I traveled to share our story and listen to our stakeholders, never once did I feel less than superbly prepared thanks to all your hard work. Thank you.

I must also thank my colleagues, the great staff of the Connecticut Insurance Department, the best regulators in the world. I may be a little biased, but I'm going with that. They rose to every challenge, from COVID-19 to climate risk and so much in between, giving me the security to travel with the absolute faith that Connecticut consumers were in good hands while I was on some flight and unreachable. In actual fact, some at this table may be thinking that Connecticut consumers were in better hands when I was unreachable. Yes, I hear your thoughts, Jon!

Next, I must take a moment to thank my family. You are my rock. You have been my inspiration, my shelter from the storm. I am so glad to have you here today. I couldn't have done it without you. Thank you.

We mind the gap, making sure that everyone has access to the protection they need because the bottom line for insurance is that it is about people, about us and the ones we love, about safety and resilience, about security where there is risk, about hope at times of sadness, about the promise of a better tomorrow.

I thank you all for affording me the pleasure and privilege of serving and sharing this message this past year. Where I have done it well, it is because of you, because I stood on the shoulders of giants like the ones around me here at the table and the ones who led the way before. People like Eric Cioppa, who we're fortunate to have join us. And for those times where I may have fallen short, I thank you for your indulgence. God is not finished with me yet. Or with us. As we begin this last meeting of 2024, we know our mission continues. We know, too, that with Commissioner Godfread at the helm, we will be in good hands.

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I thank you for this year, and I look forward to the next. God bless you.

FARMER AWARDS *Andrew N. Mais, NAIC President*

Before we adjourn and go our various directions, I have one more special announcement. As was teased earlier, NAIC Presidents have the exclusive privilege to honor our Members' leadership and exceptional service to the NAIC and its mission with the Farmer Award, which is named after my hero, former South Carolina Insurance Director and NAIC President Ray Farmer. A man of courage, a man of strength, a man who was a great leader of this organization.

Prior to being elected Insurance Commissioner, our first recipient tackled insurance issues as a broker, a health insurance executive, and a state legislator. Not only is he a passionate defender of the state-based system, but he also exemplifies its unique collaborative spirit in a divisive age with his enthusiastic willingness to work together with all to find a way forward, to find that solution. I'm proud to present the Raymond G. Farmer Award for Exceptional Leadership to Oklahoma Insurance Commissioner Glen Mulready. Come on up, Glen.

Our next recipient has also been a long-time leader in both the private and public sectors. His time in our field includes starting in state government by serving in the insurance department he would return to in 2020 to take over as commissioner. Most recently, as chair of the NAIC's Property and Casualty Insurance (C) Committee, his steady hand and committed guidance prioritized states' interests and resulted in the adoption and implementation of the state-led property/casualty (P/C) market intelligence (PCMI) data call. Our second Farmer Award recipient today is Arkansas Insurance Commissioner Alan McClain.

Now, remember that I was ready to let you go. But I see Commissioner Godfread has a few words to add.

THANK YOU/GIFT PRESENTATION *Jon Godfread, NAIC President-Elect*

I had a really long speech celebrating all your accomplishments and all you've done, and you covered that well in your speech. You have been involved in this industry since navigating the global financial crisis, the implementation of the Affordable Care Act (ACA). You joined the officers' ranks during the COVID pandemic. We are so fortunate to have you use those experiences, that wisdom, and lead the NAIC. You often mention that it takes all of us to do a lot of the things that we've done, and there's truth in that. But it takes a strong leader to get it done too.

I just have a couple of things I wanted to share with you. The first one is a crystal award and a certificate that certifies and celebrates your year as our NAIC President. Then we've got the fun ones coming next.

Serving in these officer roles, it is a sacrifice. You spend a lot of time on the road, as you mentioned. We want to thank your family and your department for supporting you through that. We also put together a little travel package for you. It's got a blanket, some eye masks, slippers—so you can be the "Passenger Prince" that we know you are. We wanted to give you this backpack full of travel goods for you. Also in there is the "Mind the Gap" trivia game, which, given your theme of the year, certainly lines up with it.

Last, but not least, for those of you who know Andy and his time at the NAIC—and again, going back to the travel—he often mentioned that, given our flights back and forth and the fact that we could really be at a conference literally every day of the week because of the industry conferences, these meetings, or international meetings. And I forgot to mention it earlier, but thank you again for the leadership on international issues. We cannot undersell how important that is to the industry and your key leadership role within that. Thank you for that. But I'm happy to announce that we pulled some strings with Jim Woody, and we were able to get that private jet that you've been looking for.

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On behalf of the NAIC and its Membership, I want to thank you for your time. Thank you for your service, and please join me in congratulating Commissioner Mais and thanking him for his time at the NAIC.

ADJOURNMENT *Andrew N. Mais, NAIC President*

Thank you all again for your support and hard work this year, and I look forward to what we will achieve together this week and throughout the remainder of 2024.

This concludes our opening session. We are adjourned.

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Date: 1/9/2025

Synopsis of the NAIC Committee, Subcommittee, and Task Force Meetings
2024 Fall National Meeting
Nov. 16–19, 2024
and Dec. 18, 2024

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 2024 Fall National Meeting, along with the actions taken by the Executive (EX) Committee during its Dec. 18 meeting. This Synopsis aims to provide NAIC Members, state insurance regulators, and interested parties with a summary of these meeting reports.

EXECUTIVE (EX) COMMITTEE AND PLENARY (Joint Session)

Nov. 19, 2024

1. Adopted by consent the committee, subcommittee, and task force minutes of the 2024 Summer National Meeting.
2. Received the report of the Life Insurance and Annuities (A) Committee. Refer to the Committee listing for details.
3. Received the report of the Health Insurance and Managed Care (B) Committee. Refer to the Committee listing for details.
4. Received the report of the Property and Casualty Insurance (C) Committee. Refer to the Committee listing for details.
5. Received the report of the Market Regulation and Consumer Affairs (D) Committee. Refer to the Committee listing for details.
6. Received the report of the Financial Condition (E) Committee. Refer to the Committee listing for details.
7. Received the report of the Financial Regulation Standards and Accreditation (F) Committee. Refer to the Committee listing for details.
8. Received the report of the International Insurance Relations (G) Committee. Refer to the Committee listing for details.
9. Received the report of the Innovation, Cybersecurity, and Technology (H) Committee. Refer to the Committee listing for details.
10. Adopted the 2025 Generally Recognized Expense Table (GRET).
11. Adopted a *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) amendment authorizing regulator discretion over NAIC designations assigned through the filing exemption (FE) process.
12. Received a status report on the state implementation of NAIC-adopted model laws and regulations.
13. Received the results of the 2025 zone officer elections:
    A. Midwest Zone: Commissioner Vicki Schmidt, Chair (KS); Director Eric Dunning, Vice Chair (NE); and Director Larry D. Deiter, Secretary (SD).
    B. Northeast Zone: Commissioner Michael Humphreys, Chair (PA); Commissioner Justin Zimmerman, Vice Chair (NJ); and Commissioner D.J. Bettencourt, Secretary (NH).
    C. Southeast Zone: Commissioner Sharon P. Clark, Chair (KY); Commissioner Alan McClain, Vice Chair (AR); and Commissioner Tregenza A. Roach, Secretary (VI).
    D. Western Zone: Commissioner Andrew R. Stolfi, Chair (OR); Commissioner Cassie Brown, Vice Chair (TX); and Director Barbara D. Richardson, Secretary (AZ).

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14. Elected the 2025 NAIC officers: Commissioner Jon Godfread, President (ND); Commissioner Scott A. White, President-Elect (VA); Director Elizabeth Kelleher Dwyer, Vice President (RI); and Commissioner Jon Pike, Secretary-Treasurer (UT).

EXECUTIVE (EX) COMMITTEE AND PLENARY (Joint Session)

Dec. 18, 2024

During this meeting, the Executive (EX) Committee took the following action:

1. Adopted the report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, which met Nov. 17 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee and Subcommittee took the following action:
   A. Adopted its Oct. 31 and Summer National Meeting minutes. During its Oct. 31 meeting, the Committee and Subcommittee took the following action:
      i. Approved the release of the proposed 2025 NAIC budget for public comment prior to its consideration by the full Membership during the joint meeting of the Executive (EX) Committee and Plenary on Dec. 18.
      ii. Received an update on the property/casualty (P/C) market intelligence (PCMI) data call.
   B. Adopted the Executive (EX) Committee's Summer National Meeting minutes.
   C. Adopted the report of the Audit Committee, which met Nov. 13 minutes. During this meeting, the Committee took the following action:
      i. Received the Sept. 30 financial update.
      ii. Received an update on the 2024 year-end financial audit.
      iii. Received an update on the upcoming Service Organization Control (SOC) 1 and SOC 2 reviews.
      iv. Heard an update on the Enterprise Resource Planning (ERP) project.
      v. Reviewed the status of Zone financials.
   D. Adopted the report of the Internal Administration (EX1) Subcommittee, including its Aug. 26 minutes. During this meeting, the Subcommittee took the following action:
      i. Received the June 30 Long-Term Investment Portfolio report.
      ii. Received the June 30 Defined Benefit Portfolio report.
      iii. Received a status update on the termination of the Defined Benefit Pension Plan.
   E. Adopted a fiscal for model office testing related to the Generator of Economic Scenarios (GOES).
   F. Approved the public release of a request for proposal (RFP) related to the due diligence framework for credit rating agencies.
   G. Heard a technology and cybersecurity report.
   H. Heard the Chief Executive Officer (CEO) report.
2. Adopted its Dec. 10 and Oct. 31 meeting reports. During these meetings, the Committee took the following action:
   A. Held a public hearing in open session to receive comments from interested parties.
   B. Adopted the NAIC 2025 proposed budget.
   C. Approved the release of the NAIC 2025 proposed budget, including eight fiscals, for public review and comment.
3. Adopted the report of the Climate and Resiliency (EX) Task Force. Refer to the Task Force listing for details.
4. Adopted the report of the Government Relations (EX) Leadership Council. Refer to the Task Force listing for details.
5. Adopted the report of the Special (EX) Committee on Race and Insurance. Refer to the Special Committee listing for details.
6. Received a status report on model law development efforts for amendments to the: *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171); *Public Adjuster Licensing Model Act* (#228); and *Privacy of Consumer Financial and Health Information Regulation* (#672).

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

Also during this meeting, the Executive (EX) Committee and Plenary took the following action:

8. Adopted the NAIC 2025 proposed budget.
9. Adopted the NAIC 2025 proposed committee charges.
10. Adopted the amendments to Model #171.
11. Adopted the summary of findings and determination with respect to the inclusion of the Canada Office of the Superintendent of Financial Institutions (OSFI) evaluation as a jurisdiction that recognizes and accepts the U.S. group capital calculation (GCC).

Climate and Resiliency (EX) Task Force

Nov. 19, 2024

1. Adopted its Summer National Meeting minutes.
2. Received an update on deliverables from the *National Climate Resilience Strategy for Insurance* (Climate Resilience Strategy) report, including an update on the development of the Natural Catastrophe Risk Dashboard. The Task Force also heard updates from the Louisiana Department of Insurance (DOI) and the Minnesota Department of Commerce on risk mitigation efforts.
3. Heard a presentation from United Policyholders (UP) on the lessons learned from recent wildfire disasters and the common challenges for consumers, both immediately after wildfires and over the long term. The Task Force also heard an update on regulatory work before and after wildfire events.
4. Heard an update from the British Columbia Financial Services Authority (BCFSA) on Canadian flood insurance, including the work to create a national flood insurance program that focuses on high flood-risk properties and consumer education.
5. Heard an update on federal activities. In 2024, the U.S. experienced 20 weather-related disasters with losses exceeding $1 billion, driven largely by severe convective storms. These events highlight the growing strain on insurance markets, and both Congress and the Federal Emergency Management Agency (FEMA) have launched initiatives to address these challenges.
6. Heard an update from the Center for Insurance Policy and Research (CIPR) on the NAIC Climate Scenario Resource Center. Following the August adoption of the new climate scenario interrogatories in the year-end 2024 property/casualty (P/C) risk-based capital (RBC) filing, the NAIC has established a Climate Scenario Resource Center to assist filers and their advisors with the disclosure requirements.

Government Relations (EX) Leadership Council

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

Special (EX) Committee on Race and Insurance

Nov. 17, 2024

1. Adopted its Summer National Meeting minutes.
2. Received a status report from the Health Workstream, the Life Workstream, and the Property/Casualty (P/C) Workstream.
3. Adopted the Life Workstream's endorsement supporting state legislation requiring a financial literacy course as a prerequisite to high school graduation.
4. Received an update on the Member Diversity Leadership Forum.

INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE

Refer to the Executive (EX) Committee listing for details.

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LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

Nov. 18, 2024

1. Adopted its Oct. 21 minutes. During this meeting, the Committee took the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Adopted the 2025 Generally Recognized Expense Table (GRET).
   C. Adopted its 2025 proposed charges and those of the Life Actuarial (A) Task Force.
2. Heard a federal update.
3. Adopted the report of the Life Actuarial (A) Task Force. Refer to the Task Force listing for details.
4. Adopted the report of the Annuity Suitability (A) Working Group, which met Nov. 17. During this meeting, the Working Group took the following action:
   A. Discussed the Working Group chair's draft safe harbor guidance document and comments. The Working Group plans to meet in December to continue discussions.
5. Received an update from the Life Workstream of the Special (EX) Committee on Race and Insurance. The Workstream finalized an endorsement in support of state legislation requiring a financial literacy course as a prerequisite to high school graduation. The Special Committee adopted this endorsement during its meeting on Nov. 17. The Life Workstream also exposed a draft survey of life insurers' use of criminal history in underwriting, which was exposed for a 30-day comment period that ended Sept. 5.
6. Heard a presentation from the American Council on Gift Annuities (ACGA) on charitable gift annuities.
7. Heard a presentation from the Coalition Against Insurance Fraud (CAIF) on fraud in life insurance and annuities.
8. Discussed "report and hold" laws.

Life Actuarial (A) Task Force

Nov. 15–16, 2024

1. Adopted its Oct. 24, Oct. 10, Oct. 9, Sept. 12, Sept. 5, and Aug. 29 minutes. During these meetings, the Task Force took the following action:
   A. Adopted the 2025 historical mortality improvement (HMI) and future mortality improvement (FMI) recommendation.
   B. Adopted its Summer National Meeting minutes.
   C. Adopted the 2025 Generally Recognized Expense Table (GRET) recommendation.
   D. Adopted amendment proposal form (APF) 2024-11, which revises the life principle-based reserve (PBR) exemption to account for updates to the blanks.
   E. Exposed APF 2024-13, which would clarify the treatment of negative interest maintenance reserves (IMRs).
   F. Exposed APF 2024-14, which would require additional reporting for surrender charge waivers.
   G. Discussed the asset adequacy testing (AAT) for the reinsurance actuarial guideline draft.
   H. Adopted its 2025 proposed charges.
2. Adopted the report of the Longevity Risk (E/A) Subgroup, which has not met since the Summer National Meeting. The Subgroup will resume meeting once the Valuation Manual (VM)-22, Statutory Maximum Valuation Interest Rates for Income Annuities, methodology is finalized to develop and recommend longevity risk factors.
3. Adopted the report of the Indexed Universal Life (IUL) Illustration (A) Subgroup, which has not met since the adoption of the Subgroup's main work product, revisions to *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest Sold (On or After Dec. 14, 2020)* (AG 49-A), by the Life Actuarial (A) Task Force on Dec. 11, 2022. However, the Subgroup is reviewing the impact of the most recent revisions to AG 49-A on the market.
4. Adopted the report of the Variable Annuities Capital and Reserves (E/A) Subgroup, which met Oct. 18. During this meeting, the Subgroup took the following action:

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A. Discussed draft additions to the Variable Annuities Supplement in the annual statement and a chair exposure of a document.
B. Discussed a plan for aligning VM-21, Requirements for Principle-Based Reserves for Variable Annuities, and VM-22.

5. Adopted the report of the Experience Reporting (A) Subgroup, which has not met since the Summer National Meeting. However, the Subgroup is monitoring the NAIC's mortality experience data collection and considering a group annuity mortality experience data collection.
6. Adopted the report of the Valuation Manual (VM)-22 (A) Subgroup, which met Nov. 6, Oct. 23, and Oct. 9. During these meetings, the Subgroup took the following action:
   A. Adopted preneed annuity exclusions edits to the VM-22 draft.
   B. Exposed the non-zero treaty-floor alternative longevity reinsurance flooring proposal and the comparison of the different methodologies for a 32-day public comment period that ended Dec. 9.
   C. Discussed comments received on the VM-22 standard projection amount (SPA) draft exposure.
   D. Discussed questions received from companies during the VM-22 field test.
7. Heard a presentation on VM-22 model office testing.
8. Adopted the report of the Generator of Economic Scenarios (GOES) (E/A) Subgroup, which met Oct. 16, Oct. 9, Oct. 2, and Sept. 25. During these meetings, the Subgroup took the following action:
   A. Exposed the GOES model governance framework.
   B. Discussed GOES field test participant feedback.
   C. Exposed questions on VM-20, Requirements for Principle-Based Reserves for Life Products; Stochastic Exclusion Ratio Test (SERT) scenarios; the VM-20 deterministic reserve (DR) scenario; and scenario statistics.
9. Discussed GOES equity calibration and interest rate flooring options.
10. Heard an update from the Society of Actuaries (SOA) on HMI and FMI factors.
11. Re-exposed APF 2024-13, which would clarify the reflection of negative IMR, for a 14-day public comment period ending Dec. 2.
12. Adopted APF 2024-14, which adds reporting requirements on waiver of surrender charges.
13. Exposed APF 2024-15, which would make a correction to the VM-21 SPA mortality application, where there is little or no company experience, for a 21-day public comment period ending Dec. 9.
14. Discussed a universal life nonforfeiture product filing issue.
15. Heard an update on the SOA's education redesign.
16. Heard an update on *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53) reports.
17. Discussed comments received on the AAT for reinsurance actuarial guideline draft.
18. Heard an update from the SOA Research Institute.
19. Heard an update from the American Academy of Actuaries (Academy) Council on Professionalism and Education.
20. Heard an update from the Academy Life Practice Council.
21. Exposed Academy Life Knowledge Statements for appointed actuaries and qualified actuaries for a 51-day public comment period ending Jan. 8, 2025.
22. Heard a presentation from the American Council on Gift Annuities (ACGA) on charitable gift annuities.
23. Reported that the Task Force met Oct. 31 in regulator-to-regulator session jointly with the Health Actuarial (B) Task Force, pursuant to paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings, to hear a confidential update regarding changes to the SOA fellowship pathway.
24. Exposed considerations on the AG reinsurance asset adequacy testing (ReAAT) for a 58-day public comment period ending Jan. 15, 2025.

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Nov. 19, 2024

1. Adopted its Summer National Meeting minutes.

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2. Adopted the report of the Consumer Information (B) Subgroup, including its Oct. 18 minutes. During this meeting, the Subgroup took the following action:
   A. Adopted its Oct. 8 and Aug. 29 minutes. During these meetings, the Subgroup took the following action:
      i. Reviewed the NAIC's *Frequently Asked Questions About Health Care Reform* document (FAQ document), which is updated yearly before the open enrollment period begins so state insurance regulators have accurate information to answer consumers' questions.
      ii. Discussed the use of current NAIC guides developed by the Subgroup.
   B. Discussed revisions to the FAQ document.
   C. Discussed potential future Subgroup projects, including using SurveyMonkey to solicit suggestions for a consumer guide on prior authorization.
3. Adopted the report of the Health Innovations (B) Working Group, including its Oct. 15 minutes. During this meeting, the Working Group took the following action:
   A. Heard a presentation on hospital price caps in Oregon, which limits payments to hospitals in the state employee plan to 200% of the Medicare amount.
   B. Heard presentations from the Center on Health Insurance Reforms (CHIR) and AHIP on federal transparency in coverage (TIC) requirements.
   C. Heard a presentation from the Pharmaceutical Research and Manufacturers of America (PhRMA) Foundation on a U.S. Department of Veterans Affairs (VA) program that helps veterans understand their prescription drugs, eliminate prescriptions that are no longer needed, and prevent conflicting drug usage.
4. Adopted the report of the Health Actuarial (B) Task Force. Refer to the Task Force listing for details.
5. Adopted the report of the Long-Term Care Insurance (B) Task Force. Refer to the Task Force listing for details.
6. Adopted the report of the Regulatory Framework (B) Task Force. Refer to the Task Force listing for details.
7. Adopted the report of the Senior Issues (B) Task Force. Refer to the Task Force listing for details.
8. Adopted its 2025 proposed charges and its task forces' 2025 proposed charges.
9. Adopted revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). The revisions update the model for consistency with its model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170).
10. Heard a presentation from NORC at the University of Chicago on research to assess the use of artificial intelligence (AI) to conduct utilization management. The presentation discussed a recent report on the use of AI in health insurance and its key findings regarding health benefit plan use, impact, and regulatory oversight. The presentation also outlined recommendations related to its use, such as transparency, accountability, and ensuring effective oversight.
11. Heard a presentation from the Center for Insurance Policy and Research (CIPR) on small group market trends.
12. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on recent activities of interest to the Committee.

Health Actuarial (B) Task Force

Nov. 16, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted its Oct. 1 minutes. During this meeting, the Task Force took the following action:
   A. Adopted its 2025 proposed charges.
   B. Exposed an American Academy of Actuaries (Academy) draft of knowledge statements for appointed actuary roles for the health blank for a 30-day public comment period that ended Oct. 31.
3. Heard an update from the Society of Actuaries (SOA) Research Institute on its activities.
4. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on: 1) the proposed 2025 Notice of Benefits and Payment Parameters; and 2) a Notice of Funding Opportunity (NOFO) on Essential Health Benefits (EHB)-Benchmark Plan Modernization for states with a Federally Facilitated Exchange (FFE).
5. Heard an update from the Academy Health Practice Council on recent and upcoming activities, publications, and webinars.

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6. Heard an Academy professionalism update.
7. Discussed comments received on the exposure of the Academy's draft knowledge statements for an appointed actuary for the health blank.
8. Heard a presentation on Nebraska's Medicare supplement insurance (Medigap) market's new business rate setting and underwriting issues.

Long-Term Care Insurance (B) Task Force

Nov. 17, 2024

1. Adopted Summer National Meeting minutes.
2. Adopted its Oct. 2 minutes. During this e-vote, the Task Force took the following action:
   A. Adopted a recommendation to the Health Insurance and Managed Care (B) Committee for 2025 proposed charges, which include disbanding the Long-Term Care Insurance (B) Task Force on Dec. 31, 2024, and charges for the Senior Issues (B) Task Force and the Health Actuarial (B) Task Force.
3. Adopted the report of the Long-Term Care Actuarial (B) Working Group, which met Nov. 16. During this meeting, the Working Group took the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Adopted its Oct. 9 minutes. During this meeting, the Working Group took the following action:
      i. Discussed comments received on the exposure of the Minnesota Approach with adjustments to haircut percentages and cumulative rate increase ranges of the cost-sharing formula as a candidate for a single long-term care insurance (LTCI) multistate rate review approach methodology for use in multistate actuarial (MSA) filing reviews.
      ii. Adopted the Minnesota Approach with the current cost-sharing formula as the single multistate rate review approach methodology for use in MSA filing reviews.
      iii. Exposed the Minnesota Approach, with a particular focus on the cost-sharing factors and blending factors associated with the if-knew/makeup approach, for a 19-day public comment period that ended Oct. 28.
   C. Discussed proposed modifications to the Minnesota Approach for use as the single LTCI MSA rate review approach.
   D. Adopted modifications to the cost-sharing formula used in the single LTCI multistate rate review approach methodology for use in MSA filing reviews.
4. Exposed revisions to the LTCI MSA Rate Review Framework, including the proposed single LTCI MSA rate review approach and modifications to the cost-sharing formula, for a 26-day comment period ending Dec. 13, 2024.
5. Heard a presentation from the Center for Insurance Policy and Research (CIPR) on the progress of the study of reduced benefit options (RBOs) letters to consumers and consumer choices. The CIPR plans to continue to review the data and report on results during future meetings.

Regulatory Framework (B) Task Force

Nov. 17, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted its Nov. 4 minutes. During this meeting, the Task Force took the following action:
   A. Adopted its 2025 proposed charges.
   B. Adopted the proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).
3. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Oct. 17 and Sept. 9 minutes. During these meetings, the Subgroup took the following action:
   A. Discussed the comments received on the May 5 and Sept. 24 drafts of proposed revisions to Section 9—Required Disclosure Provisions of Model #171.
   B. Adopted the proposed revisions to Model #171.

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4. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group.
5. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its Summer National Meeting minutes. The Working Group met Nov. 18. During this meeting, it took the following action:
   A. Heard a presentation from the U.S. Department of Labor (DOL) addressing state insurance regulator questions on the most recent final rule on requirements related to the MHPAEA.
   B. Heard a presentation from the Blue Cross Blue Shield Association (BCBSA) on health plan concerns with the final mental health parity rule.
   C. Heard a presentation from the Legal Action Center (LAC) on consumer impacts of the final mental health parity rule and recommendations for state insurance regulators.
   D. Met in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss the opioid use disorder issue.
6. Adopted the report of the Pharmaceutical Benefit Management Regulatory Issues (B) Working Group, which met Nov. 18. During this meeting, the Working Group took the following action:
   A. Heard presentations from the Pharmaceutical Care Management Association (PCMA), the Pharmaceutical Research and Manufacturers of America (PhRMA), and jointly, the National Community Pharmacists Association (NCPA) and the National Association of Chain Drug Stores (NADCS) on "Pharmacy Benefit Managers (PBMs) and How They Function." Each presentation provided insight on PBMs and how they function from their individual perspectives as a PBM company, a prescription drug manufacturer, and a community pharmacist and an independent pharmacy.
   B. Discussed providing potential assistance to the Producer Licensing Uniformity (D) Working Group to create a new section on PBM licensure best practices and uniform standards in the *State Licensing Handbook*.
   C. Discussed the progress of its work related to its charge to develop a chapter for inclusion in the *Market Regulation Handbook* establishing examination standards for PBMs and related regulated entities for referral and consideration by the Market Conduct Examination Guidelines (D) Working Group. The drafting group assignments have been circulated. However, there is still an opportunity for both state insurance regulators and non-regulators to serve on the drafting group. Those interested should reach out to the Working Group chair or vice chair or NAIC staff.
7. Heard a presentation from AffirmedRx on PBM transparency initiatives. The presentation offered a brief overview of PBMs, emphasizing the importance of transparency in PBM operations and addressing related challenges and barriers. It explored the concept of public benefit corporations (PBCs) and PBC PBMs, highlighting how PBC PBMs focus on providing transparent and ethical drug pricing while ensuring access to medications for underserved populations. This approach enhances trust among stakeholders, partners, and the public; attracts socially conscious investors; and improves public image and reputation. The discussion also covered future directions, including PBM transparency emerging trends, the potential impact of new technologies, and ongoing legislative and regulatory efforts.
8. Heard a discussion on issues related to the implementation of the federal Affordable Care Act's (ACA's) Section 1557 final regulation, including the application of its nondiscrimination provisions to Medicare supplemental insurance (Medigap) and other excepted benefit products. The discussion noted the importance of excepted benefit products to consumers. It also highlighted that Section 1557's nondiscrimination provisions apply to any health program or activity, including any part of which is receiving federal financial assistance, and that federal guidance is needed to provide clarity on how the final regulation is to be implemented, particularly with respect to Medigap plans.

Senior Issues (B) Task Force

Nov. 17, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted its Oct. 21 and Sept. 20 minutes. During these e-votes, the Task Force took the following action:

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A. Adopted its 2025 proposed charges and forwarded them to the Health Insurance and Managed Care (B) Committee for consideration.
B. Adopted a letter to the federal Centers for Medicare & Medicaid Services (CMS) regarding provider withdrawals from Medicare Advantage plans and the Medicare supplement insurance (Medigap) guaranteed issue (GI).

3. Discussed the Medicare Advantage/Medigap/Special Enrollment Period (SEP) issue with CMS.

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

Nov. 19, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted the report of the Casualty Actuarial and Statistical (C) Task Force. Refer to the Task Force listing for details.
3. Adopted the report of the Surplus Lines (C) Task Force. Refer to the Task Force listing for details.
4. Adopted the report of the Title Insurance (C) Task Force. Refer to the Task Force listing for details.
5. Adopted the report of the Workers' Compensation (C) Task Force. Refer to the Task Force listing for details.
6. Adopted the report of the Cannabis Insurance (C) Working Group, which met Nov. 18. During this meeting, the Working Group took the following action:
   A. Adopted its May 8 minutes. During this meeting, the Working Group took the following action:
      i. Adopted its Dec. 19, 2023, minutes.
      ii. Heard an update on cannabis-related legislative activities.
      iii. Heard a presentation from BDSA on trends and emerging issues in the cannabis space.
      iv. Heard a presentation from Jencap Specialty Insurance Services on insurance availability, coverage trends, and new risks in the cannabis space.
      v. Heard a presentation on the work of the Institute for Highway Safety (IIHS) and the Highway Loss Data Institute (HLDI) on the legalization of marijuana for recreational use.
   B. Heard a presentation on activities at the Colorado Marijuana Enforcement Division (MED) and Cannabis Regulators Association (CANNRA). A bill passed by the Colorado legislature in May will facilitate significant changes for businesses, including licensing processes, contaminant testing protocols, reporting obligations, compliance procedures, and operations management practices. CANNRA released a letter in May calling on Congress to clarify states' existing regulatory authority over activity involving hemp and hemp products, particularly those containing cannabinoids.
   C. Heard a presentation from the American Property Casualty Insurance Association (APCIA) on impediments for otherwise admitted carriers to write coverage for cannabis. Insurers remain concerned about expanded exposures for established coverages, safety in the workplace and on the road, coverage mandates and exclusions, and continued federal illegality.
7. Adopted the report of the Catastrophe Insurance (C) Working Group, which met Nov. 17 in joint session with the NAIC/Federal Emergency Management Agency (FEMA) (C) Advisory Group. During this meeting, the Working Group and Advisory Group:
   A. Heard an update about the recently released *The Flood Insurance Crisis: A Comprehensive Breakdown on Rising Flood Insurance Premiums* paper. This paper discusses how dire the situation is and what Congress must do to make flood insurance affordable again. Key findings include information about flood insurance costs and increased pricing, lack of transparency with the risk rating 2.0 premiums, and the legal challenges involved. It also provides information about the recommended steps.
   B. Adopted its Oct. 23 minutes. During this meeting, the Working Group took the following action:
      i. Adopted its Summer National Meeting minutes.
      ii. Exposed a draft *NAIC Catastrophe Modeling Primer* for a 30-day public comment period that ended Nov. 22.
   C. Heard a presentation from Connecticut on its new Extreme Weather Mitigation & Resiliency Advisory Council. The Advisory Council will provide expert recommendations to enhance the state's resiliency in response to the increasing frequency of extreme weather events, flooding, and other climate-related

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risks. It includes experts such as insurance industry and state insurance regulators; consumer advocates; and climate, environmental science, building construction, academics, and emergency management.

D. Heard a presentation from Pennsylvania on the *Flood Insurance Premium Assistance Task Force Final Report*. In the report, the Flood Insurance Premium Assistance Task Force delivered recommendations to increase flood insurance awareness, accessibility, and affordability.

E. Heard a presentation from the Center for Insurance Policy and Research (CIPR) on the legislative obstacles in forming a state mitigation program. Necessary considerations include: 1) educating stakeholders about programs; 2) timing of legislation and management of expectations; 3) competing legislation; and 4) situational awareness. The CIPR has mitigation program legislation resources.

F. Discussed the *NAIC Catastrophe Modeling Primer*. There were no verbal comments from the Working Group, interested state insurance regulators, or other interested parties during the meeting. The document was previously exposed for a 30-day public comment period that ended Nov. 22.

G. Discussed the ways in which the Working Group could collaborate with other NAIC working groups, task forces, and committees.

H. Heard an update on the upcoming NAIC/FEMA workshop. The NAIC and FEMA will hold a workshop Feb. 11–12, 2025, for the states in FEMA Region 5. The workshop will be hosted by the Minnesota Department of Insurance (DOI).

I. Heard from Tennessee regarding Hurricane Helene, which occurred on Sept. 27 and caused extensive flooding in the eastern part of the state. The Tennessee DOI issued bulletins clarifying what it expected from insurers. Tennessee has loans available through the Helene Emergency Assistance Plan.

J. Heard from North Carolina regarding Hurricane Helene, which resulted in $1.2 billion in damages. The North Carolina DOI has manned insurance camps and issued bulletins about its expectations.

8. Adopted the report of the Transparency and Readability of Consumer Information (C) Working Group, which met Nov. 12. During this meeting, the Working Group took the following action:
   A. Discussed revisions to the *Premium Increase Transparency Disclosure Notice Guidance for States* based on comments received during the exposure period that ended Aug. 30:
      i. Revisions for readability were incorporated.
      ii. The suggested three-year Phase Two start date was removed, and a footnote was added to specify that states should determine the Phase Two implementation time based on their review of Phase One and implementation of Phase Two considerations.
      iii. A footnote explaining that states may choose to exclude the requirement for insurers to specify each factor's dollar impact on the increase in premium was also added to the notice examples.
      iv. An exemption was added to exclude policies with an increase of less than $100 from Phase Two.
      v. The "Communication Standards" section was revised to clarify that the factors listed are not exhaustive.
   B. Adopted the revised *Premium Increase Transparency Disclosure Notice Guidance for States*.
9. Adopted the *Premium Increase Transparency Disclosure Notice Guidance for States*.
10. Adopted its 2025 proposed charges.
11. Heard a presentation from QuantivRisk on how vehicle performance data can improve auto claim adjudication.
12. Heard a presentation from FortressFire on using fire science and data to improve home resilience.
13. Heard a federal update related to property/casualty (P/C) insurance issues.
14. Heard an update on the status of the P/C market intelligence (PCMI) data call.

Casualty Actuarial and Statistical (C) Task Force

Nov. 17, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted its Oct. 8 minutes. During this meeting, the Task Force took the following action:
   A. Adopted its 2025 proposed charges.

B. Discussed a plan for assessment of the Society of Actuaries (SOA) and Casualty Actuarial Society (CAS) educational changes.
C. Discussed revisions to the appendix of the white paper on generalized linear models (GLMs).
D. Discussed Schedule P instructions drafting.

3. Reported that the Task Force met Oct. 15 and Aug. 20 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss rate filing issues.
4. Reported that the Task Force held Book Club education sessions about predictive modeling on Oct. 22 and Aug. 27. Book Club sessions included the following:
   A. The American Academy of Actuaries (Academy) Data Science and Analytics Committee presented an actuarial view of data bias.
   B. Sam Kloese (NAIC), Roberto Perez Santiago (NAIC), and Bulut Özenç (Capital Insurance Group—CIG) presented an analysis of the impact of various distributions for modeling pure premium.
5. Adopted the report of the Actuarial Opinion (C) Working Group, which met Sept. 25 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss observations resulting from state insurance regulators' review of the 2023 Statements of Actuarial Opinion (SAOs). The Working Group also met Oct. 21, Sept. 24, and Aug. 29. During these meetings, the Working Group took the following action:
   A. Discussed and adopted the *Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2024* (Regulatory Guidance).
   B. Discussed 2025 SAO instructions.
6. Adopted the report of the Statistical Data (C) Working Group, which met Oct. 9 in regulator-to-regulator session to discuss auto and home data. The Working Group also met Oct. 23. During this meeting, the Working Group took the following action:
   A. Discussed proposed changes to NAIC statistical reports.
7. Adopted a white paper appendix on penalized regression.
8. Heard a report on the actuarial educational assessment project. State insurance regulators expect materials to be submitted by the CAS and SOA soon after the Fall National Meeting.
9. Heard from Pennsylvania about how the Pennsylvania Insurance Department (PID) is pre-vetting a draft regulation about unknown or missing risk classifications.
10. Heard a presentation from the CAS on actuaries and artificial intelligence (AI).
11. Received liaison reports on the property/casualty (P/C) actuarial activities in other committees.
12. Heard activity and research reports from the Actuarial Standards Board (ASB), Actuarial Board for Counseling and Discipline (ABCD), Academy, CAS, and SOA.

Surplus Lines (C) Task Force

Nov. 7, 2024 *(in lieu of the Fall National Meeting)*

1. Adopted its Summer National Meeting minutes.
2. Adopted the report of the Surplus Lines (C) Working Group, which met Sept. 24 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings. During this meeting, the Working Group took the following action:
   A. Approved one insurer for admittance to the Oct. 1 edition of the NAIC *Quarterly Listing of Alien Insurers*.
3. Discussed comments received on the draft surplus lines service of process form that was exposed for a 30-day public comment period that ended Sept. 13. Following discussion, the Task Force chair directed the drafting group to consider additional comments on the draft and report back at the 2025 Spring National Meeting.
4. Heard a summary of 2023 surplus lines industry financial results. The industry report was posted to the Property and Casualty Insurance (C) Committee's web page.

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Title Insurance (C) Task Force

Nov. 18, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted the updated *Survey of State Insurance Laws Regarding Title Data and Title Matters* report.
3. Heard an update from NAIC Government Relations staff on recent federal activities. A strong departure from the Biden administration's work in the housing and title insurance space is expected in the second Trump administration. Former President Trump favors a deregulatory approach to housing affordability, which could potentially include privatizing Fannie Mae and Freddie Mac.
4. Heard a presentation on metrics that the American Academy of Actuaries (Academy) will use in its title-related research aimed at identifying where the industry might reduce costs. The research will examine variation in levels and composition of expenses in 2023 and over time for: 1) total expenses; 2) expenses per policy; 3) insured value per dollar of expense; 4) personnel as a share of total expenses; and 5) surveys, examinations, and abstracts as a share of total expenses.
5. Heard an update on the Aug. 29 Office of the Attorney General (OAG) for the District of Columbia settlements with four title firms over alleged kickback schemes. The OAG also announced that on Oct. 24, a settlement was reached with another firm that offered real estate agents discounted ownership interests and profit-sharing in entities created to incentivize the agents to make business referrals to it.

Workers' Compensation (C) Task Force

Nov. 17, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted its Oct. 23 minutes. During this e-vote, the Task Force took the following action:
   A. Adopted its 2025 proposed charges.
3. Heard a presentation from the American Medical Association (AMA) on its updated impairment guidelines. The latest medical advancements and evidence-based updates have been made to spine, upper, and lower extremity impairments. The 2024 methods allow for more efficient impairment ratings while retaining accuracy, consistency, reliability, and reproducibility. Compared to previous guides, the workers' compensation system could potentially save money. The transition to the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition, 2024* benefits all system stakeholders, including injured parties, employers, medical professionals, legal representatives, insurers, regulators, legislators, and policymakers.

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

Nov. 19, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted its 2025 proposed charges, which include disbanding the Market Information Systems (D) Task Force and appointing a new Market Information Systems (D) Working Group.
3. Adopted revisions to Chapter 23—Conducting the Life and Annuity Examination of the *Market Regulation Handbook* (Handbook) regarding *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest Sold (On or After Dec. 14, 2020)* (AG 49-A).
4. Adopted amendments and an implementation timeline for the NAIC Uniform Licensing Applications, which will require between 4,122 and 10,715 hours of work. National Insurance Producer Registry (NIPR) work on amending the Uniform Producer Licensing Application will begin in October 2025 and will be completed by February 2026, with implementation into production scheduled between March and May 2026.
5. Adopted the NAIC continuing education (CE) audit guidelines to provide states with instructions on auditing approved CE courses.
6. Adopted amendments to the *Public Adjuster Licensing Model Act* (#228) to strengthen regulatory standards governing the conduct of public adjusters for the following four issues: 1) individuals acting as unlicensed public adjusters; 2) contractors who are also acting as public adjusters on the same claim; 3) inappropriate assignment of benefit rights; and 4) excessive fees charged by public adjusters.

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7. Adopted the report of the Antifraud (D) Task Force. Refer to the Task Force listing for details.
8. Adopted the report of the Producer Licensing (D) Task Force. Refer to the Task Force listing for details.
9. Adopted the report of the Market Analysis Procedures (D) Working Group, which met Oct. 21. During this meeting, the Working Group took the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Received an update from the Market Analysis Prioritization Tool (MAPT) Recommendations Subgroup.
   C. Discussed Market Analysis Review System (MARS) level 1 review requirements.
   D. Discussed ratio 7 of the private passenger auto (PPA) and homeowners Market Conduct Annual Statement (MCAS) blanks.
   E. Discussed the lunch-and-learn schedule.
10. Adopted the report of the Market Conduct Annual Statement Blanks (D) Working Group, which met Sept. 5. During this meeting, the Working Group took the following action:
   A. Adopted its July 11 minutes.
   B. Discussed the removal of duplicate data element No. 51 from the other health MCAS.
   C. Discussed the draft frequently asked questions (FAQ) document and definitions related to artificial intelligence (AI) and machine learning (ML).
   D. Discussed the draft definitions for partial payments and cancellations for the pet insurance MCAS.
   E. Discussed the MCAS other health interrogatory question No. 5 next steps and additional items related to comments received.
   F. Received an update on the formation of a subject matter expert (SME) group to review the PPA MCAS blank.
11. Adopted the report of the Market Conduct Examination Guidelines (D) Working Group, which met Nov. 7. During this meeting, the Working Group took the following action:
   A. Adopted AG 49-A-related revisions to Chapter 23 of the Handbook.
   B. Discussed its 2024 work.
12. Adopted the report of the Market Regulation Certification (D) Working Group, which met Sept. 23. During this meeting, the Working Group took the following action:
   A. Discussed assistance to jurisdictions and ideas for implementing a peer review program.
   B. Discussed using the scoring matrix for self-certification.
   C. Discussed the certification session from the Insurance Summit.
   D. Discussed certification program revisions.
13. Adopted the report of the Speed to Market (D) Working Group, which met Nov. 8. During this e-vote, the Working Group took the following action:
   A. Adopted its July 30 minutes.
14. Heard an update from NAIC staff on federal activities.

Antifraud (D) Task Force

Nov. 18, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted its Oct. 31 minutes. During this e-vote, the Task Force took the following action:
   A. Adopted its 2025 proposed charges.
3. Discussed its 2025 charges.
4. Heard a presentation from the American Academy of Actuaries (Academy) on the impacts of fraud on premiums, claim costs, and the public.
5. Adopted the report of the Improper Marketing of Health Insurance (D) Working Group, which met Nov. 18. During this meeting, the Working Group took the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Heard from the federal Centers for Medicare & Medicaid Services (CMS) on the current issues consumers are experiencing with continued agent transfers of policy.

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C. Heard from CMS on Special Enrollment Period (SEP) issues and other Medicare Advantage open enrollment Issues.
D. Heard a presentation from Health Agents for America (HAFA) on federal fraud prevention efforts concerning agents.

6. Received an update from the Antifraud Technology (D) Working Group. The Working Group did not meet prior to the Fall National Meeting. However, it will continue to assist with the implementation process of the new web service and review necessary enhancements to the Online Fraud Reporting System (OFRS).
7. Heard reports from the Coalition Against Insurance Fraud (CAIF) and the National Insurance Crime Bureau (NICB) on antifraud activity.

Market Information Systems (D) Task Force

The Task Force did not meet at the Fall National Meeting.

Producer Licensing (D) Task Force

Nov. 17, 2024

1. Adopted its Oct. 31 minutes. During this meeting, the Task Force took the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Adopted its 2025 proposed charges.
   C. Adopted proposed amendments to the NAIC Uniform Licensing Applications.
   D. Discussed amendments to the *Public Adjuster Licensing Model Act* (#228) to strengthen regulatory standards governing the conduct of public adjusters for the following four issues: 1) individuals acting as unlicensed public adjusters; 2) contractors who are also acting as public adjusters on the same claim; 3) inappropriate assignment of benefit rights; and 4) excessive fees charged by public adjusters.
   E. Discussed the draft 1033 waiver template being developed as a resource that states may voluntarily use to enhance their review of 1033 waiver requests.
2. Adopted proposed amendments to Model #228.
3. Discussed the draft 1033 waiver template, which is being developed as a template that states can voluntarily use to enhance their review of 1033 waiver requests.
4. Adopted the report of the Adjuster Licensing (D) Working Group, which met Nov. 6. During this meeting, the Working Group took the following action:
   A. Discussed the review of Chapter 18—Adjusters of the *State Licensing Handbook*.
   B. Discussed an adjuster licensing survey concerning the verification of designated home state data that is submitted to the State Producer Licensing Database (SPLD).
5. Adopted the report of the Producer Licensing Uniformity (D) Working Group, which met Nov. 7 and Sept. 10. During these meetings, the Working Group took the following action:
   A. Discussed the review of the *State Licensing Handbook* and decided that 14 chapters warrant further discussion for potential revisions.
6. Adopted the report of the Uniform Education (D) Working Group, which met Nov. 13, Oct. 29, and Oct. 9. During these meetings, the Working Group took the following action:
   A. Adopted the NAIC continuing education (CE) audit guidelines.
   B. Discussed draft guidelines for course introduction statements.
   C. Discussed the review and potential revisions of the *State Licensing Handbook* (Chapter 6—Prelicensing Education, Chapter 8—Testing Programs, and Chapter 14—Continuing Education).
7. Heard a report from the National Insurance Producer Registry (NIPR) Board of Directors. Through September 2024, revenue is $61.76 million, which is 8.7% over budget. NIPR's chief of state regulatory affairs provided an update on NIPR's product rollouts, upcoming producer licensing zone training, and enhancements to NIPR's State Regulatory Affairs team.

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FINANCIAL CONDITION (E) COMMITTEE

Nov. 19, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted its Oct. 24 and Aug. 29 minutes. During these meetings, the Committee took the following action:
   A. Adopted its 2025 proposed charges.
   B. Discussed comments on the draft request for proposal (RFP) to engage a consultant to design and help implement a new due diligence program over the ongoing use of credit rating providers (CRPs).
   C. Adopted amendments to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) that provide state insurance regulators with discretion over securities that are otherwise exempt from filing with the Securities Valuation Office (SVO).
3. Adopted the report of the Accounting Practices and Procedures (E) Task Force. Refer to the Task Force listing for details.
4. Adopted the report of the Capital Adequacy (E) Task Force. Refer to the Task Force listing for details.
5. Adopted the report of the Examination Oversight (E) Task Force. Refer to the Task Force listing for details.
6. Adopted the report of the Financial Stability (E) Task Force. Refer to the Task Force listing for details.
7. Adopted the report of the Receivership and Insolvency (E) Task Force. Refer to the Task Force listing for details.
8. Adopted the report of the Reinsurance (E) Task Force. Refer to the Task Force listing for details.
9. Adopted the report of the Valuation of Securities (E) Task Force. Refer to the Task Force listing for details.
10. Adopted the report of the NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group, which met Sept. 24. During this meeting, the Working Group took the following action:
    A. Discussed the premium threshold.
    B. Heard an update from Ernst & Young on recent auditing pronouncements.
11. Adopted the report of the National Treatment and Coordination (E) Working Group, which met Nov. 4. During this meeting, the Working Group took the following action:
    A. Discussed comments received on the exposure of the *Company Licensing Best Practices Handbook*.
    B. Adopted proposal 2024-07 (Expansion Application Instructions).
    C. Discussed the pre-notification and post-notification of the redomestication application.
    D. Discussed biographical affidavits and background reports.
12. Adopted the report of the Restructuring Mechanisms (E) Working Group, which met Oct. 3. During this meeting, the Working Group took the following action:
    A. Discussed comments received on the May 10 exposure of the *Best Practices Procedures for IBT/Corporate Divisions* document and the *Restructuring Mechanisms* white paper.
13. Adopted the report of the Risk-Focused Surveillance (E) Working Group, which met Oct. 10. During this meeting, the Working Group took the following action:
    A. Referred regulatory guidance for run-off insurers to the Financial Analysis Solvency Tools (E) Working Group and the Financial Examiners Handbook (E) Technical Group.
    B. Exposed proposed regulatory review guidance for the oversight of contract regulators for a 60-day public comment period that ended Dec. 10.
    C. Discussed a referral on pandemic risk.
    D. Adopted updated examiner salary rates.
    E. Discussed an NAIC and Society of Financial Examiners (SOFE) memorandum of understanding related to regulator education and training.
    F. Received an update on the 2024 peer review program sessions.
14. Reported that the Financial Analysis (E) Working Group met Nov. 16, Oct. 23, and Oct. 2 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.
15. Reported that the Valuation Analysis (E) Working Group met Nov. 16, Nov. 4, and Sept. 6 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.

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16. Adopted a listing of qualified jurisdictions, reciprocal jurisdictions, and jurisdictions that recognize and accept the NAIC group capital calculation (GCC).
17. Received a status report on the draft reinsurance asset adequacy actuarial guideline.
18. Received an update from the Valuation of Securities (E) Task Force.
19. Received an update from the Risk-Based Capital Investment Risk and Evaluation (E) Working Group.
20. Received an update from the Center for Insurance Policy and Research (CIPR) on the Climate Scenario Resource Center.

Accounting Practices and Procedures (E) Task Force

Nov. 18, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted the report of the Statutory Accounting Principles (E) Working Group, which met Nov. 17, 2024. During this meeting, the Working Group took the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Adopted its Sept. 12 minutes. During this e-vote, the Working Group took the following action:
      i. Adopted revisions to *Statement of Statutory Accounting Principles (SSAP) No. 26—Bonds* and Issue Paper No. 169 to incorporate guidance for debt securities issued by funds that represent operating entities with a Jan. 1, 2025, effective date. (Ref #2024-01)
   C. Adopted its Oct. 4 minutes. During this e-vote, the Working Group took the following action:
      i. Exposed the updated Principles-Based Bond Definition Implementation Questions and Answers (Q&A) for a public comment period that ended Oct. 28. (Ref #2019-21)
   D. Adopted the following clarifications to statutory accounting guidance:
      i. Clarifications that expand and update guidance on tax credit investments effective Jan. 1, 2025. (Ref #2024-18)
      ii. Revisions that reject, with modification, Accounting Standards Update (ASU) 2023-09, Improvements to Income Tax Disclosures. The adoption also removes an existing *SSAP No. 101—Income Taxes* disclosure. (Ref #2024-11)
      iii. Revisions that update the definition of a clearly defined hedging strategy (CDHS) to reflect the revised guidance pursuant to Valuation Manual (VM)-01, Definitions for Terms in Requirements. (Ref #2024-17)
      iv. The exposed Q&A, updated with interested parties' comments, in a new Interpretation (INT) 24-01: Principles-Based Bond Definition Implementation Questions & Answers (Q&A). (Ref #2019-21)
   E. Rejected ASU 2024-02, Codification Improvements, as not applicable to statutory accounting. (Ref #2024-19)
   F. Exposed the following statutory accounting principle (SAP) concepts and clarifications for a public comment period ending Jan. 31, 2025, except for agenda item 2024-26EP, which was exposed for a public comment period that ended Dec. 9. 2024:
      i. Revisions to *SSAP No. 1—Accounting Policies, Risks & Uncertainties, and Other Disclosures* and the existing *Annual Statement Instructions*/illustrations for the restricted asset disclosure in Note 5L that specify how modified coinsurance and funds withheld assets reported within a ceding company's financial statements shall be captured. This exposure also includes a reconciliation of items reported as restricted between Note 5L and the general interrogatories. (Ref #2024-20)
      ii. Revisions that clarify *SSAP No. 16—Electronic Data Processing Equipment and Software* references to accounting standards codification (ASC) by including the relevant ASUs. (Ref #2024-25)
      iii. Editorial revisions that clarify the scope of the annual audited disclosure for investments receiving bond treatment by reporting categories. (Ref #2024-26EP)
      iv. Revisions for consistent terminology for financing derivatives that clarify that derivative premium shall not be captured as a realized gain or loss and shall not be included in the IMR. (Ref #2024-23)
      v. Concept agenda item with requests for comments on the options offered to include: 1) clarifying statutory accounting guidelines (and resulting reporting impacts) for investment

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subsidiaries; 2) sponsoring a blanks proposal to capture new investment schedules, or perhaps expansions to existing investment schedules, to detail the underlying assets held by an investment subsidiary; or 3) referrals to the Capital Adequacy (E) Task Force and related risk-based capital (RBC) working groups to incorporate details that allow regulators to verify the RBC calculation for the underlying assets within an investment subsidiary. (Ref #2024-21)

vi. Revisions to adopt with modification ASU 2024-01, Compensation—Stock Compensation (Topic 718), Scope Application of Profits Interest and Similar Awards, which provides clarifications on the application of the guidance to profit interests and similar awards. (Ref #2024-22)

vii. INT 24-02: Medicare Part D Prescription Payment Plans and INT 05-05: Accounting for Revenues Under Medicare Part D Coverage to provide accounting and reporting for the Medicare Part D prescription payment plans. Directed notice of the exposure to the Health Insurance and Managed Care (B) Committee and the Health Risk-Based Capital (E) Working Group and directed an annual statement blanks proposal and disclosures to be developed for future discussion. (Ref #2024-24)

viii. Annual statement revisions to provide more granular reporting lines on Schedule BA Other Invested Assets for Collateral Loans to allow for concurrent exposure with the corresponding blanks proposal. (Ref #2023-28)

G. Directed NAIC staff on the following items:

i. To prepare an agenda item to classify issue papers in level 5 of the statutory hierarchy.

ii. To modify the agenda item to remove a proposal to bifurcate embedded derivatives and instead capture limited revisions to clarify reporting when a bond is sold and reacquired from a special purpose vehicle (SPV) with derivative wrappers (or other components). (Ref #2024-16)

H. Received updates on the following:

i. U.S. generally accepted accounting principles (GAAP) exposures, noting that items will be addressed during the normal maintenance process.

ii. IMR Ad Hoc Group activities, noting that its discussions have focused on IMR from reinsurance transactions and has directed a reassessment of existing guidance.

iii. The Bond Project Implementation Small Group, which concluded its regular meetings as it addressed the items presented and referred the Q&A guide to the Working Group. The Small Group may resume future discussions if necessary.

iv. Use of third-party vendors and checklists to determine bond definition compliance and classification.

v. International Association of Insurance Supervisors (IAIS) Audit and Accounting Working Group activities, including notice of the application paper on climate risk.

vi. The comment deadline for three reinsurance-related agenda items (2024-05, 2024-06, and 2024-07) exposed at the Summer National Meeting, which was delayed to Dec. 9 and Dec. 16 at the request of the American Council of Life Insurers (ACLI). The ACLI provided short verbal comments on these items.

vii. Requests submitted by Lloyd's that resulted in the removal of several inactive syndicates from the NAIC Listing of Companies. NAIC staff are coordinating with Lloyd's to determine if a guidance memorandum regarding year-end reporting instructions needs to be sent to the Blanks (E) Working Group.

3. Adopted the report of the Blanks (E) Working Group, which met Nov. 6, 2024. During this meeting, the Working Group took the following action:

A. Adopted its Aug. 7 minutes. During this meeting, the Working Group took the following action:

i. Adopted its May 23 minutes.

ii. Adopted the following proposals:

a. 2024-11BWG—Update the annual and quarterly statement instructions and blanks for the new market tax credit changes. Changes that will be made to the annual statement include Assets; Notes to Financial Statements 5K, 14A, and 21E; Asset Valuation Reserve (AVR); Schedule BA, Parts 1 and 3; and Verification Between Years. Quarterly statement changes include Assets; Schedule BA, Part 3; and Verification Between Years.

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b. 2024-12BWG—Update the quarterly investment schedules for editorial items to the bond project. (Schedule D Verification; Schedule D, Part 1B; Schedule D, Parts 3 and 4; Schedule DL, Parts 1 and 2; and Schedule E, Parts 1 and 2). Update the Quarterly Investment Schedule General Instructions for the changes that were adopted in the Annual Investment Schedule General Instructions. (Reference adopted proposal 2023-06BWG.)

iii. Received a Statutory Accounting Principles (E) Working Group memorandum regarding instructional changes to the AVR to allow collateral loans backed by mortgage loans to flow through AVR as an "Other Invested Asset with Underlying Characteristics of Mortgage Loans."

iv. Adopted its editorial listing.

B. Exposed eight new proposals for a 90-day public comment period ending Feb. 6, 2025.

C. Adopted its editorial listing.

D. Received a Statutory Accounting Principles (E) Working Group memorandum regarding the reporting of debt securities issued by funds representing operating entities.

Capital Adequacy (E) Task Force

Nov. 18, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted its Sept. 26 minutes. During this meeting, the Task Force took the following action:
   A. Adopted its revised procedure document, which the Task Force had exposed for a 30-day public comment period that ended Sept. 13.
   B. Adopted its 2025 proposed charges, which the Task Force had exposed for a 30-day public comment period that ended Sept. 13.
3. Adopted the report of the Risk-Based Capital Investment Risk and Evaluation (E) Working Group, which met Oct. 22. During this meeting, the Working Group took the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Received updates from the Valuation of Securities (E) Task Force and the Statutory Accounting Principles (E) Working Group.
   C. Heard an update from the American Academy of Actuaries (Academy) on the structured securities risk-based capital (RBC) project.
   D. Adopted revisions to its 2024 working agenda.
   E. Discussed the status of the fund review project.
4. Adopted the report of the Life Risk-Based Capital (E) Working Group, which met Oct 23. During this meeting, the Working Group took the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Received updates from the Generator of Economic Scenarios (GOES) (E/A) Subgroup, Longevity Risk (E/A) Subgroup, and Variable Annuities Capital and Reserve (E/A) Subgroup.
   C. Exposed proposal 2024-21-L (Tax Credit Investments) for a 75-day public comment period ending Jan 6, 2025.
   D. Exposed proposal 2024 -24-L (Principles-Based Bond Project) for a 75-day public comment period ending Jan 6, 2025.
   E. Received updates from the Academy on covariance and C-3 risk.
5. Adopted the report of the Property and Casualty Risk-Based Capital (E) Working Group, which met Nov. 18 in joint session with the Catastrophe Risk (E) Subgroup. During this meeting, the Working Group took the following action:
   A. Adopted the Working Group and Subgroup's joint Summer National Meeting minutes.
   B. Adopted proposal 2024-22-CR, which adds severe convective storm data for 2015–2023 to the catastrophe event list.
   C. Adopted proposal 2024-23-CR, which adds catastrophe events for January through October 2024 to the catastrophe event list.
   D. Heard an update on the CoreLogic wildfire model review.

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E. Discussed the Working Group and Subgroup's working agenda.
F. Heard a panel discussion titled "The State of the Flood Insurance Market: Trends, Challenges, and Opportunities."
G. Discussed the Climate Scenario Resource Center.

6. Received an update from the Health Risk-Based Capital (E) Working Group regarding H2 review and development.
7. Adopted proposal 2024-22-CR, which adds severe convective storm data for 2015–2023 to the catastrophe event list.
8. Adopted proposal 2024-23-CR, which adds catastrophe events for January through October 2024 to the catastrophe event list.
9. Exposed proposal 2024-25-CA (Principle Based Bond Project for Property/Casualty [P/C] and Health) for a 75-day public comment period ending Feb. 1, 2025.
10. Exposed proposal 2024-26-CA (Tax Credit Investments for P/C and Health) for a 75-day public comment period ending Feb. 1, 2025.
11. Adopted its working agenda with a few edits to the Risk-Based Capital Investment Risk and Evaluation (E) Working Group, Property and Casualty Risk-Based Capital (E) Working Group, and Capital Adequacy (E) Task Force sections.
12. Heard an update on collateral loans from the Statutory Accounting Principles (E) Working Group.

Examination Oversight (E) Task Force

Nov. 12, 2024 (*in lieu of the Fall National Meeting*)

1. Adopted its Summer National Meeting minutes.
2. Adopted its Sept. 25 minutes. During this e-vote, the Task Force took the following action:
   A. Adopted its 2025 proposed charges, which remain unchanged from the Task Force's 2024 charges.
3. Adopted the report of the Electronic Workpaper (E) Working Group, which has not met this year. However, monthly Tele-Talk sessions continue in lieu of formal Working Group meetings to support states as they transition from TeamMate AM to TeamMate+.
4. Adopted the report of the Financial Analysis Solvency Tools (E) Working Group, which met Nov. 7 and Sept. 26. During these meetings, the Working Group took the following action:
   A. Adopted the following revisions to guidance within the *Financial Analysis Handbook*:
      i. Revisions to the property/casualty (P/C) catastrophe reinsurance program, credit risk assessment, and pricing and underwriting risks of health insurers.
      ii. Revisions to Form A and disclaimer of control/affiliation guidance.
      iii. Revisions to guidance pertaining to the Own Risk and Solvency Assessment (ORSA) and Form F exemptions.
      iv. Revisions regarding recovery and resolution planning to align the guidance with the current Insurance Core Principles (ICPs).
      v. Revisions that include new procedures for analysts to consider:
         a. When reviewing applications for capital or surplus notes.
         b. Parental guarantees and capital maintenance agreements as part of the Form A review.
      vi. Revisions regarding merged branded risk guidance and repositories.
      vii. Revisions to incorporate best practices to existing guidance on the monitoring of run-off insurers.
5. Adopted the report of the Financial Examiners Coordination (E) Working Group, which met Aug. 12 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.
6. Adopted the report of the Financial Examiners Handbook (E) Technical Group, which met Oct. 31 and Sept. 23. During these meetings, the Technical Group took the following action:
   A. Adopted the following revisions to guidance within the *Financial Condition Examiners Handbook*:
      i. Revisions to provide guidance to regulators in reviewing affiliated investment management agreements and services.

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ii. Revisions to incorporate best practices to existing guidance on the monitoring of run-off insurers.
iii. Revisions to provide a sample prospective risk and potential interview questions to help examiners gain insight into a company's executive compensation structure and related risks.
iv. Revisions to provide guidance that encourages examiners to review manual adjustments made to risk-based capital (RBC), including those related to modified-coinsurance (modco) reinsurance and separate account assets.

7. Adopted the report of the Information Technology (IT) Examination (E) Working Group, which met Oct. 31 and Oct. 10. During these meetings, the Working Group took the following action:
   A. Adopted revisions to Exhibit C, Part 2, within the *Financial Condition Examiners Handbook*, which update IT review guidance to further align it with the Cybersecurity Framework (CSF) 2.0 of the National Institute of Standards and Technology (NIST).

Financial Stability (E) Task Force

Nov. 17, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted its Oct. 17 minutes. During this e-vote, the Task Force took the following action:
   A. Adopted its 2025 proposed charges.
3. Received an update on Financial Stability Oversight Council (FSOC) developments.
4. Adopted the report of the Macroprudential (E) Working Group.
5. Exposed the proposed 2024 Liquidity Stress Testing Framework (LST Framework) for a 30-day public comment period that ended Dec. 17.
6. Received an update from the Valuation Analysis (E) Working Group.
7. 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 exercise and the sector-wide monitoring exercise. Other updates on IAIS key initiatives were discussed, including cross-border reinsurance, alternative assets, level 3 assets, and climate risk.

Receivership and Insolvency (E) Task Force

Nov. 18, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted the report of the Receivership Financial Analysis (E) Working Group, which met Nov. 18 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.
3. Heard a proposal for enhancements to the Global Receivership Information Database (GRID). The Task Force directed NAIC staff to: 1) add links to the GRID web page to the NAIC's insurance data services and the NAIC state receivership contacts list; and 2) remind states more frequently to update information in the GRID.
4. Heard an update on international resolution activities. In December, the International Association of Insurance Supervisors (IAIS) Resolution Working Group will consider adoption of revisions to Insurance Core Principle (ICP) 12 (Exit from the Market and Resolution) and ICP 16 (Enterprise Risk Management for Solvency Purposes). Additionally, the Insurance Recovery and Resolution Directive is expected to be published in December 2024 or January 2025. The Resolution Working Group will begin the review of application papers related to recovery and resolution in 2025.
5. Heard a reminder that interested parties should submit their requests to be included in the next edition of the *Directory of Receivership and Run-Off Resources* to NAIC staff by Dec. 9.

Reinsurance (E) Task Force

Oct. 24, 2024 (*in lieu of the Fall National Meeting*)

1. Adopted its Summer National Meeting minutes.

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2. Adopted the report of the Reinsurance Financial Analysis (E) Working Group, which met Sept. 26 and Aug. 28 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings. During these meetings, the Working Group took the following action:
   A. Completed the reviews of certified reinsurers and reciprocal jurisdiction reinsurers.
3. Received a status report on the reinsurance activities of the Mutual Recognition of Jurisdictions (E) Working Group, which met Oct. 24 in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings. During this meeting, the Working Group took the following action:
   A. Reapproved the status of Bermuda, France, Germany, Ireland, Japan, Switzerland, and the United Kingdom (UK) as qualified jurisdictions and Bermuda, Japan, and Switzerland as reciprocal jurisdictions that are not subject to an in-force covered agreement.
4. Heard comments on the proposal to require asset adequacy analysis to be performed using a cash-flow testing methodology for life and annuity reinsurance transactions.
5. Discussed ongoing projects at the NAIC affecting reinsurance.

Risk Retention Group (E) Task Force

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

Valuation of Securities (E) Task Force

Nov. 17, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted its Oct. 1 minutes. During this meeting, the Task Force took the following action:
   A. Exposed a proposed amendment to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) to remove references to subscript-S and update references to investment risk for a 30-day public comment period that ended Nov. 1.
   B. Exposed a proposed P&P Manual amendment to update the list of NAIC Credit Rating Providers (CRPs) and the NAIC Policy on the Use of CRP Credit Ratings for a 14-day public comment period that ended Oct. 16.
3. Adopted a proposed P&P Manual amendment to require annual review of regulatory transactions, which the Task Force previously exposed for a 30-day public comment period that ended Sept. 13.
4. Adopted a proposed P&P Manual amendment to update the list of NAIC CRPs and the NAIC Use of CRP Credit Ratings, which the Task Force previously exposed for a 14-day public comment period that ended Oct. 16.
5. Adopted a proposed P&P Manual amendment to remove references to subscript-S and update references to investment risk, which the Task Force previously exposed for a 30-day public comment period that ended Nov. 1.
6. Received a report on Statutory Accounting Principles (E) Working Group projects.
7. Received a report on the status of private letter rating (PLR) rationale report filings for 2024. The Task Force directed the Securities Valuation Office (SVO) to deactivate private rating securities issued after Jan. 1, 2022, that do not have a required corresponding rating rationale report but to permit a 30-day grace period for private rating securities that were renewed in December. If material discrepancies are found with the data, the SVO will defer deactivation until the issue is remediated.
8. Received a report on the proposed collateralized loan obligation (CLO) modeling methodology.

FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

Nov. 17, 2024

1. Adopted its Summer National Meeting minutes.

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2. Reported that it met Nov. 16 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department's compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee took the following action:
   A. Discussed state-specific accreditation issues.
   B. Voted to award continued accreditation to the insurance departments of Connecticut, Massachusetts, New York, and the U.S. Virgin Islands.
3. Adopted its 2025 proposed charges, which include the appointment of a new subordinate working group, the Accreditation Scope and Alignment (F) Working Group.
4. Adopted revisions to the review team guidelines and self-evaluation guide within the *Accreditation Program Manual* related to department oversight of contract analysis resources.

INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

Nov. 17, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted its Oct. 22, Oct. 8, and Sept. 24 minutes. During these meetings, the Task Force took the following action:
   A. Adopted a motion to approve NAIC comments on the following International Association of Insurance Supervisors (IAIS) public consultations: 1) a draft application paper on operational resilience objectives; 2) proposed changes to reflect climate risk in selected Insurance Core Principle (ICP) guidance and supporting material; and 3) a draft application paper on how to achieve fair treatment for diverse consumers.
3. Adopted its 2025 proposed charges.
4. Heard an update on the conclusion of the comparability assessment of the aggregation method to the IAIS insurance capital standard (ICS).
5. Heard an update on recent IAIS activities, including its recent committee meetings and publications, as well as ongoing discussions on the implementation of its 2025–2026 Roadmap and its 2025–2029 Strategic Plan.
6. Heard an update on international activities, including: 1) recent meetings, events, and speaking engagements with international insurance regulators; 2) bilateral meetings with certain jurisdictions; and 3) the NAIC Fall 2024 International Fellows Program.
7. Heard an update on international climate-related activities, including recent events and ongoing developments at the Sustainable Insurance Forum (SIF).

INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE

Nov. 19, 2024

1. Adopted its Summer National Meeting minutes.
2. Heard an overview of plans for a Data Call Study Group, which will help state insurance regulators obtain more detailed and higher-quality data.
3. Adopted the report of the Big Data and Artificial Intelligence (H) Working Group, which met Nov. 17. During this meeting, the Working Group took the following action:
   A. Adopted its Nov. 12 minutes. During this meeting, the Working Group took the following action:
      i. Adopted its July 29 minutes, which included the following action:
         a. Adopted its Spring National Meeting minutes.
         b. Received an update on its health insurance artificial intelligence (AI) survey work.
         c. Heard a presentation on the Society of Actuaries' (SOA's) research on inference methods.
      ii. Heard a presentation on how artificial intelligence (AI) is used in insurance, including implementation challenges and lessons learned.
      iii. Received an update on the AI Systems Evaluation Workstream.
   B. Received an update on the health AI/machine learning (ML) survey. The group of participating states issued the call letter to the surveyed companies Oct. 31 and launched the survey Nov. 11 with a response

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due date of Jan. 22, 2025. The responses will be compiled and analyzed by March 17, 2025, and a written report of the findings is targeted to be published on March 24. Highlights of the differences in the types of questions between the health survey and the prior auto, home, and life surveys include: 1) a focus on the use of AI on pre-identified product lines and operational functions of health insurers; 2) questions specifically addressing areas of data usage; 3) arrangements with third parties; and 4) coordination of governance with existing health provider governance standards.

C. Received an update on the follow-up to the private passenger auto (PPA) AI/ML survey. In the first quarter of 2024, interested state insurance regulators started meeting individually with a selected subset of personal auto carriers originally responding to the PPA AI/ML survey to get an update on: 1) any changes in their use of AI; 2) the value of the guidance included in the *Model Bulletin on the Use of Artificial Intelligence Systems by Insurers* (AI Model Bulletin); 3) the development and issues in establishing an effective governance program; 4) whether testing procedures have been developed; and 5) the challenges of using data and AI systems provided by third parties.

D. Heard a presentation from the Leukemia & Lymphoma Society (LLS) and NORC at the University of Chicago summarizing their report on health insurance companies' use of AI to conduct utilization management. The report noted the potential benefits of using AI in utilization management and concerns arising from systems based on historically biased data. The presenters recommended that: 1) transparency to state insurance regulators and consumers should be provided as a crucial component of oversight; 2) human involvement should be embedded into AI processes; 3) health insurance plans should be held accountable; and 4) an appeals process as a right for consumers should be established.

E. Heard a presentation on use case applications of AI in insurance underwriting and claims, which highlighted how the use of generative AI can streamline the underwriting process by reducing the number of questions that need to be asked from policyholders, but noted that the data collection and synthesis of input data into an AI system could suffer from algorithmic bias and a lack of transparency, data privacy issues, and unfair underwriting outcomes. The use of generative AI in claims management could also be used to automate the analysis of documentation, images, and past claims history to expedite claims processing, but there are possible model accuracy and fairness issues. Additionally, using AI to detect possible fraudulent claims could result in unfair outcomes due to insufficient historical fraud cases.

F. Discussed its 2025 proposed charges. Following the adoptions of the NAIC Principles on Artificial Intelligence (AI Principles) in 2020 and the AI Model Bulletin in 2023, the Working Group will be pursuing a discussion on AI systems evaluations and shifting to a discussion on consumer outcomes. These discussions may lead to a gap analysis of how well the current regulatory framework holds up against the potential harms from the use of AI, whether additional regulatory filings and disclosures to consumers or regulators are needed, and whether certain AI development practices may be required or prohibited.

4. Adopted the report of the Privacy Protections (H) Working Group, which met Nov. 17. During this meeting, the Working Group took the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Approved a request for a time extension to draft revisions to the *Privacy of Consumer Financial and Health Information Regulation* (#672).
   C. Heard an update on federal privacy legislation.
   D. Heard a presentation on privacy principles proposed by NAIC consumer representatives.
   E. Discussed next steps for drafting amendments to Model #672.
5. Adopted the report of the Cybersecurity (H) Working Group, which met Nov. 18. During this meeting, the Working Group took the following action:
   A. Adopted its Oct. 30 minutes. During this meeting, the Working Group took the following action:
      i. Adopted its Oct. 8 minutes. During this meeting, the Working Group took the following action:
         a. Adopted its Sept. 4 minutes. During this meeting, the Working Group took the following action:
            1) Adopted its Summer National Meeting minutes.
            2) Adopted is Aug. 1 minutes. During this meeting, the Working Group took the following action:

A) Adopted its May 29 minutes. During this meeting, the Working Group took the following action:
i) Heard a presentation from the Coalition titled "Effectiveness of Security Controls: A Meta Analysis."
B) Heard an update on federal activities related to cybersecurity and cyber insurance.
C) Heard a preview of its Summer National Meeting plan.
3) Heard a presentation from AM Best on the cyber insurance market.
4) Received a Chief Financial Regulator Forum referral.
b. Heard a presentation from the Federal Bureau of Investigation (FBI) Internet Crime Complaint Center (IC3).
ii. Received an update on the progression of the Cybersecurity Event Response Plan (CERP) and *Insurance Data Security Model Act* (#668) survey.
iii. Heard a presentation on the 2024 Cyber Insurance Report.

B. Heard comments on the confidential cybersecurity event repository and portal. This initiative to develop a confidential cybersecurity event repository at the NAIC is aimed at enhancing the cybersecurity event notification process within the U.S. insurance sector. The regulators intend for the portal to: 1) initially be focused on facilitating the transmission of event notices pursuant to Model #668; 2) be focused on the Model #668 reporting requirements, narrowing the information provided by the companies reporting to the regulators via the portal; and 3) include functionality allowing for the submission of updates to the initial notice to the department of insurance. The written comments submitted and the public comments provided during the meeting generally support the idea of a uniform notification method for state regulators. However, it is important to note that concerns about portal security, data confidentiality, and intentional sharing were voiced. A motion was made to direct NAIC staff to work with regulators to explore and test the portal's security and confidentiality with efficient documentation, with a proposal to Working Group members to vote on before putting the portal into use.

C. Heard a presentation from Alvarez & Marsal titled "Incident Response Management and Lifecycle." The presentation highlighted best practices for surviving the firestorm of a cyber incident, the many ways a cyber threat might victimize a company, and some trends observed in recent years. As a service provider, Alvarez & Marsal prioritizes helping its customers understand that they cannot necessarily stop attacks, but they can be better prepared to respond to and recover from cybersecurity incidents. The presentation also provided a reminder that an incident response plan requires ongoing enhancements in response to new technologies, increasing sophistication in attacks, and the evolving regulatory landscape.

D. Heard an update on lines of efforts being pursued by Working Group members. Shane Mead (KS) discussed the quick work made by the drafting group under the Information Technology (IT) Examination (E) Working Group. Tasked with a two-part process, the drafting group completed part one, which was to review and suggest edits to the existing Exhibit C. Part two of this process will be to identify where cybersecurity and the IT general controls overlap and, where appropriate, cybersecurity should be examined separately. Colton Schulz (ND) provided a short update on the data calls and definitions related work to help regulators understand the various data types and definitions, where they can be found and accessed, and what information is not available with the current data.

6. Adopted its 2025 proposed charges.
7. Heard a presentation from FireBreak Risk on the use of AI to help mitigate wildfire risk.
8. Heard a presentation from Clearcover and Lemonade on the responsible use of AI.

Third-Party Data and Models (H) Task Force

Nov. 18, 2024

1. Adopted its Summer National Meeting minutes.
2. Adopted its Sept. 11 minutes. During this meeting, the Task Force took the following action:
   A. Heard a presentation from the European Insurance and Occupational Pensions Authority (EIOPA) on the supervisory review and requirements for Solvency II's internal models.

EXECUTIVE (EX) COMMITTEE AND PLENARY

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Draft: 1/15/25

Executive (EX) Committee and Plenary
Virtual Meeting
December 18, 2024

The Executive (EX) Committee and Plenary met Dec. 18, 2024. The following Committee and Plenary members participated: Andrew N. Mais, Chair (CT); Jon Godfread, Vice Chair (ND); Scott A. White, Vice President, represented by Dan Bumpus (VA); Elizabeth Kelleher Dwyer, Secretary-Treasurer (RI); Chlora Lindley-Myers, Most Recent Past President (MO); Lori K. Wing-Heier (AK); Mark Fowler (AL); Peni Itula Sapini Teo (AS); Barbara D. Richardson (AZ); Ricardo Lara represented by Lucy Wang (CA); Michael Conway (CO); Karima M. Woods represented by Sharon Shipp (DC); Trinidad Navarro (DE); John F. King represented by Martin Sullivan (GA); Gordon I. Ito (HI); Doug Ommen represented by Jordan Esbrook (IA); Dean L. Cameron (ID); Ann Gillespie (IL); Holly W. Lambert (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Timothy J. Temple (LA); Michael T. Caljouw represented by Christopher Joyce (MA); Marie Grant (MD); Robert L. Carey (ME); Anita G. Fox (MI); Grace Arnold (MN); Remedio C. Mafnas (MP); Troy Downing represented by Mary Belcher (MT); Mike Causey represented by Jackie Obusek (NC); Eric Dunning (NE); Justin Zimmerman (NJ); Alice T. Kane (NM); Scott Kipper (NV); Adrienne A. Harris represented by Bhavna Agnihotri (NY); Glen Mulready (OK); Andrew R. Stolfi (OR); Michael Humphreys (PA); Michael Wise (SC); Larry D. Deiter (SD); Carter Lawrence (TN); Cassie Brown (TX); Jon Pike (UT); Kevin Gaffney (VT); Mike Kreidler represented by Jim Odiorne (WA); Nathan Houdek (WI); and Allan L. McVey (WV).

Executive (EX) Committee

1. Adopted the Nov. 17 Report of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee

Commissioner Mais reported that the Executive (EX) Committee and Internal Administration (EX1) Subcommittee met Nov. 17 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC) 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 adopted its Oct. 31 and Summer National Meeting minutes. During its Oct. 31 meeting, the Committee and Subcommittee took the following action: 1) approved the release of the proposed 2025 NAIC budget for public comment prior to its consideration by the full Membership during the joint meeting of the Executive (EX) Committee and Plenary on Dec. 18; 2) received an update on the Property & Casualty Market Intelligence (PCMI) data call; and 3) adopted the Executive (EX) Committee's Summer National Meeting minutes.

The Committee and Subcommittee adopted the report of the Audit Committee, including its Nov. 13 minutes. During these meetings, the Committee took the following action: 1) received the Sept. 30 financial update; 2) received an update on the 2024 year-end financial audit; 3) received an update on the upcoming Service Organization Control (SOC) 1 and SOC 2 reviews; 4) heard an update on the Enterprise Resource Planning (ERP) project; and 5) reviewed the status of zone financials.

The Committee and Subcommittee adopted the report of the Internal Administration (EX1) Subcommittee, including its Aug. 26 minutes. During this meeting, the Subcommittee took the following action: 1) received the June 30 Long-Term Investment Portfolio report; 2) received the June 30 Defined Benefit Portfolio report; and 3) received a status update on the termination of the Defined Benefit Pension Plan.

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The Committee and Subcommittee also: 1) adopted a fiscal for model office testing related to the Generator of Economic Scenarios (GOES); 2) approved the public release of a request for proposal (RFP) related to the due diligence framework for credit rating agencies; 3) heard a technology and cybersecurity report; and 4) heard the Chief Executive Officer (CEO) report.

Commissioner Clark made a motion, seconded by Director Lindley-Myers, to adopt the Nov. 17 report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee (Attachment One). The motion passed unanimously.

2. Adopted its Dec. 10 and Oct. 31 Meeting Reports

The Executive (EX) Committee met Dec. 10 and Oct. 31 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC) of the NAIC Policy Statement on Open Meetings. During these meetings, the Committee: 1) held a public hearing in open session to receive comments from interested parties; 2) adopted the NAIC 2025 proposed budget; and 3) approved the release of the NAIC 2025 proposed budget, including eight fiscals, for public review and comment.

Commissioner Conway made a motion, seconded by Commissioner Godfread, to adopt the Executive (EX) Committee's Dec. 10 and Oct. 31 meeting reports (Attachment Two). The motion passed unanimously.

3. Adopted the Reports of its Task Forces

Commissioner Clark made a motion, seconded by Commissioner Godfread, to adopt the reports of the: 1) Climate and Resiliency (EX) Task Force; 2) Government Relations (EX) Leadership Council; and 3) Special (EX) Committee on Race and Insurance (Attachment Three). The motion passed unanimously.

4. Received a Status Report on Model Law Development Efforts

Commissioner Mais presented a written report on the progress of ongoing model law development efforts (Attachment Four). These efforts included amendments to the: *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171); *Public Adjuster Licensing Model Act* (#228); and *Privacy of Consumer Financial and Health Information Regulation* (#672).

5. Heard a Report from the NIPR Board of Directors

Director Deiter reported that the National Insurance Producer Registry (NIPR) Board of Directors met Nov. 16. During this meeting, the Board heard that 2024 was a successful year. Through October, revenue was $69 million, 7.4% over budget, and expenses were under budget by 1.3%. The revenue share to the NAIC is $26.2 million

The Board heard a presentation about the new NIPR Apprenticeship Program. Two long-time NIPR team members, Shay Hibler and Jack Dennis, proposed the program to further the goal of creating professional development opportunities within NIPR. Members of the Board encouraged this goal. Ms. Hibler described the development of the program and the selection of this year's apprentice. Due to its success, the program will expand in 2025.

NIPR now serves all 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. In response to requests by state insurance regulators for more producer licensing training, NIPR launched the Producer Licensing Zone Training program. In collaboration with the NAIC, this training is a unique opportunity for producer licensing staff within each zone to learn about the intricacies of producer licensing best practices, tackle current and emerging regulatory issues, and foster peer-to-peer dialogue. The training is intended for state and U.S. territory producer licensing regulators.

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6. Heard a Report from the Compact

Director Dunning reported that the Interstate Insurance Product Regulation Commission (Compact) met Nov. 16. During this meeting, the Compact re-elected its current officers for another term. It re-elected Director Dunning as Chair, Commissioner McVey as Vice Chair, and Director Richardson as Treasurer. Director Dwyer will continue to serve as Past Chair.

Before the annual meeting, the Management Committee met in person with the Compact Legislative Committee. The focus of the meeting was the Compact's mission and its significance to both Compacting states and the industry. The Compact Officers committed to seeking input from the Legislative Committee on proposals for member services the Compact Office can provide using its expertise and collaborative platform.

At the annual meeting, the Compact adopted a three-year strategic plan called Insurance Compact Compass 2.0. The Compact's first strategic plan began in 2020, and with those goals accomplished, new goals have been set.

The Compact installed the Management Committee for the next annual term and approved committee assignments. The Commission adopted amendments to its group disability income uniform standards to expand them for use with non-employer groups. It also put in place its 2025 Uniform Standards Development prioritization list that provides a road map of Compact-driven priorities for the Product Standards Committee.

The Compact adopted next year's annual budget package, which includes a new full-time position for a director of regulatory affairs. The Compact is focused on building a regulatory affairs team for its members.

The Compact will end the year in a positive revenue position. However, its per-filing revenue line is approximately 30% under budget. The Compact will add a new fee to align the value of its services with the content of the product filings. The Compact is assessing an additional fee over its base fee on filings with more than a basic product. This additional fee would be an alternative to increasing filing fees across the board. This fee would have been assessed on approximately 47% of the filings in 2024 and would have covered the budget deficit the Compact experienced in the per-filing fee category over the past two years.

Other activities of the Compact include governance training for members and their designated representatives. This training occurred at in-person meetings this year and will continue into next year with its outside counsel, including former colleague Mark Afable, as well as Jeff Thomas (Mitchell Williams).

Another successful Compact Roundtable was held in Omaha in October. Record attendance included seven commissioners, a state legislator, consumer and industry representatives, state insurance regulators, and company filers. The attendees discussed proposals to bring together a collaborative advisory forum to discuss pre-filing product ideas within the scope of the Compact's product lines but outside the current Uniform Standards. The Adjunct Services Committee is further vetting this and other ideas, and it will work with members, legislators, and others to bring proposals forward in the coming year.

Executive (EX) Committee and Plenary

7. Adopted the NAIC 2025 Proposed Budget

Commissioner Godfread presented the NAIC 2025 proposed budget for approval by the Membership.

Commissioner Godfread reported that the Executive (EX) Committee and Internal Administration (EX1) Subcommittee approved the 2025 proposed budget on Dec. 10. The proposed budget includes $163.7 million in

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operating revenues and operating expenses of $173.9 million, resulting in an operating margin loss of $10.2 million. After the inclusion of $3.3 million in investment income, the NAIC's proposed 2025 budget reflects a reduction in net assets of $6.9 million.

The proposed budget includes eight fiscal impact statements as well as the Variable Annuity & Life Insurance Model Office (GOES) fiscal approved at the Fall National Meeting. The fiscals request funding for operational improvements, including: 1) a continuation of the SERFF Modernization project; 2) the addition of a VISION Support Team; 3) completing Phase IV of the Enterprise Data Asset Management project; 4) monitoring collateralized loan obligations (CLOs) as part of a Valuation of Securities (E) Task Force initiative; 5) supporting a long-term care insurance (LTCI) experience study with the Society of Actuaries (SOA); and 6) developing a proof of concept for modernizing the Financial Data Repository (FDR) platform. In addition, the Member Services division is requesting funding for a member customer relations management (CRM) system to provide enhanced member engagement and improved quality of service. Finally, several new staff members will be added to help support the growing regulatory and business requirements of the association.

Based on projected 2024 financial results and with approval of the proposed 2025 budget, the NAIC's net asset balance at the end of 2024 was expected to be $205.2 million, declining to $198.2 million at the end of 2025.

During the public exposure period, the NAIC received one comment letter from the National Association of Mutual Insurance Companies (NAMIC). NAMIC was given an opportunity to expand upon its comments during the public hearing. Overall, NAMIC's letter was supportive of the NAIC's proposed 2025 budget.

Commissioner Godfread made a motion, seconded by Director Lindley-Myers, to adopt the NAIC 2025 proposed budget, including the eight fiscals (Attachment Five). The motion passed. New York abstained.

8. Adopted the NAIC 2025 Proposed Committee Charges

Commissioner Godfread reported that the proposed NAIC 2025 committee charges reflect the continued work of the NAIC committee system. The charges include work to be conducted in 2025.

Commissioner Godfread made a motion, seconded by Director Lindley-Myers, to adopt the NAIC 2025 proposed committee charges (Attachment Six). The motion passed unanimously.

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

Director Fox reported that Model #171 and its companion model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170), were identified in 2013 as in need of revision because of the Affordable Care Act (ACA). The Regulatory Framework (B) Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup in 2016 to revise Models #170 and #171. The Subgroup completed its work on Model #170 in late 2018. The full NAIC Membership adopted the revisions to Model #170 in February 2019.

The revisions to Model #170 removed provisions for certain types of health insurance products that would not be permitted because of the requirements of the ACA, leaving only those products considered excepted benefits and, therefore, not subject to the ACA's requirements. Excepted benefit products, such as accident-only and specified disease plans, are medically underwritten and subject to preexisting condition exclusions.

The Subgroup also added short-term, limited-duration (STLD) plans to the model because no other vehicle was available to add those products, and the Subgroup did not want to create a new model for them.

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The revisions to Model #171 create consistency with Model #170. The revisions also add standards for STLD plans. Because the Subgroup did not want to dictate what benefits and coverages these plans must include, the standards specify that STLD plans must provide the benefits and coverages required by the state. The revisions also clarify and enhance provisions on consumer disclosure and outline coverage requirements, making them more understandable for consumers, including requiring specific language stating that these plans are supplemental and not intended to be major medical coverage. The Subgroup adopted the revisions on Oct. 17. The Task Force adopted the revisions on Nov. 4. The Committee adopted the revisions at the Fall National Meeting.

Prior to adopting the model revisions, the Committee discussed a provision in Model #171 that permits carriers to exclude mental health and substance use benefits from coverage. During this discussion, it was highlighted that these are excepted benefit products, not major medical coverage, and that this provision is optional. States can require such coverage if they feel it is appropriate. In addition, for STLD plans, the benefits and coverages are tied to the state's requirements. If a state requires these plans to include mental health and substance use benefits, they must include the coverage.

To emphasize such state authority, the Committee added language to drafting notes to clarify that states should carefully consider whether to permit mental health and substance use coverage exclusions for STLD plans and disability income protection policies, given the importance of such coverage.

Director Fox made a motion, seconded by Commissioner Mulready, to adopt the amendments to Model #171 (Attachment Seven). The motion passed. California, New Jersey, New York, and Pennsylvania abstained.

10. Adopted the Canada Summary of Findings

Commissioner Houdek reported that the Mutual Recognition of Jurisdictions (E) Working Group recommends the Canada Office of the Superintendent of Financial Institutions (OSFI), the Canadian regulator of most insurers in Canada, be the first non-reciprocal jurisdiction that is considered to recognize and accept the NAIC's group capital calculation (GCC). A separate list of reciprocal jurisdictions, which recognize and accept the U.S. approach to group supervision, including capital, among other things, is maintained.

In 2020, revisions were made to the *Holding Company Model Act* (#440), which allows holding company groups from such approved jurisdictions not to be required to complete and submit the GCC; rather, in the interest of mutual recognition, U.S. state insurance regulators will accept the group supervision performed in those countries for groups operating in the U.S.

This proposal was unanimously adopted by the Mutual Recognition of Jurisdictions (E) Working Group and the Financial Condition (E) Committee.

Commissioner Houdek made a motion, seconded by Director Fox, to adopt the summary of findings and determination with respect to the inclusion of the Canada OSFI evaluation as a jurisdiction that recognizes and accepts the U.S. GCC (Attachment Eight). The motion passed unanimously.

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NATIONAL MEETING
FALL / DENVER
2024 NAIC

2024 Fall National Meeting
Denver, Colorado

JOINT MEETING OF THE EXECUTIVE (EX) COMMITTEE
AND INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE
Sunday, November 17, 2024
10:00 – 11:30 a.m.

Meeting Summary Report

The Executive (EX) Committee met in joint session with the Internal Administration (EX1) Subcommittee Nov. 17, 2024. The meeting was held in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee and Subcommittee:

1. Adopted their Oct. 31 and Summer National Meeting minutes, which included the following action:
   A. Approved the release of the proposed 2025 NAIC budget for public comment prior to its consideration by the full Membership during the joint meeting of the Executive (EX) Committee and Plenary on Dec. 18.
   B. Received an update on the property/casualty (P/C) market intelligence (PCMI) data call.

2. Adopted the Executive (EX) Committee's Summer National Meeting minutes.

3. Adopted the report of the Audit Committee, including its Nov. 13 minutes. During this meeting, the Committee took the following action:
   A. Received the Sept. 30 financial update.
   B. Received an update on the 2024 year-end financial audit.
   C. Received an update on the upcoming Service Organization Control (SOC) 1 and SOC 2 reviews.
   D. Heard an update on the Enterprise Resource Planning (ERP) project.
   E. Reviewed the status of Zone financials.

4. Adopted the report of the Internal Administration (EX1) Subcommittee, including its Aug. 26 minutes. During this meeting, the Subcommittee took the following action:
   A. Received the June 30 Long-Term Investment Portfolio report.
   B. Received the June 30 Defined Benefit Portfolio report.
   C. Received a status update on the termination of the Defined Benefit Pension Plan.

5. Adopted a fiscal for model office testing related to the Generator of Economic Scenarios (GOES).

6. Approved the public release of a request for proposal (RFP) related to the due diligence framework for credit rating agencies.

7. Heard a technology and cybersecurity report.

8. Heard the Chief Executive Officer (CEO) report.

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NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meetings

EXECUTIVE (EX) COMMITTEE
December 10, 2024 / October 31, 2024

Summary Report

The Executive (EX) Committee met Dec. 10 and Oct. 31, 2024, 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.

1. During its Dec. 10 meeting, the Committee:
   A. Held a public hearing in open session to receive comments from interested parties.
   B. Adopted the NAIC 2025 proposed budget.

2. During its Oct. 31 meeting, the Committee:
   A. Approved the release of the NAIC 2025 proposed budget, including eight fiscals, for public review and comment.

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NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Draft: 12/12/24

REPORT OF THE EXECUTIVE (EX) COMMITTEE TASK FORCES

Climate and Resiliency (EX) Task Force—The Climate and Resiliency (EX) Task Force met Nov. 19 and took the following action: 1) adopted its Summer National Meeting minutes; 2) received an update on deliverables from the *NAIC National Climate Resilience Strategy for Insurance* (Climate Resilience Strategy); 3) heard a presentation from United Policyholders (UP) and state insurance regulators on the lessons learned from recent wildfire disasters; 4) heard an update from British Columbia Financial Services Authority (BCFSA) on Canadian flood insurance; 5) heard an update from NAIC staff on federal activities; and 6) heard an update from the Center for Insurance Policy and Research (CIPR) on the NAIC Climate Scenario Resource Center.

Government Relations (EX) Leadership Council—The Government Relations (EX) Leadership Council did not meet at the Fall 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.

Special (EX) Committee on Race and Insurance—The Special (EX) Committee on Race and Insurance met Nov. 17 and took the following action: 1) adopted its Summer National Meeting minutes; 2) received a status report from its workstreams and adopted the Life Workstream's endorsement supporting state legislation requiring a financial literacy course as a prerequisite to high school graduation; and 3) received an update on the Member Diversity Leadership Forum. Discussions at the beginning of 2025 will focus on transitioning the work of the Special Committee to the Standing Committees.

- **Health Workstream**—As reported during the Special (EX) Committee's Nov. 17 meeting, since the Summer National Meeting, the Health Workstream met Oct. 24 and Sept. 9. During its Sept. 9 meeting, the Workstream heard from the Pennsylvania Insurance Department (PID) about its work related to the collection of race and ethnicity data in insurance applications. The Workstream also heard from Independence Blue Cross (IBX) on how the collection of relevant demographic data helps it identify health equity issues and then intervene and monitor progress to address identified problems. The Workstream also heard about the Blue Cross Blue Shield Association's (BCBSA's) National Health Equity Strategy. This strategy aims to address health disparities and build a more equitable healthcare system. The Data Equity Coalition, a partnership between the BCBSA, National Minority Quality Forum (NMQF), and 17 other organizations, focuses on setting standards for collecting accurate and representative data on race, ethnicity, language, sexual orientation, and gender identification, with the goal of improving health outcomes by optimizing the collection of relevant demographic data and addressing barriers to providing personal information. The Workstream continued its demographic data collection discussions during its Oct. 24 meeting. During this meeting, the Workstream heard from AHIP on the challenges with demographic data collection, such as inaccurate and incomplete data, lack of interoperability, and a non-patient-centric demographic data collection process. AHIP also discussed its Demographic Data Element Modernization Initiative, which is aimed at addressing some of these issues by modernizing and enhancing national demographic data content and exchange standards so that they are culturally sensitive, sufficiently granular, and allow for alignment across stakeholders. The Workstream also heard from NCQA about its approach to building a foundation of equity data for action, including using its Health Equity Accreditation program and embedding equity in various programs to advance this goal. The Workstream plans to meet in regulator-to-regulator session after the Fall National Meeting to consider its work to date and potential year-end deliverables. The Workstream also plans to continue its work on its collaborative space on NAIC Connect, which the Workstream intends to be a platform where Workstream members can

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share with other NAIC members the information it has captured during its meetings and serve as a platform for discussions and conversations about health equity and other related topics, including adding blog posts from various stakeholders on issues and topics relevant to its work.

- **Life Workstream**—As the Life Workstream reported to the Special (EX) Committee on Race and Insurance on Nov. 17, it plans to continue to focus on "marketing, distribution, and access to life insurance products in minority communities," including focusing on criminal history. Throughout 2024, the Workstream heard a number of presentations exploring the impact of criminal history on an applicant's ability to access life insurance. To learn more, the Life Workstream circulated a draft survey asking about insurers' use of criminal history in life insurance underwriting for a public comment period that ended Sept. 5. Based on the comments received, a revised chair draft survey was distributed and discussed during a public Webex call on Oct. 17. Work continues to finalize the survey questions and develop a process for issuing the survey.

- **Property/Casualty (P/C) Workstream**—The P/C Workstream met Nov. 16 to hear updates on the District of Columbia Department of Insurance, Securities and Banking (DISB) initiative to evaluate unintentional bias in private passenger automobile (PPA) insurance; California's low-cost auto insurance program; Casualty Actuarial Society (CAS) papers related to race and insurance; and Verisk's work related to the testing of models for bias. The Workstream also discussed the possibility of how the NAIC Property and Casualty Market Intelligence (PCMI) Data Call results could be leveraged.

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Draft: 12/12/24

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 December 2019. After a long hiatus since late 2019 due to the loss of a co-chair, the COVID-19 pandemic, and 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 2023 and plans to continue meeting regularly to continue its discussions. It 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, 2023, 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 is completing work on Section 9—Required Disclosure Provisions. It recently completed its review of all the comments received on Model #171. The Subgroup set a public comment deadline of Dec. 1, 2023, to receive comments on the initial draft reflecting its discussions and preliminary revisions to Model #171. The Subgroup resumed its meetings in January to discuss the comments received. The Subgroup completed its review of those comments following the Spring National Meeting and distributed a draft reflecting all its discussions for final comment. The Subgroup received additional comments on the draft and began discussion of those comments in June. The Subgroup completed its discussion of the additional comments following the Summer National Meeting and adopted the revisions to Model #171 on Oct. 17. The Regulatory Framework (B) Task Force adopted the revisions to Model #171 on Nov. 4. The Health Insurance and Managed Care (B) Committee adopted the revisions to Model #171 on Nov. 19. The Executive (EX) Committee and Plenary will consider adoption of the proposed revisions to Model #171 during its joint meeting on Dec. 18.

Amendments to the *Public Adjuster Licensing Model Act* (#228)—The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #228 during the 2024 Spring National Meeting. The Model Law Review Request provided guidance that Model #228 should be amended to strengthen regulatory standards governing the conduct of public adjusters for the following four issues: 1) individuals acting as unlicensed public adjusters; 2) contractors who are also acting as public adjusters on the same claim; 3) inappropriate assignment of benefit rights; and 4) excessive fees charged by public adjusters.

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The Public Adjuster Licensing (D) Working Group met July 17, June 18, and April 5. During its April 5 meeting, the Working Group discussed proposed modifications to Sections 3 and 14 of the model, which address public adjuster fees. During its June 18 meeting, the Working Group discussed proposed amendments to Sections 15, 16, and 19 of the model to strengthen regulatory standards regarding individuals acting as unlicensed public adjusters; contractors who are also acting as public adjusters on the same claim; and inappropriate assignment of benefit rights. During its July 17 meeting, the Working Group adopted proposed amendments. One significant revision that industry continues to oppose is an amendment to Section 14 of the model, which provides that a public adjuster shall not charge more than 10% for any catastrophic claim settlement and no more than 15% for any insurance claim settlement.

The Producer Licensing (D) Task Force received comments on the model during its Aug. 13 meeting. The Task Force reviewed these comments during its Oct. 31 call. The Task Force adopted the revised model act on Nov. 17. The Market Regulation and Consumer Affairs (D) Committee adopted the revised model on Nov. 19.

Amendments to the *Privacy of Consumer Financial and Health Information Regulation* (#672) —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, 2022. However, after working on a draft of a new privacy model, the Working Group determined that the better path forward would be to amend the existing NAIC privacy model, Model #672.

Since then, the Working Group has gone through a leadership transition and exposed a chair draft amending Model #672. The Privacy Protections (H) Drafting Group met Sept. 30, 2024, in open session to hear comments on Section 5—Third-Party Service Provider Arrangements of the chair draft. The Drafting Group met again Oct. 31 to continue its discussion on Section 5. On Nov. 4, the Working Group met in regulator-to-regulator session to discuss next steps. Most recently, the Working Group requested comments on Article III of the chair draft. During the 2024 Fall National Meeting, the Working Group and the Innovation, Cybersecurity, and Technology (H) Committee approved a request for an extension of time to continue drafting amendments to Model #672 until Dec. 31, 2025.

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Executive Summary
NAIC 2025 Budget

The NAIC's mission is to empower its members—insurance regulators—in their efforts to protect consumers and maintain fair, competitive insurance markets. In line with this mission, the services and products provided by the NAIC are extensive and multifaceted, catering to members, the public, and insurers alike. Every function and operation within the NAIC is guided by two primary objectives: 1) to support state-based regulation, ensuring local oversight remains robust and responsive to the unique needs of each jurisdiction and 2) to assist regulators in navigating the complexities of an evolving insurance landscape.

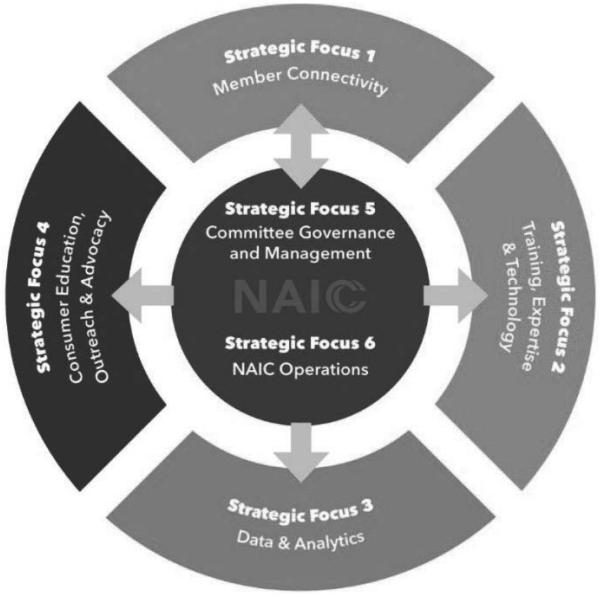
NAIC's Focus: Members and Mission

Members are state insurance regulators from diverse backgrounds—but are united in their shared commitment to set standards and ensure fair, competitive, and healthy insurance markets to protect consumers. The singular mission of the NAIC is to support its members in these noble causes.

By staying true to these guiding principles, the NAIC not only fortifies the foundation of state-based regulation but also champions innovation and adaptability. Looking toward the future, the NAIC remains steadfast in its commitment to fostering a regulatory environment that balances consumer protection with market growth, embraces technological advancements, and promotes collaboration among all stakeholders.

Through its members, the NAIC stands as a beacon of leadership and stability, ensuring that the values of transparency, fairness, and consumer advocacy continue to shape the insurance industry for generations to come. To support these values, the NAIC offers a wide range of services, including consumer education, data collection and analysis, technology support, financial analysis and reporting, licensing, and testing. Additionally, the NAIC, through its committees, task forces, and working groups, develops model laws and regulations to help standardize insurance practices across member jurisdictions, ensuring a consistent and effective regulatory framework.

The NAIC's latest strategic plan, *State Connected,* was designed to prepare both staff and system infrastructure for the next ten-plus years of member and regulatory support. With 32 significant goals spread across six strategic focus areas, NAIC membership has laid a formidable path, effectively advancing insurance regulation while increasing automation and efficiency in the insurance market—a notable win that extends beyond regulators. By enhancing technology platforms, insurers will benefit from improved data accuracy and quicker processing times, all of which will help lead to a faster speed to market.



State Connected guides decisions on budget, personnel, and resources. Consequently, the 2025 budget was crafted with great care, considered the impact and resource needs for all requests and changes, and remained aligned with the strategic plan's goals. Beyond strategic objectives, the 2025 budget continues NAIC's commitment to supporting a variety of programs, products, and services in the financial solvency and market regulatory arenas. The

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NAIC offers a wide range of systems, services, data, accreditation reviews, and many other essential services to assist insurance regulators in achieving their fundamental regulatory goals in a timely and cost-effective manner. Through this approach, the NAIC stands by to maintain the U.S. as one of the strongest and most resilient insurance markets in the world.

Support of the Membership

The NAIC is dedicated to assisting insurance regulators in serving the public interest, promoting a competitive marketplace, and ensuring the fair and equitable treatment of insurance customers. The focus is on maintaining the reliability, solvency, and financial stability of insurers while supporting and enhancing insurance regulation. By leveraging NAIC technology solutions, regulatory tools, and staff resources, members can achieve these objectives with significant cost savings. Membership in the NAIC offers a range of additional benefits and services, often at no charge. In addition to the numerous solvency tools and system access, members receive jurisdiction funding, training, analytical data, regulatory tools, and subject matter experts, all of which provide value that far exceeds the cost of membership. Many of NAIC's systems would be prohibitively expensive for jurisdictions to implement independently. Without the NAIC's collective support and economies of scale, the cost of regulating insurers would rise significantly, leading to higher expenses for insurers, and therefore consumers. Maintaining the NAIC's funding mechanisms benefits all parties involved by keeping regulatory costs manageable.

By the Numbers

NAIC products and services.

- **System for Electronic Rates & Forms Filing (SERFF)** 517,571 transactions processed in 2023.
- **Online Premium Tax for Insurance (OPT*ins*)** 191,719 transactions processed in 2023.
- **State Based Systems (SBS)** Back-office services, with varying functionality, currently provided to 36 jurisdictions.
- **Professional Designation Program** 2,254 designations awarded since the program's inception in 2006 through year-end 2023.
- **Center for Insurance Policy and Research (CIPR)** Nearly 150 briefs currently available online including NAIC key initiatives and topics ranging from cybersecurity and innovation to natural catastrophe risk and resiliency.
- In 2023, the NAIC processed nearly **$6.2 Billion** in payments on behalf of the members, which represents a significant efficiency for both regulators and insurers.

A Focus on Consumers

The NAIC employs a multi-channel approach to help consumers make informed decisions and effectively utilize their insurance benefits. The website offers a wealth of information, including insurance advice articles, interactive learning modules, and the widely-used Life Insurance Policy Locator. The NAIC also runs various communication campaigns, provides the NAIC Home Inventory mobile app, and engages in media initiatives. Additionally, in the event of an unforeseen disaster, NAIC offers regulatory support to provide local regulators with additional tools and resources to assist the public in their time of need.

Valuable Products and Services

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

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The NAIC remains committed to maintaining and enhancing its infrastructure by staying abreast of emerging technologies. This commitment ensures that regulators are equipped with the necessary tools to protect consumers and promote a fair, competitive, and healthy insurance market. Accordingly, the 2025 budget includes eight fiscal impact statements (fiscals), five of which are focused on technology. These fiscals either continue ongoing modernization efforts, initiate new projects to upgrade critical regulatory support and communication systems, or provide additional resources to improve the speed of system enhancements. The remaining three fiscals will sponsor a significant study on long-term care insurance, provide the infrastructure needed for financial modeling of various types of securities held by insurers, and adds staffing in areas with critical needs.

Building the Budget

The NAIC is committed to transparency in both its budgeting process and overall operations. Each May, department managers evaluate the current year's revenues and expenses to forecast a year-end financial outlook. They then develop budget proposals for the upcoming year, including fiscals for new or significant projects, aligning requests with operational goals and member-driven initiatives. Managers focus on articulating the differences between the current year's budget and projected outcomes, as well as anticipated needs for the following year. This comprehensive process involves reviewing all projects, products, programs, services, committee directives, and technology initiatives in relation to the NAIC's mission, its strategic plan, and member directives. Following this, the NAIC's Chief Executive Officer and senior management conduct a detailed review of each department's budget to make necessary adjustments, ensuring alignment with the association's strategic and financial goals, before consolidating all requests into a single, unified budget.

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

Expected Results for 2024

Based on actual operating results through June 30, 2024, the NAIC projects an operating loss of $3.8 million compared to a budgeted negative operating margin of $5.6 million, an improvement of $1.8 million. Investment income is projected to be a gain of $15.1 million, resulting in a net asset increase of $11.3 million, resulting in $205.2 million in projected net assets at year-end. While investment income is projected at $11.8 million over budget at year-end, it is important to note that $7.8 million is based on market valuations. Markets remain volatile and increasing uncertainty may impact future financial performance.

2025 Budget

The 2025 NAIC total operating budget reflects revenues of $163.7 million and expenses of $173.6 million, which represent a 6.3% and 8.8% increase, respectively, from the 2024 budget, resulting in $9.9 million in projected expenses over revenues. Viewed in relation to the 2024 projected totals, the 2025 budget represents an operating revenue increase of 4.5% and operating expense increase of 8.2%. Additional information about the 2025 budget is included in the detailed footnotes of the budget.

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A fiscal is prepared for new or existing NAIC initiatives with revenue, expense, or capital impacts of $100,000 or more either in the current budget or within the following few years' budgets, or which require more than 1,150 hours of internal technical resources to accomplish. Each fiscal includes a detailed description of the initiative; impact on key stakeholders; financial and operational impact; and an assessment of the risks. The total financial impact of the eight fiscals included in the 2025 budget is $4.5 million in expenses and $5.9 million in capital spending. Additional information about each initiative is included in the various fiscal sections of the budget.

The 2025 budget also includes $3.3 million in investment income from the NAIC's long-term investment portfolio and cash equivalent investments. Investment income is composed of interest and dividends earned, reduced by investment management fees. Investment gains and losses are volatile and therefore are not projected nor included in the budget.

Combining budgeted results from operations with budgeted investment income, the 2025 budget has a reduction in net assets of $6.7 million, with projected net assets of $198.5 million at the end of 2025.

Ensuring Financial Stability

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

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

2025 Fiscal Impact Statements

SERFF Modernization – 2025 Transition Stages
Continues funding of a multi-year initiative to improve the SERFF platform. In 2025, life and property/casualty users will move into the platform. This request includes the addition of two headcount.
- Expense of $716K for headcount, travel, and amortization.
- Capital of $5.9M for professional and other services.

VISION Support Team
Includes the addition of five technical staff to support the NAIC's Capital Markets and Investment Analysis Office's immediate and long-term development needs.
- Expense of $428K for staffing.

Enterprise Data Asset Management – Phase IV
Continues to build upon previous phases which delivered a cloud-based enterprise data platform populated with financial and regulatory data and includes the addition of one headcount for development and ongoing system maintenance.
- Expense of $719K for staffing and consulting.

Monitoring Collateralized Loan Obligations (CLOs)
Responds to a Valuation of Securities (E) Task Force initiative to maintain credit assessments for various insurer-owned securities, specifically CLOs. This fiscal includes the addition of one headcount for analytical support.
- Expense of $561K for staffing, consulting, and software.

Long-Term Care Insurance Experience Study
Sponsors an upcoming study with the Society of Actuaries. NAIC members will receive training as well as the study results for assisting with the expenses of this study.
- Expense of $100K for sponsorship.

Financial Data Repository (FDR) – Modernization Proof-of-Concept
Requests funding for a proof-of-concept (PoC) to explore a third-party solution to house and manage FDR's technical infrastructure. This will demonstrate the vendor's capabilities and potential benefits from utilizing their technology which will modernize the FDR platform.
- Expense of $450K for the PoC.

Member Customer Relationship Management
Provides funding for a customer relationship management system to improve member engagement and service quality.
- Expense of $454K for staffing, consulting, and software.

Operational Staffing
Requests the addition of eight headcount in operational and regulatory support areas.
- Expense of $1.1M for staffing, travel, and equipment.

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operating reserves. The new methodology reviews three areas: working capital needed to maintain day-to-day operations over three months; an assessment of the funds needed to mitigate potential risks if certain events were to occur; and funding necessary for strategic initiatives planned in the upcoming three years.

Operating Reserve Target

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

Based on the evaluation of these three areas, the current operating reserve target of $170.4 million was approved. This reserve reflects support of its business operations as well as the ongoing investments required to enhance and modernize many of the association's information technology and technical infrastructure applications. Details of these investments can be seen throughout the 2025 budget.

Preparing for the Unknown

The budget and operating reserve includes all activities anticipated to occur in 2025. However, situations or additional strategic or emerging projects may arise that require additional funding. In such an event, a funding request will be prepared and presented to the Executive (EX) Committee and Internal Administration (EX1) Subcommittee for consideration and direction. Supplemental funding can also come from the Regulatory Modernization and Initiatives Fund, which is an extra layer of protection established in 2005 to manage requests that arise following the adoption and implementation of an annual budget. This fund is based on 1.5% of the NAIC's projected net assets as of December 31, 2025, or $3.0 million.

Contact Information

The NAIC appreciates the opportunity to present this budget and believes it provides a comprehensive review of the NAIC's business and financial operations for the current and upcoming year. A summary of the key components of the 2025 budget is included in the budget overview.

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

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Draft: 12/4/24
Pending Adoption by the Executive (EX) Committee and Plenary, Dec. 18, 2024

2025 Proposed Charges

EXECUTIVE (EX) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

1. The **Executive (EX) Committee** will:
   A. Identify the goals and priorities of the organization and make recommendations to achieve such goals and priorities based on input of the membership. Make recommendations by the 2025 Commissioners' Conference.
   B. Create/terminate task force(s) and/or Executive (EX) Committee-level working groups to address special issues and monitor the work of these groups. Create necessary task force(s) and/or Executive (EX) Committee-level working groups throughout 2025 as necessary.
   C. Submit reports and recommendations to NAIC members concerning the activities of its subcommittee and the standing committees. Submit a report at each national meeting.
   D. Consider requests from NAIC members for friend-of-the-court briefs.
   E. Establish and allocate functions and responsibilities to be performed by each NAIC zone.
   F. Pursuant to the Bylaws, oversee the NAIC offices to assist the organization and the individual members in achieving the goals of the organization.
   G. Conduct strategic planning on an ongoing basis.
   H. Plan, implement and coordinate communications and activities with the Federal Insurance Office (FIO).
   I. Plan, implement and coordinate communications and activities with other state, federal, local and international government organizations to advance the goals of the NAIC and promote understanding of state insurance regulation.
   J. Review and approve requests for the development of model laws and/or regulations. Coordinate the review of existing model laws and/or regulations.
   K. Select NAIC national meeting sites five and six years in advance of the meeting date to ensure efficient and economical locations and facilities.
   L. Review and revise, as necessary and appropriate, the criteria and categories for registrants at NAIC national meetings.

NAIC Support Staff: Andrew J. Beal/Kay Noonan

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Draft: 11/5/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Climate and Resiliency (EX) Task Force, Nov. 6, 2024

2025 Proposed Charges

CLIMATE AND RESILIENCY (EX) TASK FORCE

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

1. The **Climate and Resiliency (EX) Task Force** will:

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

NAIC Support Staff: Aaron Brandenburg/Libby Crews

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Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Government Relations (EX) Leadership Council, Nov. 6, 2024

2025 Proposed Charges

GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

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

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

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Draft: 8/26/24
Adopted by Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Internal Administration (EX1) Subcommittee, Aug. 26, 2024

2025 Proposed Charges

INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

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Draft: 10/11/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Life Insurance and Annuities (A) Committee, Oct. 21, 2024

2025 Proposed Charges

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Life Insurance and Annuities (A) Committee** will:
   A. Monitor the activities of the Life Actuarial (A) Task Force.

2. The **Annuity Suitability (A) Working Group** will:
   A. Consider how to promote greater uniformity in the adoption of the *Suitability in Annuity Transactions Model Regulation* (#275) across NAIC member jurisdictions.

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

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Draft: 9/23/24
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Adopted by the Life Insurance and Annuities (A) Committee, Oct. 21, 2024
Adopted by the Life Actuarial (A) Task Force, Oct. 9, 2024

2025 Proposed Charges

LIFE ACTUARIAL (A) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Life Actuarial (A) Task Force** will:
   A. Work to keep reserve, reporting, and other actuarial-related requirements current. This includes principle-based reserving (PBR) and other requirements in the *Valuation Manual*, actuarial guidelines, and recommendations for appropriate actuarial reporting in blanks. Respond to charges from the Life Insurance and Annuities (A) Committee and referrals from other groups or committees, as appropriate.
   B. Report progress on all work to the Life Insurance and Annuities (A) Committee and provide updates to the Financial Condition (E) Committee on matters related to life insurance company solvency. This work includes the following:
      i. Work with the American Academy of Actuaries (Academy) and the Society of Actuaries (SOA) to develop new mortality tables for valuation and minimum nonforfeiture requirements for life insurance and annuities, as appropriate.
      ii. Provide recommendations for guidance and requirements for accelerated underwriting (AU) and other emerging underwriting practices, as needed.
      iii. Work with the SOA on the annual development of the Generally Recognized Expense Table (GRET) factors.
      iv. Provide recommendations and changes to other reserve and nonforfeiture requirements to address issues as appropriate and provide actuarial assistance and commentary to other NAIC committees relative to their work on actuarial matters.
      v. Work with the selected vendor to develop and implement the new generator of economic scenarios (GOES) for use in regulatory reserve and capital calculations.
      vi. Monitor international developments regarding life and health insurance reserving, capital, and related topics. Compare and benchmark these with PBR requirements.
      vii. Coordinate with the Reinsurance (E) Task Force on actuarial items related to reinsurance.

2. The **Experience Reporting (A) Subgroup** will:
   A. Continue the development of the experience reporting requirements within the *Valuation Manual*. Provide input on the process regarding the experience reporting agent, data collection, and subsequent analysis and use of experience submitted.

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

3. The **Generator of Economic Scenarios (GOES) (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor that the economic scenario governance framework is being appropriately followed by all relevant stakeholders involved in scenario delivery.
   B. Review material GOES updates, either driven by periodic model maintenance or changes to the economic environment, and provide recommendations.
   C. Regularly review key economic conditions and metrics to evaluate the need for off-cycle or significant GOES updates, and maintain a public timeline for GOES updates.
   D. Support the implementation of the GOES for use in statutory reserve and capital calculations.
   E. Develop and maintain acceptance criteria that reflect history as well as plausibly more extreme scenarios.

4. The **Life and Annuity Illustration (A) Subgroup** will:
   A. Consider changes to *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold on or After December 14, 2020* (AG 49-A), as needed. Provide recommendations for the consideration of changes to the *Life Insurance Illustrations Model Regulation* (#582) to the Task Force, as needed.
   B. Consider any guidance, actions, or recommendations that may be necessary to regulate annuity illustration practices.

5. The **Longevity Risk (E/A) Subgroup** of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group will:
   A. Provide recommendations for recognizing longevity risk in statutory reserves and/or risk-based capital (RBC), as appropriate.

6. The **Variable Annuities Capital and Reserve (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor the variable annuities (VA) reserve framework and RBC calculation, and determine if revisions need to be made.
   B. Develop and recommend appropriate changes, including those to improve the accuracy and clarity of VA capital and reserve requirements and reporting.

7. The **Valuation Manual (VM)-22 (A) Subgroup** will:
   A. Recommend requirements for non-variable (fixed) annuities in the accumulation and payout phases for consideration by the Task Force, as appropriate. Continue working with the Academy on a PBR methodology for non-variable annuities.

NAIC Support Staff: Scott O'Neal/Jennifer Frasier

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Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 19, 2024

2025 Proposed Charges

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Health Insurance and Managed Care (B) Committee** will:
   A. Respond to inquiries from the U.S. Congress (Congress), the White House, and federal agencies; analyze policy implications and their effect on the states of proposed and enacted federal legislation and regulations; and communicate the NAIC's position through letters and testimony, when requested.
   B. Monitor the activities of the Health Actuarial (B) Task Force.
   C. Monitor the activities of the Regulatory Framework (B) Task Force.
   D. Monitor the activities of the Senior Issues (B) Task Force.
   E. Serve as the official liaison between the NAIC and the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), the National Committee for Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC).
   F. Examine factors that contribute to rising health care costs and insurance premiums. Review state initiatives to address cost drivers.
   G. Coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues.
   H. Coordinate with the Market Regulation and Consumer Affairs (D) Committee, as necessary, to collect uniform data and monitor market conduct trends on plans that are not regulated under the federal Affordable Care Act (ACA), including short-term, limited-duration (STLD) insurance, association health plans (AHPs), and packaged indemnity health products.

2. The **Consumer Information (B) Working Group** will:
   A. Develop information or resources, as needed, that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance.
   B. Review NAIC publications that touch on health insurance to determine if they need updating. If updates are needed, suggest specific revisions to the appropriate NAIC group or NAIC division to make the changes.

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

3. The **Health Innovations (B) Working Group** will:
   A. Gather and share information, best practices, experience, and data to inform and support health innovation at the state and national levels, including, but not limited to, state flexibility options through the ACA and other health insurance-related policy initiatives.
   B. Discuss state innovations related to health care—i.e., access, insurance plan designs, underlying medical and prescription drug costs, stability for health care and insurance as a whole, health insurer and provider consolidation or competition, the use of data in regulatory and policy decision making, and health care delivery and financing models—to achieve better patient outcomes and lower spending trends.
   C. Explore sources and methods for state insurance regulators to obtain data to inform health reform initiatives.
   D. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to use the information gathered by the Working Group.
   E. Take up other matters as directed by the Health Insurance and Managed Care (B) Committee.

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

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Adopted by the Health Actuarial (B) Task Force, Oct. 1, 2024

2025 Proposed Charges

HEALTH ACTUARIAL (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Health Actuarial (B) Task Force** will:
   A. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate long-term care insurance (LTCI) rates, rating practices, and rate changes.
   B. Provide support for issues related to implementation of, and/or changes to, the federal Affordable Care Act (ACA).
   C. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.
   D. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.
   E. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary to other NAIC groups relative to their work on health actuarial matters.
   F. Monitor and evaluate the actuarial approach used in the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document, and make modifications, as appropriate. Additionally, monitor and evaluate the progress of the MSA rate review process and the state insurance department rate review actions related to the MSA Framework.

2. The **Long-Term Care Actuarial (B) Working Group**:
   A. Assist the Health Actuarial (B) Task Force in completing the following charges:
      i. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate LTCI rates, rating practices, and rate changes.
      ii. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a PBR framework.
      iii. Develop LTCI experience reporting requirements in VM-50 and VM-51, Experience Reporting Formats, of the *Valuation Manual*.
      iv. Monitor and evaluate the actuarial approach used in the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document, and make modifications, as appropriate. Additionally, monitor and evaluate the progress of the MSA rate review process and the state insurance department rate review actions related to the MSA Framework.

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Adopted by the Regulatory Framework (B) Task Force, Nov. 4, 2024

2025 Proposed Charges

REGULATORY FRAMEWORK (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Regulatory Framework (B) Task Force** will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace, and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority, and structures.
   C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group, and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2025.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze, and report developments related to association health plans (AHPs).
   F. Monitor, analyze, and report, as necessary, developments related to excepted benefits coverage and short-term, limited-duration (STLD) coverage.

2. The **ERISA (B) Working Group** will:
   A. Monitor, report, and analyze developments related to ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate with the states and the U.S. Department of Labor (DOL) efforts related to sham health plans.
   C. Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to ERISA.
   D. Review the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook), and modify it, as necessary, to reflect developments related to ERISA. Report annually.

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

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

4. The **Pharmaceutical Benefit Management Regulatory Issues (B) Working Group** will:
   A. Serve as a forum to educate state insurance regulators on issues related to pharmacy benefit manager (PBM) regulation and other stakeholders in the prescription drug ecosystem.
   B. Gather and share information, best practices, experience, and data to inform and support dialogue and information-sharing among state insurance regulators on issues related to PBM regulation, such as examinations and contracting, and pharmaceutical drug pricing and transparency.
   C. As the subject matter experts (SMEs) and to promote uniformity across the states, while remaining sensitive to variation in state approaches, develop a chapter for inclusion in the *Market Regulation Handbook* establishing examination standards for PBMs and related regulated entities for referral and consideration by the Market Conduct Examination Guidelines (D) Working Group.
   D. Maintain a current listing of PBM laws and regulations and case law for reference by state insurance regulators.
   E. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to use the information gathered by the Working Group.
   F. Monitor, facilitate, and coordinate with the states and federal agencies to ensure compliance and enforcement efforts regarding PBMs.

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

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2025 Proposed Charges

SENIOR ISSUES (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Senior Issues (B) Task Force** will:
   A. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on Medicare supplement insurance, senior counseling programs, and other insurance issues that affect older Americans. Work with federal agencies to advance appropriate regulatory standards for Medicare supplement and other forms of health insurance applicable to older Americans. Review the *Medicare Supplement Insurance Minimum Standards Model Act* (#650) and the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651) to determine if amendments are required based on changes to federal law. Work with the federal Centers for Medicare & Medicaid Services (CMS) to revise the annual joint publication, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*.
   B. Monitor the Medicare Advantage and Medicare Part D marketplace. Assist states, as necessary, with regulatory issues. Maintain dialogue and coordinate with the CMS on regulatory issues, including solvency oversight of waived plans and agent misconduct. Assist states and serve as a clearinghouse for information on Medicare Advantage plan activity.
   C. Provide the perspective of state insurance regulators to the U.S. Congress, as appropriate, and the CMS on insurance issues, including those concerning the effect and result of federal activity on the senior citizen health insurance marketplace and regulatory scheme. Review and monitor state and federal relations with respect to senior health care initiatives and other impacts on the states.
   D. Monitor developments concerning State Health Insurance Assistance Programs (SHIPs), including information on legislation affecting the funding of SHIPs. Assist the states with issues relating to SHIPs and support a strong partnership between SHIPs and the CMS. Provide the perspective of state insurance regulators to federal officials, as appropriate, on issues concerning SHIPs.
   E. Monitor, maintain, and review, in accordance with changes to Model #651, a record of state approvals of all Medicare supplement insurance new or innovative benefits for use by state insurance regulators and others. Review state-approved new or innovative benefits and consider whether to recommend that they be made part of standard benefit plan designs in Model #651.
   F. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on LTCI, including the study and evaluation of evolving LTCI product design, rating, suitability, and other related factors. Monitor ongoing research and maintenance of guidance regarding reduced benefit options (RBOs) and make necessary modifications to the *Long-Term Care Insurance Model Act* (#640) and the *Long-Term Care Insurance Model Regulation* (#641). Work with federal agencies, as appropriate.

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SENIOR ISSUES (B) TASK FORCE *(Continued)*

G. Examine examples of health-related financial exploitation of seniors and work with other NAIC committees, task forces, and working groups on possible solutions.
H. Examine the effects of structural racism and the COVID-19 pandemic on access, affordability, and outcomes for older insurance consumers.

NAIC Support Staff: David Torian

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2025 Proposed Charges

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

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

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

L. Assist state insurance regulators in better assessing their markets and insurer underwriting practices by developing property market data intelligence so regulators can better understand how markets are performing in their states, and identify potential new coverage gaps, including changes in deductibles and coverage types, and affordability and availability issues. Provide analysis of property insurance markets to states.
M. Provide a forum for discussing issues related to the use of telematics in insurance, and consider the development of a white paper or regulatory guidance.

2. The **Cannabis Insurance (C) Working Group** will:
   A. Assess and periodically report on the status of federal legislation and regulation involving cannabis, especially as it pertains to protecting financial institutions from liability associated with providing services to cannabis businesses operating legally under state law.
   B. Support insurance regulators' efforts to encourage the development of admitted market insurers, as well as the expansion of existing admitted market insurers, and reinsurers supporting the market, to ensure coverage adequacy in states where cannabis, including hemp, is legal.
   C. Stay abreast of new products and innovative ideas that may shape insurance in this space. Provide insurance resources to insurance regulators and stakeholders, as needed.
   D. Explore potential sources of constraint to coverage limits and availability of cannabis insurance products within the admitted and non-admitted market. Explore the effect of the use of cannabis and related products on P/C insurance lines of business.

3. The **Catastrophe Insurance (C) Working Group** will:
   A. Monitor and recommend measures to improve the availability and affordability of insurance and reinsurance related to catastrophe perils for personal and commercial lines.
   B. Evaluate potential state, regional, and national programs to increase capacity for insurance and reinsurance related to catastrophe perils, including mitigation efforts being used in states and investigating loss trends in homeowners markets, with the goal to provide rate stability in the marketplace and protect consumers.
   C. Monitor and assess proposals that address disaster insurance issues at the federal and state levels. Assess concentration-of-risk issues and whether a regulatory solution is needed.
   D. Provide a forum for discussing issues and recommending solutions related to insuring for catastrophe risk, including terrorism, war, and natural disasters.
   E. Investigate and recommend ways the NAIC can assist states in responding to disasters by continuing to build the NAIC's Catastrophe Resource Center for state insurance regulators to better prepare for disasters.
   F. Continue to monitor the growth of the private flood insurance market and assess the actions taken by individual states to facilitate growth. Update the Considerations for Private Flood Insurance appendix to include new ways states are growing the private flood insurance market and discuss.
   G. Collaborate with other Task Forces and Working Groups regarding discussion of comparable topics, monitor catastrophe-related data calls, and keep informed about projects addressing the special needs of catastrophe data.
   H. Study, in coordination with other NAIC task forces and working groups, earthquake, severe convective storms, and wildfire matters of concern to state insurance regulators.
   I. Work with the Catastrophe Modeling Center of Excellence (COE) in order to be aware of what states are doing related to mitigation.

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

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

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

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

NAIC Support Staff: Aaron Brandenburg

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2025 Proposed Charges

CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

The mission of the Casualty Actuarial and Statistical (C) Task Force is to identify, investigate and develop solutions to actuarial problems and statistical issues in the property/casualty (P/C) insurance industry.

The Task Force's goals are to assist state insurance regulators with maintaining the financial health of P/C insurers; ensuring P/C insurance rates are not excessive, inadequate or unfairly discriminatory; and ensuring that appropriate data regarding P/C insurance markets are available.

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

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

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

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

NAIC Support Staff: Kris DeFrain/Roberto Perez/Libby Crews

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2025 Proposed Charges

SURPLUS LINES (C) TASK FORCE

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

1. The **Surplus Lines (C) Task Force** will:

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

2. The **Surplus Lines (C) Working Group** will:

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

NAIC Support Staff: Andy Daleo

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2025 Proposed Charges

TITLE INSURANCE (C) TASK FORCE

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

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

NAIC Support Staff: Anne Obersteadt/Aaron Brandenburg

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2025 Proposed Charges

WORKERS' COMPENSATION (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services:

1. The **Workers' Compensation (C) Task Force** will:
   A. Oversee the activities of the NAIC/International Association of Industrial Accident Boards and Commissions (IAIABC) Joint (C) Working Group.
   B. Discuss issues with respect to advisory organizations, rating organizations, statistical agents, and insurance companies in the workers' compensation arena.
   C. Monitor the movement of business from the standard markets to the assigned risk pools. Alert state insurance department representatives if the growth of assigned risk pools changes dramatically.
   D. Follow workers' compensation issues regarding cannabis in coordination with the Cannabis Insurance (C) Working Group.
   E. Discuss issues affecting workers' compensation.

2. The **NAIC/International Association of Industrial Accident Boards and Commissions (IAIABC) Joint (C) Working Group** will:
   A. Study issues of mutual concern to state insurance regulators and the IAIABC. Review relevant IAIABC model laws and white papers and consider possible charges based on the Working Group's recommendations.

NAIC Support Staff: Sara Robben/Aaron Brandenburg

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2025 Proposed Charges

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Market Regulation and Consumer Affairs (D) Committee** will:
   A. Monitor the centralized collection and storage of market conduct data, national analysis, and reporting at the NAIC, including issues regarding the public availability of data.
   B. Monitor and assess the current process for multi-jurisdictional market conduct activities, and provide appropriate recommendations for enhancement, as necessary.
   C. Oversee the activities of the Antifraud (D) Task Force.
   D. Oversee the activities of the Producer Licensing (D) Task Force.
   E. Monitor the underwriting and market practices of insurers and producers, as well as the conditions of insurance marketplaces, including urban markets, to identify specific market conduct issues of importance and concern. Hold public hearings on these issues at the NAIC national meetings, as appropriate.
   F. In collaboration with other technical working groups, discuss and share best practices through public forums to address broad consumer concerns regarding personal insurance products.
   G. Coordinate with the International Insurance Relations (G) Committee to develop input and submit comments to the International Association of Insurance Supervisors (IAIS) and/or other related groups on issues regarding market regulation concepts.
   H. Coordinate with the Health Insurance and Managed Care (B) Committee to provide policy recommendations regarding uniform state enforcement of the federal Affordable Care Act (ACA).

2. The **Advisory Organization (D) Working Group** will:
   A. Revise the protocols, as necessary, for the examination of national or multistate advisory organizations (including rating organizations and statistical agents) to be more comprehensive and efficient. Solicit input and collaboration from other interested and affected committees and task forces.
   B. Monitor the data reporting and data collection processes of advisory organizations (including rating organizations and statistical agents) to determine if they are implementing appropriate measures to ensure data quality. Report the results of this ongoing charge, as needed.
   C. Actively assist with and coordinate multistate examinations of advisory organizations (including rating organizations and statistical agents).

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

3. The **Market Actions (D) Working Group** will:
   A. Facilitate interstate communication, and coordinate collaborative state regulatory actions.
   B. Facilitate interstate communication, and coordinate collaborative state regulatory activities involving nontraditional market actions through the Coordinated Market Investigation Subgroup.

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

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

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

7. The **Market Information Systems (D) Working Group** will:
   A. Analyze the data in the NAIC Market Information Systems (MIS). In accordance with the first recommendation of the adopted *Review of Artificial Intelligence Techniques in Market Analysis*, recommend methods to ensure better data quality.
   B. In conjunction with the Market Analysis Procedures (D) Working Group and in accordance with the second recommendation of the adopted *Review of Artificial Intelligence Techniques in Market Analysis*, assess currently available market analysis data to identify needed improvements in the effectiveness of the data for market analysis and the predictive abilities of the market scoring systems utilizing the data.

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

C. Provide guidance on the appropriate use of the MIS and the data entered in them.
   i. Complaints Database System (CDS).
   ii. Electronic Forums.
   iii. Market Actions Tracking System (MATS).
   iv. Market Analysis Profile.
   v. Market Analysis Prioritization Tool (MAPT).
   vi. Market Analysis Review System (MARS).
   vii. Market Conduct Annual Statement (MCAS).
   viii. Regulatory Information Retrieval System (RIRS).
   ix. 1033 State Decision Repository (SDR1033) (in conjunction with the Antifraud (D) Task Force).

D. Serve as the business partner to review and prioritize submitted Uniform System Enhancement Request (USER) forms to ensure efficient use of available NAIC staffing and resources.

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

9. The **Speed to Market (D) Working Group** will:
   A. Consider proposed System for Electronic Rates & Forms Filing (SERFF) features or functionality presented to the Working Group by the Product Steering Committee (PSC). Review periodic reports from the PSC, as needed.
   B. Provide feedback and recommendations concerning the SERFF modernization when requested by the Executive (EX) Committee and any group assigned oversight of the SERFF modernization by the Executive (EX) Committee.
   C. Discuss and oversee the implementation and ongoing maintenance/enhancement of speed-to-market operational efficiencies related to product filing needs, efficiencies, and effective consumer protection. This includes the following activities:
      i. Provide a forum to gather information from the states and the industry regarding tools, policies, and resolutions to assist with common filing issues. Provide oversight in evaluating product filing efficiency issues for state insurance regulators and the industry, particularly regarding uniformity.
      ii. Use SERFF data to develop, refine, implement, collect, and distribute common filing metrics that provide a tool to measure the success of the speed-to-market modernization efforts, as measured by nationwide and individual state speed-to-market compliance, with an emphasis on monitoring state regulatory and insurer responsibilities for speed to market for insurance products.
      iii. Facilitate proposed changes to the product coding matrices (PCMs) and the uniform transmittal document (UTD) on an annual basis, including the review, approval, and notification of changes. Monitor, assist with, and report on state implementation of any PCM changes.

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

iv. Facilitate the review and revision of the *Product Filing Review Handbook*, which contains an overview of all the operational efficiency tools and describes best practices for industry filers and state reviewers regarding the rate and form filing and review process. Develop and implement a communication plan to inform the states about the *Product Filing Review Handbook*.

D. Provide direction to NAIC staff regarding SERFF functionality, implementation, development, and enhancements. Receive periodic reports from NAIC staff, as needed.

E. Conduct the following activities, as desired, by the Interstate Insurance Product Regulation Commission (Compact):

i. Provide support to the Compact as the speed-to-market vehicle for asset-based insurance products, encouraging state participation in, and the industry's usage of, the Compact.

ii. Receive periodic reports from the Compact, as needed.

NAIC Support Staff: Tim Mullen/Randy Helder

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Adopted by the Antifraud (D) Task Force, Oct. 31, 2024

2025 Proposed Charge

ANTIFRAUD (D) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The **Antifraud (D) Task Force** will:
   A. Work with NAIC committees, task forces, and working groups (e.g., Title Insurance (C) Task Force, etc.) to review issues and concerns related to fraud activities and schemes related to insurance fraud.
   B. Coordinate efforts to address national concerns related to agent fraud and activities of unauthorized agents related to insurance sales.
   C. Coordinate the enforcement and investigation efforts of state and federal securities regulators with state insurance fraud bureaus.
   D. Coordinate with state, federal, and international law enforcement agencies in addressing antifraud issues relating to the insurance industry.
   E. Review and provide comments to the International Association of Insurance Supervisors (IAIS) on its Insurance Core Principles (ICPs) related to insurance fraud.
   F. Coordinate activities and information from national antifraud organizations, and provide information to state insurance fraud bureaus.
   G. Coordinate activities and information with state and federal fraud divisions to determine guidelines that will assist with reciprocal involvement concerning antifraud issues resulting from natural disasters and catastrophes.
   H. Coordinate efforts with the insurance industry to address antifraud issues and concerns.
   I. Evaluate and recommend methods to track national fraud trends.
   J. Develop seminars, trainings, and webinars regarding insurance fraud. Provide three webinars by the 2025 Fall National Meeting.

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ANTIFRAUD (D) TASK FORCE (*Continued*)

2. The **Antifraud Technology (D) Working Group** will:
   A. Work with the NAIC to develop an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions. Complete by the 2025 Fall National Meeting.
   B. Evaluate sources of antifraud data, and propose methods for enhancing the utilization and exchange of information among state insurance regulators, fraud investigative divisions, law enforcement officials, insurers, and antifraud organizations. Complete by the 2025 Fall National Meeting.

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

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Adopted by the Producer Licensing (D) Task Force, Oct. 31, 2024

2025 Proposed Charges

PRODUCER LICENSING (D) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

2. The **Adjuster Licensing (D) Working Group** will:
   A. Monitor state implementation of adjuster licensing and reciprocity; update the NAIC adjuster licensing standards, as necessary.

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

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

NAIC Support Staff: Tim Mullen/Greg Welker

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2025 Proposed Charges

FINANCIAL CONDITION (E) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Financial Condition (E) Committee** will:
   A. Monitor all changes to the annual/quarterly financial statement blanks and instructions, risk-based capital (RBC) formulas, *Financial Condition Examiners Handbook*, *Accounting Practices and Procedures Manual* (AP&P Manual), *Financial Analysis Handbook*, *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual), NAIC model laws, NAIC accreditation standards, and other NAIC publications.
   B. Appoint and oversee the activities of the following: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Financial Stability (E) Task Force; Examination Oversight (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention Group (E) Task Force; and Valuation of Securities (E) Task Force.
   C. Oversee the implementation of the NAIC "Framework for Regulation of Insurer Investments – A Holistic Review," ensuring that updates or reviews of the Risk-Based Capital (RBC) framework align with the Framework's principles and take into consideration insurers evolving role of the insurance sector in financing the economy and reducing the protection gap.
   D. Oversee a process to address financial issues that may compromise the consistency and uniformity of the U.S. solvency framework, referring valuation and other issues to the appropriate committees as needed.
   E. Use the Risk-Focused Surveillance (E) Working Group to address specific industry concerns regarding regulatory redundancy, and review any issues that industry subsequently escalates to the Committee.

2. The **Financial Analysis (E) Working Group** will:
   A. Analyze nationally significant insurers and groups that exhibit characteristics of trending toward or being financially troubled; determine if appropriate action is being taken.
   B. Interact with domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods, and action(s).
   C. Support, encourage, promote, and coordinate multistate efforts in addressing solvency problems, including identifying adverse industry trends.
   D. Increase information-sharing and coordination between state insurance regulators and federal authorities, including through representation of state insurance regulators in national bodies with responsibilities for system-wide oversight.

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FINANCIAL CONDITION (E) COMMITTEE *(Continued)*

3. The **Group Capital Calculation (E) Working Group** will:
   A. Continually review and monitor the effectiveness of the group capital calculation (GCC), and consider revisions, as necessary, to maintain the effectiveness of its objective under the U.S. solvency system.
   B. Liaise, as necessary, with the International Insurance Relations (G) Committee on international group capital developments, and consider input from participation of U.S. state insurance regulators in the International Association of Insurance Supervisors (IAIS) monitoring process.

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

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

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

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

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FINANCIAL CONDITION (E) COMMITTEE *(Continued)*

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

9. The **Restructuring Mechanisms (E) Working Group** will:
   A. Evaluate and prepare a white paper that:
      i. Addresses the perceived need for restructuring statutes and the issues those statutes are designed to remedy. Also, consider alternatives that insurers are currently employing to achieve similar results.
      ii. Summarizes the existing state restructuring statutes.
      iii. Addresses the legal issues posed by an order of a court (or approval by an insurance department) in one state affecting the policyholders of other states.
      iv. Considers the impact that a restructuring might have on guaranty associations and policyholders that had guaranty fund protection prior to the restructuring.
      v. Identifies and addresses the legal issues associated with restructuring using a protected cell.
   B. Consider requesting approval from the Executive (EX) Committee on developing changes to specific NAIC models as a result of findings from the development of the white paper.
   C. Develop best practices to be used 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.
   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.

10. The **Risk-Focused Surveillance (E) Working Group** will:
   A. Continually review the effectiveness of risk-focused surveillance, and develop enhancements to processes as necessary.
   B. Continually review regulatory redundancy issues identified by interested parties, and provide recommendations to other NAIC committee groups to address as needed.
   C. Oversee and monitor the Peer Review Program to encourage consistent and effective risk-focused surveillance processes.
   D. Continually maintain and update standardized job descriptions/requirements and salary range recommendations for common solvency monitoring positions to assist insurance departments in attracting and maintaining suitable staff.

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FINANCIAL CONDITION (E) COMMITTEE (Continued)

11. The **Valuation Analysis (E) Working Group** will:
    A. Work with NAIC resources to assist in prioritizing and responding to issues and questions regarding principle-based reserves (PBR) and asset adequacy analysis, including actuarial guidelines or other requirements.
    B. Develop and implement a plan to coordinate PBR reviews/examinations.
    C. Review, on a targeted basis, asset adequacy analysis filings for *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53), and coordinate with states as appropriate.
    D. Review, on a targeted basis, long-term care (LTC) reserve adequacy filings for *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51), and coordinate with states as appropriate.
    E. Provide a confidential forum to address questions/issues regarding PBR and asset adequacy analysis, as well as related reinsurance risk transfer issues, and make referrals, as appropriate, to other NAIC regulator groups.
    F. Refer questions/issues, as appropriate, to the Life Actuarial (A) Task Force that may require consideration of changes/interpretations to be provided in the *Valuation Manual* or related actuarial guidelines.
    G. Assist NAIC resources in the use of models and other analytical tools to support the review of PBR/asset adequacy analysis.
    H. Make referrals, as appropriate, to the Financial Analysis (E) Working Group.
    I. Perform other work to carry out the Valuation Analysis (E) Working Group procedures.

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2025 Proposed Charges

ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Accounting Practices and Procedures (E) Task Force** will:
   A. Oversee the activities of the Blanks (E) Working Group and the Statutory Accounting Principles (E) Working Group.

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

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

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

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2025 Proposed Charges

CAPITAL ADEQUACY (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

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

2. The **Health Risk-Based Capital (E) Working Group**, **Life Risk-Based Capital (E) Working Group**, and **Property and Casualty Risk-Based Capital (E) Working Group will:**
   A. Evaluate refinements to the existing NAIC RBC formulas implemented in the prior year. Forward the final version of the structure of the current year life and fraternal, property/casualty (P/C), and health RBC formulas to the Financial Condition (E) Committee by June.
   B. Consider improvements and revisions to the various RBC blanks to: 1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity; and 2) oversee the development of additional reporting formats within the existing RBC blanks as needs are identified. Any proposal that affects the RBC structure must be adopted no later than May 15 of the reporting year, and any proposal that affects the RBC factors and/or instructions must be adopted no later than June 30 of the reporting year. Adopted changes will be forwarded to the Financial Condition (E) Committee by the next scheduled meeting. Any adoptions made to the annual financial statement blanks or statutory accounting principles that affect an RBC change adopted by June 30 and result in an amended change may be considered and adopted by July 30, where the Capital Adequacy (E) Task Force votes to pursue by two-thirds consent of members.
   C. Monitor changes in accounting and reporting requirements resulting from the adoption and continuing maintenance of the revised *Accounting Practices and Procedures Manual* (AP&P Manual) to ensure that model laws, publications, formulas, analysis tools, etc., supported by the Task Force continue to meet regulatory objectives.
   D. Review the effectiveness of the NAIC's RBC policies and procedures as they affect the accuracy, audit ability, timeliness of reporting access to RBC results, and comparability between the RBC formulas. Report on data quality problems in the prior year RBC filings at the Summer National Meeting and Fall National Meeting.

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

3. The **Longevity Risk (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Provide recommendations for the appropriate treatment of longevity risk transfers by new longevity factors.

4. The **Variable Annuities Capital and Reserve (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor the impact of the changes to the variable annuities reserve framework and RBC calculation, and determine if additional revisions need to be made.
   B. Develop and recommend appropriate changes, including those to improve the accuracy and clarity of variable annuity (VA) capital and reserve requirements.

5. The **Catastrophe Risk (E) Subgroup** of the Property and Casualty Risk-Based Capital (E) Working Group will:
   A. Recalculate the premium risk factors on an ex-catastrophe basis, if needed.
   B. Continue to update the U.S. and non-U.S. catastrophe event list.
   C. Continue to evaluate the need for exemption criteria for insurers with minimal risk.
   D. Evaluate the RBC results inclusive of a catastrophe risk charge.
   E. Refine instructions for the catastrophe risk charge.
   F. Continue to evaluate any necessary refinements to the catastrophe risk formula.
   G. Evaluate other catastrophe risks for possible inclusion in the charge.

6. The **Risk-Based Capital Investment Risk and Evaluation (E) Working Group** will:
   A. Perform a comprehensive review of the RBC investment framework for all business types, which could include:
      i. Identifying and acknowledging uses that extend beyond the purpose of the *Risk-Based Capital (RBC) for Insurers Model Act* (#312).
      ii. Assessing the impact and effectiveness of potential changes in contributing to the identification of weakly capitalized companies; i.e., those companies at action levels.
      iii. Documenting the modifications made over time to the formulas, including, but not limited to, an analysis of the costs in study and development, implementation (internal and external), assimilation, verification, analysis, and review of the desired change to the RBC formulas and facilitating the appropriate allocation of resources.

7. The **Generator of Economic Scenarios (GOES) (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor that the economic scenario governance framework is being appropriately followed by all relevant stakeholders involved in scenario delivery.
   B. Review material economic scenario generator updates, either driven by periodic model maintenance or changes to the economic environment and provide recommendations.
   C. Regularly review key economic conditions and metrics to evaluate the need for off-cycle or significant economic scenario generator updates and maintain a public timeline for economic scenario generator updates.
   D. Support the implementation of an economic scenario generator for use in statutory reserve and capital calculations.
   E. Develop and maintain acceptance criteria that reflect history as well as plausibly more extreme scenarios.

NAIC Support Staff: Eva Yeung

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Adopted by the Examination Oversight (E) Task Force, Sept. 25, 2024

2025 Proposed Charges

EXAMINATION OVERSIGHT (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Examination Oversight (E) Task Force will:**
   A. Accomplish its mission using the following groups:
      i. Electronic Workpaper (E) Working Group.
      ii. Financial Analysis Solvency Tools (E) Working Group.
      iii. Financial Examiners Coordination (E) Working Group.
      iv. Financial Examiners Handbook (E) Technical Group.
      v. Information Technology (IT) Examination (E) Working Group.

2. The **Electronic Workpaper (E) Working Group** will:
   A. Monitor and support the state insurance departments in using electronic workpaper software tools to conduct and document solvency monitoring activities.
   B. Provide ongoing oversight in the transition of electronic workpaper work to the TeamMate+ application.
   C. Monitor state insurance regulator use of TeamMate+ to proactively identify best practices and improvements to the application, as necessary.

3. The **Financial Analysis Solvency Tools (E) Working Group** will:
   A. Provide ongoing maintenance and enhancements to the *Financial Analysis Handbook* and related applications for changes to the NAIC annual/quarterly financial statement blanks based on input from other regulators and the work or referrals from other NAIC committees, task forces, and working groups to develop, as well as enhancements developed to assist in the risk-focused analysis and monitoring of the financial condition of insurance companies and groups.
   B. Provide ongoing development maintenance and enhancements to the automated financial solvency tools that were developed to assist in conducting risk-focused analysis and the monitoring of the financial condition of insurance companies and groups. Prioritize and perform analysis to ensure that the tools remain reliable and accurate.
   C. Coordinate with the Financial Examiners Handbook (E) Technical Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.

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EXAMINATION OVERSIGHT (E) TASK FORCE (C*ontinued*)

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

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

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

NAIC Support Staff: Bailey Henning

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Adopted by the Financial Stability (E) Task Force, Oct. 17, 2024

2025 Proposed Charges

FINANCIAL STABILITY (E) TASK FORCE

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

Ongoing Support of NAIC Program, Products, or Services

1. The **Financial Stability (E) Task Force** will:
   A. Manage the macroprudential supervisory component of the NAIC financial solvency framework.
      i. Monitor the U.S. insurance industry's macroprudential risk levels.
      ii. Maintain macroprudential regulatory tools.
      iii. Identify data gaps and enhanced disclosure needs for the statutory financial statement and/or other reporting mechanisms.
      iv. Propose enhancements and/or additional supervisory measures to the Financial Condition (E) Committee or other relevant committees, and consult with such committees on implementation.
   B. Monitor U.S. macroprudential policy issues, and respond as appropriate.
      i. Support and work with the state insurance regulator representative to the Financial Stability Oversight Council (FSOC) to address confidential FSOC or other federal agency macroprudential work.
      ii. Participate in public FSOC or other federal agency macroprudential work.
   C. Monitor international macroprudential policy issues, and participate/respond as appropriate.
      i. Coordinate with the International Insurance Relations (G) Committee to address International Association of Insurance Supervisors (IAIS) or other international macroprudential work.

2. The **Macroprudential (E) Working Group** will:
   A. Oversee the implementation and maintenance of the Liquidity Stress Testing Framework (LST Framework).
   B. Monitor domestic and global activities, including those enumerated in the "Plan for the List of Macroprudential Working Group (MWG) Considerations" document.
   C. Execute the original Macroprudential Initiative (MPI) projects related to counterparty disclosures and capital stress testing.
   D. Continue to develop and administer data collection tools as needed, leveraging existing data where feasible, to provide the Financial Stability (E) Task Force with meaningful macroprudential information regarding how the insurance sector is navigating the prevailing market conditions.
   E. Oversee the development, implementation, and maintenance process for a new macroprudential risk assessment system (i.e., policies, procedures, and tools) to enhance regulators' ability to monitor industry trends from a macroprudential perspective.
   F. Oversee the documentation of the NAIC's macroprudential policies, procedures, and tools.
   G. Provide the Task Force with updates to IAIS and other international initiatives as needed.

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Adopted by the Receivership and Insolvency (E) Task Force, Aug. 14, 2024

2025 Proposed Charges

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Receivership and Insolvency (E) Task Force** will:
   A. Monitor and promote efficient operations of insurance receiverships and guaranty associations.
   B. Monitor and promote state adoption of insurance receivership and guaranty association model acts and regulations, and monitor other legislation related to insurance receiverships and guaranty associations.
   C. Provide input and comments to the International Association of Insurance Supervisors (IAIS), the Financial Stability Board (FSB), and other related groups on issues regarding international resolution authority.
   D. Monitor, review, and provide input on federal rulemaking and studies related to insurance receiverships.
   E. Provide an ongoing review of the *Receiver's Handbook for Insurance Company Insolvencies* (Receiver's Handbook), other related NAIC publications, and the Global Receivership Information Database (GRID), and make any necessary updates.
   F. Monitor the work of other NAIC committees, task forces, and working groups to identify and address any issues that affect receivership law and/or regulatory guidance.
   G. Perform additional work as directed by the Financial Condition (E) Committee and/or received through referrals by other groups.

2. The **Receivership Financial Analysis (E) Working Group** will:
   A. Monitor receiverships involving nationally significant insurers/groups to support, encourage, promote, and coordinate multistate efforts in addressing problems.
   B. Interact with the Financial Analysis (E) Working Group, domiciliary regulators, and lead states to assist and advise on the most appropriate regulatory strategies, methods, and/or action(s) regarding potential or pending receiverships.

3. The **Receivership Law (E) Working Group** will:
   A. Review and provide recommendations on any issues identified that may affect states' receivership and guaranty association laws (e.g., any issues that arise as a result of market conditions, insurer insolvencies, federal rulemaking and studies, international resolution initiatives, or the work performed by or referred from other NAIC committees, task forces, and/or working groups).
   B. Discuss significant cases that may affect the administration of receiverships.

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Adopted by the Reinsurance (E) Task Force, July 22, 2024

2025 Proposed Charges

REINSURANCE (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Reinsurance (E) Task Force** will:
   A. Provide a forum for the consideration of reinsurance-related issues of public policy.
   B. Oversee the activities of the Reinsurance Financial Analysis (E) Working Group.
   C. Coordinate with the Mutual Recognition of Jurisdictions (E) Working Group on matters regarding reinsurance.
   D. Communicate and coordinate with the Federal Insurance Office (FIO), other federal authorities, and international regulators and authorities on matters pertaining to reinsurance.
   E. Monitor reinsurance-related activities of other task forces and working groups at the NAIC.
   F. Consider any other issues related to the *Credit for Reinsurance Model Law* (#785), *Credit for Reinsurance Model Regulation* (#786), and *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787).
   G. Monitor the development of international principles, standards, and guidance with respect to reinsurance. This includes, but is not limited to, monitoring the activities of various groups within the International Association of Insurance Supervisors (IAIS), including the Reinsurance and Other Forms of Risk Transfer Subcommittee, the Reinsurance Mutual Recognition Subgroup, and the Reinsurance Transparency Group.
   H. Consider the impact of reinsurance-related federal legislation, including, but not limited to, the federal Nonadmitted and Reinsurance Reform Act of 2010 (NRRA) and the Federal Insurance Office Act, and coordinate any appropriate NAIC action.
   I. Continue to monitor the impact of reinsurance-related international agreements, including the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement).

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REINSURANCE (E) TASK FORCE *(Continued)*

2. The **Reinsurance Financial Analysis (E) Working Group** will:
   A. Operate in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, and operate in open session when discussing certified reinsurance topics and policy issues, such as amendments to the Uniform Application for Certified or Reciprocal Jurisdiction Reinsurers.
   B. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. The process of reviewing applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.
   C. Provide a forum for discussion among NAIC jurisdictions of reinsurance issues related to specific companies, entities, or individuals.
   D. Support, encourage, promote, and coordinate multistate efforts in addressing issues related to certified reinsurers, including, but not limited to, multistate recognition of certified or reciprocal jurisdiction reinsurers.
   E. Provide analytical expertise and support to the states with respect to certified reinsurers, reciprocal jurisdiction reinsurers, and applicants.
   F. Provide advisory support on issues related to the determination of qualified jurisdictions.
   G. Ensure the public passporting website remains current.

NAIC Support Staff: Jake Stultz/Dan Schelp

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Adopted by the Risk Retention Group (E) Task Force, July 24, 2024

2025 Proposed Charges

RISK RETENTION GROUP (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Risk Retention Group (E) Task Force** will:
   A. Monitor and evaluate the work of other NAIC committees, task forces, and working groups that may affect the filing requirements or compliance of risk retention groups (RRGs) (e.g. actions that affect compliance with the NAIC Accreditation Standards Program.
   B. Monitor and review any federal activities, including any U.S. Government Accountability Office (GAO) reports, and consider any necessary action.
   C. Monitor the resources available to domiciliary and non-domiciliary state insurance regulators of RRGs, including educational programs or enhancements or the development of new resources.

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2025 Proposed Charges

VALUATION OF SECURITIES (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

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2025 Proposed Charges

FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

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

2. The **Accreditation Scope and Alignment (F) Working Group** will:
   A. Review the current scope of the NAIC Financial Regulation Standards and Accreditation Program to: 1) evaluate whether it aligns with the program's objectives; and 2) determine whether any multistate companies/activities are not currently covered in the program's scope.
   B. Analyze state regulations to understand how states regulate companies within the scope of the accreditation program and identify any discrepancies or unique regulatory practices across states. Maintain a resource that summarizes the results of this analysis.

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

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2025 Proposed Charges

INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Ryan Workman/Nikhail Nigam

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2025 Proposed Charges

INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Innovation, Cybersecurity, and Technology (H) Committee** will:
   A. Provide forums, resources and materials related to developments and emerging issues in innovation, cybersecurity, data privacy, and the uses of technology in the insurance industry in order to educate state insurance regulators on these developments and how they affect consumer protection, insurer and producer oversight, marketplace dynamics, and the state-based insurance regulatory framework.
   B. Consider and coordinate the development of regulatory guidance and examination standards related to innovation, cybersecurity, data privacy, the use of big data and artificial intelligence (AI) including machine learning (ML) in the business of insurance, and technology, including drafting and revising model laws, white papers, and other recommendations as appropriate.
   C. Oversee the work of the Data Call Study Group to study the enhancement of regulator access to high-quality and timely data allowing for evidence-informed decisions, enhanced supervisory capabilities, and improved efficiency.
   D. Track the implementation of and issues related to all model laws pertaining to innovation, technology, data privacy, and cybersecurity, including the *Insurance Data Security Model Law* (#668), the *NAIC Insurance Information and Privacy Protection Model Act* (#670), the *Privacy of Consumer Financial and Health Information Regulation* (#672), and the *Unfair Trade Practices Act* (#880) rebating language and providing assistance to state insurance regulators as needed.
   E. Coordinate and facilitate collaboration with and among other NAIC committees and task forces to promote consistency and efficiency in the development of regulatory policy, education, training, and enforcement materials and tools related to innovation; cybersecurity; data privacy; and the use of technologies, big data, and artificial intelligence (AI), including machine learning (ML), in the business of insurance. Evaluate and recommend certifications, continuing education (CE), and training for regulatory staff related to technology, innovation, cybersecurity, and data privacy.
   F. Follow the work of federal, state, and international governmental bodies to avoid conflicting standards and practices.

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

2. The **Big Data and Artificial Intelligence (H) Working Group** will:
   A. Research the use of big data and AI (including ML) in the business of insurance. Proactively communicate findings, and present recommendations to the Innovation, Cybersecurity, and Technology (H) Committee.
   B. Monitor state, federal, and international activities on AI, including working with the Innovation, Cybersecurity, and Technology (H) Committee to: 1) respond to such activities, where appropriate, and 2) address potential impacts on existing state insurance laws or regulations.
   C. Facilitate discussion to consider updates to the regulatory framework for the oversight of the use of AI by insured entities. Provide recommendations to the Innovation, Cybersecurity, and Technology (H) Committee in response to such activities.
      i. Monitor and support adoption of the *Model Bulletin on the Use of Artificial Intelligence Systems by Insurers.*
      ii. Monitor and report on state, federal, and international activities related to governmental oversight and regulation of the use of AI in insurance and non-insurance industries.
      iii. Research, identify, and monitor the impacts of the use of AI systems by insurance companies to understand the potential benefits, value propositions, risks, and adverse consumer outcomes related to the use of AI systems.
   D. Facilitate discussion related to AI systems evaluation including:
      i. Identifying existing tools, resources, materials, and training that will assist and guide regulators in their review of AI systems used by licensees, including an insurer's AI program. This includes establishing a coordinated work plan and timeline for further development of those resources.
      ii. Develop new regulatory tools or regulatory guidance to assist regulators in their review of AI systems used by licensees, including an insurer's AI program.
      iii. Coordinate the development of review and enforcement tools, resources, guidelines, and training related to AI systems for regulators across the NAIC.
   E. Facilitate and coordinate foundational and contextual educational content for regulators on topics related to the use of big data and AI techniques, tools and systems in the insurance industry.

3. The **Cybersecurity (H) Working Group** will:
   Cybersecurity Charges
   A. Monitor cybersecurity trends such as vulnerabilities, risk management, governance practices, and breaches with the potential to affect the insurance industry.
   B. Facilitate communication across state insurance departments regarding cybersecurity risks and events.
   C. Develop and maintain regulatory cybersecurity response guidance to assist state insurance regulators in the investigation of national insurance cyber events.
   D. Monitor federal and international activities on cybersecurity engaging in efforts to manage and evaluate cybersecurity risk.
   E. Coordinate NAIC committee cybersecurity work, including cybersecurity guidance developed by the Market Conduct Examination Guidelines (D) Working Group and the Information Technology (IT) Examination (E) Working Group.
   F. Advise NAIC staff on the development of cybersecurity training for state insurance regulators.
   G. Work with the Center for Insurance Policy and Research (CIPR) to receive updates on cybersecurity research efforts, by the CIPR and others, and to analyze publicly available cybersecurity-related information.
   H. Support the states with implementation efforts related to the adoption of the *Insurance Data Security Model Law* (#668).
   I. Coordinate with NAIC staff to facilitate intelligence-driven cybersecurity tabletop exercises with state departments of insurance (DOIs) providing input on scope and timing as necessary.

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

Cyber Insurance Charges

A. Monitor industry trends pertaining to cyber insurance, including meeting with subject matter experts (SMEs) and evaluating data needs of state insurance regulators. Considerations should include the availability and affordability/pricing of cyber insurance, disclosures, limits and sub-limits in policies, policy language and trends in requirements, underwriting practices, and the role of reinsurance in the cyber insurance market.
B. Coordinate with NAIC work groups addressing cyber insurance related issues, such as the Casualty Actuarial and Statistical (C) Task Force.
C. Monitor federal and international activities related to cyber insurance and financing mechanisms for cyber risk.
D. Coordinate with NAIC staff to conduct analysis pursuant to the NAIC's Cyber Insurance Report. Review the NAIC's *Property & Casualty Annual Statement Cybersecurity and Identity Theft Supplement* recommending changes and/or developing reports to supplement data development as necessary. Consider and develop a guide for states on cyber insurance data analysis best practices.

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

5. The **SupTech/GovTech Subgroup** will:
   A. Facilitate technology, innovation, and SupTech/GovTech presentations from leading technology companies for state insurance regulators to provide them with insights into cutting-edge technology and innovation.
   B. Facilitate technology, innovation, and SupTech/GovTech presentations from specialized vendors for state insurance regulators to assist in identifying vendor solutions that may benefit regulators.

NAIC Support Staff: Miguel Romero/Scott Sobel/Scott Morris

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Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Innovation, Cybersecurity, and Technology (H) Committee, Nov. 19, 2024
Adopted by the Third-Party Data and Models (H) Task Force, Oct. 10, 2024

2025 Proposed Charges

THIRD-PARTY DATA AND MODELS (H) TASK FORCE

The mission of the Third-Party Data and Models (H) Task Force is to develop and propose an optimal regulatory framework for the regulatory oversight of third-party data and predictive models.

Ongoing Support of NAIC Programs, Products, or Services:

1. The **Third-Party Data and Models (H) Task Force** will:
   A. Develop and propose a framework for the regulatory oversight of third-party data and predictive models.
   B. Monitor and report on state, federal, and international activities related to governmental oversight and regulation of third-party data and model vendors and their products and services. Provide recommendations to the Innovation, Cybersecurity, and Technology (H) Committee regarding responses to such activities.

NAIC Support Staff: Kris DeFrain/Scott Sobel

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Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Reaffirmed by the NAIC/Consumer Liaison Committee, Oct. 16, 2024

2025 Proposed Mission Statement

NAIC/CONSUMER LIAISON COMMITTEE

The mission of the NAIC/Consumer Liaison Committee is to assist the NAIC in its mission to support state insurance regulation by providing consumer views on insurance regulatory issues. The Liaison Committee provides a forum for ongoing dialogue between NAIC members and NAIC consumer representatives. The Liaison Committee's activities in 2025 are closely aligned with the priorities of the NAIC/Consumer Participation Board of Trustees.

NAIC Support Staff: Lois E. Alexander

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Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Reaffirmed by the NAIC/American Indian and Alaska Native Liaison Committee, Oct. 15, 2024

2025 Proposed Mission Statement

NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE

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

NAIC Support Staff: Lois E. Alexander

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Reaffirmed by the Executive (EX) Committee and Plenary, Dec. --, 2024
Reaffirmed by the Internal Administration (EX1) Subcommittee, Aug. 13, 2024
Reaffirmed by the Audit Committee, Aug. 1, 2024

2025 Proposed Committee Charter

AUDIT COMMITTEE

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

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AUDIT COMMITTEE *(Continued)*

D. Provide continuous oversight of the service advisory firm that conducts the Service Organization Control (SOC) 1 and SOC 2 reviews.
   i. Receive annual audit reports provided by the service advisory firm.
   ii. Instruct the independent service advisory firm that the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee are the auditor's clients.

E. Conduct scheduled audit activities, including:
   i. Recommend the selection of the independent auditor for approval by the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, approve the compensation of the independent auditor, and review and approve the discharge of the independent auditor.
   ii. Review annually the audit scope and plan of the independent auditor with management and the independent auditor, including:
      a. The independent auditor's audit of the financial statements, accompanying footnotes, and its report thereon.
      b. Any significant changes required in the independent auditor's audit plans.
      c. Any difficulties or disputes with management encountered during the year under audit.
      d. Other matters related to the conduct of the audit, which are to be communicated to the Committee under generally accepted auditing standards (GAAS).
   iii. Arrange for the independent auditor to be available to the full Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, as needed.

F. Conduct other activities when necessary, including:
   i. Review and approve needs-based funding allocations, as needed.
   ii. Review and update the Committee charter on at least an annual basis.
   iii. Review and approve requests for any management consulting engagement to be performed by the independent auditor and be advised of any other study undertaken at the request of management that is beyond the scope of the audit engagement letter.
   iv. Conduct and/or authorize investigations into any matters within the Committee's scope of responsibilities. The Committee shall be empowered to retain independent counsel and other professionals to assist in the conduct of any investigation.
   v. Ensure that members of the Committee receive the appropriate orientation to the Committee and receive a copy of the policy manual.

NAIC Support Staff: Jim Woody

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MODEL REGULATION TO IMPLEMENT THE SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

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Section 1. Purpose

The purpose of this regulation is to implement [insert reference to state law equivalent to the NAIC *Supplementary and Short-Term Health Insurance Minimum Standards Model Act*] (the Act) to standardize and simplify the terms and coverages, to facilitate public understanding and comparison of coverage, to eliminate provisions that may be misleading or confusing in connection with the purchase and renewal of the coverages or with the settlement of claims and to provide for full disclosure in the marketing and sale of supplementary and short-term health insurance, as defined in the Act. This regulation is also intended to assert the commissioner's jurisdiction over limited scope dental coverage and limited scope vision coverage, and to provide for disclosure in the sale of those coverages.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [insert reference to state law equivalent to NAIC *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* and any other appropriate section of law regarding authority of commissioner to issue regulations].

Section 3. Applicability and Scope

A. This regulation applies to all individual and group insurance policies and certificates providing hospital indemnity or other fixed indemnity, accident only, specified accident, specified disease, limited benefit health and disability income protection, referred to collectively in Section 1 of the Act and hereafter, as "supplementary health insurance," delivered or issued for delivery in this state on and after [insert effective date] that are not specifically exempted from this regulation. This regulation applies to short-term, limited-duration insurance coverage offered, delivered or issued for delivery to residents of this state regardless of the situs of the delivery of the contract on and after [insert effective date].

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B. This regulation applies to limited scope dental coverage and limited scope vision coverage only as specified.

C. This regulation shall not apply to:

(1) Medicare supplement policies subject to [insert reference to state law equivalent to the Model Regulation to Implement the NAIC *Medicare Supplement Insurance Minimum Standards Model Act*];

(2) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act*];

(3) TRICARE (Chapter 55, Title 10 of the United States Code) supplement insurance policies; or

(4) Limited long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Limited Long-Term Care Insurance Model Act*].

Drafting Note: TRICARE supplement insurance is not subject to federal regulation. TRICARE supplement policies are sold only to eligible individuals as determined by the Department of Defense and are tied to TRICARE benefits. In general, states regulate TRICARE supplement insurance policies under the state group or individual insurance laws.

D. The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted.

Section 4. Effective Date

This regulation shall be effective on [insert a date not less than 120 days after the date of adoption of the regulation]. The amendments to this regulation shall apply to any policies [or certificates] issued on or after the effective date of the adoption of the amended regulation.

Section 5. Definitions

For purposes of this regulation:

A. "Excepted benefits" means coverage listed at section 2791(c) of the Public Health Service Act (PHSA) or subsequently added by regulation where authorized.

B. "Medicare" means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

C. "Short-term, limited-duration insurance" has the meaning stated in Section 3I of the Act.

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Section 6. Policy Definitions

A. (1) Except as provided in this regulation, a supplementary health insurance or a short-term limited duration insurance policy delivered or issued for delivery to any person in this state and to which this regulation applies shall contain definitions respecting the matters set forth below that comply with the requirements of this section.

(2) Except as provided in this regulation, to the extent these definitions are used in a policy [or certificate], definitions used in a policy [or certificate] may vary from the definitions in this section, but not in a manner that restricts coverage.

B. "Convalescent nursing home," "extended care facility," "skilled nursing facility," "assisted living facility" or "continued care retirement community" means in relation to its status, facility and available services.

(1) A definition of the home or facility shall not be more restrictive than one requiring that it:

(a) Be operated pursuant to law;

(b) Be approved for payment of Medicare and/or Medicaid benefits or be qualified to receive approval for payment of Medicare and/or Medicaid benefits, if so requested;

(c) Be engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(d) Except for an "assisted living facility" or a "continued care retirement community," provide continuous twenty-four-hour-a-day nursing service by or under the supervision of a registered nurse; and

(e) Maintain a daily medical record of each patient.

(2) The definition of the home or facility is permitted but is not required to exclude:

(a) A home, facility or part of a home or facility used primarily for rest;

(b) A home or facility for the aged and/or for the care of individuals with a substance use disorder; or

(c) A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care.

Drafting Note: The laws of the states relating to nursing and extended care facilities recognized in health insurance policies are not uniform. Reference to the individual state or federal Medicare or Medicaid law may be required in structuring this definition.

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C. “Home health care agency":

(1) Is an agency approved under Medicare;

(2) Is licensed to provide home health care under applicable state law; or

(3) Meets all the following requirements:

(a) It is primarily engaged in providing home health care services;

(b) Its policies are established by a group of professional personnel, including at least one physician and one licensed nurse;

(c) A physician or a registered nurse provides supervision of home health care services;

(d) It maintains clinical records on all patients; and

(e) It has a full-time administrator.

Drafting Note: State licensing laws vary concerning the scope of “home health care” or “home health agency services” and should be consulted. In addition, a few states have mandated benefits for home health care, including the definition of required services.

D. “Hospital” means in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission.

(1) The definition of the term “hospital” shall not be more restrictive than one requiring that the hospital:

(a) Be an institution licensed to operate as a hospital pursuant to law;

(b) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and

(c) Provide twenty-four-hour nursing service by or under the supervision of registered nurses.

(2) The definition of the term “hospital” is permitted but is not required to exclude:

(a) Convalescent homes or, convalescent, rest or nursing facilities;

(b) Facilities affording primarily custodial, educational or rehabilitative care;

(c) Facilities for the aged or individuals with a substance use disorder; or

(d) A military or veterans' hospital, a soldiers' home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services where a legal liability for the patient exists for charges made to the individual for the services.

Drafting Note: The laws of the states relating to the type of hospital facilities recognized in health insurance policies are not uniform. References to individual state law may be required in structuring this definition.

E. (1) "Injury" means a bodily injury resulting from an accident, independent of disease, which occurs while the coverage is in force.

(2) The definition shall not use words such as "external, violent, visible wounds" or similar words of characterization or description.

(3) The definition may state that the disability shall have occurred within a specified period of time (not less than thirty (30) days) of the injury, otherwise the condition shall be considered a sickness.

(4) The definition may provide that "injury" shall not include an injury for which benefits are provided under workers' compensation, employers' liability or similar law; or under a motor vehicle no-fault plan, unless prohibited by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.

F. "Mental or nervous disorder" means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or its successor.

G. "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as an advance practice nurse, a registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words "nurse," "advance practice nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

Drafting Note: States may want to consider whether the functions of an advance practice nurse fall under this definition or the definition of "physician" in Subsection J.

H. "One period of confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

I. "Partial disability" means that, due to a disability, an individual:

(1) Is unable to perform one or more but not all the "major," "important" or "essential" duties of the individual's employment or existing occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation; and

(2) Is in fact engaged in work for wage or profit.

J. (1) "Physician" means and includes words such as "qualified physician" or "licensed physician" and may not be defined more narrowly than applicable state licensing laws.

(2) The definition or concept may exclude the insured, the owner, the assignee, any person related to the insured, owner or assignee by blood or marriage, any person who shares a significant business interest with the insured, owner or assignee, or any person who is a partner in a legally sanctioned domestic partnership or civil union with the insured, owner or assignee.

Drafting Note: The laws of the states relating to the type of providers' services recognized in health insurance policies are not uniform. References to the individual state law may be required in structuring this definition.

K. "Preexisting condition" means a condition for which medical advice or treatment was recommended by a physician or received from a physician within a [two-] year period preceding the effective date of the coverage of the insured person."

Drafting Note: This definition does not prohibit an insurer, using an application or enrollment form, including a simplified application form, designed to elicit the health history of a prospective insured and on the basis of the answers on that application or enrollment form, from underwriting in accordance with that insurer's established standards and in accordance with state law. It is assumed that an insurer that elicits a health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition, the policy or certificate will be endorsed or amended by including the specific exclusion. This same requirement of notice to the prospective insured of the specific exclusion will also apply to insurers that elect to use simplified application or enrollment forms containing questions relating to the prospective insured's health. This definition does, however, prohibit an insurer that elects to use a simplified application or enrollment form, with or without a question as to the proposed insured's health at the time of application or enrollment, from reducing or denying a claim on the basis of the existence of a preexisting condition that is defined more restrictively than above.

L. "Residual disability" means in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important" or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy that provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import that in the opinion of the commissioner adequately and fairly describes the benefit.

M. "Sickness" means sickness, illness, or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period that shall not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be modified to exclude sickness or disease

for which benefits are provided under a workers' compensation, occupational disease, employers' liability or similar law.

N. "Total disability"

(1) A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience; and is not in fact engaged in any employment or occupation for wage or profit.

(2) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to:

(a) Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation"; or

(b) Engage in a training or rehabilitation program.

(3) An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may require care by a physician other than the insured or a member of the insured's immediate family.

Section 7. Prohibited Policy Provisions

A. (1) Except as provided in this subsection, a policy shall not contain provisions establishing a probationary or waiting period during which coverage under the policy is excluded or restricted.

(2) A policy, other than an accident only policy, may exclude coverage for a loss due to a preexisting condition, as defined in Section 6J, for a period not to exceed twelve (12) months following the issuance of the policy or certificate. The twelve-month limitation is not required if the condition was disclosed during the application or enrollment process and specifically excluded by the terms of the policy or certificate, or when the insured knowingly made a material misrepresentation during the application or enrollment process.

(3) A policy, other than an accident only policy or a short-term, limited duration health insurance policy, may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting from disease or condition related to hernia, disorder of the reproductive organs, varicose veins, adenoids, and tonsils, except when the specified diseases or conditions are treated on an emergency basis.

B. A disability income protection policy may contain a "return of premium" or "cash value benefit" option so long as the return of premium or cash value benefit is not reduced by an amount greater

than the aggregate of claims paid under the policy; and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to the Act and this regulation shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

Drafting Note: This provision is optional and the desirability of its use should be reviewed by the individual states.

C. Policies providing hospital indemnity or other fixed indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

D. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except for the following permitted exclusions:

Drafting Note: States should review the provisions of this subsection carefully to determine if any of the exceptions to limiting or excluding coverage by type of illness, accident, treatment or medical condition included in the subsection should apply to short-term, limited-duration health insurance coverage.

(1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;

(2) Mental or emotional disorders, alcoholism and drug addiction;

Drafting Note: This provision is optional. States should review the desirability of permitting such exclusions, particularly those exclusions related to mental health and substance use, in Paragraph (2) of this subsection above and Paragraph (4) of this subsection, in short-term, limited-duration insurance policies and disability income protection insurance policies.

(3) Pregnancy, except for complications of pregnancy, other than for policies defined in Section 8C of this regulation;

(4) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it;

(b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

(c) Non-commercial or recreational aviation;

(d) With respect to short-term nonrenewable policies, interscholastic sports; and

(e) With respect to disability income protection policies, incarceration.

Drafting Note: What should be an allowable exclusion in disability income protection insurance policies generates much debate. States should be aware that some argue for exclusion of certain diseases or conditions that are difficult to diagnose or are potentially subject to frequent claims (e.g., carpal tunnel and chronic fatigue syndromes). Others argue that carriers have the ability to detect fraudulent claims and deny payment on that basis without singling out specific conditions for blanket exclusion.

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(5) Cosmetic surgery, except for reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly that has resulted in a functional defect;

(6) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or asymptomatic complaints of the feet;

(7) Chiropractic care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

Drafting Note: States should examine any existing "freedom of choice" statutes that require reimbursement of treatment provided by chiropractors and make adjustments if needed.

(8) Benefits provided under Medicare or other governmental program (except Medicaid), a state or federal workers' compensation, employers liability or occupational disease law, or motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance;

(9) Dental care or treatment, except where the provision of dental services is medically necessary due to the underlying covered medical condition or clinical status of the covered person, including but not limited to, reconstructive surgery;

(10) Eyeglasses, hearing aids and examination for the prescription or fitting of them;

(11) Rest cures, custodial care, transportation and routine physical examinations;

(12) Territorial limitations, provided that they do not exclude coverage for services rendered within the United States and its territories or possessions; and

(13) Genetic testing not ordered by a medical provider, and not used to diagnose or treat a disease.

Drafting Note: Some of the exclusions set forth in this provision may be unnecessary or in conflict with existing state legislation and should be deleted.

E. Notwithstanding Subsection D of this section, this regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page.

F. The enumeration in this section of specific precluded policy provisions shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with [cite Section 4B of the *Supplementary and Short-Term Health Insurance Minimum Standards Act*] that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.

G. A policy providing a type of supplementary health insurance that is not defined as a "plan" under the *Coordination of Benefits Model Regulation* (#120) shall not include a coordination of benefits provision or any other provision that allows it to reduce its benefits based on the existence of other coverage its insured may have.

H. A policy shall not limit an insured's choice of health care provider if the provider is licensed or otherwise qualified under state law and the services to be provided are within the health care provider's scope of practice.

Drafting Note: Former Subsection B in this section established provisions related to the issuance of a policy or rider for additional coverage as a dividend under specified circumstances. Subsection B was deleted because insurers rarely offer consumers policy dividends as a benefit on policies covered by this regulation. Such provisions are common in life insurance policies. If policy dividends are available on policies covered by this regulation in your state, you should look to the treatment of dividends in life insurance. Generally, consumers should be allowed to take the policy dividend as a cash payment, but insurers may offer the consumer additional policy benefits in lieu of a cash payment at the option of the consumer.

Section 8. Supplementary and Short-Term Health Insurance Minimum Standards for Benefits

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. A supplementary or short-term health insurance policy or certificate shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for the specified categories or the commissioner finds that the policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the outline of coverage in Section 9H of this regulation.

This section shall not preclude the issuance of any policy or contract combining two or more categories of excepted benefits set forth in [cite state law equivalent to Section 5B and C of the NAIC *Supplementary and Short-Term Health Insurance Minimum Standards Model Act*].

A. General Rules

(1) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" individual supplementary policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy shall provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured.

Drafting Note: States should review the use of the term "spouse" in Paragraph (1) above and replace it or add additional terms in accordance with state law or regulations.

(2) (a) The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Section 9A.

(b) The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in an individual supplementary policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

(c) Except as provided in Subparagraph (d) of this paragraph, the term "guaranteed renewable" may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

(d) An individual supplementary policy or individual accident-only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may be designated as "guaranteed renewable" if it provides that the insured has the right to continue the policy, while actively and regularly employed, at least until the insured has reached full retirement and, as defined under the federal Social Security Act.

(3) In an individual supplementary policy covering a married couple or civil union couple, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in the policy.

Drafting Note: The references to "married couple" and "civil union couple" in paragraph (3) above are intended to apply to any legally recognized marital relationship or domestic partnership recognized in the state. States should revise the language in accordance with state law or regulations. In addition, states should review the use of the term "spouse" and replace it or add additional terms in accordance with state law or regulations.

Drafting Note: For Paragraphs (2) and (3) above, coverage subject to Title XXVII of the federal Public Health Service Act (PHSA), as enacted by HIPAA and amended by the federal Affordable Care Act (ACA), must be guaranteed renewable except for reasons stated in PHSA § 2742 (42 U.S.C. § 300gg-42), unless it is an excepted benefit as described in PHSA § 2791(c) (42 U.S.C. § 300gg-91(c)). Applicable state law may impose requirements that mirror or exceed the federal requirements.

(4) When accidental death and dismemberment coverage is part of the individual supplementary insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.

(5) If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.

(6) Policies providing pregnancy benefits shall provide for an extension of benefits, in the event the insurer cancels or refuses to renew for reasons other than non-payment of premium, as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

(7) Policies providing convalescent or extended care benefits following hospitalization may condition the benefits upon admission to the convalescent or extended care facility within a specified time after discharge from the hospital, as long as the required admission date is not less than thirty (30) days after discharge from the hospital.

(8) In individual supplementary or short-term health insurance policies, coverage shall continue for a dependent child who is incapable of self-sustaining employment due to intellectual or physical disability on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days after the date the insurer receives due proof of the disability in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.

(9) A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.

(10) A policy may contain a provision relating to recurrent disabilities; but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six (6) months.

(11) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income protection benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.

(12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(13) An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage and the disclosure materials required under Section 9 of this regulation the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.

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(14) Termination of the policy shall be without prejudice to the right to receive benefits for a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.

(15) A policy providing coverage for certain illnesses and injuries may not define covered illnesses and injuries in a way that is misleading or includes unfair exclusions. For example, a policy providing coverage for fractures or dislocations may not provide benefits only for "full or complete" fractures or dislocations.

B. Hospital Indemnity or Other Fixed Indemnity Coverage

(1) "Hospital indemnity or other fixed indemnity coverage" provides benefits as a result of hospital confinement or other health-related events and based on a fixed dollar amount, regardless of the amount of expenses incurred, without coordination with any other health coverage.

(2) "Hospital indemnity coverage" may provide a single lump sum benefit for hospital confinement of not less than $[X], and/or daily benefit for hospital confinement on an indemnity basis in an amount not less than $[X] per day and not less than [X] days during each period of confinement for each person insured under the policy.

Drafting Note: Paragraph (2) above provides a framework for the state insurance regulators to establish minimum benefit amounts they feel are appropriate for hospital indemnity coverage. When setting these minimum benefit amounts, state insurance regulators should be mindful to not set a benefit amount so low such that the product does not provide a meaningful benefit to the consumer or set a benefit amount so high that a consumer could be led to believe the product is comprehensive major medical coverage. State insurance regulators can address this issue by requiring that this coverage is not offered, marketed, or sold as a substitute for, or an alternative to, comprehensive major medical coverage, and requiring the use of disclosures that this coverage is supplementary insurance.

(3) Coverage shall not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.

Drafting Note: Hospital indemnity or other fixed indemnity coverage is supplementary coverage. Any hospital indemnity or other fixed indemnity coverage, therefore, must be payable regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of hospital indemnity or other fixed indemnity coverage. Section 3H(4) of the *Coordination of Benefits Model Regulation* states that the definition of a plan (for the purposes of coordination of benefits)…shall not include individual or family insurance contracts…." States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of hospital indemnity or other fixed indemnity coverage purchased by the insured.

Drafting Note: For indemnity products that are triggered by a variety of health events and provide a variety of daily benefit dollar amounts, state insurance regulators should examine the amount payable per day and the total amount payable per year or lifetime to determine whether an indemnity product's benefits could be mistaken for comprehensive major medical coverage. Indemnity products should not be offered, marketed, or sold as an alternative to, or substitute for, or replacement for major medical coverage. It is the marketing of supplementary coverage as an alternative, substitute or replacement for comprehensive major medical coverage that presents the unfair trade practice, and not the supplementary coverage itself when it is offered and marketed as supplementary excepted benefits coverage and accurately described to the consumer.

C. Disability Income Protection Coverage

"Disability income protection coverage" is a policy that provides for periodic payments, no less frequently than monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them that:

(1) Provides that a plan is prohibited from reducing periodic payments based on age, except that a plan may reduce periodic payments provided that such reductions do not take place until the individual has reached full retirement age, as defined under the federal Social Security Act, to receive Social Security benefits;

Drafting Note: Age 62 was removed so that retirement age would align with the federal Social Security Act full retirement age.

(2) Contains an elimination period no greater than:

(a) Fifty percent (50%) of the benefit period in the case of coverage providing a benefit of one hundred and eighty (180) days or less;

(b) Ninety (90) days in the case of a coverage providing a benefit of one hundred and eighty (180) days to one year;

(c) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or

(d) Three hundred and sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury;

(3) Has a period of time of at least three (3) months for which it is payable during disability. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period; and

(4) Where a policy provides both total disability benefits and partial disability benefits, only one elimination period may be required.

D. Accident Only Coverage

"Accident only coverage" is a policy that provides coverage, singly or in combination, for death, dismemberment, disability, injury, or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least $[X] and a single dismemberment amount shall be at least $[X].

E. Specified Disease Coverage

(1) "Specified disease coverage" pays benefits for the diagnosis and treatment of a specifically named disease or diseases. A specified disease policy must meet the following rules in paragraph (2) and one of the following sets of minimum standards for benefits:

(a) Insurance covering cancer only or cancer in conjunction with other conditions or diseases must meet the standards of Paragraph (4), (5) or (6) of this subsection.

(b) Insurance covering specified diseases other than cancer must meet the standards of Paragraphs (3) and (6) of this subsection.

(2) General Rules

Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following rules shall apply to specified disease coverages in addition to all other rules imposed by this regulation. In cases of conflict between the following and other rules, the following shall govern:

(a) Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this section.

(b) Any policy issued pursuant to this section that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead.

(c) Notwithstanding any other provision of this regulation, specified disease policies shall provide benefits to any covered person not only for the specified disease or diseases, but also for any other conditions or diseases directly caused or aggravated by a specified disease or the treatment of the specified disease.

(d) Individual supplementary policies containing specified disease coverage shall be at least guaranteed renewable.

(e) No policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days. A specified disease policy may contain a waiting or probationary period following the issue or reinstatement date of the policy or certificate in respect to a particular covered person before the coverage becomes effective as to that covered person.

(f) An application or enrollment form for specified disease coverage shall contain a statement above the signature of the applicant or enrollee that a person to be covered for specified disease is not covered also by any Title XIX program (Medicaid, MediCal or any similar name). The statement may be combined with any other statement for which the insurer may require the applicant’s or enrollee’s signature.

Drafting Note: States may prohibit individuals who are covered by a Title XIX program from enrolling in a specified disease policy. However, this would not prohibit an individual who purchases a specified disease policy and later becomes eligible for coverage under a Title XIX program from utilizing the benefits of the specified disease policy to which the individual may be entitled to receive.

(g) Payments may be conditioned upon an insured person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.

(h) Benefits for specified disease coverage shall be paid regardless of other coverage, except as permitted by [insert reference to state law equivalent to Section 3B(3) of the *Uniform Individual Accident and Sickness Policy Provision Law* (UPPL) (#180), regarding multiple policies with the same insurer].

Drafting Note: Specified disease coverage is recognized as supplementary coverage. Any specified disease coverage, therefore, must be payable in addition to and regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of specified disease coverage. Section 3H(4) of the *Coordination of Benefits Model Regulation* (#120) states that the definition of a "plan" (for the purpose of coordination of benefits) "shall not include individual or family insurance contracts." States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of specified disease coverage purchased by the insured.

(i) After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis.

(j) Policies providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount of expenses. Instead, the term "charge," "expense," or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase "actual charges" or "actual expenses."

(k) "Preexisting condition" shall not be defined to be more restrictive than the following and shall be consistent with the provisions of Section 7B of the Act: "Preexisting condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within the six (6) month period preceding the effective date of coverage of an insured person."

(l) Coverage for specified diseases will not be excluded due to a preexisting condition for a period greater than six (6) months following the effective date of coverage of an insured person unless a named preexisting condition is specifically excluded.

(m) Hospice Care.

(i) "Hospice" means a provider licensed, certified or registered in accordance with state law that provides a formal program of care that is:

(I) For terminally ill patients whose life expectancy is less than six (6) months;

(II) Provided on an inpatient or outpatient basis; and

(III) Directed by a physician.

(ii) Hospice care is an optional benefit. However, if a specified disease insurance product offers coverage for hospice care, it shall meet the following minimum standards:

(I) Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less;

(II) A fixed-sum payment of at least $[X] per day; and

(III) A lifetime maximum benefit limit of at least $[X].

(iii) Hospice care does not cover non-terminally ill patients who may be confined in a:

(I) Convalescent home;

(II) Rest or nursing facility;

(III) Skilled nursing facility;

(IV) Rehabilitation unit; or

(V) Facility providing care or treatment for persons suffering from mental disorders , who are aged, or who have a substance use-related disorder.

(3) The following minimum benefits standards apply to non-cancer coverages:

(a) Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of $[X] and an overall aggregate benefit limit of no less than $[X] and a benefit period of not less than [two (2) years] for at least the following incurred expenses:

(i) Hospital room and board and any other hospital furnished medical services or supplies;

(ii) Treatment by a licensed physician, surgeon, or other health care professional acting within the scope of their license;

Drafting Note: States should review their laws and regulations to determine whether to use the word "acting" or "performing" in Paragraph (3)(a)(ii) above. Some states use the word "acting," while others use the word "performing."

(iii) Private duty services of a licensed nurse;

(iv) Tests, procedures, and other medical services and supplies used in diagnosis and treatment;

(v) Professional ambulance for service to or from a hospital nearest able to appropriately treat the condition;

(vi) Blood transfusions, including expense incurred for blood donors;

(vii) Drugs and medicines prescribed by a physician;

(viii) Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;

(ix) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and

(x) May include coverage of any other expenses necessarily incurred in the treatment of the disease.

(b) Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than $[X] payable at the rate of not less than $[X] a day while confined in a hospital and a benefit period of not less than 500 days.

(4) A policy that provides coverage on an expense-incurred basis for cancer-only coverage, or for cancer in combination with one or more other specified diseases shall provide coverage for each insured person for services, supplies, care and treatment of cancer, consistent with the requirements in this paragraph.

(a) Coverage may be limited to amounts not in excess of the usual and customary charges, with a deductible amount not in excess of $[X], an overall aggregate benefit limit of not less than $[X], and a benefit period of not less than three (3) years.

(b) A policy shall include at least the minimum benefits specified in this subparagraph. Coverages under items (i) through (xiv) of this subparagraph may be subject to cost-sharing by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an outpatient basis:

(i) Treatment by, or under the direction of, a licensed physician, surgeon, or other health care professional acting within the scope of their license;

Drafting Note: States should review their laws and regulations to determine whether to use the word "acting" or "performing" in Paragraph (3)(a)(ii) above. Some states use the word "acting," while others use the word "performing."

(ii) Tests, procedures, and other medical services and supplies used in diagnosis and treatment;

(iii) Blood transfusions and their administration, including expense incurred for blood donors;

(iv) Drugs and medicines prescribed by a physician, including but not limited to, chemotherapy, including both oral and IV administered, immunotherapy, targeted therapies, and chemotherapy supportive drugs;

(v) Private duty services of a licensed nurse provided in a hospital;

(vi) Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;

(vii) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease;

(viii) (I) Home health care that is necessary care and treatment provided at the insured person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person's attending physician, who shall approve the program prior to its start.

Drafting Note: State licensing laws vary concerning the scope of "home health care" or "home health agency services" and should be consulted. In addition, a few states have mandated benefits for home health care including the definition of required services.

(II) Home health care includes, but is not limited to:

a. Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse;

b. Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapists;

c. Physical, occupational or speech and hearing therapy; and

d. Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital;

(ix) Physical, speech, hearing and occupational therapy;

(x) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, disposable absorbent pads, oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances;

(xi) Prosthetic devices including wigs and artificial breasts;

(xii) Nursing home care for noncustodial services;

(xiii) Reconstructive surgery when deemed necessary by the attending physician;

(xiv) Hospice services, as defined in Paragraph (2)(m) above;

(xv) Hospital room and board and any other hospital furnished medical services or supplies; and

(xvi) Professional ambulance for service to or from a hospital nearest able to appropriately treat the condition.

(c) A policy may include coverage of any other expenses necessarily incurred in the treatment of the disease.

Drafting Note: Policies that offer transportation and lodging benefits for an insured person should not condition those benefits on hospitalization.

(5) (a) The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons:

(i) A fixed-sum payment of at least $[X] for each day of hospital confinement for at least [365] days;

(ii) A fixed-sum payment of at least [X%] the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least 365 days of treatment; and

(iii) A fixed-sum payment of at least $[X] per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.

(b) Benefits tied to receipt of care in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal or exceed the following:

(i) A fixed-sum payment equal to [X%] the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.

(ii) A fixed-sum payment equal to [X%] the hospital in-patient benefit for each day of home health care for at least 100 days.

(iii) Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease.

(iv) Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in (b)(i) and (b)(ii) whether by definition or otherwise, shall be no more restrictive than those under Medicare.

(6) The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease:

(a) These coverages must pay indemnity benefits for a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of $[X].

Drafting Note: Policies that offer extremely high dollar benefits may induce fraud and concealment on the part of applicants for coverage. The commissioner should avoid approving these policies in light of the fact that these policies are not intended to be comprehensive coverage and are not intended to be sold as such. Policies offering extremely low dollar amounts, however, may offer illusory coverage that may not be understood by consumers. State insurance regulators can address this issue by requiring that this coverage is not offered, marketed, or sold as a substitute for, or alternative to, comprehensive major medical coverage, and requiring the use of disclosures that this coverage is supplementary coverage.

(b) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease unless there are clearly identifiable subtypes with significantly lower treatment costs, in which case lesser amounts may only be payable if the policy clearly differentiates that subtype and its reduced benefits.

Drafting Note: The purpose of requiring equal coverage for all subtypes of a specified disease is to ensure that specified disease policies actually provide what people reasonably expect them to. In approving exceptions, commissioners should consider whether a specified disease policy might mislead if it treats a subtype of a disease differently from the rest of the specified disease.

F. Specified Accident Coverage

"Specified accident coverage" is a policy that provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than $[X] for accidental death, $[X] for double dismemberment $[X] for single dismemberment.

G. Limited Benefit Health Coverage

(1) "Limited benefit health coverage" is a policy or contract, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under Subsections B, D, and F. These policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section 8H of this regulation is completed and delivered as required by Section 8B of this regulation and the policy or certificate is clearly labeled as a limited benefit policy or certificate as required by Section 8A(17). A policy covering a single specified disease or combination of diseases shall meet the requirements of Section 7E and shall not be offered for sale as "limited benefit health coverage."

(2) This subsection does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance, as defined in [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act* and *Medicare Supplement Insurance Minimum Standards Model Act*].

Drafting Note: The NAIC *Long-Term Care Insurance Model Act* (#640) defines long-term care insurance as a policy that provides coverage for not less than twelve months. If a state allows issuance of policies that provide benefits similar to long-term care insurance for a period of less than twelve months, then those policies should be considered limited long-term care insurance policies and should be subject to the *Limited Long-Term Care Insurance Model Act* (#642) and its implementing regulation, the *Limited Long-Term Care Insurance Model Regulation* (#643).

Drafting Note: This regulation permits the combining of excepted benefit-type products described in this section with other excepted benefit plans. However, it should be noted that combining excepted benefit coverages described in this section with other coverages, whether or not described in this section, could cause the combined product to fail to meet the requirements for excepted benefits under HIPAA or for similar exemptions under state law. This would mean that major medical insurance requirements under federal and state law may apply, such as guaranteed availability, guaranteed renewability, and premium rating restrictions. State insurance regulators should also require that supplementary coverage is not offered, marketed, or sold as a substitute for, or alternative to, comprehensive major medical coverage, including enforcement of the requirements in this regulation for disclosures that this coverage is supplementary coverage.

H. Short-Term, Limited-Duration Health Insurance Coverage

(1) "Short-term, limited-duration health insurance" means health insurance coverage offered or provided to residents of the state pursuant to a contract with a health carrier, regardless of the situs of the contract, that has an expiration date specified in the contract that is less than [X] [days or months] after the original effective date and, taking into

account any extensions that may be elected by the policyholder with or without the carrier's consent, has a duration no longer than [X] [days or months] after the original effective date of the contract.

(2) (a) Short-term, limited-duration health insurance must comply with the benefit and coverage requirements of this state, including, if the state requires, providing benefits and coverage of state-mandated benefits and being subject to the state's external and internal review requirements.

Drafting Note: States should consider whether mental health and substance use disorder benefits, as described in Section 7D(2) and Section 7D(4) of this regulation, should be permitted exclusions to short-term, limited-duration insurance policies.

(b) A short-term, limited-duration health insurance policy or certificate must have:

(i) An annual or lifetime limit of no less than [$1,000,000];

(ii) A coinsurance requirement of no more than fifty percent (50%) of covered charges; and

(iii) A family maximum out-of-pocket limit of not more than [X] per year.

Drafting Note: The annual and lifetime limit and the out-of-pocket limits should vary depending on the specific state interest. For states that have severely limited coverage time frames with limited renewals or extensions, smaller annual and lifetime limits and out-of-pocket maximums should apply.

(3) Short-term, limited-duration health insurance cannot be issued if it would result in an individual being covered by a short-term, limited duration health insurance policy or certificate for more than [X] months [in any 12-month period].

(4) Short-term, limited-duration health insurance, including individual policies and group certificates:

(a) May not be marketed as guaranteed renewable;

(b) Must be marketed as either nonrenewable, or renewable for a limited time without re-underwriting;

(c) Must clearly state the duration of the initial term and the total maximum duration, including any renewal options;

(d) May not be modified after the date of issuance, except by signed acceptance of the policyholder or the certificate holder, if the policy holder or the certificate holder contributes to the premium; and

(e) If the coverage is renewable, the individual policy or group certificate must:

(i) Include a statement that the insured has a right to continue the coverage in force by timely payment of premiums for the number of terms listed;

(ii) Include a statement that the carrier will not increase premium rates or make changes in provisions in the policy or certificate on renewal based on individual health status; and

(iii) Include a statement that the carrier, at the time of renewal, may not deny renewal based on individual health status.

(5) A short-term, limited-duration health insurance carrier may not include a waiting period or a probationary period.

(6) A carrier may not rescind a short-term limited duration health insurance policy or certificate during the coverage period except if the insured intentionally fails to disclose a prior diagnosis of a health condition or if the insured intentionally fails to disclose the insured was previously covered under a short-term limited duration health insurance policy or certificate. If the policy or certificate is rescinded, the carrier must refund all payments to the insured to the extent that they exceed claims paid under the rescinded policy or certificate.

Drafting Note: States should be aware that the language in Paragraph (6) concerning an insured's failure to disclose prior coverage under a short-term, limited-duration health insurance policy or certificate will need to be tailored to the state's laws and regulations concerning such disclosures of prior coverage.

(7) A carrier may not cancel a short-term, limited-duration health insurance policy or certificate during the coverage period except in the following circumstances:

(a) Nonpayment of premium;

(b) Violation of the carrier's published policies approved by the commissioner;

(c) An insured's commitment of fraudulent acts as to the carrier;

(d) An insured's material breach of the insurance contract; or

(e) A change or implementation of a federal or state law or regulation that no longer permits the continuing offering of the coverage.

(8) In the event of a cancellation or rescission of a short-term, limited-duration health insurance policy or certificate, the carrier must notify the insured in writing [thirty (30) days] prior to the cancellation date or in writing a notice of rescission with an appeal period of [thirty (30) days].

Drafting Note: The timeframe for notifying the insured of a cancellation or rescission is bracketed because states may have different timeframes for such notices.

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Drafting Note: States should carefully examine their health insurance markets to determine the appropriate maximum term and duration for such plans and whether additional definitions or standards may be needed. In addition, states should review any relevant federal regulations establishing requirements for short-term, limited duration insurance coverage that could differ from the state's requirements.

Section 9. Required Disclosure Provisions

A. General Rules

(1) (a) All applications, policies, and certificates for coverage of supplementary or short-term health insurance shall include a prominent disclosure statement, as required by this section, that reflects the type of coverage being provided.

(b) The disclosures required by this section may be modified only as needed to improve the accuracy and clarity of the disclosure and only with the approval of the commissioner.

Drafting Note: Because states may have different statutory requirements for short-term, limited duration insurance coverage, states should carefully review the disclosure statement requirements in this section for such coverage to ensure it accurately reflects a state's specific requirements. States also should be aware that proposed federal regulations for short-term, limited duration insurance coverage and hospital indemnity or other fixed indemnity coverage include specific disclosure statement requirements for these coverages and recognize that the disclosure statement requirements in this section may need to contain additional information as required by applicable state law, rules, or guidance. A state also may need to require disclosure language to reflect any additional requirements a state may have, such as requirements regarding minimum essential coverage or special enrollment periods for expiration or loss of eligibility for this coverage.

(c) The disclosure statement shall be in a sans serif font, in a font size at least equal to the size type used for headings or captions of sections of the document.

(d) In the application, the disclosure statement shall be placed in close proximity to the applicant's signature block.

(e) In the policy and certificate, the disclosure statement shall be placed on the first page.

(f) In this section, the term "prominent" means one or more methods are used to draw attention to the language, including using a larger font size, leading, underlining, bolding, color, or italics.

Drafting Note: States should review their existing readability laws and regulations to help to ensure the statements above are readable. States should also review their existing laws and regulations to ensure the statements above are accessible to potential applicants, including those with disabilities such as blindness or macular degeneration, deafness or hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity, and combinations of these.

(2) Any disclosures, and the documents to which they refer, shall be delivered in the written medium (digital or heard copy) the applicant requests. These documents shall be provided before the applicant submits a completed application.

(3) For hospital indemnity coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "fixed dollar benefits" made prominent:

"This [policy] [certificate] pays fixed dollar benefits as a result of a covered hospitalization due to a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

Drafting Note: States should review the above notice and disclosure requirements for hospital indemnity coverage for consistency with their state regulations. In addition, states should review any relevant federal regulations establishing notice and disclosure requirements for hospital indemnity coverage that could differ from the state's requirements.

(4) For other fixed indemnity coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "fixed dollar benefits" made prominent:

"This [policy] [certificate] pays fixed dollar benefits as a result of covered events due to a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

Drafting Note: States should review the above notice and disclosure requirements for other fixed indemnity coverage for consistency with their state regulations. In addition, states should review any relevant federal regulations establishing notice and disclosure requirements for other fixed indemnity coverage that could differ from the state's requirements.

(5) For disability income protection coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "while you are disabled" made prominent:

"This [policy] [certificate] provides periodic payments [weekly, bi-weekly, or monthly] for a set length of specific period of time while you are disabled from a covered sickness or injury. Read the description of benefits provided along with your [enrollment form/application] carefully."

(6) For accident only coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "from a covered accident" made prominent:

"This [policy] [certificate] pays benefits for covered injuries from a covered accident. It does not provide benefits resulting from sickness. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(7) For specified disease coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "of a covered disease" made prominent:

"This [policy] [certificate] pays limited benefits as a result of the diagnosis or treatment of a covered disease specified in the [policy] [certificate]. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(8) For specified accident coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "for a specifically identified type of accident" made prominent:

"This [policy] [certificate] provides benefits for a specifically identified type of accident as named in the [policy] [certificate]. It does not provide benefits resulting from sickness. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(9) For limited benefit coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "limited benefits and only for the events specified" made prominent:

"The [policy] [certificate] pays limited benefits and only for the events specified in the [policy] [certificate]. These limited benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(10) For limited scope dental coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the sentence "It is not intended to cover all dental expenses." made prominent:

"The [policy] [certificate] provides dental benefits only. It is not intended to cover all dental expenses. Read your [policy] [certificate] carefully to understand what dental services it covers and any cost-sharing that may be your responsibility."

(11) For limited scope vision coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the sentence "It is not intended to cover all vision expense." made prominent:

"The [policy] [certificate] provides vision benefits only. It is not intended to cover all vision expenses. Read your [policy] [certificate] carefully to understand what vision services are covered and any cost-sharing that may be your responsibility."

(12) For short-term health insurance, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the word "Important" and the sentence "It is not comprehensive health insurance." made prominent:

"Important: This is short-term health insurance. This is temporary insurance. It is not comprehensive health insurance. Read your [policy] [certificate] carefully to make sure you understand what is covered and any limitations on coverage.

This insurance might not cover or might limit coverage for:
- Preexisting conditions; or
- Essential health benefits (such as pediatric, hospital, emergency, maternity, mental health, substance use services, prescription drugs, or preventive care).

- You will not qualify for federal financial help to pay for premiums or out-of-pocket costs for this policy.
- You are not protected from surprise medical bills.
- When this policy ends, you might have to wait until an open enrollment period to get comprehensive health insurance.

Visit HealthCare.gov online or call 1-800-318-2596 (TTY: 1-855-889-4325) to review your options for comprehensive health insurance. If you're eligible for coverage through your employer or a family member's employer, contact the employer for more information. Contact the [State] department of insurance if you have questions or complaints about this policy."

(13) Each policy of individual supplementary or short-term health insurance subject to this regulation, as provided in Section 3A of this regulation, shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(14) All riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law. The signature requirement in this paragraph applies to group supplemental health insurance certificates only where the certificate holder also pays the insurance premium.

(15) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy or certificate and the combined total premium clearly identified as such.

(16) A policy or certificate that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of the terms and a clear explanation of the terms in its accompanying outline of coverage.

(17) If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall be clearly explained in a separate paragraph of the policy or certificate labeled "Preexisting Conditions Limitations."

(18) All policies and certificates, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed in sans serif font on the first page of the policy or certificate or attached to it stating clearly that the policy or certificate holder shall have the right to return the policy or certificate within thirty [30] days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason.

Drafting Note: This paragraph should be included only if it is consistent with applicable state law.

(19) If age is to be used as a determining factor to reduce the benefits made available in the policy or certificate as originally issued, a clear explanation of how age is used shall be prominently set forth in the outline of coverage.

(20) If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be "Conversion Privilege" or words of similar import. The provision shall clearly explain which persons are eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person who may exercise the conversion privilege. The provision shall clearly specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

(21) (a) Outlines of coverage delivered in connection with policies defined in this regulation as hospital indemnity or other fixed indemnity (Section 8B), specified disease (Section 8E), or limited benefit health coverages (Section 8G) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Subsections D and F, the following language, which shall be printed on or attached to the first page of the outline of coverage, with the sentence "This is not a Medicare Supplement policy." made prominent:

This is not a Medicare Supplement policy. If you are eligible for Medicare, ask the company for the Guide to Health Insurance for People with Medicare.

Drafting Note: States may want to review the disclosure language in paragraph (21)(a) above for consistency with the consumer disclosure language in Appendix C of the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651).

(b) An insurer shall deliver to persons eligible for Medicare any notice required under [insert reference to state law equivalent of Section 17D of the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act*].

Drafting Note: States that permit individuals under the age of 65 with Medicare coverage to purchase Medicare supplement policies should review how insurers should provide the notices required under Paragraph (21)(a) to these individuals.

(22) Insurers shall give a person applying for specified disease insurance a Buyer's Guide approved by the commissioner at the time of application enrollment and shall obtain all recipients' written acknowledgement of the guide's delivery.

Drafting Note: Paragraph (22) only applies if a state has such a Buyer's Guide.

B. Outline of Coverage Requirements

(1) An insurer shall deliver an outline of coverage to an applicantof all applicable plans as required in Section 6 of the Act.

(2) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) point sans serif type, immediately above the company name, with the sentence "It is different from the outline of coverage you received when you [applied] [enrolled]." made prominent:

"NOTICE: Read this outline of coverage carefully. It is different from the outline of coverage you received when you [applied][enrolled]. The coverage you applied for was not issued."

(3) In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the commissioner for prior approval. In such instances, no policies may be sold or renewed until approved by the commissioner.

(4) Advertisements may fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage in Section 6H of the Act as well as this regulation.

C. Hospital Indemnity or Other Fixed Indemnity Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section 8B of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

[Hospital Indemnity] [Other Fixed Indemnity] Coverage

The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage.
They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read your [policy][certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) [Hospital indemnity] [Other fixed indemnity] coverage is designed to pay a fixed dollar benefit as a result of a covered [hospital stay] [event] due to a sickness or injury. The benefit may be limited in ways described in the [policy] [certificate]. The fixed dollar benefit may be less than the [hospital stay's] [event's] cost.

(3) [A brief, but clear and specific, description of the benefits in the following order:

(a) When the benefits are payable;

(b) The duration of benefits described in (a); and

(c) The fixed dollar amount of the benefits.]

(4) [A clear description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit, described in Paragraph (3) above.]

(5) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

(6) [A clear description of any benefits provided in addition to the fixed dollar [hospital] [event] benefit.]

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D. Disability Income Protection Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section 8C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Disability Income Protection Coverage

OUTLINE OF COVERAGE

(1) Read your [policy] [certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) Disability income protection coverage is designed to pay a benefit for disabilities resulting from a covered sickness or injury. The benefit may be limited in the ways described in the [policy] [certificate]. The benefit might not fully replace your income.

(3) [Brief, but clear and specific, description of the benefits contained in the [policy] [certificate].]

(4) [A clear description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

E. Accident-Only Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with policies or certificates meeting the standards of Section 8D of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Accident-Only Coverage

The benefits in this [policy] [certificate] are limited.
They are intended to supplement your other health insurance coverage.

They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read your [policy][certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) Accident-only coverage pays benefits for covered injuries from a covered accident. It does not provide benefits resulting from sickness. The benefits may be limited in ways described in the [policy] [certificate].

(3) [Brief, but clear and specific, description of the benefits and a description of any deductible or copayment provisions applicable to the benefits described.]

(4) [A clear description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above. Proper disclosure of benefits that vary according to the type of accidental cause shall be made in accordance with Section 8A(13) of this regulation.]

(5) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

F. Specified Disease or Specified Accident Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with policies or certificates meeting the standards of Sections 8E and F of this regulation. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Specified Disease or Specified Accident Coverage (Outline of Coverage)

The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage.
They are not intended to cover all expenses.
OUTLINE OF COVERAGE

(1) Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

Drafting Note: States should review whether they have the Buyer's Guide to Specified Disease Insurance referenced above. If they do, the state should determine if it is up to date before requiring such a guide to be provided. If the state does not have such a guide, then the state should revise this outline of coverage accordingly.

(2) Read your [policy] [certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate]

details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(3) [Specified disease] [Specified accident] coverage is designed to pay limited benefits as a result of the diagnosis or treatment [of a covered disease] or [resulting from a specifically identified type of accident]. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(4) [Brief, but clear and specific, description of the benefits, including dollar amounts and a description of any deductible or copayment provisions applicable to the benefits described.] Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 8A(13) of this regulation.

G. Limited Benefit Health Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates which do not meet the minimum standards of Sections 8B, D and G of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Limited Benefit Health Coverage
The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage.
They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read your [policy][certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) Limited benefit health coverage pays limited benefits. This [policy] [certificate] is not major medical insurance and does not replace it.

(3) [Brief, but clear and specific, description of the benefits, including dollar amounts and a description of any deductible or copayment provisions applicable to the benefits described.]

(4) [A clear description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

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H. Short-Term, Limited Duration Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section 8H of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Short-Term, Limited Duration Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

The [policy] [certificate] may not cover preexisting conditions.

OUTLINE OF COVERAGE

(1) Read your [policy] [certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) This is a short-term, limited duration [policy] [certificate]. This is temporary insurance. It is not comprehensive health insurance. It might not cover or might limit coverage for preexisting conditions. It might not cover essential health benefits such as pediatric, hospital, emergency, maternity, mental health, substance use services, prescription drugs, or preventive care. Read your [policy] [certificate] carefully to make sure you understand what is covered and any limitations on coverage.

(3) [Brief, but clear and specific, description of the benefits in the following order:

(a) Benefits covered by the policy or certificate, including required cost-sharing;

(b) Benefits that are not covered by the policy or certificate; and

(c) Duration of benefits described above.]

(4) A clearly worded prominent notice that cost-sharing limitations do not apply to benefits not covered by the policy or certificate.

(5) [A clear description of provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(6) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

Model Regulation to Implement the Supplementary and Short-Term Health Insurance Minimum Standards Model Act

I. Limited Scope Dental Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with dental care policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Limited Scope Dental Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read your [policy][certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) Limited scope dental coverage pays benefits for dental benefits only. It is not intended to cover all dental expenses. Read your [policy] [certificate] carefully to understand what dental care it covers and any cost-sharing that may be your responsibility.

(3) [Brief, but clear and specific, description of the benefits.]

(4) [A clear description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

J. Limited Scope Vision Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with vision care policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Limited Scope Vision Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

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(1) Read your [policy][certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) Limited scope vision coverage pays benefits for vision benefits only. It is not intended to cover all vision expenses. Read your [policy] [certificate] carefully to understand what vision care it covers and any cost-sharing that may be your responsibility.

(3) [Brief, but clear and specific, description of the benefits.]

(4) [A clear description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

Section 10. Requirements for Replacement of Individual Supplementary and Short-Term Health Insurance Coverage

A. An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other supplementary or short-term health insurance subject to this regulation, as provided in Section 3A of this regulation, presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used.

B. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subsection C below. The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in Subsection D below. However, this notice is not required in the solicitation of accident-only policies or the replacement of single-premium nonrenewable policies.

C. The notice required by Subsection B above for an insurer, other than a direct response insurer, shall provide, in substantially, the following form:

Notice to Applicant About Replacement of [Supplementary] [Short-Term] Health Insurance

According to [your application] [information you have provided], you intend to lapse or otherwise end the supplementary or short-term health insurance you have now and replace it with a policy the [insert company name] Insurance Company will issue. For your own protection, you should know how replacing your policy with a new one might affect your coverage.

(1) A new policy might not pay claims that the policy you have now would pay. A new policy might not cover health conditions that you might have now (preexisting conditions) or

might not cover them right away. A new policy might cover some but not all the costs related to treating preexisting conditions.

Drafting Note: This subsection may be modified if preexisting conditions are covered under the new policy.

(2) Talk with your current insurance agent or company representative about replacing your policy. It is in your best interest to be sure you understand how replacing your policy could affect your future coverage.

(3) If you decide to buy a new policy, be sure to truthfully and completely answer all questions on the application about your medical/health history. If you do not, the company could deny any future claims and refund your premium as though your policy had never been in force. Check that the information on your application is complete and correct before you sign it.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

D. The notice required by Subsection B of this section for a direct response insurer shall be as follows:

Notice to Applicant About Replacement of [Supplementary] [Short-Term] Health Insurance

According to [your application] [information you have provided], you intend to lapse or otherwise end the supplementary or short-term health insurance you have now and replace it with the attached policy issued by [insert company name] Insurance Company. You have thirty days to decide at no cost if you want to keep the new policy. For your own protection, you should know how replacing your policy with a new one might affect your coverage.

(1) A new policy might not pay claims that the policy you have now would pay. A new policy might not cover health conditions you have now (preexisting conditions) or might not cover them right away. A new policy might cover some but not all the costs related to preexisting conditions.

(2) Talk with your insurance agent or company representative about replacing your policy. It is in your best interest to be sure you understand how replacing your policy could affect your future coverage.

(3) [To be included only if the application is attached to the policy]. If you decide to buy a new policy, read the copy of the attached application and be sure that all questions are answered fully and correctly. If they are not, the company could refuse to pay an otherwise valid claim. Carefully check the application and write to [insert company name

and address] within ten days if any information is not correct and complete, or if any past medical history has been left off the application.

[COMPANY NAME]

Drafting Note: The sentence "You have thirty days to decide at no cost if you want to keep the new policy." should only be required if the state has adopted Section 9A(18).

Section 11. Separability

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

_____

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1975 Proc. I 2, 6, 573, 575, 590-605 (adopted).
1977 Proc. I 26, 28, 54-77, 317, 325 (amended).
1979 Proc. II 31, 34, 327, 333, 339-344 (amended regarding Medicare supplement insurance).
1980 Proc. II 22, 26, 588, 591, 594, 622, 634-636 (amended).
1989 Proc. II 13, 23-24, 467-468, 518-519, 548-570 (amended to remove reference to Medicare supplement insurance).
1998 Proc. 4th Quarter 16, 17, 652, 654, 660-687 (amended and reprinted).
Fall 2024 (amended).

PROJECT HISTORY

**MODEL REGULATION TO
IMPLEMENT THE ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS MODEL ACT (#171)**

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

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). Therefore, they did not require approval of a Request for NAIC Model Law Development by the Executive (EX) Committee.

In 2013, the Regulatory Framework (B) Task Force was charged with reviewing existing NAIC models related to health insurance to determine whether they needed to be amended, considering all the changes made by the ACA. During that review process, Model #170 and its companion model regulation, Model #171, were added to the list of NAIC models to be considered for revision, given the model's provisions for certain types of health insurance plans that would not be permitted under the ACA.

Beginning at the 2014 Fall National Meeting, the Task Force began discussing revisions to Model #170 and Model #171. At the 2015 Spring National Meeting, the Task Force decided, given its other priorities for 2015, specifically with respect to revising the formerly titled *Managed Care Network Adequacy Model Act* (#74), now the *Health Benefit Plan Network Access and Adequacy Model Act* (#74), to defer discussing additional revisions to the models until it finished its work on Model #74. The Task Force finished that work in late 2015.

In February 2016, the Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup, with Wisconsin as chair, to begin working on revising Model #170 and Model #171. At the 2017 Spring National Meeting, concerned with the uncertainty of the ACA's future, given congressional proposals to repeal, replace, and/or repair it, the Task Force decided to halt Subgroup meetings until there was more certainty about actions at the congressional level.

At the 2017 Fall National Meeting, the Task Force decided to move forward with discussing revisions to Model #170 and Model #171, and it directed the Subgroup to resume its work in early 2018. The Subgroup completed the revisions to Model #170 in late 2018, which the Executive (EX) Committee and Plenary adopted in February 2019.

The Model #170 revisions removed provisions for certain types of health insurance products that would not be permitted because of the requirements of the ACA leaving only those products considered excepted benefits, and therefore, not subject to the ACA's requirements. The Model #170 revisions also added short-term, limited-duration plans to the model because there was no other vehicle available to add those products and the Subgroup did not want to create a whole new model for them.

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 due to the loss of a co-chair, the COVID-19 pandemic, and 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. The Subgroup completed its review of all the comments received on Model #171 in September. The Subgroup adopted the revisions to Model #171 during a meeting Oct. 17, 2024. The Regulatory Framework (B)

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Task Force adopted the revisions on Nov. 4 and the Health Insurance and Managed Care (B) Committee adopted the revisions during a meeting on Nov. 19.

The revisions to Model #171 revise the model for consistency with the revisions to Model #170. The revisions also add standards for short-term, limited-duration (STLD) plans. Because the Subgroup did not want to dictate what benefits and coverages these plans must include, the standards specify that short- term, limited-duration plans must provide the benefits and coverages required by the state. The revisions also clarify provisions on consumer disclosure and outline of coverage requirements making them much more understandable for consumers, including requiring specific language stating that these plans are supplemental and are not intended to be major medical coverage.

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

The Accident and Sickness Insurance Minimum Standards (B) Subgroup drafted the revisions to Model #171. At the time of adoption on Oct. 17, 2024, the Subgroup members were: Oklahoma, Co-Chair; Texas, Co-Chair; District of Columbia; Florida; Louisiana; Maine; Missouri; Nebraska; South Carolina; Utah; Vermont; and Washington.

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

In February 2016, the Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup, with Wisconsin as chair, to begin working on revising Model #170 and Model #171. The Subgroup adopted the revisions to Model #170 in July 2018. Soon after completing its work on Model #170, with Oklahoma and Minnesota as co-chairs, the Subgroup began discussing 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 starting in late 2019 due to the loss of a co-chair, the COVID-19 pandemic, and other resource issues, the Subgroup, with Oklahoma and Nebraska as co-chairs, resumed its meetings in June 2021. In late 2022, the Subgroup lost Nebraska as co-chair but resumed its meetings in early 2023, with Texas replacing Nebraska as co-chair. The Subgroup continued meeting on a regular basis to discuss the comments received on Model #171. The Subgroup completed its review of all the comments received on Model #171 in September 2024. The Subgroup adopted the revisions to Model #171 during a meeting Oct. 17, 2024.

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.

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 due to the loss of a co-chair, the COVID-19 pandemic, and other resource issues, the Subgroup resumed its meetings and discussions of the comments received in June 2021. The Subgroup met on a regular basis to discuss the comments received on Model #171 until it adopted the model revisions Oct. 17, 2024.

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 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.

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The Subgroup resumed its meetings in February 2023, reviewing and discussing comments received 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, 2023, 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 is completing work on Section 9—Required Disclosure Provisions. In October 2023, the Subgroup completed its review of all the comments received on Model #171. The Subgroup set a public comment deadline of Dec. 1, 2023, to receive comments on the initial draft reflecting its discussions and preliminary revisions to Model #171.

The Subgroup resumed its meetings in January 2024 to discuss the comments received. The Subgroup completed that review in April 2024 and distributed a final draft, dated May 3, to stakeholders in anticipation of adopting the proposed revisions in June. The Subgroup received additional comments on that draft, and as a result, it resumed its meetings in June 2024 to discuss the comments. The Subgroup completed its review of those comments in September 2024 and distributed another final draft in anticipation of adopting the revisions to Model #171 during a meeting in October. The Subgroup adopted the revisions to Model #171 during a meeting Oct. 17, 2024.

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)

Throughout the drafting process the Subgroup solicited comments from stakeholders, which included consumer and industry representatives, as well as state insurance regulators. The Subgroup discussed and reviewed those comments during public meetings. All the comments received were posted on the Subgroup's webpage. Each proposed revision draft was also posted on the Subgroup's web page.

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

Among the issues debated during the drafting process concerned the purpose of excepted benefit products and the fact that they are not intended to be comprehensive major medical coverage. In addressing this issue, the Subgroup enhanced the consumer disclosure provisions and outline of coverage provisions to ensure consumers will be aware that excepted benefit products are not meant to be comprehensive health insurance coverage. The Subgroup also included additional language in the draft highlighting that insurers should not offer, market, or sell excepted benefit products as a substitute for, or alternative to, comprehensive major medical coverage.

In addition, during the drafting process, the Subgroup and stakeholders involved had to keep in mind that the model sets minimum standards, which means the states and insurance carriers can go above them. In addressing another issue that arose during the process concerning potential and recurring federal changes related to hospital indemnity or other fixed indemnity plans and STLD plans, the Subgroup included in the revisions suggestions that, prior to adopting the model revisions, states review any relevant federal regulations, establishing that requirements for these products that could differ from the state's requirements.

One significant issue discussed and addressed during the drafting process related to the provisions establishing standards for STLD plans, including what benefits should be included. In resolving this issue, the STLD plan provisions rely on a state's requirements for benefits and coverage under such plans.

Another significant issue discussed concerned a provision in the model that allows plans to exclude mental health

and substance use coverage from excepted benefit plans. During this discussion, it was highlighted that these are excepted benefit products, not major medical coverage subject to the ACA's guarantee issue and preexisting condition exclusion requirements. Excepted benefit plans are medically underwritten and subject to preexisting condition exclusions. It was also noted that this provision is optional, which means states can require such coverage if they feel it is appropriate. In addition, as already noted, for short-term, limited-duration plans, the benefits and coverages for these plans are tied to a state's requirements. If a state requires these plans to include mental health and substance use benefits, then they must include the coverage. As a compromise to address these concerns, before its adoption of the Model #171 revisions, the Health Insurance and Managed Care (B) Committee added language to a drafting note in Section 7D—Prohibited Policy Provisions making it clear that states should carefully consider whether to permit mental health and substance use coverage exclusions for STLD plans and disability income protection policies given the importance of such coverage. The Committee added similar language to a drafting note in Section 8H—Short-Term, Limited-Duration Health Insurance Coverage.

7. List the key provisions of the model (sections considered most essential to state adoption)

This is not applicable. All the sections are essential to state adoption.

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

This is not an accreditation model.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Summary of Findings and Determination

Canada Office of the Superintendent of Financial Institutions (OSFI)

Evaluation as a Jurisdiction that Recognizes and Accepts the U.S. Group Capital Calculation

Issued for Public Comment By:

Mutual Recognition of Jurisdictions (E) Working Group

October 24, 2024

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I. Executive Summary & Recommendation

The Mutual Recognition of Jurisdictions (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to the evaluation of the Canada Office of the Superintendent of Financial Institutions (OSFI) as a jurisdiction that Recognizes and Accepts the U.S. Group Capital Calculation ("Recognize and Accept Jurisdiction"). It is the recommendation of the Working Group that the NAIC approve the OSFI as a Recognize and Accept Jurisdiction and place it on the *NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation*, to be effective immediately. Finally, the Working Group recommends that the Department of Insurance and Financial Services for the State of Michigan (DIFS) be the Lead State for purposes of regulatory cooperation and information sharing with the OSFI. These recommendations are based on the following analysis:

II. Procedural History

The Working Group is responsible for overseeing the process for evaluating jurisdictions and maintaining a listing of jurisdictions that meet the NAIC requirements for recognizing and accepting the US approach to the Group Capital Calculation (GCC). As background, on December 9, 2020, the NAIC adopted revisions to the NAIC *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). These revisions implement the GCC filing requirements for insurance groups at the level of the ultimate controlling person for the purpose of evaluating solvency at the group level. The revisions specifically provide that the requirement to file the NAIC's GCC applies to U.S.-based groups, while a group headquartered outside the U.S. is exempt from the GCC (subject to limited exceptions) if its groupwide supervisor "recognizes and accepts" the GCC for U.S. groups doing business in that jurisdiction. Likewise, a U.S. group subject to a group capital calculation specified by the Federal Reserve Board is exempt from the GCC. This process codifies the concepts of mutual recognition and one group/one group-wide supervisor. To further implement the GCC provisions of Model #440 and Model #450, the Working Group adopted the *Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation* (Recognize and Accept Process) on December 15, 2021.

Section 4L(2) of Model #440 provides two ways a non-U.S. jurisdiction may meet the standards for its insurance groups to be exempt from the GCC:

> (a) If the jurisdiction has been determined to be a Reciprocal Jurisdiction for purposes of credit for reinsurance, which includes a requirement that the jurisdiction "recognizes the U.S. state regulatory approach to group supervision and group capital" or
>
> (b) <u>If the jurisdiction has otherwise been determined to recognize and accept the GCC by procedures specified in regulation</u>.

As of this date, the only jurisdictions that have been deemed to meet the standards are the current Reciprocal Jurisdictions (European Union member states, United Kingdom, Bermuda, Japan, and Switzerland).

On November 9, 2023, the DIFS requested that the Working Group perform a review of the OSFI under the NAIC Recognize and Accept Process, and further that the DIFS agreed to act as the Lead State. The relevant provisions with respect to the review procedure are summarized, as follows:

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- The Working Group will follow the Procedure for Evaluation of Non-U.S. Jurisdictions as set forth in paragraph 8 of the Recognize and Accept Process. This will include public notice on the NAIC website, and consideration of public comments from state regulators, U.S. insurance groups, and any other interested parties. Relevant U.S. state and federal authorities will be notified of the Working Group's decision to evaluate the OSFI.

- Following these public actions, the Working Group will prepare a Preliminary Evaluation Report and Final Evaluation Report in regulator-to-regulator session, followed by a public Summary of Findings and Determination recommending that the OSFI be included on the list of Recognize and Accept Jurisdictions.

- The Working Group may rely on written confirmation by the OSFI that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction. This may be done by signature to the letter template found in the Appendix of the Process. The Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination the representations in the written confirmation are true and accurate.

- Finally, the OSFI and Michigan must have a memorandum of understanding to share applicable information with each other, which Michigan as the lead state would share with other NAIC states. Both the OSFI and DIFS are signatories to the IAIS Multilateral Memorandum of Understanding, which we have concluded to be satisfactory for these purposes.

- Upon the NAIC's adoption of an affirmative recommendation with respect to the Summary of Findings and Determination, the OSFI will be added to the NAIC List of Recognize and Accept Jurisdictions. Once approved, a Recognize and Accept Jurisdiction is subject to periodic annual review under an abbreviated process.

To conduct the review, NAIC staff reviewed any public information that was available, focusing on the *June 2019 International Monetary Fund (IMF) Financial System Stability Assessment (FSAP)* and the *January 2020 IMF FSAP Technical Note—Insurance Sector: Regulation and Supervision*. During the review, it was noted that the domestic financial regulator for insurance companies that are domiciled in Quebec is the Quebec Autorité des marchés financiers (AMF), while any companies domiciled in any of the other nine Canadian provinces are regulated by OSFI. The scope of this review only covers OSFI.

The review that was conducted only focused on any issues that would cause the jurisdiction to not meet the standards in Model #440 and Model #450 pertaining to the ability to recognize and accept the U.S. approach to the group capital calculation. During review of the IMF reports, there were no issues noted that would cause any concerns for the OSFI. In addition to the review performed by NAIC staff, the Working Group received a letter from OSFI dated April 9, 2024, confirming the following requirements in the Recognize and Accept Process:

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- OSFI recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction.

- Information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to a lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and OSFI, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.

- OSFI will immediately notify the NAIC upon any changes to the assurances provided in this letter.

III. Summary of Findings and Recommendation

Therefore, it is the recommendation of the Mutual Recognition of Jurisdictions (E) Working Group that the NAIC recognize the OSFI as a Recognize and Accept Jurisdiction and place it on the *NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation*, to be effective immediately. Finally, the Working Group recommends that the Department of Insurance and Financial Services for the State of Michigan (DIFS) be the Lead State for purposes of regulatory cooperation and information sharing with the OSFI.

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CLIMATE AND RESILIENCY (EX) TASK FORCE

Climate and Resiliency (EX) Task Force Nov. 19, 2024, Minutes.....3-122

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Draft: 12/3/24

Climate and Resiliency (EX) Task Force
Denver, Colorado
November 19, 2024

The Climate and Resiliency (EX) Task Force met in Denver, CO, Nov. 19, 2024. The following Task Force members participated: Lori K. Wing-Heier, Co-Chair (AK); Ricardo Lara, represented by Mike Peterson, Co-Chair (CA); Andrew R. Stolfi, Co-Vice Chair (OR); Jeff Rude, Co-Vice Chair (WY); Mark Fowler represented by Sheila Travis (AL); Alan McClain (AR); Barbara D. Richardson (AZ); Andrew N. Mais represented by George Bradner and Wanchin Chou (CT); Michael Conway represented by Jason Lapham (CO); Karima M. Woods represented by Pratima Lele (DC); Trinidad Navarro represented by Christina Miller (DE); Michael Yaworsky represented by Anoush Brangaccio (FL); Gordon I. Ito represented by Jerry Bump (HI); Doug Ommen (IA); Ann Gillespie represented by Kathleen Stralka and Shannon Whalen (IL); Sharon P. Clark represented by Shawn Boggs (KY); Timothy J. Temple and Chuck Myers (LA); Michael T. Caljouw represented by Jackie Horigan (MA); Marie Grant represented by Greg Ricci (MD); Robert L. Carey represented by Timothy N. Schott and Sandra Darby (ME); Anita G. Fox represented by Chad Arnold (MI); Grace Arnold represented by Peter Brickwedde (MN); Chlora Lindley-Myers represented by Cynthia Amann (MO); Mike Chaney represented by Andy Case (MS); Mike Causey represented by Jackie Obusek (NC); Jon Godfread (ND); D.J. Bettencourt represented by Christian Citarella (NH); Justin Zimmerman (NJ); Judith L. French represented by Tom Botsko (OH); Michael Humphreys represented by Jodi Frantz and Shannon Logue (PA); Elizabeth Kelleher Dwyer (RI); Michael Wise represented by Diane Cooper (SC); Scott A. White (VA); Tregenza A. Roach (VI); Kevin Gaffney and Rosemary Raszka (VT); Mike Kreidler represented by Jay Bruns (WA); and Nathan Houdek (WI). Also participating were: Michelle Santos (Guam) and Cassie Brown (TX).

1. Adopted its Summer National Meeting Minutes

Commissioner Rude made a motion, seconded by Commissioner Stolfi, to adopt the Task Force's Aug. 15 (*see NAIC Proceedings – Summer 2024, Climate and Resiliency (EX) Task Force*) minutes. The motion passed unanimously.

2. Received a Status Report on Deliverables from the Climate Resilience Strategy

Commissioner Rude said the natural catastrophe risk dashboard drafting group is comprised of state insurance regulators and has met three times to review the dashboard. NAIC staff walked through each risk indicator, which includes nearly 40 indicators in total, providing a rationale for the inclusion of each and displaying the historical trend of each indicator where available. The drafting group provided comments and suggestions, and changes were incorporated as appropriate.

Commissioner Rude said now that the drafting group has seen each metric and how it fits into the overall dashboard, the drafting group will review all indicators again one by one and confirm their inclusion in the dashboard. The next phase of the project will involve assessing the impact, utilizing the current measure of the indicators and the historical trend. The tool itself is meant for regulators, providing a detailed indicator analysis for regulator-only access. In addition, the group has an initial plan to have a version of a public summary of the work.

Commissioner Rude said more than 10 states have existing grant or incentive programs for encouraging more resilient buildings. Alabama crossed an important threshold this year, with 50,000 homes that meet the Insurance Institute for Business and Home Safety (IBHS) FORTIFIED program. Many states are making progress on their own risk mitigation programs and the national strategy prioritizes learning from the experience of states facing different perils.

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Commissioner Temple said the FORTIFIED program is the path to insurability in Louisiana, and insurance markets and reinsurance markets are responding favorably to mitigation and fortified roof building. Louisiana has a coastal protection restoration authority. The $50 billion-funded program is focused on rebuilding marshes as they help reduce storm surge and wind speeds associated with hurricanes. He said making communities insurable will make them resilient. Louisiana was able to build up its resiliency program thanks to the work of Commissioner Fowler and the Alabama Department of Insurance and the blueprint provided by its program.

Myers said the Louisiana program was codified by the legislature in 2022 and funding for the program began in 2023. The program includes a mandatory discount for fortified roofs, as well as a statutory requirement for companies to offer an endorsement that would allow the insured who has experienced a total roof loss to replace the roof with one that meets the FORTIFIED program standards. Due to the interest in the program and the limitations on the number of grants they have been able to provide, the program runs on a lottery system for each round, and the latest round has been focused on coastal parishes. Louisiana now has 1,667 fortified roofs and 1,053 applications in progress. He said they are looking to build a program specifically targeting low-to-moderate-income households in the coastal areas.

Myers said that others looking to do a similar program in their state should make sure their IT group is ready to automate and secure the program. He said states should make sure that consumers understand how to register for the program and how to obtain the roof endorsement should they not take part in the grant program. He said it is important to coordinate the payment of the grants, legal aspects, as well as any contractor licensing entities within the state. He said states should work closely with the IBHS and Brian Powell with the Center for Insurance Policy and Research (CIPR).

Brickwedde said the Strengthen Minnesota Homes program was established by the legislature in 2023. He emphasized the importance of a good IT structure when setting up this type of program. Minnesota is looking to create a pilot program to work with Habitat for Humanity and other similar organizations to install fortified roofs and other weatherization elements on these types of homes. The Minnesota legislature established a requirement to provide a discount or rate reduction for insureds who install fortified roofs. The Minnesota program is looking to provide grants for fortified roofs and is also looking to create an economic ecosystem that allows fortified roofs to be placed without grants.

3. Heard a Presentation from UP and State Regulators on Wildfire Effects

Amy Bach (United Policyholders—UP) said the goal of UP and insurance regulators is to facilitate the flow of accurate information and insurance dollars to people experiencing a traumatizing event. Two-thirds of people who experience a total loss in a wildfire event do not have enough insurance, and federal aid becomes extremely important. The disaster recovery centers or insurance villages offer a one-stop shop for those affected to obtain information on all aspects of recovery, and there has been an increase in consumer questions and concerns about evacuation costs, additional living expenses (ALEs), underinsured homes, uninsured homes, debris removal, patterns of non-renewals following disasters, and questions about rebuilding costs and codes.

Common short-term insurance challenges after a major wildfire disaster include temporary accommodations, victims needing cash advances, communication problems with adjusters and carriers, getting lender signoffs on insurance checks, and estimate disparities. She said things that have helped consumers the most in the first three months after a disaster include help finding current and complete copies of insurance policies, advances on ALEs and contents, coordinated debris removal programs, insurance villages, regulator assistance with getting lender signoffs, regulator intervention with scammers, and UP's trained disaster survivor volunteers.

Bach said common long-term insurance challenges after a major wildfire disaster include costs overwhelming local governments, underinsurance being more prevalent than expected, permit offices being overwhelmed and

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understaffed, building code enforcement, a shortage of experienced adjusters, over-reliance on "touchless" adjusting tools, and coverage and claim disputes. She said things that have helped consumers recover long-term include prompt dissemination of accurate information on consumer rights, policy benefit advantages, sustained engagement by regulators, coordination between Federal Emergency Management Agency (FEMA) and local governments, FEMA financial assistance, voluntary organizations active in disaster (VOADs), long-term recovery groups, and charitable funding for unmet needs.

Bach said that UP can collaborate with state departments of insurance to incorporate state bulletins into resource libraries after disasters and bring together regulators, government officials, and other volunteer groups to get information out to those affected by disasters in an organized manner.

Superintendent Kane gave an update on the recent wildfire in Ruidoso, NM. The wildfire forced 10,000 to 12,000 evacuees to be sent to other towns, and emergency orders were issued. The orders asked companies to pay evacuees $5,000 in ALEs, and companies were not allowed to non-renew or cancel policies. She said new policies are not being written in the area. The New Mexico Office of the Superintendent of Insurance (OSI) worked with other agencies to figure out how residents were going to rebuild and how to move forward in high-risk areas. OSI has asked the state Fair Access to Insurance Requirements (FAIR) plan to increase its coverage limits, and they are looking at a legislative approach as well. The OSI is working with IBHS, local fire marshals, and counties to update building code standards.

Lapham said in Colorado, the Marshall fire destroyed over 1,000 homes and revealed a large amount of underinsured homeowners. He said it was determined that typical ALE coverage was not high enough, in part because of the extended time period of debris removal due to the size of the fire. Legislative updates include the requirement to offer up to 24 months of ALE at the time of application and at renewal and offering policyholders a minimum of 65% of the limits of contents coverage without a written inventory. The Colorado Division of Insurance is working on a report to be the source of information on rebuilding costs, and it has engaged with a third party to conduct a study to address the issue of partial losses due to smoke and ash damage, as well as identifying remediation standards which will be referred to the state legislature.

Commissioner Stolfi said in September 2020, an Oregon wildfire burned about 400,000 acres in in three days and caused $3 billion in losses, which was more than the last 40 years combined of all catastrophe losses in the state. One lesson learned from this event is that regulators need to act quickly to protect consumers and let insurers know what is expected of them. Oregon has expanded its consumer education and advocacy efforts both pre- and post-disaster, and it has increased interagency cooperation and coordination between the Oregon Division of Financial Regulation, the state fire marshal, the emergency management department, and the forestry department. He said Oregon has invested hundreds of millions of dollars into supporting the national cohesive wildland management strategy which includes restoring and maintaining landscapes, building fire-adapted communities, and responding to fire. Bills have been introduced to increase ALE coverage, require a higher percentage of contents coverage to be paid without inventory, require insurers to disclose a detailed explanation of why a consumer was non-renewed due to wildfire, and require insurers to take all home hardening measures into account during the underwriting process. The division is looking to adopt a statewide risk map that will help identify high-risk areas and implement proper building code standards in those areas.

4. Heard an Update from BCFSA on Canadian Flood Insurance

Lucas Neufeld (BC Financial Services Authority—BCFSA) gave an update on three workstreams on Canadian flood insurance. A national flood insurance program, which is being led by Public Safety Canada (PSC), is targeted at high-risk properties which is about 10% of all households in Canada. This program would provide comprehensive flood coverage, including storm surge, river flooding, and urban overland flooding. Flood insurance will still be available in the private market to ensure all Canadians have access to flood insurance.

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Neufeld said a federal flood risk portal (also led by PSC) would be an authoritative, publicly accessible source on flood hazards by compiling flood maps and data with the ability to search by postal code. He said the goal is to go live with this portal in the next 12 months.

Neufeld said the Canadian Council of Insurance Regulators (CCIR) is working with an industry led working group of both insurers and intermediaries to enhance existing practices to help Canadians better understand their natural catastrophe risk.

Neufeld said there is a need for the right skill set, knowledge, and tools to engage customers in a meaningful dialogue at the same time that customers are increasingly expecting a quick and seamless process. There is a need to engage all financial service providers to help ensure customers are receiving similar risk information at all stages of the homeownership lifecycle. He said there is a significant shift away from thinking only about insurance and risk transfer but instead focusing on getting risk out of the system.

5. Heard a Federal Update

Alexander Swindle (NAIC) said the insurance industry continues to navigate an increasingly complex landscape of climate risks, financial constraints, and evolving disaster response needs. In 2024, the U.S. experienced 20 weather-related disasters that had losses exceeding $1 billion, driven largely by severe convective storms. These events highlight the growing strain on insurance markets, and both Congress and FEMA have launched initiatives to address these challenges.

Swindle said FEMA offers various grant programs to states, including the Hazard Mitigation Grant Program (HMGP) for rebuilding after disasters and the Building Resilient Infrastructure and Communities (BRIC) program for climate resilience. These programs have granted nearly $2 billion this past year, and they have also expanded training through the FEMA National Disaster & Emergency Management University, focusing on climate, cyber, and pandemic risks. Just eight days into fiscal year (FY) 2025 (or Oct. 11), FEMA had already spent nearly half of its $20 billion disaster relief budget on Hurricanes Helene and Milton, which caused an estimated $60 billion in damage. FEMA Administrator Deanne Criswell warned that spending may need to be restricted unless Congress provides additional funding, but no new funding has been approved despite President Biden's requests.

Swindle said the recent hurricanes exposed gaps in flood risk models, emphasizing the need for better data and more accurate risk assessments to improve public awareness and insurance coverage. He said Sen. Bill Cassidy (R-LA) continues to advocate for reforms to the National Flood Insurance Program (NFIP). Cassidy has said that FEMA's Risk Rating 2.0 methodology has caused premiums to spike for his constituents. NAIC staff have met with his office to discuss his concerns and potential next steps, including mapping updates and affordability options, with reauthorization hearings expected by early spring.

Swindle said a meeting with the U.S. Department of the Treasury (Treasury Department) was attended by Director Wise, Commissioner Causey, and Commissioner Yaworsky. Discussions focused on the ongoing recovery efforts, the role of the private insurance sector, and the importance of strengthening pre-disaster mitigation strategies. Insurance companies increased their efforts by deploying mobile branches and claims offices, although gaps in flood insurance coverage continue to be a critical issue. Concerns also persist over rising homeowners insurance premiums and insurers pulling out of high-risk areas. He said Treasury Department officials highlighted their focus on consumer protection in response to climate threats and emphasized that more than half of U.S. counties face increasing future exposures to flooding, wildfire, or extreme heat.

Swindle said Moody's recently held a Capitol Hill panel on insurance affordability amid climate risks, with House Financial Services Committee members discussing litigation's impact on insurance prices and the need for NFIP

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debt forgiveness. Rep. Warren Davidson (R-OH), Rep. Maxine Waters (D-CA), and Rep. Emmanuel Cleaver (D-MO) participated, with Cleaver calling for a long-term solution for NFIP funding.

Swindle said several bills are expected to be reintroduced in the next session, focusing on mitigation and resilience funding. Key proposals include: the Disaster Mitigation and Tax Parity Act (H.R. 4070), the Disaster Resiliency and Coverage Act of 2024 (H.R. 7849), the Fix Our Forests Act (H.R. 8790), and the Disaster Assistance Simplification Act (S. 1528).

Swindle said that looking ahead to 2025, the second Trump Administration and new Republican majority in Congress will likely bring significant shifts in policy. He said cabinet appointments are still pending, but they are anticipated to depart from Biden's approach, particularly in resilience matters, with a likely lighter federal regulatory touch.

6. Heard an Update on the Climate Scenario Resource Center

Jeff Czajkowski (NAIC) said following the August adoption of the new climate scenario interrogatories in the year-end 2024 property and casualty (P/C) risk-based capital (RBC) filing, the NAIC has established a Climate Scenario Resource Center to assist filers and their advisors with the disclosure requirements. The NAIC Climate Scenario Resource Center is located on the NAIC Center of Catastrophe Modeling Center of Excellence's website.

Resources include the RBC blanks relating to catastrophe risk, a presentation by the NAIC, and a frequently asked questions (FAQ) document, as well as a dedicated email address for insurers and their advisors to submit questions to the NAIC relating to the new climate scenario interrogatories.

He said the link has been shared with the Reinsurance Association of America (RAA), the National Association of Mutual Insurance Companies (NAMIC), the American Property Casualty Insurance Association (APCIA), catastrophe (CAT) modelers, and reinsurance brokers to ensure RBC filers and their advisors are informed of the requirements and the tight deadline. (Year-end 2024 RBC filings are due on March 1, 2025.) He said details have also been circulated to chief financial regulators and several commissioners for awareness and as a resource to engage with their domestic companies.

Having no further business, the Climate and Resiliency (EX) Task Force adjourned.

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GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

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

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SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE

Special (EX) Committee on Race and Insurance Nov. 17, 2024, Minutes 3-129
Adopted the Endorsement Supporting State Legislation Requiring a Financial Literacy Course as a Prerequisite to High School Graduation (Attachment One)..... 3-133

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Draft: 12/3/24

Special (EX) Committee on Race and Insurance
Denver, Colorado
November 17, 2024

The Special (EX) Committee on Race and Insurance met in Denver, CO, Nov. 17, 2024. The following Special Committee members participated: Andrew N. Mais, Co-Chair (CT); Jon Godfread, Co-Chair (ND); Elizabeth Kelleher Dwyer, Co-Vice Chair (RI); Scott A. White, Co-Vice Chair (VA); Lori K. Wing-Heier (AK); Mark Fowler (AL); Ricardo Lara represented by Chandara Phanachone (CA); Michael Conway (CO); Karima M. Woods (DC); Doug Ommen (IA); Ann Gillespie (IL); Holly W. Lambert (IN); Sharon P. Clark (KY); Timothy J. Temple (LA); Marie Grant (MD); Anita G. Fox (MI); Grace Arnold (MN); Mike Causey (NC); Eric Dunning (NE); Justin Zimmerman (NJ); Scott Kipper (NV); Judith L. French (OH); Andrew R. Stolfi (OR); Michael Humphreys (PA); Michael Wise (SC); Cassie Brown (TX); Kevin Gaffney (VT); Mike Kreidler (WA); Nathan Houdek (WI); and Jeff Rude (WY). Also participating was Gary Jones (PA).

1. Adopted its Summer National Meeting Minutes

Commissioner Godfread made a motion, seconded by Commissioner Arnold, to adopt the Special Committee's Aug. 13 minutes (*see NAIC Proceedings – Summer 2024, Special (EX) Committee on Race and Insurance*). The motion passed unanimously.

2. Received a Status Report on its Health Workstream

Commissioner Arnold reported that the Health Workstream met on Oct. 24 and Sept. 9. The Workstream continued its demographic data collection discussions during the Oct. 24 meeting. During this meeting, the Workstream heard from AHIP on the challenges with demographic data collection, such as inaccurate and incomplete data, lack of interoperability, and a non-patient-centric demographic data collection process. AHIP also discussed its Demographic Data Element Modernization Initiative, which is aimed at addressing some of these issues by modernizing and enhancing national demographic data content and exchange standards so that they are culturally sensitive, sufficiently granular, and allow for alignment across stakeholders. The Workstream also heard from the National Committee for Quality Assurance (NCQA) about its approach to building a foundation of equity data for action, including using its Health Equity Accreditation program and embedding equity in various programs to advance this goal.

During its Sept. 9 meeting, the Workstream heard from the Pennsylvania Department of Insurance (DOI) about its work related to collecting race and ethnicity data in insurance applications. The Workstream also heard from Independence Blue Cross on how the collection of relevant demographic data helps it identify health equity issues and then intervene and monitor progress to address identified problems.

The Workstream also heard about the Blue Cross Blue Shield Association's (BCBSA's) National Health Equity Strategy initiative. This initiative aims to address health disparities and build a more equitable health care system. The initiative's Data Equity Coalition focuses on setting standards for collecting accurate and representative data on race, ethnicity, language, sexual orientation, and gender identification with the goal of improving health outcomes by optimizing the collection of relevant demographic data and addressing barriers to providing personal information.

Commissioner Arnold reported that the Workstream plans to meet in regulator-to-regulator session after the Fall National Meeting to consider its work to date and potential year-end deliverables.

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The Workstream also plans to continue its work on its collaborative space on NAIC Connect, which the Workstream intends to be a platform where Workstream members can share with other NAIC members the information it has captured during its meetings and serve as a platform for discussions and conversations related to health equity and other related topics, including adding blog posts from various stakeholders on issues and topics relevant to its work.

3. Received a Status Report on its Life Workstream and Adopted the Endorsement of a Financial Literacy Course

Commissioner Humphreys reported that the Life Workstream finalized an endorsement supporting state legislation requiring a financial literacy course as a prerequisite to high school graduation. The mandatory financial literacy courses in high schools make a difference in the lives of kids, especially those in underserved communities. Commissioner Humphreys stated that it makes sense to have this body on the record as supporting state efforts to require coursework in financial education at the high school level.

According to the Champlain College Center for Financial Literacy 2023 National Report Card, for the graduating class of 2023, only seven states required students to take a stand-alone half-year course in personal finance or its equivalent as a high school graduation requirement. However, by or before the graduating class of 2028, 25 states are projected to require this financial education requirement, showing significant support among state legislatures. The idea is to close the gap between the remaining 25 states and encourage insurance commissioners to work with departments of education and state legislatures to recognize the importance of financial education, including insurance education, as a prerequisite for graduation.

Commissioner Humphreys noted that the endorsement contains strikethroughs of some language that, although initially included in the endorsement, is not critical to its meaning and goal. In addition, the NAIC consumer representatives and the National Association of Mutual Insurance Companies (NAMIC) have expressed support of the NAIC formally endorsing financial education.

Since the Summer National Meeting, the Life Workstream has continued to focus on "marketing, distribution, and access to life insurance products in minority communities," including a focus on criminal history. The Life Workstream heard a number of presentations exploring the impact of criminal history on a person's ability to access life insurance.

In order to learn more, the Life Workstream circulated a draft survey for public comment asking about insurers' use of criminal history in life insurance underwriting. Comments were requested by Sept. 5. Based on the comments received, a revised chair draft survey was distributed and discussed during a call on Oct. 17. Once the survey questions are finalized, the process for issuing the survey can also be finalized.

Commissioner Humphreys said the idea is to use the same process that was used to conduct the big data/artificial intelligence (AI) survey of life companies. Like the AI survey, states can choose to participate (or not), with a focus on getting participation from companies that make up a significant percentage of the life insurance market.

Commissioner Humphreys said he and Commissioner Fowler have had internal discussions with NAIC staff and the Market Regulation and Consumer Affairs (D) Committee about the process for conducting the survey and to ensure there is coordination with any other surveys that may be going on.

Commissioner Humphreys made a motion, seconded by Commissioner Fowler, to adopt the endorsement supporting state legislation requiring a financial literacy course as a prerequisite to high school graduation.

Commissioner Mais noted that the Special Committee received a request from NAMIC and the NAIC consumer representatives to amend the endorsement to include additional text to the section, "Financial Literacy in Schools

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Through an Equity Lens," to include "an equity lens also raises the need for personal finance courses to be as universally available and accessible as possible, taught using a variety of approaches and to all students, including those with developmental or intellectual disabilities."

Commissioner Humphreys made a motion, seconded by Commissioner Fowler, to amend the endorsement supporting state legislation requiring a financial literacy course as a prerequisite to high school graduation (Attachment One). The motion passed unanimously.

4. Received a Status Report on its P/C Workstream

Commissioner Gaffney reported that the Property/Casualty (P/C) Workstream met Nov. 16 and heard from the District of Columbia about its recent report studying potential unintentional bias in private passenger auto (PPA) insurance. The report is publicly posted and lists a number of potential next steps including studying telematics, wealth-related factors, additional information on quotes, and driving loss costs for certain populations. Other states may wish to look at the D.C. report for the tools and methodologies it used.

The Workstream heard from California about its Low-Cost Auto Program. This program has been around since 1999 and has seen recent growth. It provides low liability limits for low-income drivers and appears to have assisted the state in lowering the uninsured population.

The Workstream heard an update from the Casualty Actuarial Society (CAS) about four new reports the CAS has released. Of note, one paper surveyed state insurance departments about their perspectives on auto rating factors and bias testing methodologies, among other things. Another paper looked into telematics and how it can reduce reliance on other, more controversial, rating variables. The four reports are posted on the CAS website.

The Workstream heard from Verisk about tools it has created to evaluate bias in models. These include statistical methods used to remove the potential contribution of protected class information on the final variables in the model, imputing race via appropriate methodology, and bootstrapping to properly assess the role of race in the models. Verisk also touched upon AI governance principles and its governance life cycle.

Finally, the Workstream is following the work of the Property and Casualty Insurance Market Intelligence (PCMI) Data Group to understand how homeowners data can be analyzed, including looking at coverage gaps and understanding changes in the market and how they impact different groups.

5. Received an Update on the Member Diversity Leadership Forum

Chandara Phanachone, who is the co-chair of the Member Diversity Leader Forum, provided an update on the DE&I Leadership Forum's strategic plan. The strategic plan hinges on three pillars of impact: 1) collaboration and sharing best practices; 2) community engagement by implementing a guest speaker series where the Forum will amplify the voices and impact of community leaders; and 3) education and awareness by continuing education and developing Phase II of the Foundations of DE&I coursework for regulators.

Gary Jones concluded by providing a shared learning update. Jones informed the Special Committee that in October, the Forum invited Norman Bristol Colón, chief diversity officer for the Commonwealth of Pennsylvania, to speak at the Forum. Colón spoke about Pennsylvania's Diversity, Equity, Belonging, and Inclusion (DEBI) program. Colón stated that DEBI is an economic, human relations, competitive, and nonpartisan initiative and that the program is a development of human capital and will help sustain our future. Jones explained the economic impact of diverse consumers and how they make up a significant amount of gross domestic product (GDP) throughout the world.

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Mr. Jones recognized the last two living Navajo Code Talkers of the U.S. Marines. The Navajo Code Talkers were a group of 20th-century war heroes who aided in securing victories for the U.S. and its allies during World War II. The Code Talkers used the Navajo language to communicate without U.S. adversaries being able to decipher the messages.

6. Discussed Other Matters

Commissioner Mais noted that the Special Committee did not adopt its 2025 proposed charges. As part of its 2025 activities, the Special Committee will consider the transition of its work to the letter committees. Discussions will continue with committee leadership and the Membership as a whole. He said that there will be more to come in terms of new charges and deliverables moving into 2025.

Having no further business, the Special (EX) Committee on Race and Insurance adjourned.

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Revision - for consideration by the Special (EX) Committee on Race and Insurance

National Association of Insurance Commissioners (NAIC)

Special (EX) Committee on Race and Insurance – Life Workstream

Endorsement of Financial Literacy Courses in High Schools

THIS DOCUMENT recommends that state insurance departments engage with state financial regulators, state departments of education, and state legislators to promote a student's completion of stand-alone financial literacy and personal finance coursework as a prerequisite for high school graduation that includes an insurance component. This policy endorsement begins with the premise that a basic financial education, including one that introduces insurance types and concepts, is fundamental to an individual's future financial success. State insurance regulators are uniquely positioned to offer expertise in identifying key insurance concepts and skills to be included in the curriculum of a mandated course. We encourage insurance regulators to partner with those who have experience and expertise developing curriculum and teaching high school students to identify or create curriculum that includes insurance content for a mandated course. Insurance regulators can also offer their expertise to serve as resources for teachers as they prepare to deliver insurance-related content, including partnering with those designing and delivering teacher training.

Insurance regulators should play a key role in advancing conversations surrounding the need for financial literacy courses in our high schools, as financial education and individual financial circumstances may impact both insurability and cost of all insurance products, including life insurance. Further, comprehensive financial education for all students is expected to contribute to successfully addressing financial disparities among historically underrepresented groups.

FINANCIAL FUTURES BEGIN EARLY

It is never too early to begin teaching our youngest generations about financial responsibility, as these lessons can last a lifetime. While that education can start at home, according to T. Rowe Price, 57 percent of parents have some reluctance about discussing financial matters with their kids and 37 percent do not like to talk to their children about money, making classroom-provided education all the more important. In addition, foster children, a population that is overrepresented by African-American children[1], have been found to experience financial capability challenges, especially when transitioning out of the foster care system and into adulthood.[2]

For too many children, the only financial education available to them may be the one offered (hopefully required) through their school curriculums. And because many graduating high schoolers[3] will go directly into the workforce[4], it is important that financial education and skills are developed before graduation

[1] According the to Annie E. Casey Foundation, while black children represented 21 percent of the total child population in 2021, they represented 22 percent of all kids in foster care.

[2] *Study Finds Foster Youth Lack Critical Financial Skills*. March 24, 2021. Washington State University.

[3] According to the National Center for Education Statistics, in school year 2019-2020, the U.S. average adjusted cohort graduation rate (ACGR) for public high school students was 87 percent, with varying rates among demographic populations: Asian/Pacific Islander (93 percent), White (90 percent), Hispanic (83 percent), Black (81 percent), and American Indian/Alaska Native (75 percent).

[4] According to the National Center for Education Statistics, in 2021, about 62 percent of people who completed high

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to provide individuals with the best opportunity to achieve financial success.

STATE STATUTORY ENVIRONMENT

In recent years, states have focused on the importance of bringing financial literacy to high school classrooms. According to the Center for Financial Literacy at Champlain College, 7 states required high school graduates in the Class of 2023 to have taken a personal finance course before graduation with that number growing to 25 states for the Class of 2028. That still leaves students in half the country without state-required access to a basic financial education and provides an opportunity for state insurance and financial regulators to work with legislators to enact meaningful policy solutions.

FINANCIAL LITERACY IN SCHOOLS THROUGH AN EQUITY LENS

A state mandate is necessary to provide all graduating high schoolers with a similar baseline understanding of personal finance and will help to address inequities in access to financial education. According to research commissioned by Next Gen Personal Finance, in states that do not mandate a personal finance course as a graduation requirement (leaving such decisions up to local school district control), predominantly-minority high schools have only a 7 percent chance of being locally required to take such a course, while predominantly-white high schools are more than twice as likely to have such a local graduation requirement (14.2 percent). An equity lens also raises the need for personal finance courses to be as universally available and accessible as possible, taught using a variety of approaches and to all students, including those with developmental or intellectual disabilities.

FINANCIAL LITERACY AND INSURANCE

A comprehensive financial curriculum should focus on an understanding of the fundamentals of insurance, such as risk pooling, cost sharing, underwriting and premiums. A curriculum also should include exposure to insurances more likely to resonate with high school students, as well as include an introduction to the largest personal lines insurance coverages (auto, homeowners, health, and life) to prepare students for decisions that they face soon after graduation. Not only will personal finance coursework better prepare individuals for insurance decisions and transactions, but it may also improve their access to affordable insurance for the next several years of their lives or longer. It is particularly important for younger individuals to understand the difference between whole and term life insurance so that they may make informed decisions about which product to buy and the best time to purchase, including the benefits of accumulating cash value. Further, research consistently finds that requiring financial education in high school increases credit scores, particularly through reducing the likelihood of credit delinquencies. Increased credit scores resulting from high school financial education could have the effect of reducing premium prices that consumers will pay for insurance products well into their financial futures.

school or earned a GED certificate immediately enrolled in college. Asian/Pacific Islander students had the highest ACGR (93 percent), followed by White (89 percent), Hispanic (82 percent), Black (80 percent), and American Indian/Alaska Native (74 percent) students.

EXECUTIVE (EX) COMMITTEE AND PLENARY

Executive (EX) Committee and Plenary, Nov. 19, 2024, Minutes 4-2
Adopted the 2025 Generally Recognized Expense Table (GRET) (Attachment One) 4-8
Adopted a *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) Amendment Authorizing State Insurance Regulator Discretion over NAIC Designations Assigned through the Filing Exemption (FE) Process (Attachment Two) 4-10
Report on States' Implementation of NAIC-Adopted Model Laws and Regulations (Attachment Three) 4-20

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Draft: 12/3/24

Executive (EX) Committee and Plenary
Denver, Colorado
November 19, 2024

The Executive (EX) Committee and Plenary met in Denver, CO, Nov. 19, 2024. The following Committee and Plenary members participated: Andrew N. Mais, Chair (CT); Jon Godfread, Vice Chair (ND); Scott A. White, Vice President (VA); Elizabeth Kelleher Dwyer, Secretary-Treasurer (RI); Chlora Lindley-Myers, Most Recent Past President (MO); Lori K. Wing-Heier (AK); Mark Fowler (AL); Alan McClain (AR); Peni Itula Sapini Teo (AS); Barbara D. Richardson (AZ); Ricardo Lara represented by Lucy Wang (CA); Michael Conway (CO); Karima M. Woods represented by Sharon Shipp (DC); Trinidad Navarro (DE); Michael Yaworsky (FL); John F. King (GA); Michelle B. Santos (GU); Gordon I. Ito represented by Jerry Bump (HI); Doug Ommen (IA); Dean L. Cameron (ID); Ann Gillespie (IL); Holly W. Lambert represented by Meggan Brumbaugh (IN); Vicki Schmidt represented by Barbara Rankin (KS); Sharon P. Clark (KY); Timothy J. Temple represented by Barrow Peacock (LA); Michael T. Caljouw represented by Kevin P. Beagan (MA); Marie Grant (MD); Robert L. Carey represented by Timothy N. Schott (ME); Anita G. Fox (MI); Grace Arnold (MN); Mike Chaney (MS); Mike Causey represented by Jackie Obusek (NC); Eric Dunning (NE); D.J. Bettencourt (NH); Justin Zimmerman (NJ); Alice T. Kane represented by Sahar Hassanin (NM); Scott Kipper (NV); Adrienne A. Harris represented by Bhavna Agnihotri (NY); Judith L. French represented by Matt Peters (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Michael Humphreys (PA); Michael Wise (SC); Larry D. Deiter (SD); Carter Lawrence represented by Toby Compton (TN); Cassie Brown (TX); Jon Pike (UT); Tregenza A. Roach (VI); Kevin Gaffney (VT); Mike Kreidler represented by Jim Odiorne (WA); Nathan Houdek represented by Lauren Van Buren (WI); and Allan L. McVey (WV).

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

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

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

Commissioner Ommen reported that the Life Insurance and Annuities (A) Committee met Nov. 18. During this meeting, the Committee adopted its Oct. 21 minutes, which included the following action: 1) adopted the 2025 Generally Recognized Expense Table (GRET); and 2) adopted its 2025 proposed charges and those of the Life Actuarial (A) Task Force.

The Committee also: 1) heard a federal update from Taylor Walker (NAIC); and 2) adopted the report of the Life Actuarial (A) Task Force.

Additionally, the Committee adopted the report of the Annuity Suitability (A) Working Group, which met Nov. 17. During this meeting, the Working Group took the following action: 1) discussed the Working Group chair's draft safe harbor guidance document and comments; and 2) announced plans to reconvene the small drafting group that developed the initial draft guidance document to review the comments received and revise the draft accordingly.

The Committee received an update from the Special (EX) Committee on Race and Insurance's Life Workstream. During its Nov. 17 meeting, the Special (EX) Committee on Race and Insurance adopted the endorsement of a mandatory financial education course as a prerequisite to high school graduation developed by the Life Workstream. The Life Workstream also exposed a draft survey of life insurers' use of criminal history in

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underwriting, received comments, and discussed a revised draft based on the comments received. The next steps include finalizing the survey questions and the process for issuing the survey.

The Committee also: 1) heard a presentation from the American Council on Gift Annuities (ACGA) reacquainting state insurance regulators with charitable gift annuities; and 2) heard a presentation from the Coalition Against Insurance Fraud (CAIF) on the types of fraud it is currently hearing about involving life insurance and annuities.

3. Adopted the 2025 Generally Recognized Expense Table (GRET)

Commissioner Ommen reported that the Society of Actuaries (SOA) Committee on Life Insurance Company Expenses submitted its GRET analysis to the Life Actuarial (A) Task Force for the upcoming year. Around 40% of companies use GRET for sales illustration purposes. To develop the GRET, the SOA takes average industry expense data for the most recent two years for each distribution channel. The SOA's methodology has been consistent since 2015.

No concerns were raised with this year's SOA updates, and the Life Insurance and Annuities (A) Committee adopted the 2025 GRET during its Oct. 21 meeting.

Commissioner Ommen made a motion, seconded by Acting Director Gillespie, to adopt the 2025 GRET (Attachment One). The motion passed unanimously.

4. 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 Nov. 19 and adopted its Summer National Meeting minutes.

The Committee also: 1) adopted its subgroup, working group, and task force reports and interim minutes; and 2) adopted its 2025 proposed charges and its task forces' 2025 proposed charges.

The Committee adopted revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). The revisions update the model for consistency with its model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170).

The Committee heard a presentation from NORC at the University of Chicago on research to assess the use of artificial intelligence (AI) to conduct utilization management. The presentation covered the use of AI in health insurance and key findings regarding health benefit plan use, impact, and regulatory oversight. The presentation also outlined recommendations related to the use of AI, such as transparency, accountability, and ensuring effective oversight.

Additionally, the Committee: 1) heard a presentation from the Center for Insurance Policy and Research (CIPR) on small group market trends; and 2) heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on recent activities of interest to the Committee.

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

Commissioner McClain reported that the Property and Casualty Insurance (C) Committee met Nov. 19 and adopted its Summer National Meeting minutes.

The Committee adopted the reports of its task forces and working groups: Casualty Actuarial and Statistical (C) Task Force; Surplus Lines (C) Task Force; Title Insurance (C) Task Force; Workers' Compensation (C) Task Force;

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Cannabis Insurance (C) Working Group; Catastrophe Insurance (C) Working Group; Terrorism Insurance Implementation (C) Working Group; and Transparency and Readability of Consumer Information (C) Working Group.

The Committee also: 1) adopted the *Premium Increase Transparency Guidance*, which is a voluntary template for states to use if they wish to require insurers to provide additional information related to premium increases; and 2) adopted its 2025 proposed charges.

Additionally, the Committee: 1) heard a presentation from QuantivRisk on the intersection of advanced vehicle technology and auto claim adjudication; 2) heard a presentation from FortressFire on using fire science and data to deliver home resilience; 3) heard a federal update; and 4) heard an update on the status of the Property & Casualty Market Intelligence (PCMI) data call.

6. 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 Nov. 19 and adopted its Summer National Meeting minutes.

The Committee adopted its 2025 proposed charges, which include disbanding the Market Information Systems (D) Task Force and appointing a new Market Information Systems (D) Working Group.

The Committee adopted revisions to Chapter 23—Conducting the Life and Annuity Examination of the *Market Regulation Handbook* regarding *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest Sold On or After Dec. 14, 2020* (AG 49-A).

The Committee adopted amendments and an implementation timeline for the NAIC Uniform Licensing Applications, which will require between 4,122 and 10,715 hours of work. National Insurance Producer Registry (NIPR) work on amending the Uniform Producer Licensing Application will begin in October 2025 and will be completed by February 2026, with implementation into production scheduled between March and May 2026.

The Committee adopted the NAIC continuing education (CE) audit guidelines to provide states with instructions on auditing approved CE courses.

The Committee adopted amendments to the *Public Adjuster Licensing Model Act* (#228) to strengthen regulatory standards governing the conduct of public adjusters in the following areas: 1) individuals acting as unlicensed public adjusters; 2) contractors who are also acting as public adjusters on the same claim; 3) inappropriate assignment of benefit rights; and 4) excessive fees charged by public adjusters.

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

The Committee also heard an update on federal activities from NAIC staff.

Commissioner Pike noted that 11 states have completed the Market Regulation Certification program's self-assessments and are now provisionally certified.

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

Director Wise reported that the Financial Condition (E) Committee met Nov. 19. During this meeting, the Committee adopted its Oct. 24, Aug. 29, and Summer National Meeting minutes, which included the following action: 1) adopted its 2025 proposed charges; 2) made changes to address comments on the draft request for proposal (RFP) to engage a consultant to design and help implement a new due diligence program over the ongoing use of credit rating providers (CRPs); and 3) adopted amendments to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) that provide state insurance regulators with discretion over securities that are otherwise exempt from filing with the Securities Valuation Office (SVO).

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

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

The Committee also: 1) received a status report on the draft reinsurance asset adequacy actuarial guideline; 2) a status report from the Valuation of Securities (E) Task Force; and 3) a status report from the Risk-Based Capital Investment Risk and Evaluation (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 concerning a particular item, the technical changes will be considered adopted by the NAIC membership and effective immediately.

8. Adopted a P&P Manual Amendment Authorizing State Insurance Regulator Discretion over NAIC Designations Assigned through the FE Process

Director Wise reported that the amendment to the P&P Manual provides state insurance regulators with discretion over the NAIC Designations assigned to securities based on a conversion from NRSRO ratings that otherwise are exempt from filing with the SVO.

The Task Force considered the changes over the past year and the proposal went through three iterations before being adopted. Each iteration elicited constructive criticism, and the ultimate product was improved. The most noteworthy change was the addition of specific language to ensure that it is clear that a subgroup of state insurance regulators will have the ultimate authority over the outcome of any given challenge and to clarify the expected involvement of the domiciliary regulator(s). Among other important changes, language was added to clarify the open dialogue expected between the insurer and the SVO. In some cases, the SVO may need additional information, particularly for some private transactions.

Language was also added to clarify the anticipated frequency of the tool's use. Given the number of steps involved in the process, it would be difficult to use this process often because the NAIC does not have enough resources.

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Finally, language was added to clarify that the insurer may involve any authorized party in the discussion, which includes, but is not limited to, the credit rating provider.

Director Wise made a motion, seconded by Commissioner White, to adopt the P&P Manual amendment authorizing regulator discretion over NAIC Designations assigned through the filing exemption (FE) process (Attachment Two). The motion passed unanimously.

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

Commissioner Clark reported that the Financial Regulation Standards and Accreditation (F) Committee met Nov. 17. During this meeting, the Committee reported that it met Nov. 16 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 Connecticut, Massachusetts, New York, and the U.S. Virgin Islands.

The Committee adopted its Summer National Meeting minutes and its 2025 proposed charges, which include the formation of a new subordinate Working Group, the Accreditation Scope and Alignment (F) Working Group.

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

Director Dunning reported that the International Insurance Relations (G) Committee met Nov. 17 and adopted its Summer National Meeting minutes.

The Committee also adopted its Oct. 22, Oct. 8, and Sept. 24 minutes and its 2025 proposed charges.

The Committee also: 1) heard an update on the conclusion of the comparability assessment of the aggregation method to the International Association of Insurance Supervisors (IAIS) insurance capital standard (ICS); 2) heard an update on recent IAIS activities, including its recent committee meetings and publications, as well as ongoing discussions on the implementation of its 2025–2026 Roadmap and 2025–2029 Strategic Plan; and 3) heard an update on international activities, including: a) recent meetings, events, and speaking engagements with international insurance regulators; b) bilateral meetings with certain jurisdictions; c) the NAIC Fall 2024 International Fellows Program; and d) an update on international climate-related activities, including recent events and ongoing developments at the Sustainable Insurance Forum (SIF).

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

Commissioner Gaffney reported that the Innovation, Cybersecurity, and Technology (H) Committee met Nov. 19 and adopted its Summer National Meeting minutes.

The Committee adopted the reports of its task force and working groups, which included the following: 1) formation of the Data Call Study Group; 2) approval of the Privacy Protections (H) Working Group's request to extend the deadline for the completion of its revisions to the *Privacy of Consumer Financial and Health Information Regulation* (#672) until Dec. 31, 2025; and 3) an update on the Cybersecurity (H) Working Group's ongoing discussions to consider building a cybersecurity event response notice portal to assist state insurance regulators and the insurance industry in simplifying the notice provision process.

The Committee adopted its 2025 proposed charges.

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The Committee also: 1) heard a presentation from FireBreak Risk on the use of AI to help mitigate wildfire risk; and 2) heard a presentation from Clearcover and Lemonade on the responsible use of AI.

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

Commissioner Mais referred attendees to the written report for updates on states' implementation of NAIC-adopted model laws and regulations (Attachment Three).

13. Heard the Results of the 2025 NAIC Zone Officer Elections

The Executive (EX) Committee and Plenary received the results of the 2025 zone officer elections:

- Midwest Zone: Commissioner Vicki Schmidt, Chair (KS); Director Eric Dunning, Vice Chair (NE); and Director Larry D. Deiter, Secretary (SD).
- Northeast Zone: Commissioner Michael Humphreys, Chair (PA); Commissioner Justin Zimmerman, Vice Chair (NJ); and Commissioner D.J. Bettencourt, Secretary (NH).
- Southeast Zone: Commissioner Sharon P. Clark, Chair (KY); Commissioner Alan McClain, Vice Chair (AR); and Commissioner Tregenza A. Roach, Secretary (VI).
- Western Zone: Commissioner Andrew R. Stolfi, Chair (OR); Commissioner Cassie Brown, Vice Chair (TX); and Director Barbara D. Richardson, Secretary (AZ).

14. Elected the 2025 NAIC Officers

The NAIC Membership elected the 2025 NAIC officers: Commissioner Jon Godfread, President (ND); Commissioner Scott A. White, President-Elect (VA); Director Elizabeth Kelleher Dwyer, Vice President (RI); and Commissioner Jon Pike, Secretary-Treasurer (UT).

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

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NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Adopted by the Executive (EX) Committee and Plenary on Nov. 19, 2024
Adopted by the Life Insurance and Annuities (A) Committee on Oct. 21, 2024
Adopted by the Life Actuarial (A) Task Force on Sept. 5, 2024

TABLE 1

PROPOSED 2025 GRET FACTORS, BASED ON AVERAGE OF 2022/2023 DATA

DESCRIPTION	Acquisition per Policy	Acquisition per Unit	Acquisition per Premium	Maintenance per Policy	Companies Included	Average Premium Per Policy Issued During Year	Average Face Amt (000) Per Policy Issued During Year
Independent	204	$1.10	51%	61	147	3,008	241
Career	227	1.20	57%	68	86	2,739	218
Direct Marketing	239	1.30	59%	72	24	465	119
Niche Marketing	131	0.70	33%	39	27	649	12
Other*	159	0.90	40%	48	94	869	81
* Includes companies that did not respond to this or prior year surveys					378		

TABLE 2

CURRENT 2024 GRET FACTORS, BASED ON AVERAGE OF 2021/2022 DATA

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

APPENDIX A -- DISTRIBUTION CHANNELS

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

1. Independent – Business written by a company that markets its insurance policies through an independent insurance agent or insurance broker not primarily affiliated with any one insurance company. These agencies or agents are not employed by the company and operate without an exclusive distribution contract with the company. These include most PPGA arrangements.

2. Career – Business written by a company that markets insurance and investment products through a sales force primarily affiliated with one insurance company. These companies recruit, finance, train, and often house financial professionals who are typically referred to as career agents or multi-line exclusive agents.

3. Direct Marketing – Business written by a company that markets its own insurance policies direct to the consumer through methods such as direct mail, print media, broadcast media, telemarketing, retail centers and kiosks, internet, or other media. No direct field compensation is involved.

4. Niche Marketers – Business written by home service, pre-need, or final expense insurance companies as well as niche-market companies selling small face amount life products through a variety of distribution channels.

5. Other – Companies surveyed were only provided with the four options described above. Nonetheless since there were many companies for which we did not receive a response (or whose response in past years' surveys confirmed an "other"

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categorization (see below), values for the "other" category are given in the tables in this memo. It was also included to indicate how many life insurance companies with no response (to this survey and prior surveys) and to indicate whether their exclusion has introduced a bias into the resulting values.

APPENDIX B – UNIT EXPENSE SEEDS

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

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

2006-2010 (AVERAGE) CLICE STUDIES:

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

CURRENT UNIT EXPENSE SEEDS:

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

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Amendments Adopted by:
The Executive (EX) Committee and Plenary, Nov. 19, 2024
The Valuation of Securities (E) Task Force, Aug. 13, 2024
The Financial Condition (E) Committee, Aug. 29, 2024

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)
Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Revised Amendment to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (the "P&P Manual") Authorizing the Procedures for the SVO's Discretion Over NAIC Designations Assigned Through the Filing Exemption Process

DATE: July 30, 2024

Summary: The Valuation of Securities (E) Task Force exposed the prior version of this amendment, dated June 4, 2024, for a 38-day comment period that ended on July 26, 2024. The following updates have been made to this prior version and reflect recommendations received from interested parties.

- Clarification that the process will be consistently applied to all CRPs.
- The term "authorized insurers" is defined.
- Clarification of the SVO's written summary of its analysis during the review phase.
- Including other authorized parties to discuss the security with the SVO.
- IAO shall communicate in writing its opinion of the appropriate NAIC Designation Category.
- The annual summary will be anonymized and will not disclose information on specific securities, CRPs or impacted insurers.
- The SVO will publish within 45 days of a security being removed from the Filing Exemption process an anonymized summary (without references specific to the security or CRP, to avoid disclosing confidential information).
- Impact to issuers that have multiple securities within the same debt class.

Recommendation: The SVO recommends adoption of this proposed amendment authorizing the procedures for the SVO's discretion over NAIC Designations assigned through the FE process with an effective date of January 1, 2026. The effective date can be amended, if needed, if additional time is needed to implement the applicable technological enhancements, as previously discussed. The proposed text changes to P&P Manual are shown in red-underline or ~~red-strikethrough~~ below with new text since the last exposure highlighted in yellow.

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PART ONE
POLICIES OF THE NAIC VALUATION OF SECURITIES (E) TASK FORCE

POLICIES APPLICABLE TO THE FILING EXEMPTION (FE) PROCESS

NOTE: The policies below provide the policy framework for "Procedure Applicable to Filing Exempt (FE) Securities and Private Letter (PL) Rating Securities" in Part Three and are related to "The Use of Credit Ratings of NRSROs in NAIC Processes" discussed above; "NAIC Policy on the Use of Credit Ratings of NRSROs" and the "Definition – Credit Ratings Eligible for Translation to NAIC Designations" in Part Two ("Eligible NAIC CRP Credit Ratings" excludes the use of any credit rating 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.)

Determinations

80. The VOS/TF is resolved that the benefit obtained from the use of credit ratings in state regulation of insurance (i.e. conservation of limited regulatory resources) must be balanced against the risk of blind reliance on credit ratings. To ensure the Task Force properly understands the composition and risk of the filing exempt securities population~~:~~, promote uniformity in the production of NAIC Designations, reduce reporting exceptions for filing exempt securities and increase the efficiency of this NAIC process, the SVO and SSG (hereafter, the IAO) is charged with administration of the filing exempt process defined in Part Three of this Manual.

Directives

81. The IAO shall:

- Recommend improvements to the production of NAIC Designations based on NRSRO credit ratings.
- Identify monitoring and communication procedures that enhance the possibility of regulatory intervention by the VOS/TF to respond to risks to insurer solvency posed by securities in the filing exempt population.
- Identify and develop correctives to the administrative, operational and system-based causes of reporting exemptions in the filing exempt process.
- Change the NAIC Designation equivalent calculated for filing exempt securities when necessary to correct errors or other anomaly that occur in the automated filing exempt process.
- Develop a staff-administered reporting exceptions resolution process that incorporates state insurance regulator and insurance companies' participation.

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- In furtherance of the above directives, exclude specific otherwise Eligible NAIC CRP Credit Ratings from the automated filing exemption process in accordance with the administrative procedures outlined in Part Two of this Manual, if a Sub-group of the Task Force agrees with the determination of the IAO Credit Committee that the resulting NAIC Designation equivalent does not provide a reasonable assessment of investment risk for regulatory purposes.

…

PART TWO
OPERATIONAL AND ADMINISTRATIVE INSTRUCTIONS APPLICABLE TO THE SVO

SVO ORGANIZATION

SVO Administrative Symbols

153. SVO administrative symbols convey information about a security or an administrative procedure instead of an opinion of credit quality. The administrative symbols in use by the SVO and their meanings are described below.

SVO Analytical Department Symbols

154. All SVO analytical departments use the following administrative symbols:

…

- **UR** means the NAIC Designation assigned pursuant to the filing exemption process is under review by the NAIC's Investment Analysis Office.
- **ER** means that one or more otherwise Eligible NAIC CRP Credit Ratings have been excluded from the filing exemption process when determining the NAIC Designation through the Eligible NAIC CRP Rating exclusion procedures in this Manual.

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PROCESS FOR EXCLUDING AN ELIGIBLE NAIC CRP RATING FROM FILING EXEMPTION FOR A SPECIFIC SECURITY

Overview

164. This section outlines the process by which a state insurance regulator or IAO staff can contest an NAIC Designation Category assigned through the filing exemption process which it thinks is not a reasonable assessment of investment risk of the security for regulatory purposes. The process in this section will be consistently applied to all CRPs, without favor to any individual CRP or class of CRPs, and is not expected to be used often. For purposes of this section, the term "authorized insurers" is defined as: Holders of the affected securities that agree to the confidentiality provisions required by the NAIC.

(Note: The guidance in this part is effective as of January 1, 2026, but this date may be amended if additional time is needed to implement the necessary NAIC technological enhancements to IAO systems.)

Request for Information

165. The IAO staff will bring to the attention of the Credit Committee any filing exemption-eligible security assigned an NAIC Designation Category equivalent through the automated filing exemption process as being a security under review if (i) a state insurance regulator notifies the IAO staff that it has determined the NAIC Designation Category equivalent may not be a reasonable assessment of investment risk of the security for regulatory purposes, or (ii) the IAO staff, in its opinion, determines that the NAIC Designation Category equivalent may not be a reasonable assessment of investment risk of the security for regulatory purposes. State insurance regulator notification pursuant to this section does not negate the authority of state insurance regulators under "States May Require a Filing of Exempt or Other Transactions" in Part One of this Manual.

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166. The Credit Committee will convene to determine if, in its opinion, the NAIC Designation Category assigned pursuant to the filing exemption process is a reasonable assessment of investment risk of the security for regulatory purposes. As part of its review, the Credit Committee may consider observable factors including, but not limited to (i) a comparison to peers rated by different CRPs, (ii) consistency of the security's yield at issuance or current market yield to securities with equivalently calculated NAIC Designations rated by different CRPs, (iii) the IAO's assessment of the security applying available methodologies, and (iv) any other factors it deems relevant. If the Credit Committee's opinion is that the assigned NAIC Designation Category is likely a reasonable assessment of investment risk of the security for regulatory purposes, no further action will be taken at that time. If the Credit Committee's opinion is that the assigned NAIC Designation Category is likely not a reasonable assessment of investment risk of the security for regulatory purposes, an information request will be initiated and the security will be put under review.

167. The IAO will notify insurance company holders of the security determined to be a Filing Exempt Security "Under Review" by issuing an information request and publishing a separate SVO Analytical Department Symbol of "UR" for under review in NAIC systems. The SVO Analytical Department Symbol of "UR" will not be reported on the statutory investment schedules. The purpose of the information request is to notify insurance company holders of the security to provide the IAO staff with sufficient information to perform a full analysis of the security. The information provided by insurers should be comparable to an Initial Filing, as described in this Manual, and must be accompanied by each insurer's internal analysis. Consistent with the informational deficiency instructions in this Manual, security information consistent with an Initial Filing should be provided to the IAO within 45 days unless an extension has been granted to the insurance company by the IAO, not to exceed 90 days in total from the date that the IAO issues an information request. The IAO may contact the insurance company's domiciliary chief financial regulator for assistance after the initial 45 days if there has been no meaningful response. If after 90 days additional information equivalent to an Initial Filing has not been provided to the IAO, the IAO may proceed with removal of the otherwise Eligible NAIC CRP Credit Rating(s) from the Filing Exempt process without convening the Sub-group of the Task Force, as described in this section.

For the avoidance of doubt, if an issuer has multiple securities within the same debt class (i.e. position in the capital stack) whose ratings are placed Under Review, for purposes of this process only, insurers must only provide requested information materials once. After a final determination is made regarding the CRP ratings for the affected securities, should the IAO's proposed NAIC Designation Category prevail, insurers would then need to file all securities/identifiers individually to receive an IAO-assigned NAIC Designation upon NAIC Designation renewal.

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Full Review

168. At any time during the information request submission period or during the IAO's subsequent analysis of the security, the insurance company holders of the security are encouraged to provide additional information to the IAO such as their internal analysis, presentations from the issuer, meetings with the issuer's management team and any other information that may be useful or persuasive in the analysis of the security. ~~The IAO will coordinate verbally and in writing with the authorized insurer(s) staff to discuss any questions or issues the IAO may have about the security and answer any question that the authorized insurer(s) staff may have about the IAO's analysis~~. The IAO will provide a written summary of its analysis and its view of why it believes the CRP's risk assessment is an unreasonable assessment of investment risk for regulatory purposes to authorized insurers. It will also coordinate verbally and in writing with the authorized insurer(s) staff to discuss any questions or issues the IAO may have about the security and answer any question that the authorized insurer(s) staff may have about the IAO's analysis. The authorized insurer(s) staff may invite other authorized parties that have agreed to the confidentiality provisions required by the NAIC to these discussions with the IAO.

169. Upon satisfactory receipt of the information through the information request, the IAO will perform a full analysis of the security during which time the SVO Analytical Department Symbol "UR" will remain in place but this symbol will not be reported on the statutory investment schedules.

IAO Determination and Materiality Threshold

170. Upon completion of the IAO's analysis, the Credit Committee will reconvene to determine its own opinion of the NAIC Designation Category. The Credit Committee will then determine whether the NAIC Designation Category assigned through the automated filing exemption process is materially different from its own assessment of the security's risk.

171. The IAO will consider the materiality of the difference between the Eligible NAIC CRP Credit Rating used in the filing exempt process and the IAO's own assessment of the risk. The IAO may propose the removal of an otherwise Eligible NAIC CRP Credit Rating from the Filing Exemption process to a Task Force Sub-group only if the Credit Committee determines, based upon its review, that the Eligible NAIC CRP Credit Rating for the security is three (3) or more notches different than the IAO's assessment (e.g. NAIC Designation Category 1.G versus 2.C) (the "Materiality Threshold").

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Valuation of Securities (E) Task Force Oversight

172. The Credit Committee shall schedule a call with a VOS/TF Sub-Group (the composition of which shall be determined by the VOS/TF chair) to discuss and explain its analytical basis for any Eligible NAIC CRP Credit Rating being recommended for removal from Filing Exemption eligibility. The Credit Committee will use communication processes that maintain confidentiality and ~~notify~~ invite the domiciliary regulators of insurer holders of the security ~~of~~ to participate in the Sub-group meeting.

173. If the Credit Committee identifies that there is a recurring analytical pattern or concern, the IAO Director(s) will inform the VOS/TF chair and they will decide if an issue paper, referral, amendment to this Manual or some other action is needed to be introduced into Task Force proceedings and deliberation.

174. Insurance company staff, and other parties invited by the insurer, that are authorized to discuss the security and who have agreed to confidentiality provisions required by the NAIC, may present their analytical basis to maintain the Eligible NAIC CRP Credit Rating's eligibility for Filing Exemption to the ~~joint~~ meeting of the VOS/TF Sub-group ~~and the Credit Committee~~. Prior to inviting insurers to discuss the security and CRP ratings in question, the IAO shall communicate in writing what it believes the NAIC Designation Category to be, citing the main considerations that form the basis of the IAO's proposed NAIC Designation Category. Any materials shared during, or in advance of, this meeting with the VOS/TF Sub-group ~~and Credit Committee~~ are considered highly confidential and may not be shared beyond those participants at the meeting that have been identified as having been authorized to receive such materials and have agreed to maintain their confidentiality.

175. At any time, the VOS/TF chair may direct the VOS/TF to review the described process to ensure it remains effective and efficient and to recommend revisions to any components.

Assignment of NAIC Designation Category

176. If the VOS/TF Sub-group disagrees with the Credit Committees' NAIC Designation Category opinion and determines that the NAIC Designation Category assigned pursuant to the Filing Exemption process *does not* meet the Materiality Threshold, the Eligible NAIC CRP Credit Rating shall remain eligible for Filing Exemption, the SVO Analytical Department Symbol "UR" will be deactivated, and no further action will be taken at that time. This determination shall not preclude the IAO from placing the same Eligible NAIC CRP Credit Rating under analytic review at a later date following a subsequent review should changing conditions warrant.

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177. If the VOS/TF Sub-group agrees with the Credit Committees' NAIC Designation Category opinion and determines that the NAIC Designation Category assigned pursuant to the Filing Exemption process *does* meet the Materiality Threshold, the IAO is authorized to block the otherwise Eligible NAIC CRP Credit Rating in NAIC systems to prevent that otherwise Eligible NAIC CRP Credit Rating from being used in the automated Filing Exempt Securities Process.

178. If an Eligible NAIC CRP Rating has been removed from Filing Exemption eligibility for a security according to this section and the security has other Eligible NAIC CRP Rating(s) which have not been removed or the security receives an additional Eligible NAIC CRP Rating at any time during or after this process, then the security can receive its NAIC Designation Category through the Filing Exemption process based on the Eligible NAIC CRP Rating(s) that have not been removed. If there is no alternate Eligible NAIC CRP Rating in NAIC systems, the Credit Committee's NAIC Designation Category will be entered into NAIC systems to assign an NAIC Designation Category to the security.

Reinstatement of Filing Exemption Eligibility

179. If an insurer would like the IAO to re-evaluate an Eligible NAIC CRP Credit Rating that was removed from Filing Exemption Eligibility for possible reinstatement in a subsequent filing year, it can follow the operational steps outlined in Appeals of SVO Determinations in this Manual to submit the request.

Reporting Securities Removed from Filing Exemption Eligibility

180. The IAO Director(s) will prepare an anonymized summary that does not disclose specific securities, CRPs or impacted insurers of the removed from Filing Exemption Eligibility actions taken over the prior calendar year.

181. Within 45 days of a security being removed from the Filing Exemption process, the IAO will also publish an anonymized summary (without references specific to the security, to avoid disclosing confidential information) of each unique situation encountered for the securities subject to removal from Filing Exemption Eligibility and publish it on an insurer accessible web location.

182. To facilitate transparency as to the SVO's application of discretion, the SVO Analytical Department Symbols "ER' will be added in NAIC Systems to securities with an excluded otherwise Eligible NAIC CRP Credit Rating(s). The SVO Analytical Department Symbols, "ER" *will be* reported on the insurer's statutory investment schedules for the effected security instead of SVO Administrative Symbols "FE" for filing exemption.

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NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: 11/15/24

State Implementation Reporting of NAIC-Adopted Model Laws and Regulations
As of November 14, 2024

Executive (EX) Committee

- Amendments to the ***Unfair Trade Practices Act* (#880)**—The Executive (EX) Committee and Plenary adopted these revisions at the 2024 Spring National Meeting. NAIC staff are not aware of adoption by any jurisdiction.

Property and Casualty Insurance (C) Committee

- Adoption of the ***Pet Insurance Model Act* (#633)**—The Executive (EX) Committee and Plenary adopted Model #633 at the 2022 Summer National Meeting. Eleven jurisdictions have adopted this model.

- Adoption of the ***Nonadmitted Insurance Model Act* (#870)**—The Executive (EX) Committee and Plenary adopted Model #870 at the 2023 Summer National Meeting. One jurisdiction has adopted this model.

Financial Condition (E) Committee

- Adoption of the ***Property and Casualty Insurance Guaranty Association Model Act* (#540)**—The Executive (EX) Committee and Plenary adopted Model #540 at the 2023 Fall National Meeting. NAIC staff are not aware of adoption by any jurisdiction.

- Adoption of the ***Mortgage Guaranty Insurance Model Act* (#630)**—The Executive (EX) Committee and Plenary adopted Model #630 at the 2023 Summer National Meeting. NAIC staff are not aware of adoption by any jurisdiction.

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LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

Life Insurance and Annuities (A) Committee Nov. 18, 2024, Minutes....5-2
Life Insurance and Annuities (A) Committee Oct. 21, 2024, Minutes (Attachment One)....5-9
Life Actuarial (A) Task Force 2025 Proposed Charges (Attachment One-A)....5-11
Life Insurance and Annuities (A) Committee 2025 Proposed Charges (Attachment One-B)....5-13
Annuity Suitability (A) Working Group Nov. 17, 2024, Minutes (Attachment Two)....5-14
Chair Draft Safe Harbor Guidance Sept. 23, 2024 (Attachment Two-A)....5-16

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Draft: 11/27/24

Life Insurance and Annuities (A) Committee
Denver, Colorado
November 18, 2024

The Life Insurance and Annuities (A) Committee met in Denver, CO, Nov. 18, 2024. The following Committee members participated: Judith L. French, Chair (OH); Doug Ommen, Co-Vice Chair, Andrew Hartnett and Mike Yanacheak (IA); Carter Lawrence, Co-Vice Chair, represented by Toby Compton (TN); Mark Fowler (AL); Barbara D. Richardson (AZ); Karima M. Woods represented by Philip Barlow (DC); Grace Arnold (MN); Justin Zimmerman (NJ); Adrienne A. Harris represented by Mark McLeod (NY); Glen Mulready represented by Andrew Schallhorn (OK); Elizabeth Kelleher Dwyer (RI); Scott A. White represented by Craig Chupp (VA); and Nathan Houdek (WI). Also participating were: Nour Benchaaboun (MD); Fred Andersen (MN); Eric Dunning (NE); Michael Humphreys (PA); and Rachel Hemphill (TX).

1. Adopted its Oct. 21 Minutes

Director French said the Committee met Oct. 21 and took the following action: 1) adopted its Summer National Meeting minutes; 2) adopted the 2025 Generally Recognized Expense Table (GRET); and 3) adopted its 2025 proposed charges and those of the Life Actuarial (A) Task Force.

Director Richardson made a motion, seconded by Commissioner Arnold, to adopt the Committee's Oct. 21 minutes (Attachment One). The motion passed unanimously.

2. Heard a Federal Update

Taylor Walker (NAIC) gave an update on the U.S. Department of Labor's (DOL's) proposed Retirement Security Rule, also known as the fiduciary rule, and amendments to the prohibited transaction exemptions (PTEs), which exempt fiduciaries from what would otherwise be prohibited conflicts. Walker reminded the Committee that the final version of the fiduciary rule was published in the Federal Register on April 25, 2024.

Walker explained that the fiduciary rule: 1) expands the definition of an investment advice fiduciary. Fiduciary status applies to nearly all financial professionals who provide retirement guidance, including life insurers who sell annuity products; 2) the fiduciary definition eliminates the requirement that advice be given on a "regular basis"; and 3) the fiduciary rule adds additional restrictions and requirements to the PTEs.

Walker explained that most of the fiduciary rule was set to take effect on Sep. 23, 2024. But in July 2024, two federal district courts in Texas, in two separate cases, stayed the rule. This means that the industry does not have to comply with the fiduciary rule until the lawsuits are resolved. The first suit was filed by the Federation of Americans for Consumer Choice (FACC), along with several independent insurance agents. The second was brought by nine insurance trade associations, including the American Council of Life Insurers (ACLI), the National Association of Insurance and Financial Advisors (NAIFA), the Insured Retirement Institute (IRI), and the National Association for Fixed Annuities (NAFA). In both court cases, the judges noted that the fiduciary rule shares many of the same legal defects as the Obama-era 2016 fiduciary rule and exceeds the DOL's statutory authority. It is widely believed that the fiduciary rule will not go forward under the incoming Trump Administration.

3. Adopted the Report of Life Actuarial (A) Task Force

Hemphill said the Life Actuarial (A) Task Force met Nov. 15–16. Hemphill said the Task Force discussed the Asset Adequacy Testing for Reinsurance Actuarial Guideline draft and, after its discussion, exposed considerations for

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Reinsurance Asset Adequacy Testing. The discussion and exposure included: 1) initially focusing on affiliated treaties, 2) adopting a disclosure-based approach for 2025, with individual regulators retaining the ability to follow up on any concerns that may be identified based on this reporting, and 3) allowing for aggregation within a counterparty (as opposed to at a treaty level), with more granular testing where the company or regulators have documented concern that aggregation benefits may not ultimately be realized across different lines of business or product types under moderately adverse conditions.

Hemphill said the Task Force continues to make progress toward implementing a replacement generator of economic scenarios (GOES), including discussion of equity calibration and interest rate flooring options. She reported that the Task Force had a robust and productive dialogue with regulators and interested parties, with increasing common ground. She said some regulators requested that ACLI present additional interest rate flooring options, to which the ACLI agreed. The Generator of Economic Scenarios (GOES) (A) Subgroup will continue to meet over the coming months. The Subgroup is working toward meeting later this year to consider whether an alternate equity calibration or interest rate flooring option should be model office tested. Hemphill said this model office testing would then allow regulators and the industry to understand the potential impact of any change being considered for the GOES before adoption.

Hemphill said the Task Force heard a presentation on *Valuation Manual* (VM)-22, Requirements for Principle-Based Reserves for Non-Variable Annuities, and model office testing. Field test results are currently being aggregated and will be presented publicly at a future meeting, where the number of responses allows for sufficient anonymization in aggregate results. These presentations will confirm whether industry results are generally consistent with the model office results.

Chupp made a motion, seconded by Director Dwyer, to adopt the report of the Life Actuarial (A) Task Force. The motion passed unanimously.

4. Adopted the Report of the Annuity Suitability (A) Working Group

Yanacheak said the Annuity Suitability (A) Working Group met Nov. 17, 2024. During this meeting, the Working Group discussed the chair's draft safe harbor guidance document and the comments received during the public comment period that ended Nov. 8. Yanacheak said the Working Group discussed its next steps. The Working Group plans to reconvene the small drafting group that developed the initial draft guidance document to review the comments received and revise the draft accordingly. He said the Working Group anticipates distributing the revised draft guidance document for public comment and holding a future meeting to discuss the comments received.

Yanacheak made a motion, seconded by Director Dwyer, to adopt the report of the Annuity Suitability (A) Working Group (Attachment Two). The motion passed unanimously.

5. Heard an Update on the Life Workstream of the Special (EX) Committee on Race and Insurance

Commissioner Fowler reminded the Committee that the Life Workstream of the Special (EX) Committee on Race and Insurance finalized an endorsement in support of state legislation requiring a financial literacy course as a prerequisite to high school graduation. This endorsement was adopted by the Special (EX) Committee on Race and Insurance during its meeting on Nov. 17.

Commissioner Fowler said the Life Workstream has continued to focus on "marketing, distribution, and access to life insurance products in minority communities," including focusing on criminal history. He explained that the Life Workstream has heard several presentations exploring the impact of criminal history on a person's ability to

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access life insurance. To learn more, the Life Workstream circulated a draft survey for public comment asking about insurers' use of criminal history in life insurance underwriting. Comments were requested by Sept. 5.

Based on the comments received, a revised chair draft survey was distributed and discussed during a public meeting on Oct. 17, 2024.

Commissioner Fowler said once the survey questions are finalized, the process for issuing the survey will also be finalized. The plan is to use the same process that was used to do the big data/artificial intelligence (AI) survey of life companies. Like the AI survey, states will choose to participate, with a focus on getting participation from companies that make up a significant percentage of the life insurance market. Commissioner Fowler said that he and fellow Life Workstream co-chair Commissioner Humphreys have had internal discussions with NAIC staff and the Market Regulation and Consumer Affairs (D) Committee about the process for conducting the survey and ensuring coordination with any other surveys that may be going on.

Commissioner Fowler said that the Special (EX) Committee on Race and Insurance reported during its meeting on Nov. 17 that discussions regarding transitioning the workstream work to the letter committees will begin shortly. He and Commissioner Humphreys look forward to participating in that process for the Life Workstream and plan to move forward with the survey in the meantime.

6. Heard a Presentation from the ACGA Reacquainting Regulators With Charitable Gift Annuities

Shane Leib (American Council on Gift Annuities—ACGA) gave a presentation to raise awareness of the ACGA and its purpose as well as reacquaint or introduce regulators to gift annuities. The ACGA is available to regulators if questions about gift annuities arise. Leib explained that the ACGA advocates for charities and nonprofits and their donors. The ACGA recommends payout rates charities can use for their annuities. The ACGA also monitors regulations and tries to interface with regulators. The ACGA conducts studies to help charities plan and analyze their gift annuity programs and provides training and education to various charities.

Leib explained that a charitable annuity is a way for a donor to make a contribution to a charity that serves two purposes: 1) to provide the donor with a lifetime income based on a payout rate and 2) to allow for money to be left over for the charity once the donor dies. The expectation is that 50% of the original amount of the gift annuity will be available to the charity after the death of the donor. One tax benefit to donors who buy a gift annuity is the ability to take a deduction for the amount that is expected to be left to the charity after the donor dies.

Leib said that charitable gift annuities are issued frequently and are the leading planned gift vehicle today. Charitable gift annuities share the same risks as traditional payout annuities, such as longevity risk, interest rate risk, investment risk, and inflation. There are safeguards in place to address these risks. New charitable annuities have minimum ages and amounts, and the ACGA has capped payout rates at the age of 90 to help with longevity risk. Charities set up segregated funds to hold the reserves that are determined based on the state requirements. Leib said charities tend to be prudent investors with long-term perspective. If the gift annuity is large enough, the charity may use reinsurance to help offset risk.

There are some unique challenges for charitable gift annuities that stem from the way they are designed to work. Some donors want to fund specific charitable efforts, like a particular department within an educational institution or a specific subsidiary of a larger institution, such as the Indiana chapter of the United Way. This restricts the ability to aggregate those individual risks across large pools of people. There is also a potentially heightened concentration risk for small pools. Some of the small charities issuing gift annuities may only have a handful on their books. Additionally, donations tend to increase when markets are doing well. Donors are prompted to make this kind of donation when they can maximize the tax advantages and make as large a contribution as possible. This inconsistent gift activity can concentrate inflation, interest rate, and market risks.

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Leib explained the safeguards in place that are unique to charitable gift annuities. When a charity issues a gift annuity and promises to make payments for life, those payments are backed by reserves, but at the end of the day, all the funds a charity has on hand are available to fund those payments. The general assets of the charity serve as a backstop if the original donated funds are exhausted, which can be quite significant through endowments and other donations. Payout rates are determined with the expectation that 50% of the initial amount will go to the charity, so only 50% of the initial funds are being used to determine the payout rate. Additionally, a donor could always decide to forgo future payments if they felt they were eating into the charity's general assets.

Leib explained how the ACGA supports its members to help them avoid risky behaviors. The ACGA suggests appropriate payout rates and studies charitable gift annuity mortality experience to determine what drives the mortality and should be used in their assumptions. The ACGA performs industry studies to understand the effectiveness of the payout rates as well as verify and validate the rates that the ACGA suggests against the financial results of the charities. The ACGA brings in actuaries and outside consultants to review the methodologies on a regular basis. The ACGA also provides educational opportunities and webcasts to help charities understand the operational aspects and risk management topics.

Dave Ely (ACGA) shared some information about state regulation of gift annuities. The *Charitable Gift Annuities Model Act* (#240) was adopted in 2000 and does a good job with definitions, reserve, surplus, general asset, investment, annual report, and contract filing requirements. There is a lot of variation in filing requirements among states. Several states require initial and ongoing filings. Some states require an initial registration, and some states are completely silent. There is one state where it is a felony to issue a gift annuity without registration, so the ACGA wants to make sure all their member charities follow the appropriate laws across the country. Ely said the ACGA has drafted model registration requirements to help standardize and assist charities in following state requirements.

Ely said one of the reasons for giving this presentation is to be able to partner with state regulators going forward. Ely gave the example of partnering with the New York State Department of Financial Services (DFS) a couple of years ago when charitable gift annuities got caught up in some changes the DFS was making to the regulation of commercial annuities. The ACGA was able to work with the DFS to draft and pass legislation that retained its ability to regulate charitable gift annuities but alleviated some of the requirements that might impede a charity's ability to meet fundraising goals to support its missions.

7. Heard a Presentation from the CAIF on Fraud Involving Life Insurance and Annuities

Michelle Rafeld (Coalition Against Insurance Fraud—CAIF) gave a presentation on the rapidly evolving landscape of insurance fraud in the life and annuity markets. Rafeld explained that the CAIF is the nation's only alliance uniting consumers, government organizations, and insurers to combat insurance fraud.

Rafeld said there has been a dramatic change in consumer attitudes toward insurance fraud. Over 50 million Americans do not view insurance fraud as a crime. In addition, technology has profoundly transformed the world of insurance fraud.

Rafeld explained that technology has revolutionized how insurance fraud is prevented, detected, and investigated, but at the same time, it has created new avenues and opportunities for insurance fraud. The insurance industry is facing significant risks and challenges that demand immediate attention, increased resources, added partnerships, and innovative solutions. Insurance carriers and fraud fighters are finding themselves up against very sophisticated criminals, many of whom are malicious cyber hackers, affiliated with organized crime networks operating in the U.S. and abroad.

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Rafeld outlined some key fraud trends that life and annuity writers are confronting. One of the most pervasive issues reported by carriers is the intentional misrepresentation of information on applications. Both consumers and agents motivated by a commission payout are misstating health conditions, financial status, lifestyle factors, and dates of birth to avoid policy denials or to secure lower premiums or higher coverage limits. Material misrepresentations lead to policy rescissions, claim denials, and substantial carrier losses, and while insurers are increasingly using data analytics and third-party verifications to combat these tactics, the problem continues to persist.

Another trend that has been around for years is advance commission schemes, and it remains one of the top concerns of life and annuity writers as agents continue to manipulate the advanced commission structure for personal gain.

Rafeld said while some agents regularly churn their business or game the "free look" period to pocket increased commissions, carriers are also seeing an increase in agents creating, submitting, and paying the initial premium for fraudulent life and annuity policies. Agents are collaborating with individuals willing to act as fake policyholders, submitting applications for nonexistent individuals, or using the personal and financial information of existing clients without their knowledge or permission, which is not only insurance fraud but identity theft, one of the most significant issues impacting both consumers and the industry today.

Rafeld said that identity theft is increasingly prevalent. Unlawfully obtained consumer data is being sold on the dark web where sophisticated criminals are taking out policies using bogus or stolen names to file fraudulent claims. Criminals are also impersonating consumers to cash out life and annuity products that have a high cash value, and the potential financial impact on a company is concerning.

Rafeld said that earlier this year, an overseas company was defrauded of nearly $25 million dollars by a fraudster who, through an email compromise scheme, went on to orchestrate a Zoom call where they then used manipulated images and voices of company personnel to authorize the cutting of checks to the con artist. While the organization victimized was not an insurance carrier, this story illustrates the tactics being used against insurers today. The technology is so sophisticated that bad actors are successfully defeating the voice, signature recognition, and antifraud security systems that insurers have in place.

Rafeld said insurers are also seeing an increase in the use of synthetic IDs in identity theft schemes. In these schemes, criminals combine real and fictitious information to create new identities, enabling fraudsters to apply for and access policies without triggering typical identity verification safeguards. These synthetic identities can go undetected, resulting in fraudulent policies that are later cashed out or surrendered, often leaving insurers with substantial financial losses.

Rafeld said that another trend is account takeovers, where criminals are using phishing, social engineering, or purchased credentials to breach accounts, allowing them to make withdrawals, change beneficiaries, or even transfer ownership. The fraudsters will often intercept or redirect communications to conceal their actions from policyholders. Older policyholders are particularly vulnerable to account takeover schemes due to the fact that they are less familiar with the cybersecurity attacks and methods being used today.

Rafeld said another scheme involves the creation and submission of fraudulent documents. In today's technology age, the possibilities for exaggerating and fabricating authentic-looking government IDs, medical records, x-rays, and counterfeit death certificates are virtually endless as policyholders, third parties, and criminals can easily use online platforms and AI to buy or create fraudulent documents. Along these same lines are criminals who forge policy changes or policy surrenders to the detriment of insurers and policyholders. It is imperative that life and annuity carriers implement tighter controls and added monitoring and verification protocols.

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Rafeld said synthetic identities and stolen consumer information are also fueling new Stranger-Originated Life Insurance (STOLI) schemes. Using stolen consumer data, fraudsters are arranging for imposters to apply for coverage and pose as the insured when, in reality, the “victims” are typically unhealthy and would never qualify for insurance. These schemes typically involve policies ranging from $25,000 to $500,000, with fraudsters sometimes "stacking" policies across multiple carriers to rake in millions. Another troubling trend involves health care workers stealing the identities of their patients. Disturbingly, several human trafficking cases have involved traffickers taking out insurance on trafficked individuals.

Rafeld said that fraudsters are also targeting life and annuity insurers to launder money. While banks and other financial institutions are typically bound by "know your customer" regulations, criminals have recognized the insurance industry has fewer regulatory requirements for vetting customers and their sources of funds, making life and annuity products the perfect tool to wash illegal funds. In addition to establishing whole-life policies where withdrawals, loans, or surrenders are then later made, money launderers are also depositing funds into annuities and converting the dirty money into clean dollars through income distributions. According to the United Nations, $800 billion dollars a year is illegally laundered on an annual basis, with drug cartels being a major source of the cash being used. Both the industry and state regulators may wish to consider the benefits of adding “know your customer” risk mitigation strategies.

Rafeld explained that in the U.S., the annual cost of insurance fraud has reached a staggering level of $308.6 billion dollars. Of that figure, close to $75 billion each year is lost to life insurance fraud. Some risk mitigation strategies insurers currently use include: 1) adopting advanced technologies; 2) leveraging data analytics to enhance the monitoring of agents and activities; 3) implementing new commission structures; and 4) collaborating with state fraud bureaus and law enforcement in an attempt to hold identified fraudsters accountable.

Insurance fraud can have a detrimental financial impact on a carrier that could affect both its profitability and stability. Rafeld suggested that regulators look to utilize the financial examination process to ensure companies have robust antifraud risk mitigation systems in place. Reviewing antifraud plans offers valuable insights into an insurer’s preparedness. Robust, regularly updated plans are a strong indicator of an organization’s commitment to fraud mitigation. By conducting interviews and analyzing key antifraud data, regulators can help carriers identify potential opportunities where their antifraud efforts can be strengthened. Such a process can also help foster education and collaboration between regulators and insurers, which would only strengthen the industry as a whole.

Rafeld said that the CAIF stands ready to unite and empower private and public groups to fight insurance fraud through outreach, advocacy, and research. The coalition is comprised of over 310 member organizations, including a majority of the state departments of insurance, and has committees and task forces. Like NAIC committees and working groups, these groups meet virtually, as well as in person, to discuss and educate one another about key issues in the insurance fraud world. Rafeld said additional information about membership and their activities can be found on the CAIF website.

Hartnett asked Rafeld whether the CAIF has been seeing romance scams used to initiate account takeovers. A primary complaint on the security side in Iowa has involved situations where somebody has convinced the customer to make a request. Rafeld said that situation has not come up. What they are seeing is criminals who obtain the data illegally and sell it on the dark web to people who use it to circumvent security protocols and take over accounts.

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8. Discussed "Report and Hold" Laws

Commissioner Ommen said he wanted to raise a financial exploitation issue that has come up on the security side that this Committee may want to consider in the context of life insurance and annuities. He said that approximately 10 insurance departments also regulate securities. He met with Maureen Adolf (Eversheds Sutherland), who, along with the law firm of Davis & Harman, represents the Committee of Annuity Insurers (CAI). Commissioner Ommen spoke to Adolf regarding some of the protections on the securities side that are in place to guard against the financial exploitation of older Americans.

Hartnett explained that around 40 states have implemented securities laws that are commonly referred to as "report and hold" laws. The idea is that if there is a reasonable suspicion that a requested transaction will result in financial exploitation, the transaction can be suspended without legal repercussions as long as certain steps have been taken, including notifying the client and the state securities regulator.

Adolf explained that the CAI was formed to address federal legislative and regulatory issues relevant to the annuity industry and to participate in the development of federal tax and securities policies regarding annuities. The committee is a coalition of 32 of the largest issuers of annuity contracts and represents approximately 80% of the annuity business in the United States. The CAI has a senior investors working group that has been focused on senior investor protection issues. The working group has been pleased with the efforts of securities regulators to protect the elderly and vulnerable from financial exploitation. These protections include Financial Industry Regulatory Authority (FINRA) rule 4512, which allows the naming of a trusted contact for an account suspected of exploitation, and rule 2165, which allows firms to pause disbursement to customers if they have a reasonable belief that financial exploitation is taking place.

North American Securities Administration (NASAA) also passed a rule similar to FINRA and the laws that Hartnett mentioned. However, there is nothing similar for insurance products with cash value, like whole life or annuities. Adolf suggested that the Life Insurance and Annuities (A) Committee might want to consider looking into the viability of a similar regime that allows for a pause on a customer's request to withdraw funds when there is a reasonable belief that financial exploitation is taking place to allow time to investigate the matter or refer the matter to authorities. Commissioner Ommen said this was just an introduction to the topic and hopes that the Committee can have discussions in the future.

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.

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Draft: 10/24/24

Life Insurance and Annuities (A) Committee
Virtual Meeting
October 21, 2024

The Life Insurance and Annuities (A) Committee met Oct. 21, 2024. The following Committee members participated: Judith L. French, Chair (OH); Doug Ommen, Co-Vice Chair (IA); Carter Lawrence, Co-Vice Chair (TN); Barbara D. Richardson (AZ); Karima M. Woods represented by Philip Barlow (DC); Grace Arnold represented by Fred Andersen (MN); Justin Zimmerman (NJ); Adrienne A. Harris represented by Bill Carmello (NY); Glen Mulready (OK); Scott A. White (VA); and Nathan Houdek (WI). Also participating was: Rachel Hemphill (TX).

1. Adopted its Summer National Meeting Minutes

Commissioner Lawrence made a motion, seconded by Commissioner White, to adopt the Committee's Aug. 15 minutes (*see NAIC Proceedings – Summer 2024, Life Insurance and Annuities (A) Committee*). The motion passed, with Carmello abstaining.

2. Adopted the 2025 GRET

Hemphill explained that the Society of Actuaries (SOA) provided the Life Actuarial (A) Task Force with the annual update to the Generally Recognized Expense Table (GRET). She said no concerns were raised with the SOA updates, and the Task Force unanimously adopted the updated 2025 GRET Sept. 5.

Commissioner Richardson made a motion, seconded by Andersen, to adopt the 2025 GRET (*see NAIC Proceedings – Fall 2024, Executive (EX) Committee and Plenary, Attachment One*). The motion passed, with Carmello abstaining.

3. Adopted the Life Actuarial (A) Task Force's 2025 Proposed Charges

Hemphill summarized the changes to the Life Actuarial (A) Task Force's 2025 proposed charges. She said the Task Force has an added charge for 2025 to "Coordinate with the Reinsurance (E) Task Force on actuarial items related to reinsurance." She said that the Task Force has been actively coordinating with the Reinsurance (E) Task Force on reinsurance-related workstreams, but given its importance, it is being added explicitly to its charges. Hemphill said it is proposed that the Indexed Universal Life (IUL) Illustration (A) Subgroup be changed to the Life and Annuity Illustration (A) Subgroup. The focus of the Subgroup was expanded from only IUL illustrations to both life and annuity illustrations, and a corresponding charge was added for the Subgroup to "[c]onsider any guidance, actions, or recommendations that may be necessary to regulate annuity illustration practices." Lastly, Hemphill said minor revisions were made to the Variable Annuities Capital and Reserve (E/A) Subgroup's charges to reflect the transition from initial monitoring to ongoing maintenance of the variable annuity (VA) reserve framework. Hemphill said no concerns were raised with the update, and the Task Force adopted its 2025 proposed charges Oct. 9.

Commissioner Ommen made a motion, seconded by Commissioner Lawrence, to adopt the Life Actuarial (A) Task Force's 2025 proposed charges (Attachment One-A). The motion passed, with Carmello abstaining.

4. Adopted its 2025 Proposed Charges

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Director French summarized the Committee's 2025 proposed charges. The Accelerated Underwriting (A) Working Group has been disbanded, as it accomplished its charge with the adoption of the *Accelerated Underwriting in Life Insurance Regulatory Guidance and Considerations* document by this Committee at the Summer National Meeting. Director French reminded the Committee that a referral was made to the Market Conduct Examination Guidelines (D) Working Group to consider additions to the *Market Regulation Handbook* on this topic. Director French said the Committee stands ready to assist if asked under its overarching charge. Director French said the Annuity Suitability (A) Working Group and its charge are being retained. The Working Group has resumed its work on a frequently asked questions (FAQ) document addressing the implementation of the safe harbor provisions in the *Annuity Disclosure Model Regulation* (#245).

Commissioner Mulready made a motion, seconded by Commissioner Houdek, to adopt the Committee's 2025 proposed charges (Attachment One-B). The motion passed, with Carmello abstaining.

5. Discussed Other Matters

Director French said the Committee is scheduled to meet at the Fall National Meeting on Monday, Nov. 18, 2024, from 3:00 – 4:00 p.m.

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A Cmte/2024 Fall National Meeting/11-21-22 ACmte min final

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Draft: 9/23/24

Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Life Insurance and Annuities (A) Committee, 10/21/2024
Adopted by the Life Actuarial (A) Task Force, 10/9/2024

2025 Proposed Charges

LIFE ACTUARIAL (A) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Life Actuarial (A) Task Force** will:
   A. Work to keep reserve, reporting, and other actuarial-related requirements current. This includes principle-based reserving (PBR) and other requirements in the *Valuation Manual*, actuarial guidelines, and recommendations for appropriate actuarial reporting in blanks. Respond to charges from the Life Insurance and Annuities (A) Committee and referrals from other groups or committees, as appropriate.
   B. Report progress on all work to the Life Insurance and Annuities (A) Committee and provide updates to the Financial Condition (E) Committee on matters related to life insurance company solvency. This work includes the following:
      i. Work with the American Academy of Actuaries (Academy) and the Society of Actuaries (SOA) to develop new mortality tables for valuation and minimum nonforfeiture requirements for life insurance and annuities, as appropriate.
      ii. Provide recommendations for guidance and requirements for accelerated underwriting (AU) and other emerging underwriting practices, as needed.
      iii. Work with the SOA on the annual development of the Generally Recognized Expense Table (GRET) factors.
      iv. Provide recommendations and changes to other reserve and nonforfeiture requirements to address issues as appropriate~~,~~ and provide actuarial assistance and commentary to other NAIC committees relative to their work on actuarial matters.
      v. Work with the selected vendor to develop and implement the new generator of economic scenarios (GOES) for use in regulatory reserve and capital calculations.
      vi. Monitor international developments regarding life and health insurance reserving, capital, and related topics. Compare and benchmark these with PBR requirements.
      ~~vi.~~vii. Coordinate with the Reinsurance (E) Task Force on actuarial items related to reinsurance.

2. The **Experience Reporting (A) Subgroup** will:
   A. Continue the development of the experience reporting requirements within the *Valuation Manual*. Provide input on the process regarding the experience reporting agent, data collection, and subsequent analysis and use of experience submitted.

3. The **Generator of Economic Scenarios (GOES) (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor that the economic scenario governance framework is being appropriately followed by all relevant stakeholders involved in scenario delivery.

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B. Review material GOES updates, either driven by periodic model maintenance or changes to the economic environment, and provide recommendations.

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

~~B.~~ Regularly review key economic conditions and metrics to evaluate the need for off-cycle or significant GOES updates, and maintain a public timeline for GOES updates.

~~C. **LIFE ACTUARIAL (A) TASK FORCE (*continued*)**~~

~~D.~~C.

~~E.~~D. Support the implementation of the GOES for use in statutory reserve and capital calculations.

~~F.~~E. Develop and maintain acceptance criteria that reflect history as well as plausibly more extreme scenarios.

4. The ~~**Indexed Universal** **Life and Annuity** **(IUL)**~~ **Illustration (A) Subgroup** will:
   A. Consider changes to *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold on or After December 14, 2020* (AG 49-A), as needed. Provide recommendations for the consideration of changes to the *Life Insurance Illustrations Model Regulation* (#582) to the Task Force, as needed.
   ~~A.~~B. Consider any guidance, actions, or recommendations that may be necessary to regulate annuity illustration practices.

5. The **Longevity Risk (E/A) Subgroup** of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group will:
   A. Provide recommendations for recognizing longevity risk in statutory reserves and/or risk-based capital (RBC), as appropriate.

6. The **Variable Annuities Capital and Reserve (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor the ~~impact of the changes to the~~ variable annuities (VA) reserve framework and RBC calculation, and determine if ~~additional~~ revisions need to be made.
   B. Develop and recommend appropriate changes, including those to improve the accuracy and clarity of VA capital and reserve requirements and reporting.

7. The **Valuation Manual (VM)-22 (A) Subgroup** will:
   A. Recommend requirements for non-variable (fixed) annuities in the accumulation and payout phases for consideration by the Task Force, as appropriate. Continue working with the Academy on a PBR methodology for non-variable annuities.

NAIC Support Staff: Scott O'Neal/Jennifer Frasier

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Draft: 10/11/24

Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Life Insurance and Annuities (A) Committee, Oct. 21, 2024

2025 Proposed Charges

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Life Insurance and Annuities (A) Committee** will:
   A. Monitor the activities of the Life Actuarial (A) Task Force.

~~2. The **Accelerated Underwriting (A) Working Group** will:~~
   ~~A. Consider the use of external data and data analytics in accelerated life underwriting, including consideration of the ongoing work of the Life Actuarial (A) Task Force on the issue; and, if appropriate, draft guidance for the states.~~

~~3~~2. The **Annuity Suitability (A) Working Group** will:
   A. Consider how to promote greater uniformity in the adoption of the *Suitability in Annuity Transactions Model Regulation* (#275) across NAIC member jurisdictions.

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

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Attachment Two
Life Insurance and Annuities (A) Committee
11/18/24

Draft: 11/25/24

Annuity Suitability (A) Working Group
Denver, Colorado
November 17, 2024

The Annuity Suitability (A) Working Group of the Life Insurance and Annuities (A) Committee met in Denver, CO, Nov. 17, 2024. The following Working Group members participated: Doug Ommen, Chair (IA); Lauren Van Buren, Vice Chair (WI); Jimmy Gunn (AL); Jodi Lerner (CA); Sally Frechette (DE); Shannon Hohl (ID); Craig VanAalst (KS); Renee Campbell (MI); Maggie Reinert (NE); Keith Nyhan and Michelle Heaton (NH); Daniel Bradford (OH); Andrew Schallhorn (OK); and Matt Gendron (RI). Also, participating were: Chris Heisler (IL); Nour Benchaaboun (MD); and Travis Jordan (SD).

1. Discussed the Chair Draft Safe Harbor Guidance Document

Commissioner Ommen said the purpose of this meeting is for the Working Group to discuss the comments received by the Nov. 8 public comment deadline on the chair's draft safe harbor guidance document (Attachment Two-A) on the safe harbor/comparable standards provision in the revised *Suitability in Annuity Transactions Model Regulation* (#275), which added a best interest standard of conduct for insurers and producers. He said the Working Group received comments from the Joint Trades—in a joint comment submission from the Insured Retirement Institute (IRI), the American Council of Life Insurers (ACLI), the National Association of Insurance and Financial Advisers (NAIFA), the Committee of Annuity Insurers (CAI), the Financial Services Institute (FSI), the Indexed Annuity Leadership Council (IALC), the National Association for Fixed Annuities (NAFA), Finseca, the Securities Industry and Financial Markets Association (SIFMA), and the Institute for Portfolio Alternatives (IPA)—and the Federation of Americans for Consumer Choice (FACC), Brenda J. Cude (NAIC consumer representative), and the Washington State Office of the Insurance Commissioner.

Sara Wood (IRI) outlined the Joint Trades' general recommendations and key concerns on the draft guidance included its comment letter. She said the Joint Trades included in the comments a chart outlining the different scenarios under which insurers can comply with their supervisory obligations and a redline, track version of the draft guidance providing suggested revisions and comments for the Working Group's consideration.

Wood highlighted the four main themes the Joint Trades' comment letter includes: 1) the draft guidance should provide greater clarity as to the distinctions between an insurer's responsibilities under the safe harbor and the provision that permits insurers to contract with third parties to perform the insurer's supervisory obligations and clarity on how insurers can satisfy their obligations under Section 6C(1) of Model #275 in either scenario; 2) the draft guidance should make clear that insurers do not need to separately determine compliance with a "comparable standard," as defined under the model matches the specific terms and obligations under the model; 3) the draft guidance should make it clear that insurers reviewing recommendations falling under the safe harbor can rely on screening system, as allowed under the model; and 4) the draft guidance should provide adequate flexibility for companies to develop compliance programs that meet their particular business models and circumstances.

Wood noted that the draft guidance appears to suggest that insurers must review the policies and procedures of their third-party distributors, but Model #275 does not include such an explicit requirement. She said the Joint Trades suggest the draft guidance include alternatives, either individually or collectively, that would achieve the same result as a direct review of policies and procedures such as interviews with the distributor or the receipt of a certification. She said the Joint Trades envision such a certification could be crafted to provide strong assurances,

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specific representations, and legal protections in lieu of a generic certification of compliance with all applicable requirements.

Gendron expressed concern about an insurer relying on a certification from its third-party distributors to satisfy its supervisory obligations. He asked how an insurer would know if the third-party distributor is in compliance with the model's requirements if the insurer does not review the distributor's policies and procedures. Wood acknowledged that a review of a distributor's policies and procedures is one way to satisfy an insurer's supervisory obligations, but she noted that some insurers conduct verbal interviews with the distributor, which provides documentation. She said certifications could be a component as well. Wood noted that what the Joint Trades are seeking is flexibility depending on the insurer's relationship with the third-party distributor.

Gendron pointed out the Joint Trades' suggestion to delete the specific examples of the information or data the draft guidance suggests insurers share with the supervising entity to ensure the entity has as much information as possible in making supervisory decisions. Wood said the Joint Trades suggest deleting this language because some of its members have suggested that different data points could be provided to achieve the same goal. She also said that if the language remained, the Joint Trades would like the Working Group to clarify it to ensure the examples are illustrative. She said insurers do not want to get into the position where a state insurance regulator would take the list and use it as a checklist because some of the information or data might not be relevant to the particular relationship.

Commissioner Ommen acknowledged Wood's perspective that the third-party supervision component and the safe harbor are two different issues. He noted, however, that the supervision component in the safe harbor provision is part of the secondary review or transactional review process that the insurer is also required to do under Section 6C(1) of the model, but he believes this supervisory obligation could be satisfied through a third-party supervision assignment process. He asked Wood to describe how such a supervisory agreement would be incorporated into the framework of the contract if an insurer uses such an assignment process. Wood said some IRI members are building such arrangements into part of the contracting process, but she would have to contact her members to get specific information on how this is done.

Wayne Melman (ACLI) said that the ACLI, as a signatory to the Joint Trades comment letter, concurs with Wood's comments. He said the ACLI appreciates the Working Group's work on this issue and urges the Working Group to expose a revised draft guidance document that incorporates the Joint Trades' suggested revisions.

Commissioner Ommen said that following this meeting, the Working Group will reconvene the small drafting group that developed the initial draft guidance document to review the comments received and revise the draft accordingly. He said the Working Group anticipates distributing the revised draft guidance document for public comment and meeting in the future to discuss the comments received.

Having no further business, the Annuity Suitability (A) Working Group adjourned.

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Comments are being requested on this draft on or before Nov. 8, 2024. Comments should be sent by email only to Jolie Matthews at jmatthews@naic.org.

Annuity Best Interest Regulatory Guidance Considerations

Summary

The Life and Annuity (A) Committee of the National Association of Insurance Commissioners offers the following regulatory guidance for state Departments of Insurance (DOIs) to use when reviewing a life insurer's compliance with the *Suitability in Annuity Transactions Model Regulation*, Model 275-1 (the "Model Regulation"). The regulatory guidance is focused on offering guidance concerning insurance company obligations under the safe harbor provisions embodied in Section 6E—Safe Harbor of the Model Regulation, which provides:

> Recommendations and sales of annuities made in compliance with comparable standards shall satisfy the requirements under this regulation. This subsection applies to all recommendations and sales of annuities made by financial professionals in compliance with business rules, controls and procedures that satisfy a comparable standard even if such standard would not otherwise apply to the product or recommendation at issue. However, nothing in this subsection shall limit the insurance commissioner's ability to investigate and enforce the provisions of this regulation.[1]

Generally, the safe harbor would be available to an insurance producer who is also registered as a financial professional under securities law and is subject to another comparable supervisory control system as a result.

This regulatory guidance and consideration document addresses five elements of the safe harbor in the Model Regulation. First, to avail itself of the safe harbor, and to create a circumstance where an insurance producer may reasonably rely on the safe harbor, the insurance company must determine that the conditions of the safe harbor have been met. Second, in each annuity transaction the insurance company must still have "a reasonable basis to believe the annuity would effectively address the particular consumer's financial situation, insurance needs and financial objectives based on the consumer's consumer profile information,"[2] although the insurer may base its analysis on information received from either the financial professional[3] or the entity supervising

[1] Section 6(E)(1). The prohibited practices in Section 6(D) still apply in Safe Harbor transactions.
[2] *See* Section 6(C)(1); *see also* Section 6(E)(2)("Nothing in Paragraph (1) shall limit the insurer's obligation to comply with Section 6(C)(1) of this regulation. . . ."
[3] A financial professional is a producer that is regulated and acting as
(a) A broker-dealer registered under federal [or state] securities laws or a registered representative of a broker-dealer;
(b) An investment adviser registered under federal [or state] securities laws or an investment adviser representative associated with the federal [or state] registered investment adviser; or

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the financial professional. Third, for the safe harbor to apply, an insurance company must "[m]onitor the relevant conduct of the financial professional. . . or the entity supervising the financial professional."[4] Fourth, an insurance company must also "[p]rovide to the entity responsible for supervising the financial professional . . . information and reports that are reasonably appropriate to assist such entity to maintain its supervision system." Finally, an insurance company must distinguish between its obligations under the safe harbor from the situation where it has contracted with a third party for supervision.

Requirements of the Safe Harbor

One of the most common situations that will generate the use of the safe harbor is the licensed insurance producer who is also registered as a securities agent and is subject to the supervisory control system of a registered securities broker-dealer. Pursuant to the safe harbor, recommendations and sales of annuities made in compliance with business rules, controls and procedures that would satisfy comparable standards[5] are deemed to be compliant with the requirements under the Model Regulation. As an example, a financial professional recommending a variable annuity registered with the United States Securities and Exchange Commission (the "SEC") under the safe harbor is deemed to comply with the Model Regulation if the securities agent's broker-dealer has established "business rules, controls and procedures" or a supervisory control system pursuant to FINRA Rules 3110, 3120 and 3130[6] that (1) govern the appropriate recommendation of an SEC registered variable annuity and (2) that satisfies the SEC's Regulation Best Interest ("Reg BI").[7]

Making a recommendation in compliance with comparable standards means in compliance with the "business rules, controls and procedures that satisfy a comparable standard…" To avail itself of the safe harbor, the insurance company should review the broker-dealer's business rules, processes, and procedures that pertain to

(c) A plan fiduciary under Section 3(21) of the Employee Retirement Income Security Act of 1974 (ERISA) or fiduciary under Section 4975(e)(3) of the Internal Revenue Code (IRC) or any amendments or successor statutes thereto.

[4] *See* Section 6(E)(3)(a).

[5] "Comparable standards" is defined in the Model Regulation in Section 6(E)(5) to mean:

(a) With respect to broker-dealers and registered representatives of broker-dealers, applicable SEC and FINRA rules pertaining to best interest obligations and supervision of annuity recommendations and sales, including, but not limited to, Regulation Best Interest and any amendments or successor regulations thereto;

(b) With respect to investment advisers registered under federal [or state] securities laws or investment adviser representatives, the fiduciary duties and all other requirements imposed on such investment advisers or investment adviser representatives by contract or under the Investment Advisers Act of 1940 [or applicable state securities law], including but not limited to, the Form ADV and interpretations; and

(c) With respect to plan fiduciaries or fiduciaries, means the duties, obligations, prohibitions, and all other requirements attendant to such status under ERISA or the IRC and any amendments or successor statutes thereto.

[6] https://www.finra.org/finramanual/rules/r3110; https://www.finra.org/finramanual/rules/r3120; https://www.finra.org/finramanual/rules/r3130

[7] 17 CFR 240.15l-1 (§ 240.15l-1 Regulation best interest)

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the firm's supervisory control system over the registered variable annuities to ensure that they are adequate and that they provide comparable controls as those required under the Model Regulation.

Another common dual license situation involves a licensed insurance agent who is also registered as an investment adviser representative. To avail itself of the safe harbor in this circumstance in a recommendation involving a SEC registered variable annuity, the insurance company should review the business rules, controls, and procedures of the investment adviser to ensure they are adequate and provide comparable controls as those required under the Model Regulation. The fact that an investment adviser by law is a fiduciary and carries potential liabilities for breach of those duties does not in and of itself meet the requirements of the safe harbor. The investment adviser that is in the contractual relationship with the investment adviser representative must have written business rules, controls and procedures that pertain to recommendations of the registered variable annuity that are comparable to the controls that the insurance company would need to directly establish under the Model Regulation but for the safe harbor.

The safe harbor is also available for recommendations of fixed indexed annuities if the insurance company has been able to determine that the securities broker-dealer or investment adviser has established business rules, controls and procedures that were specifically and expressly designed to apply to fixed indexed annuities. As stated in the Model Regulation, an insurance company and insurance producer may avail themselves of the comparable standards safe harbor "even if such standard would not otherwise apply to the product or recommendation at issue." Even though Reg BI does not apply to insurance products, the safe harbor allows insurance producers who are also regulated under securities laws to operate under those securities business rules, controls, and procedures so long as they are substantially similar to those otherwise required under the Model Regulation. It is important to note that these systems must be adapted to recognize the very significant differences in features and characteristics of fixed index annuities from securities. It would be problematic for an insurance company to allow a broker-dealer agent/insurance producer to recommend its fixed index annuities under the terms of the safe harbor if the broker-dealer's policies and procedures were narrowly designed to address the sale of securities under Reg BI, but do not reference fixed index annuities or consider their particular features and characteristics. Insurers may want to provide guidelines with which the partner must comply as part of the onboarding process to ensure that the entity's processes are adequate.

Reasonable Basis

When analyzing a safe harbor transaction, the model regulation is not proscriptive about how an insurer comes to have a reasonable basis to believe that an annuity would effectively address the particular consumer's financial situation, insurance needs and objectives. That said, given that the rule says that the insurer may base

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its analysis on information received from the financial professional or the entity supervising the financial professional, it is clear that the rule expects the insurer to conduct an analysis that goes beyond blind adherence to the analysis and conclusions of the entity supervising the financial professional.

What should this analysis consist of? An insurance company must ascertain that a recommendation was made and documented as required by the other comparable standard. The insurer must receive adequate consumer profile information and other evidence of a good faith basis for the transaction to determine that the annuity would effectively address the consumer's financial situation, insurance needs and objectives. In light of this responsibility and its more general underwriting responsibilities, an insurer should receive, review, and retain transactional customer profile and underwriting information. Of course, insurers may not always receive precisely the same data points from the entity supervising the financial professional as it collects on the transactions it directly supervises. The more divergent the data an insurer reviews on safe harbor transactions compared to transactions it directly supervises, the more questions a regulator may have about whether the company is able to comply with Section 6(C)(1) of the Model Regulation on safe harbor transactions.

Monitor the Relevant Conduct

To avail themselves of the safe harbor, insurance companies must monitor the business conduct of the financial professional or the entity supervising the financial professional. As the following aspects of a successful monitoring program will make clear, simply relying on the statement of a financial professional that he or she complied with a comparable standard falls short of the monitoring required of an insurer. Aspects of a successful monitoring program include:

- **Onboarding**: Entering into a new contractual relationship with an entity to sell annuities should involve a review of the entity's business rules, processes, and procedures to ensure that they are adequate and that they address all the annuities that will be sold under the contractual arrangement. Insurers may want to provide guidelines with which the partner must comply as part of the onboarding process to ensure that the entity's processes are adequate.
- **Audits**: After onboarding a financial partner, insurers need to ensure that the entity's policies and procedures remain adequate, and that the entity is doing what it says it will do. This will likely involve creating a strong audit program. Hallmarks of a strong audit program include selecting an adequate sample size, auditing each financial partner frequently enough, and escalation procedures for any financial partner that fails to respond, up to and including termination of the relationship. Selection of audit frequency should be risk-based based on the volume that comes through the channel as well as other risk factors available to the insurer. An appropriate audit program will also ensure that all partners are audited on a regular cycle.

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- **Due Diligence Questionnaires**: As a supplement to audits, insurers may use due diligence questionnaires as part of their monitoring of their financial partners. These questionnaires may be stand-alone safe harbor questionnaires or wrapped into a larger vendor due diligence process that could include cybersecurity, state specific requirements, and other issues. Due diligence questionnaires are a stronger form of monitoring than certifications.
- **Ongoing Monitoring**: Due diligence questionnaires are not the only form of ongoing monitoring. Sales data, both aggregated and as segregated by partner, can be categorized, and sorted by number of contracts and by premiums to risk rate producers and partners for key elements such as sales to older consumers, free-look cancellations, early surrenders, replacements, and others.
- **Receiving Data**: Insurers might also request data on an ongoing, perhaps quarterly, basis to aid in their monitoring, including:
    - commissions paid to the producer;
    - number of policies issued;
    - number of replacements issued;
    - number of replacements subject to surrender charges at the prior company;
    - Applications that were turned down due to suitability or other concerns; and
    - Number of consumer complaints related to annuity sales received by the entity supervising the financial professional.

Insurance companies may have some of this data, of course, such as commission paid on an annuity, but the idea of this information sharing is broader than re-sharing individual transaction data. It is, rather, to ensure that both the insurer and entity supervising the financial professional have the holistic information necessary to make supervision decisions.

Provide Information and Reports

The insurance company must also give information to the entity supervising the financial professional to ensure that that entity has as much information as possible in making supervisory decisions. Information the insurer might share with the supervising entity includes the following:

- Total contracts issued through the producer over the period, including number and type of annuity;
- Amount of commissions paid for each sale to that producer over the period;
- Identify whether the insurer issued any other annuities for the same producer, and if so, how many;
- Identify how many internal replacements were issued by the same producer;
- Number of consumer complaints or lawsuits received by the insurer related to the producer;

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- Number of contracts for the producer that were surrendered less than 2 years from policy issue, years 2-5, years 6-10 and more than 10 years from issuance;
- Whether any surrenders were subject to surrender charges.

Insurers may be able to offer partners detailed reports and charts that illustrate customer profile factors for fixed and variable annuities, including issue age, share class, withdrawal charges, rider elections, and free look information.

As mentioned in the last section, the idea of this information sharing requirement is not to duplicate individual transaction data the other party already has. It is, rather, to ensure that both the insurer and entity supervising the financial professional have the holistic information necessary to make supervision decisions.

Safe Harbor or Contracting for Performance of Supervision

The Model Regulation has two different mechanisms in which third parties perform part or all the supervisory process for insurers. They appear superficially similar, but are actually quite different, and it is important that insurers understand under which provision of the Model Regulation they are operating. In addition to the safe harbor, insurers may contract for performance of a part or all its supervisory function pursuant to Section 6(C)(3)(a). Where an insurer contracts for performance, it must monitor the conduct of the party to whom it outsourced its supervision, including by conducting audits, as appropriate.[8] As a result, these two circumstances seem similar, but they differ in important ways.

In a safe harbor transaction, although the financial professional and the entity supervising the financial professional make the decision that the annuity is in the best interest of the customer, the final responsibility to decide whether an annuity would effectively address the particular consumer's financial situation, insurance needs and objectives resides with the insurance company. The insurer is almost certainly basing its decision on customer profile information and the basis for the transaction collected by the entity supervising the financial professional, but the safe harbor does not relieve the insurer of its obligation to only issue annuities where it has a reasonable basis to believe "the annuity would effectively address the particular consumer's financial situation, insurance needs and financial objectives based on the consumer's consumer profile information."[9] Because of the safe harbor, however, the intent of the disclosure and procedural requirements that are found in the Model Regulation may be achieved by comparable business rules and procedures. For example, a broker-dealer agent would have given Form CRS to his or her client but would not have to give Appendix A to the client

[8] Section 6(C)(3)(b)(1).
[9] *See* Section 6(C)(1); *see also* Section 6(E)(2)("Nothing in Paragraph (1) shall limit the insurer's obligation to comply with Section 6(C)(1) of this regulation. . . ."

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when selling an annuity. The onboarding, audits, due diligence questionnaires, contractual policies, and other methods an insurer uses to monitor the entity are to ensure that the entity's policies, procedures, and implementation of those policies and procedures are truly "comparable" to what is required under the Model Regulation.

On the other hand, where an insurer has contracted for performance, all the provisions of the Model Regulation apply. If the insurer has delegated the entire supervisory process by contract, the entity with which the insurer has contracted for performance would be the one that decides whether the annuity is in the best interest of the consumer on behalf of the insurer. This delegated supervision cannot just be simply transactions-based and must incorporate all aspects of the supervision that the insurer would have incorporated. The insurer must monitor the entity's conduct, including audits, as appropriate, to ensure that the supervisory system the entity has built "is reasonably designed to achieve the insurer's and its producers' compliance with this regulation."[10] And if the insurer is delegating to an entity that otherwise stands to benefit from the transaction, that potential conflict must be reasonably addressed.

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[10] Section 6(C)(2).

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Life Actuarial (A) Task Force
Denver, Colorado
November 15–16, 2024

The Life Actuarial (A) Task Force met in Denver, CO, Nov. 15–16, 2024. 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 Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak and Kevin Clark (IA); Ann Gillespie represented by Vincent Tsang and Matt Cheung (IL); Holly W. Lambert represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Robert L. Carey represented by Marti Hooper (ME); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung and John Rehagen (MO); Eric Dunning represented by Margaret Garrison (NE); D.J. Bettencourt represented by Jennifer Li (NH); Justin Zimmerman represented by Seong-min Eom and David Wolf (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). Also participating was David Hippen (WA).

1. Adopted its Oct. 24, Oct. 10, Oct. 9, Sept. 12, Sept. 5, and Aug. 29 Minutes and the Reports of the IUL Illustration (A) Subgroup, the Experience Reporting (A) Subgroup, the Variable Annuities Capital and Reserve (E/A) Subgroup, and the Longevity Risk (E/A) Subgroup

The Task Force met Oct. 24, Oct. 10, Oct. 9, Sept. 12, Sept. 5, and Aug 29. During these meetings, the Task Force took the following action: 1) adopted the 2024 Valuation Manual (VM)-20, Requirements for Principle-Based Reserves for Life Products, historical mortality improvement (HMI) and future mortality improvement (FMI) recommendation; 2) adopted its Summer National Meeting minutes; 3) adopted the 2025 Generally Recognized Expense Tables (GRET) recommendation; 4) adopted amendment proposal form (APF) 2024-11, which revises the life principle-based reserve (PBR) exemption to account for updates to the blanks; 5) exposed APF 2024-13, which would clarify the treatment of negative interest maintenance reserves (IMRs); 6) exposed APF 2024-14, which would require additional reporting for surrender charge waivers for variable annuities; 7) discussed the asset adequacy testing (AAT) for reinsurance actuarial guideline (AG ReAAT) draft; and 8) adopted its 2025 proposed charges.

The Task Force reviewed the reports of the Indexed Universal Life (IUL) Illustration (A) Subgroup, the Variable Annuities Capital and Reserve (E/A) Subgroup, the Experience Reporting (A) Subgroup and the Longevity Risk (E/A) Subgroup. Mary Bahna-Nolan (Society of Actuaries—SOA) provided an experience reporting update, noting that the SOA's Mortality Oversight Group (MOG) would be working on the development of a new Valuation Basic Table (VBT). Bahna-Nolan said that the group would work with the Experience Reporting (A) Subgroup to get input from regulators during the development of the new VBT. She also mentioned that the MOG would be restarting efforts to enhance the VM-51, Experience Reporting Formats, to better capture the impact of different underwriting practices including accelerated underwriting (AU).

Chupp noted some editorial corrections that needed to be made to the Oct. 24 and Sept. 5 meeting minutes.

Chupp made a motion, seconded by Yanacheak, to adopt the Task Force's Oct. 24 (Attachment One), Oct. 10 (Attachment Two), Oct. 9 (Attachment Three), Sept. 12 (Attachment Four), Sept. 5 (Attachment Five), and Aug. 29 minutes (Attachment Six) with the corrections noted by Chupp and the reports of the IUL Illustration (A) Subgroup (Attachment Seven), the Variable Annuities Capital and Reserve (E/A) Subgroup (Attachment Eight) and its Oct.

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18 minutes (Attachment Nine), the Experience Reporting (A) Subgroup (Attachment Ten), and the Longevity Risk (E/A) Subgroup (Attachment Eleven). The motion passed unanimously.

2. Adopted the Report of the VM-22 (A) Subgroup and Heard a Presentation on VM-22 Model Office Testing Results

Slutsker walked through the report of the VM-22 (A) Subgroup. The Subgroup met Nov. 6, Oct. 23, and Oct. 9. During these meetings, the Subgroup took the following action: 1) exposed longevity reinsurance reserve flooring methodologies for a 32-day public comment period ending Dec. 9; 2) discussed comments received on the VM-22 standard projection amount (SPA) draft exposure; 3) discussed questions received from companies during the VM-22 field test; 4) adopted a proposal to exclude preneed annuities from the scope of VM-22; and 5) made edits to the VM-22 draft based on Subgroup discussions.

Slutsker made a motion, seconded by Reedy, to adopt the report of the VM-22 (A) Subgroup (Attachment Twelve), including its Nov. 6 (Attachment Thirteen), Oct. 23 (Attachment Fourteen), and Oct. 9 (Attachment Fifteen) minutes. The motion passed unanimously.

Steve Jackson (American Academy of Actuaries—Academy), Chris Conrad (Academy), Angela McShane (Ernst & Young—EY) and Sean Abate (EY) delivered a presentation (Attachment Sixteen) on VM-22 model office testing results. Slutsker asked if it was fair to say that most of the difference between the Commissioner's Annuity Reserve Valuation Method (CARVM) and the VM-22 model office results for fixed deferred annuities with guaranteed lifetime withdrawal benefits (FDAs with GLWBs) was driven by the change in the policyholder behavior efficiency assumption. Abate confirmed that the change in the policyholder efficiency assumption was the major driver. Slutsker then asked what the largest driver of differences was for the single-premium immediate annuity (SPIA) model office results between the two methodologies. Abate replied that the SPIA model offices representative portfolio of long duration assets was the main driver of the change in results and noted that companies with other asset profiles could experience different impacts.

Connie Tang (Retired), noting that SPA results in the model office were higher than the stochastic reserve (SR) for some products, asked if the larger SPA results were due to SPA assumptions that were a work in progress or assumptions for the SR in the model office that needed more refinement. Abate stated that it was likely a bit of both, noting that: 1) the model office assumptions were less developed than what some companies might use, and 2) some companies had noted large deviations between their assumptions and those used in the SPA. Hemphill also asked Abate if the SPA results could be broken out into the unbuffered SPA and the buffer amount, to which he agreed.

Regarding the stochastic exclusion ratio test (SERT) scenarios and the limited results variation between the alternative mortality factors, Hemphill asked if Abate had any suggestions for alternative SERT sensitivity designs. Abate responded that perhaps a sensitivity involving lapses would be more impactful. Weber inquired why the VM-22 SERT had additional mortality assumption sensitivities compared to the VM-20 SERT, which only included varying economic scenarios. Hemphill noted that VM-20 has a deterministic reserve, whereas VM-22 does not. Slutsker added that mortality was added instead of policyholder behavior in order to ensure that companies were developing reasonable mortality assumptions rather than simply relying on a prescribed mortality table.

3. Adopted the Report of the GOES (E/A) Subgroup and Heard an Update on the GOES Field Test

Yanacheak and O'Neal walked through a presentation (Attachment Seventeen) providing an update on the Generator of Economic Scenarios (GOES) (E/A) Subgroup. The Subgroup met Oct. 16, Oct. 9, Oct. 2, and Sept. 25. During these meetings, the Subgroup took the following action: 1) exposed the GOES model governance framework for a 58-day public comment period ending Nov. 22; 2) discussed GOES field test participant feedback;

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and 3) exposed questions on VM-20 SERT scenarios, the VM-20 deterministic reserve (DR) scenario, and scenario statistics for a 30-day public comment period ending Nov. 14.

After Yanacheak concluded the presentation with next steps for the Subgroup, Eom suggested that the model governance program should be developed and adopted by the time the changes to the VM are adopted mid-2025. Brian Bayerle (American Council of Life Insurers—ACLI) said that although the changes to the life risk-based capital (RBC) blanks were due later than the VM amendments, it would be beneficial for companies to see the changes in conjunction with those being worked on for the VM.

Yanacheak made a motion, seconded by Slutsker, to adopt the report of the GOES (E/A) Subgroup, including its Oct. 16 (Attachment Eighteen), Oct. 9 (Attachment Nineteen), Oct. 2 (Attachment Twenty) and Sept. 25 (Attachment Twenty-One) minutes. The motion passed unanimously.

4. Discussed GOES Equity Calibration and Interest Rate Flooring Options

Bayerle delivered a presentation (Attachment Twenty-Two) on the ACLI's alternative GOES equity calibration proposal. Yanacheak, noting that the current GOES equity calibration was likely more conservative than the ACLI's proposal, asked what the best approach would be to determining the model to use going forward. Bayerle noted that the ACLI's proposal was developed using a "history-plus" lens framework where worse scenarios than what has occurred in history would be reflected. Hemphill said that it makes sense to consider how the Academy developed the acceptance criteria using the average of multiple reasonably calibrated reference models. Hemphill noted that in her review of the acceptance criteria, she found that the reference model average in the lower tail was often heavily influenced by an outlier reference model result that was much less conservative than the corresponding results of the other reference models; Hemphill noted that often in the lower tail three of the four reference models were all comfortably below the average. Therefore, Hemphill concluded that she had a concern that risk could be understated by simply hitting the average target or sometimes exceeding the average target, as the ACLI calibration does. Bayerle noted challenges with governance in determining when a scenario set was valid without either closely hitting a target or establishing ranges around which a model result is acceptable. Hal Pedersen (Academy) noted that from the Academy's perspective, the equity acceptance criteria were meant to be hit closely.

Daniel Finn (Conning) then walked through a presentation (Attachment Twenty-Three) on Conning's review of the ACLI's proposed equity calibration. Bayerle asked Finn how the recalibration process would work going forward if Conning's recommended equity model was chosen for adoption. Finn said the approach had similarities to what the ACLI outlined in its calibration approach but also included certain proprietary elements that would not be fully disclosed.

Bayerle then delivered a presentation (Attachment Twenty-Four) on the ACLI's proposed dynamic generalized fractional floor (DGFF) interest rate flooring methodology. Slutsker said that the ACLI's proposed DGFF would severely limit the reflection of negative interest rates and that he supported a steady state one-year UST negative rate frequency of at least 5% in the scenarios, given the international experience and an aging population in the US. Hemphill also noted that she would support higher negative UST rate frequencies than what was included in the ACLI's presentation. Pedersen noted that the Academy is not generally supportive of the DGFF given the tradeoffs with overriding a greater proportion of the scenarios.

5. Heard a Presentation on VM-20 HMI and FMI

Marianne Purshotham (SOA) delivered a presentation (Attachment Twenty-Five) on an updated methodology to develop the VM-20 HMI and FMI factors. Reedy asked if there were any concerns with not being able to distinguish term conversion business. Purushotham replied that the SOA is currently working on a mortality and lapse

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experience study that may be able to help inform the HMI and FMI analysis. Noting that the SOA had utilized a predictive model to analyze the HMI and FMI under a variety of factors, Chou asked why the final assumption was only split by gender. Purushotham responded that the analysis under different factors was useful in determining that further breakdowns of the assumption into other categories were not needed.

Hemphill noted a divergence between the overall population and insured population mortality improvement at older ages and asked how Purushotham became comfortable with including positive mortality improvement in the older ages when the insurer experience showed deterioration. Purushotham said that the deterioration seen in the older ages surprised the SOA's Mortality Improvement Life Working Group (MILWG), and that they would be working with NAIC staff to perform model office testing of the potential impact on the mortality improvement assumptions in the older ages to guide its thinking on the development of the assumptions. Chou asked about the source of the decline in the overall population mortality improvement experience seen approximately in ages 50 to 70. Purushotham stated that the MILWG has not been able to pinpoint the exact cause but noted that the decline was not present in the insured data and speculated that it could be due to early retirees not having access to healthcare ahead of access to Medicare at age 65. Chupp asked what the plan was to utilize data after 2019 to better assess the impact of COVID-19 on the mortality improvement in the insured population. Purushotham said that the MILWG relied on the receipt of insured population mortality experience from the NAIC which had provided data up to 2019 thus far. However, Purushotham noted that the MILWG would also consider additional recent data sources to provide more information on the impact of COVID-19.

6. Re-Exposed APF 2024-13

Chupp made a motion, seconded by Chou, to expose APF 2024-13 for a 14-day public comment period ending Dec. 2. The motion passed unanimously.

7. Adopted APF 2024-14

Hemphill reintroduced APF 2024-14, noting that the amendment would add a reporting requirement for companies to provide documentation of circumstances when they would waive policyholder surrender charges, the historical frequency of any waived surrender charges, and how the waived surrender charges were reflected in their valuation. Colin Masterson (ACLI) spoke to the ACLI's comment letter, noting concerns with data availability and the additional reporting effort required for an amount that could be immaterial. Donna Claire (Claire Thinking Inc.) said that another more common practice at insurance companies was to waive surrender charges on required minimum distributions. Hemphill noted that the analysis of company historical data to illustrate the materiality of waived surrender charges could be performed and then it could perhaps be a period of years before the analysis would need to be refreshed. Slutsker suggested noting that in the minutes that if there are challenges with getting data on the surrender charge waivers, to work with the domestic regulator to determine a reasonable alternative. Hemphill agreed and noted that potential revisions to the language could occur later after state insurance regulators receive some initial information on surrender charge waivers.

Slutsker made a motion, seconded by Reedy, to adopt APF 2024-14 (Attachment Twenty-Six) and note in the minutes the flexibility in meeting these requirements. The motion passed unanimously.

8. Exposed APF 2024-15

Weber introduced APF 2024-15 to correct a mistake, which was introduced with the adoption of APF 2024-07 that unintentionally changed the industry mortality table used in the VM-21, Requirements for Principle-Based Reserves for Variable Annuities, SPA from a ceiling to a floor for variable annuities with guaranteed living benefits.

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Weber made a motion, seconded by Chupp, to expose APF 2024-15 for a 21-day public comment period ending Dec. 9. The motion passed unanimously.

9. Discussed a Universal Life Nonforfeiture Product Filing Issue

Katie Campbell (Interstate Insurance Product Regulation Commission—Compact) requested guidance from the Task Force on nonforfeiture issues that had come up at the Compact's Product Standards Committee regarding universal life (UL) products. Campbell noted that UL products evolved with many features that were not addressed by the requirements in the *Universal Life Insurance Model Regulation* (Model #585), including multipliers, bonuses, and early cash value features. Campbell said that the two most pressing UL nonforfeiture issues are: 1) for a UL product with multiple account values with differing interest and/or expense guarantees, should the guarantees for each account be tested for compliance; and 2) what interest rate should be used to determine the expense allowance. Regarding the second issue, Campbell stated that as minimum guaranteed interest rates had declined in recent years, so had the rate used to determine the expense allowance.

Regarding the first issue, Weber stated that testing of both accounts should be done so that you can determine the constraining minimum guarantee. Naomi Kloeppersmith (Compact) said that type of testing at issue would be challenging to determine what would always be the constraining minimum guarantee path. Hemphill said that the guidance to the Compact would be to test the guarantee for each account associated with the policy. Carmello asked whether the Task Force needed to consider whether an actuarial guideline or other formal feedback was needed to resolve the Compact's issue. Hemphill said that the Task Force could provide informal guidance today and consider whether more formal guidance would need to be delivered later. Hemphill also stated that more work would need to be done on the second issue before any guidance from the Task Force could be determined.

10. Heard an Update on the SOA's Education Redesign

Doug Norris (SOA) provided an update on SOA's changes to its fellowship pathway. Norris noted that the current structure that locks Fellowship candidates into distinct educational tracks would be changed so that candidates could have more flexibility to choose different coursework as suited to their needs. Norris said that one challenge with this approach would be that depending on which coursework a candidate chooses, they may not be qualified to sign a life actuarial opinion. Norris said that the SOA would develop a life regulatory certificate to address these concerns and allow a candidate to demonstrate their competency.

11. Heard an Update on AG 53 Reporting

Andersen walked through a presentation (Attachment Twenty-Seven) that provided an update on state insurance regulators' reviews of Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves (AG 53) filings.

12. Discussed the AAT for Reinsurance Actuarial Guideline Draft

Andersen delivered a presentation (Attachment Twenty-Eight) that highlighted key issues in developing the AG ReAAT draft. Andersen proposed that drafting efforts on the AG ReAAT be focused first on affiliated reinsurance transactions due to concerns with lack of data for non-affiliated treaties. Noting that sometimes there can be gray areas in determining affiliated versus non-affiliated treaty status, Andersen also suggested that any treaty falling into the gray area be treated as affiliated for purposes of the AG ReAAT. No Task Force members objected to this approach. On the topic of aggregation, Bayerle commented the ACLI would support allowing aggregation up to the individual counterparty level at a minimum. Hemphill noted a concern with allowing too much aggregation and a desire for

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consistency with the reserving categories present in principle-based reserving. Yanacheak agreed and stated that if aggregation across reserving categories were allowed it would incentivize more affiliated offshore reinsurance. Bayerle said that the less aggregation that was allowed, the further away from the spirit of cashflow testing. Andersen noted that historically AAT has been applied as an additional guardrail for business that has already been reserved for under a conservative methodology. He continued that some of the concerning treaties may not have reserves with this level of conservatism behind them, making the AAT all the more important to determining adequacy. Slutsker suggested evaluating current treaties to see how different lines of business were being aggregated to inform the development of the AG ReAAT.

Regarding the choice of whether to go with a rules-based or disclosure-based approach, Yanacheak said that moving forward with a disclosures-based approach for AG ReAAT would make progress, whereas the rules-based approach may not work. Hemphill agreed but noted that known concerns could also potentially be addressed. Eom noted a desire to have companies post additional reserves where deficiencies are revealed through AAT. Reedy supported a disclosure-based approach but noted that states should have the authority to require companies to hold additional reserves with or without the adoption of the AG ReAAT. Clark supported the disclosure-based approach, noting that there are likely to be complications in assessing the practices of other jurisdictions and their comparability and other unforeseen challenges that make a disclosure-based approach more appropriate starting out. Andersen noted a consensus seemed to be forming with the disclosure-based approach. Bayerle noted that the ACLI supported the disclosure-based approach to promote an increased understanding of the underlying issues. Patricia Matson (Risk & Regulatory Consulting—RRC) said that there could be a rush of companies trying to enter into reinsurance agreements ahead of potential prescriptive requirements and that the language in the AG ReAAT should account for that.

13. Heard an Update from SOA Research and Education

Dale Hall (SOA) presented the SOA Research Institute's update (Attachment Twenty-Nine). Discussing the SOA's dashboard for life insurance mortality experience, Tsang noted a correlation between face amounts and actual-to-expected ratios and inquired about the presence of additional underlying factors. Hall confirmed the existence of other factors, such as socioeconomic status, and highlighted that the dashboard is interactive, allowing for the study of these impacts.

14. Heard an Update from the Academy Council on Professionalism and Education

Darrel Knapp (Academy), Kevin Dyke (Actuarial Standards Board—ASB), and Shawna Ackerman (Actuarial Board for Counseling and Discipline—ABCD) jointly presented an update from the Academy Council on Professionalism and Education (COPE). Knapp discussed the Academy's Committee on Qualifications (COQ) and the US Qualification Standards (USQS), which outline the qualifications required for issuing a statement of actuarial opinion. He noted that the COQ is closely monitoring draft proposals for potential changes to the education and underlying US actuarial credentials in relation to the USQS. The COQ will provide appropriate qualifications guidance.

Dyke highlighted recent work on Actuarial Standards of Practice (ASOPs), including the adoption of updates to ASOP 24, which pertains to compliance with the *Life Insurance Illustrations Model Regulation* (Model #582). He also mentioned a new exposure draft on pricing reinsurance or similar risk transfer transactions involving life insurance, annuities, or long-duration health benefit plans, which closed on Nov. 1 and received 12 comment letters. The ASB will review these comments and present any revisions to the exposure draft in 2025. Additionally, the ASB has approved a second exposure draft for ASOP 41 on external communications and is expected to release a new enterprise risk management standard that would consolidate ASOP 46 and 47. Ackerman emphasized the outreach efforts of the ABCD, and the professionalism webinars conducted by its members.

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15. Heard an Update from the Academy Life Practice Council

Amanda Barry-Moilanen (Academy) delivered a presentation (Attachment Thirty) on the activities of the Academy's Life Practice Council.

16. Exposed Academy Life Knowledge Statements for Appointed Actuaries and Qualified Actuaries

Linda Lankowski (Academy), Patricia Matson (Academy), and Knapp presented on the Academy's work regarding life knowledge statements (Attachment Thirty-One).

Hemphill exposed the Appointed Actuary and Qualified Actuary knowledge statements for a 51-day public comment period ending Jan. 8, 2025.

17. Heard a Presentation on Charitable Gift Annuities

Phil Purcell (American Council of Gift Annuities—ACGA), David Ely (ACGA), and Shane Leib (ACGA) delivered a presentation (Attachment Thirty-Two) on ACGA's role in the gift annuity space.

Yanacheak inquired about the credibility of the 50,000 contracts under study and their size relative to the annuity market. Ely noted that it is challenging to determine due to non-standard state regulations affecting gift annuity (GA) reporting. Yanacheak further asked how the GA experience study results compare to mortality tables specific to annuity valuation. Leib responded that the results closely align with the 2012 Individual Annuity Reserving (IAR) tables, with the study showing that the mortality experience is, on average, about 110% of the 2012 IAR. Tang asked if GAs allow for joint survivorship. Leib explained that ACGA produces rates for both individuals and joint gift annuities. Leung asked if ACGA requires insurance companies to price according to its assumptions. Ely responded that the ACGA suggests gift annuity payout rates to charities nationwide, but donors and charities have the option not to use ACGA rates. Carmello mentioned that in this context, the charity acts as the insurance company, and some have recently started reinsuring their books of business with insurance companies to mitigate concentration risk.

18. Disclosed Regulator only Session

Hemphill disclosed that the Task Force met on Oct. 31 in regulator-to-regulator session jointly with the Health Actuarial (B) Task Force pursuant to paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings. The Task Forces heard a confidential update regarding changes to the SOA fellowship pathway.

19. Exposed Considerations for Reinsurance Asset Adequacy Testing

Andersen discussed a series of questions and considerations on the AG ReAAT that could help inform its development. Andersen made a motion, seconded by Chou, to expose the AG ReAAT considerations for a 58-day public comment period ending Jan. 15, 2025. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Committees/Member Meetings/A CMTE/LATF/2024-3 Fall/National Meeting/Minutes Packet/LATF Fall National Meeting Minutes.docx

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Life Actuarial (A) Task Force
Virtual Meeting
October 24, 2024

The Life Actuarial (A) Task Force met Oct. 24, 2024. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Mark Fowler represented by Sanjeev Chaudhuri (AL); Lori K. Wing-Heier represented by Sharon Comstock (AK); Ricardo Lara represented by Ahmad Kamil and Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak and Kevin Clark (IA); Ann Gillespie represented by Vincent Tsang (IL); Holly W. Lambert represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Robert L. Carey represented by Marti Hooper (ME); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung and John Rehagen (MO); Eric Dunning represented by Margaret Garrison (NE); D.J. Bettencourt represented by Jennifer Li (NH); Justin Zimmerman represented by Seong-min Eom and David Wolf (NJ); Adrienne A. Harris represented by Bill Carmello and Amanda Fenwick (NY); Judith L. French represented by Pete Weber (OH); Michael Humphreys represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT).

1. Received a Summary of its Oct. 17 Meeting

Hemphill said that the Task Force met Oct. 17 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss specific company indexed universal life (IUL) illustrations and universal life nonforfeiture calculations, and that no actions were taken.

2. Continued Discussion on Comments Received on the Scope and Aggregation Sections of the AAT for Reinsurance Actuarial Guideline Draft

Andersen gave a presentation (Attachment One-A) highlighting key decision points related to the scope and aggregation sections of the Asset Adequacy Testing (AAT) for Reinsurance Actuarial Guideline (AG) draft. Regarding the question for whether treaties could be excluded if a report meeting similar standards to *Valuation Manual* (VM)-30, Actuarial Opinion and Memorandum Requirements was filed with a relevant regulator, Yanacheak noted that it was not sufficient to simply file a report. He added that the report needs to be done to high standards. Eom stated that when considering what reports would qualify as similar, that it was important to make sure AAT was performed as part of the testing supporting the report. Hemphill noted that there were potentially two approaches in determining what constituted a similar report: 1) defining "similar" in the AAT for Reinsurance AG; or 2) creating a smaller list of aspects used to make the determination.

Andersen asked for an example of a report that could be considered similar to VM-30. Jeff Mulholland (Insurance Capital Markets Holdings) said that rating agencies require reporting that would meet many if not all of the VM-30 requirements. Jeremy Trader (Knighthead Annuity & Life Assurance) noted that comparisons of reporting across regulatory and rating agency regimes were available online. Clark said that even if a report is filed, it is not always accessible to the cedant's state insurance regulator. Brian Bayerle (American Council of Life Insurers—ACLI) stated that he supported developing a set of guidelines to define what a report similar to VM-30 could mean. Andsersen said that the next step would be to review reporting that may be considered similar to VM-30 requirements to see how they compare.

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Andersen then prompted the next discussion topic on whether treaties could be exempted if the assuming company held full U.S. statutory reserves. Hemphill noted that when referring to "full U.S. statutory reserves," commenters are often talking about formula reserves which may be found to be deficient with AAT. Therefore, Hemphill stated that she would not be comfortable with not requiring AAT at all for treaties where full US statutory reserves are held. Hemphill then suggested AAT could be performed at the onset of the treaty with additional sensitivity testing representing alternative economic environments to give state insurance regulators comfort that the formula reserves held were not deficient. Hemphill concluded by stating that she would be comfortable with exempting treaties where the assuming company holds full U.S. statutory reserves computed under principle-based requirements.

Andersen then asked whether the Task Force would have concerns with exempting treaties where there was no reserve reduction. Leung noted that this type of exemption would mean that all US reinsurers would be exempted because they hold US statutory reserves. Eom asked whether Leung would include captives as a US reinsurer, to which Leung replied that his comments applied to any US reinsurer that held US statutory reserves. Chou said that captives need additional consideration.

Andersen concluded by stating that the Task Force will further discuss a revised version of the AAT for Reinsurance AG at the Fall National Meeting.

Having no further business, the Life Actuarial (A) Task Force adjourned.

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Reinsurance Asset Adequacy Testing scope items

Fred Andersen, FSA, MAAA

10/24/2024

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10/24/2024

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Status of scope topics – progress previously made

- Broad or narrow scope?
  - **Narrow, decided 10/10/24**
- Restrict consideration of cash-flow testing (CFT) requirements to asset intensive reinsurance
  - **Yes, have placeholder definition to discuss**
- Application to transactions as of certain dates
  - **Likely going with bifurcation of affiliated (wider scope of dates) and non-affiliated (narrower scope of dates)**
- Exclude from scope if assuming company files a VM-30 report
  - **A lot of support but issues to work through later**

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Status of scope topics – attempt initial progress

- Potential considerations re: not performing CFT for large, impactful reinsurance transaction
  - Summary of comments (little or no LATF discussion yet):
    - Actuarial memorandum similar to VM-30 is filed elsewhere
    - Full US stat reserves are held
    - Funds withheld and ModCo impact
- Reasons for focus on reserve adequacy in addition to collectability

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"CFT is not needed since an Actuarial Memorandum similar to VM-30 is filed elsewhere"

- Examples of where alternatives are filed:
  - To assuming company's offshore regulator
  - To assuming captive's state regulator
  - To cedant

- Could be required by ceding company's state regulator
  - But perhaps in a different form than contemplated by AG ReAAT

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VM-30 Actuarial Memorandum aspects include:

- Asset descriptions
- Assumption documentation
  - "Such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions"
  - "And (form a conclusion) on whether the assumptions contribute to the conclusion that reserves make provision for 'moderate adverse conditions'"
- Methodology
  - Rationale for degree of rigor in analyzing different blocks of business.
  - Include in the rationale the level of "materiality" that was used in determining how rigorously to analyze different blocks of business.

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VM-30 Actuarial Memorandum aspects , cont.:

- Criteria for determining asset adequacy
- Changes from the prior year's analysis
- Summary of results
- Conclusions

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VM-30 Actuarial Memorandum aspects, AG 53 additions:

- Consideration of conditions negatively impacting cash flows from complex assets
- Recognition that higher expected gross return assets are, to some extent, associated with higher risk
- Explanation of valuation of complex assets in AAT
- Identification of Projected High Net Yield assets
- Description of and justification of model rigor
- Investment expense expectations
- Documentation of assets and related assumptions in an easy-to-read template
- Other items as described in the AG 53 Guidance Document

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What would make a "Similar" Actuarial memorandum sufficient?

- What is meant by "following US standards" or "equivalent to VM-30"?
  - Are most/all aspects from the previous three slides included?

- Scope of assuming company actuarial memorandum:
  - Company wide (same as what onshore assuming company would file with state),
  - Counterparty (ceding company)-specific, or
  - Treaty-specific?
    - Focus on specific risks and safeguards of the individual treaty

- Subject to oversight by states re: assumptions and methods?
  - NY 7 risk-free rate scenarios?
  - Reasonable reflection of risk of high-yield assets
  - Reasonable mortality, policyholder behavior, and other assumptions

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What would make a "Similar" Actuarial memorandum sufficient?

Are there cases where this information would suffice?

"Full US Stat Reserves Are Held"

- **Does that statement make it less important for CFT to be performed?**

- Questions:
  - Are there "hard assets" supporting the full amount?
  - Was initial CFT performed, with sensitivities, to determine whether US Stat reserves are sufficient and would continue to be adequate under a reasonable range of economic scenarios?
    - OR, are US Stat Reserves determined on a PBR basis?
  - Are full US stat reserves only held to support the book value, but an economic value is used to support the market value?
  - **Others?**

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Focus on reserve adequacy in addition to collectability

- Previously stated:
  - Rating agencies rely on state regulation of reserves
  - Focus on capital & surplus of insurers
    - C&S is overstated if reserves are inadequate
- Reserve adequacy is the foundation of financial strength analysis and ratings
  - Otherwise can't rely on C&S (and related capital ratios) as sign of financial strength
  - Where there are the very common safeguards such as funds withheld, modco, or assets held in trust, the primary argument typically given for collectability relies on an assumption of reserve adequacy
- Collectability risk may be evaluated based on the current economic environment and considering a certain mix of counterparties

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Funds withheld and ModCo impact on CFT scope

- Pros of this argument:
  - All else equal, represents less risk than traditional coinsurance.
- Cons of this argument:
  - Are there admitted assets at least equal to US stat reserves available to pay claims?
  - Is it measured if US stat reserves are inadequate, as is the case when VM-30 testing is performed?
  - Are any other collateral measures outside of available assets, such as comfort trusts, used to support such transactions?
- Consideration: availability of assets to support liabilities upon a situation in which the counterparty faces financial distress
- **Other considerations?**

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Draft: 11/5/24

Life Actuarial (A) Task Force
Virtual Meeting
October 10, 2024

The Life Actuarial (A) Task Force met Oct. 10, 2024. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Mark Fowler represented by Sanjeev Chaudhuri (AL); Lori K. Wing-Heier represented by Sharon Comstock (AK); Ricardo Lara represented by Ahmad Kamil and Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak and Kevin Clark (IA); Ann Gillespie represented by Vincent Tsang (IL); Vicki Schmidt represented by Nicole Boyd (KS); Robert L. Carey represented by Marti Hooper (ME); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung and John Rehagen (MO); Justin Zimerman represented by Seong-min Eom and David Wolf (NJ); Adrienne A. Harris represented by Bill Carmello and Amanda Fenwick (NY); Judith L. French represented by Pete 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. Discussed Comments Received on the Scope and Aggregation Sections of the AAT for Reinsurance Actuarial Guideline Draft

Jason Kehrberg (American Academy of Actuaries—Academy), Brian Bayerle (American Council of Life Insurers—ACLI), Greg Mitchell (Cayman International Reinsurance Companies Association—CIRCA), Leung, Peter Gould (Retired Annuity Consumer), John Robinson (Retired), Tricia Matson (Risk Regulatory Consulting—RRC), Aaron Ziegler (Representing Self), and Karalee Morell (Reinsurance Association of America—RAA) each spoke to their comment letters on the scope and aggregation sections of the asset adequacy testing (AAT) for Reinsurance Actuarial Guideline (AG) draft (Attachment Two-A).

Andersen asked the Task Force whether they favored a broader scope for the draft actuarial guideline or preferred an approach more focused on the riskiest treaties. Fenwick stated that she would not like disparate treatment for treaties with similar levels of risk. Leung said that specific treaties may be more or less risky depending on the materiality to the ceding company, to which Clark agreed. Wolf noted that a smaller scope for the draft AG would not prohibit a domestic regulator from requesting additional analysis from a company not included in the scope of the actuarial guideline. Tsang said that he was worried about a level playing field for both large and small insurance organizations and would not want to discourage reinsurance agreements between small companies and reinsurers. After the discussion, Andersen requested a straw poll of Task Force members on the question of scope. Task Force members voted in favor of a more risk-focused scope, with Fenwick dissenting in favor of a broader scope.

Andersen then began discussion on the merits of defining the term “asset-intensive reinsurance” within the AAT for Reinsurance AG for use in determining scope. Hemphill supported creating a definition but noted that a given treaty could contain both asset-intensive and non-asset-intensive components. Bayerle suggested that the Appointed Actuary could use judgement of when to perform additional analysis on the component of the treaty that is asset-intensive. Andersen asked the Task Force if there was any objection to proceeding with defining asset-intensive reinsurance to determine the scope of the AAT for Reinsurance AG, to which no Task Force member objected.

Andersen introduced applicability of treaties based on effective date as the next topic for discussion. He noted that he performed an analysis that highlighted the potential need for different treaty effective dates based on

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affiliated or non-affiliated status. Andersen continued that his analysis showed that the non-affiliated treaties of interest had effective dates of 2020 and after, while treaties of interest that were effective before 2020 tended more to be affiliated. Chupp asked how the RAA came up with an effective date of 2020, to which Morell replied that the RAA was trying to keep the scope narrow while capturing a large percentage of the treaties of interest to state insurance regulators. Eom suggested using the earlier effective date based on Andersen's analysis, rather than splitting effective date based off affiliated status. Chupp and Chou both noted state specific regulatory practices that should be considered when determining treaties in-scope.

Gould noted concerns with missing risky reinsurance treaties if part of the scope only went back as far as 2020. Andersen noted that his analysis showed that more risky non-affiliated reinsurance treaties were effective on or after 2020, and that the idea behind a refined scope was to focus most on the riskiest reinsurance treaties. After noting there was no serious objection to pursuing a bifurcated approach to determining applicability based on effective date and affiliated status, Andersen said that this approach would be included in a revised AG draft.

Andersen introduced the next topic for discussion, the potential for reliance on reports deemed equivalent to the VM-30, Actuarial Opinion and Memorandum Requirements reports. Andersen said that equivalence could be possible if non-VM-30 reports contained adequate modeling of risks and transparency of assumptions. Hemphill noted the practical challenges of determining what types of reports would be equivalent, to which Eom agreed. Andersen noted that perhaps an anonymized report from a company could be discussed during a future meeting to provide an example of a report that may be able to be considered equivalent. Matson and Bayerle highlighted a potential situation where one could have reporting deemed equivalent but still see a decrease in total reserves held between cedant and reinsurer due to jurisdictional differences. They said that understanding these differences would be important.

Having no further business, the Life Actuarial (A) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/2024-3-Fall/LATF Calls/10 10/Oct 10 Minutes.docx

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October 3, 2024

Rachel Hemphill
Chair, Life Actuarial (A) Task Force
National Association of Insurance Commissioners

Re: AAT for Reinsurance Actuarial Guideline Draft Exposure

Dear Chair Hemphill:

On behalf of the Life Practice Council (LPC) of the American Academy of Actuaries,[1] I appreciate the opportunity to provide comments to the Life Actuarial Task Force (LATF) regarding the AAT for Reinsurance Actuarial Guideline Draft (the Exposure). The LPC believes this is an important issue and appreciates LATF's consideration of public comments.

In response to the Exposure, the LPC offers the following feedback, which we developed to express our view that the Appointed Actuary should be able to apply actuarial principles and judgment in their Asset Adequacy Testing (AAT), while understanding the need for regulators to provide additional guidance regarding the specific risks causing concern.

It is important to us that any new requirements appropriately consider the protection of insurance company policyholders and the general public. Therefore, we support exploring where existing policyholder protections may not be working as intended, with any necessary new requirements focused on ensuring an appropriate level of policyholder protections based on risk.

Further, we recognize that reinsurance has proved to be an effective risk mitigation tool, and believe that any changes to AAT requirements should be targeted to material treaties that are of concern to avoid these changes disincentivizing insurance companies from implementing appropriate reinsurance solutions. Targeting specific treaties should also minimize the creation of adverse effects on policyholders.

Based on LATF's request, the LPC has focused our comments in this letter solely on the Scope and Aggregation sections. However, analyzing individual components of the draft may cause a need to revisit previous discussions before any formal finalization, given the interdependencies

[1] The American Academy of Actuaries is a 20,000-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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of each section within the proposed Actuarial Guideline. Of particular note is the definition of scope and the associated level of newly required analysis, as they are intertwined. For these reasons, this feedback should be considered "directional" in nature.

Scope

1. We assume that the impact of the proposal's scope would only cover whether a life insurer is subject to **any** new requirements introduced by the Exposure, and not specifically what those requirements are, which is covered in other sections.
2. Regarding the options laid out in the Exposure, we recommend "Option 1: Narrow scope, some analysis expected for all treaties in the scope." We suggest that any new Actuarial Guideline requiring more detailed analysis than is already performed by the Appointed Actuary be a function of the specific risks of concern to the regulators. As noted in LATF's original goals on this topic, there is a desire to "prevent work by US ceding companies where there's immaterial risk,"[2] and therefore, a narrow scope is appropriate.

   We also believe that a narrow scope has the following benefits:

   a. Provides added policyholder protection elements in instances in which there are specific risks of regulatory concern
   b. Limits the burden on the industry by reducing non-value-added analysis / work being prepared for the regulator that is non-responsive to regulator needs.
   c. Minimizes the review burden on the regulatory community.
   d. Excludes certain treaties / business that are clearly not the drivers of current regulatory concern (e.g., traditional YRT; immaterial reinsurance exposure to any single counterparty).
   e. Allows for more timely implementation.
   f. Eases implementation efforts and allow for learning from the first set of submissions.

   In addition, there is already guidance for actuaries when performing actuarial services in connection with preparing, determining, analyzing, or reviewing financial reports for internal or external use that reflect reinsurance or similar risk transfer programs on life insurance, annuities, or health benefit plans (including disclosure requirements) contained in Actuarial Standard of Practice No. 11, *Treatment of Reinsurance or Similar Risk Transfer Programs Involving Life Insurance, Annuities, or Health Benefit Plans in Financial Reports*.

[2] From attachment 9 of the LATF Spring 2024 meeting materials

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3. We support the proposed exemption criteria as laid out in Section 2A. However, we have the following suggestions for improvement:
    a. The size threshold refers to "reserve credit or funds withheld or modified coinsurance reserve." As written, this could lead to double-counting, as the reserve credit may already include the funds withheld. We suggest clarifying so that double-counting does not occur.
    b. The treatment of business that includes separate accounts is unclear. We suggest clarifying that if the reinsured business includes separate accounts for which associated risks are assumed by the reinsurer, those separate account reserve credits would be considered in assessing the size threshold.
    c. We suggest including reserves held in Exhibit 7, rather than only including Exhibit 5 reserves in the quantitative scope criteria.
    d. For the quantitative exclusion criteria in Section 2A (1)-(4), we note that the reinsurance reserve reported in Schedule S, Part 3 may not reflect the actual reserve exposure of the reinsurance agreement. For example, when a business is subject to PBR and reserve credits are determined on an allocation basis. Therefore, it may not be appropriate for determining materiality. In such instances, it may be more appropriate to use a reserve calculated by the cedant as the difference between an aggregate reserve pre-reinsurance ceded and an aggregate reserve post reinsurance ceded.
4. We also recommend considering the materiality of a group of treaties or counterparties when determining if a life insurer is in scope. Doing so may help avoid a situation in which multiple immaterial treaties or counterparties have the same outcome as one material treaty or counterparty, but would otherwise cause the life insurer to be exempt from the requirements solely due to individual treaty size.
5. We believe that a key concern raised by regulators relates to reinsurance treaties that result in the pursuit of more aggressive investment strategies and/or a significant reduction in the total asset requirement (reserves plus required capital). Based on this belief and given LATF's stated objective to prevent work by U.S. ceding companies where there is immaterial risk, we believe it may be appropriate to exempt treaties where such conditions do not exist. For example, consideration for an exemption could be given to treaties that meet all of the following: (1) no assets are transferred or assets transferred are segregated (for example, using modified coinsurance, a funds withheld, or having assets held in trust); (2) such assets are adequate (e.g., based on the latest standalone asset adequacy testing) to support the business on a stand-alone basis; and (3) have not been subject to subsequent changes (e.g., material deterioration in experience or material changes in the investment portfolio) that would bring into question the conclusions arrived at in (2).

6. We support the inclusion of older treaties with significant reinsurance collectability risk, as outlined in Section 2.B.

Aggregation Considerations

1. ASOP No. 22 currently provides guidance to Appointed Actuaries (AAs) applying judgment as to when blocks of business may be aggregated for purposes of testing the adequacy of assets supporting booked reserves.

   If LATF chooses to provide additional guidance on aggregation in an Actuarial Guideline, to the extent possible we recommend aligning it with existing guidance in section 3.1.4 of ASOP No. 22, i.e., "the actuary may aggregate reserves … for multiple blocks of business if the assets or cash flows from the blocks are available to support the reserves. … [T]he actuary should not use assets or cash flows from one block of business to discharge the reserves and other liabilities of another block of business if those assets or cash flows cannot be used for that purpose."
   In instances in which such aggregation still results in policyholder protection concerns, we note that the Standard Valuation Law enables the regulator to require an alternative methodology or alternative assumptions: "The commissioner may require a company to change any assumption or method that in the opinion of the commissioner is necessary in order to comply with the requirements of the valuation manual or this Act; and the company shall adjust the reserves as required by the commissioner."
2. Regarding item B of the Exposure, we would support new requirements that include disclosure by the Appointed Actuary of the rationale for aggregation.
3. Regarding item C of the Exposure, which comments on reliability and stability of a sufficient block that is "subsidizing" a deficient one, we believe it would be appropriate to follow the guidance in ASOP No. 22, which states: "When considering aggregation of results to offset deficiencies, the actuary should take into account the type and timing of cash flows, the related cash flow risks, and the comparability of elements of the analysis such as analysis methods, scenarios, discount rates, and sensitivity of assumptions" (section 3.2.4). For example, if a sufficient block has very "back ended" cash flows that are available to support a deficient block on a present value basis, we believe the Appointed Actuary should take into account whether those back ended cash flows can actually support the earlier cash shortfalls for the deficient block. In addition, ASOP No. 7, *Analysis of Life, Health, or Property/Casualty Insurer Cash Flows*, states, "The actuary should consider the impact of any negative interim earnings during the cash flow projection period, if it is appropriate for the purpose of the analysis" (section 3.11). As occurs today, we believe that evaluation of interim surplus results is an important consideration in assessing adequacy. If there are future interim shortfalls on an aggregate

book value basis under moderately adverse conditions, the Appointed Actuary would evaluate whether additional reserves might be needed to address the shortfall.

*****

If you have any questions or would like to discuss these comments further, please contact Amanda Barry-Moilanen, the Academy's life policy analyst.

Sincerely,

Jason Kehrberg, MAAA, FSA
Chairperson, Life Practice Council



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October 3, 2024

Rachel Hemphill,
Chair, NAIC Life Actuarial (A) Task Force (LATF)

Fred Andersen,
Minnesota Department of Commerce

Re: AAT for Reinsurance Actuarial Guideline Draft – Scope and Aggregation

Dear Chair Hemphill and Mr. Andersen:

The American Council of Life Insurers (ACLI) appreciates the opportunity to provide feedback on the recently exposed Asset Adequacy Testing (AAT) for Reinsurance Actuarial Guideline Draft (Guideline/draft AG) that was exposed by LATF shortly after the NAIC 2024 Summer National Meeting in Chicago, Illinois. We would also like to take this time to express our sincere gratitude to LATF members and staff for the extensive amount of work and discussion that has taken place so far this year as a part of this effort.

Industry remains committed to helping regulators address the concerns articulated during LATF meetings. We appreciate that LATF and the regulatory community are working hard to balance the importance of reinsurance as an effective risk-mitigation tool with maintaining policyholder protection and enabling consumer access to essential life insurance and retirement solutions. Additionally, we appreciate the engagement of LATF, its parent A Committee, the impacted E Committee, and NAIC Commissioners at large as we continue this important dialogue and come to a shared understanding of the concerns and mitigants in place.

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133

The American Council of Life Insurers 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 275 member companies represent 93 percent of industry assets in the United States.
acli.com

Our comments are provided with an understanding that the results of the analysis required by this Guideline would not be binding but would instead give the Appointed Actuary, domestic regulator, and interested regulators greater transparency into the risks associated with the reinsurance counterparties and inform Appointed Actuaries' assessment of reinsurance counterparties.

ACLI would also like to emphasize the interconnected nature of all sections of the Guideline and the need for this to be an iterative process. As the Guideline development progresses, our views on individual sections may evolve based on developments in other areas of the conversation.

The following describes our position with respect to Scope (Section 2) and Aggregation (Section 7). ACLI believes the Guideline should provide greater transparency regarding reserve adequacy associated with material asset intensive reinsurance transactions and be targeted to address the potential risks in the transactions of specific concern to regulators.

Scope

We suggest refining the Scope by creating an affirmative definition of asset intensive reinsurance transactions. Specifically, Asset Intensive Reinsurance Transactions ("AIRT") are coinsurance arrangements involving life insurance products that transfer significant, inherent investment risk including credit quality, reinvestment, or disintermediation risk. The matrix included in Appendix A-791 of the Life and Health Reinsurance Agreements Model Regulation identifies the following life products with significant, inherent investment risk:

- Universal Life Fixed Premium
- Universal Life Flexible Premium
- Indeterminate Premium Permanent Life
- Adjustable Premium Permanent Life
- Traditional Participating Permanent Life
- Traditional Non-participating Permanent Life
- Single Premium Whole Life
- Other Annuity Deposit Business
- Guaranteed Interest Contracts
- Flexible Premium Deferred Annuities
- Single Premium Deferred Annuities[1]
- Immediate Annuities[1]

For avoidance of doubt, yearly renewable term (YRT)[2] reinsurance, retrocession transactions with underlying YRT business, and nonproportional reinsurance such as stop loss or catastrophe reinsurance are not considered asset intensive reinsurance transactions and would not be considered within the scope of the Actuarial Guideline.

Given the regulator concerns around the level of reserve reduction and lack of transparency in the assets and asset assumptions supporting certain transactions, we would appreciate a broader discussion at the Fall National Meeting related to situations where assets are being held at appropriate levels (such as at the US statutory reserve) and with transparency into those assets and their assumptions. For example, we recommend removing modified coinsurance where fully

[1] ACLI views Pension Risk Transfer as included within Immediate Annuities and Deferred Annuities
[2] Yearly renewable term transactions as defined by *SSAP 61R – Life, Deposit-Type and Accident and Health Reinsurance* only transfer mortality/morbidity risk for a premium that varies each year with the amount of risk and age of insureds. This form of reinsurance does not transfer permanent plan reserves and thus should be considered out of scope for asset intensive reinsurance.

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admissible assets equal to the full US statutory reserve are held on the cedant's balance sheet, given the level and transparency into the assets held. Additional reinsurance arrangements would have similar logic, so we would like to better understand regulator concerns around such structures. At a minimum, the structures should be considered as part of the assessment of risk and the mitigants available to address those risks.

In addition to excluding counterparties that are VM-30 filers from scope, we also recommend excluding counterparties that can demonstrate "VM-30 equivalence" in the reporting to their domestic regulator. This concept would need to be a defined term in the Guideline, and we would like to work with regulators to establish what information would need to be disclosed to achieve this equivalence.

Proposed language for these changes can be found in Appendix A.

Further, we suggest a greater emphasis on the relationship between scope and level and degree of rigor of any subsequent analysis. This could include the consideration of whether reinsurance transactions have been subject to regulatory approval (by cedant and/or assuming entity regulator), the company's existing stress testing, ongoing experience monitoring, supporting collateral balances, recapture analysis, and other similar analyses in lieu of further testing. We will provide additional considerations in our next letter.

Aggregation

Aggregation is a critical component in AAT, and that principle should carry over in this Guideline. For cash flow testing or an alternative analysis, the Appointed Actuary should be allowed to aggregate all treaties within a counterparty at their discretion, including treaties that are not otherwise in scope (such as those before the cutoff date). Aggregation should be consistent with Section 3.1.4 of ASOP 22 (allowance of aggregation of ". . . reserves and other liabilities for multiple blocks of business if the assets or cash flows from the blocks are available to support the reserves and other liabilities of the aggregated blocks of business"). Further, given our understanding that this is intended as a disclosure requirement, we do not believe that definitions for "Deficient Block" or "Sufficient Block" are necessary, and we would recommend striking them.

While these are our initial thoughts, ACLI has been discussing a framework for how the scope could be correlated with rigor, and we look forward to working with regulators and NAIC staff on this aspect. Additionally, we are continuing to evaluate alternative solutions that could address regulator concerns related to the amount of reserves and types of assets supporting life insurance business that relies substantially on asset returns.

As we understand this to be an iterative drafting and revising process, ACLI would again like to thank you for the opportunity to provide this feedback and we look forward to continued conversations with regulators as we begin to finalize Scope, Aggregation, and the other remaining issues that must be addressed prior to implementation.

Much appreciated,



cc: Scott O'Neal, NAIC

Appendix A - Proposed Edits to Draft Actuarial Guideline:

[Replace Section 2 Scope with the following]

2. Scope

This Guideline shall apply to all life insurers with:

A. Asset Intensive Reinsurance Transactions that:
   (i) Are ceded to entities that have **not** submitted a VM-30 memorandum or VM-30 Equivalent Report to their domestic regulator in transactions established 1/1/[YEAR][3] or later; AND
   (ii) is **not** fully secured by collateral qualified under the NAIC Model Regulation on Credit for Reinsurance; AND
   (iii) Meet any of the criteria determined by counterparty in subsections (1) through (4) below:
      (1) Combined reserve credit[4] in excess of $5 billion
      (2) Combined reserve credit[3] in excess of:
         a) $1 billion, and
         b) 2% of ceding company gross reserves[5]
      (3) Combined reserve credit[3] in excess of:
         a) $100 million, and
         b) 10% of ceding company gross reserves[4]
      (4) Combined reserve credit[3] in excess of:
         a) $10 million, and
         b) 20% of ceding company gross reserves[4]

[New Section 3.A Definition with existing definitions relabeled]

Asset Intensive Reinsurance Transactions ("AIRT") - Coinsurance arrangements involving life insurance products that transfer significant, inherent investment risk including credit quality, reinvestment, or disintermediation risk as determined by Appendix A-791 of the Life and Health Reinsurance Agreements Model Regulation.

[Remove Section 3.B "Deficient Block" and 3.F "Sufficient Block" with existing definitions relabeled]

[Replace Section 7 Aggregation Considerations with the following]

7. Aggregation Considerations

A. When performing quantitative analysis with respect to this Guideline, the Appointed Actuary may aggregate all treaties within a counterparty at their discretion and consistent with Section 3.1.4 of ASOP 22, including treaties that are not otherwise in scope (such as those established before 1/1/[YEAR]).

[3] ACLI recommends prospective application of the requirements

[4] Reserve credit determined based upon the statutory annual statement filed by the ceding company for the prior year. Including funds withheld and reserve credit would be double counting certain amounts on funds withheld treaties

[5] Gross reserves include separate accounts where the life insurance company retains investment risk plus Exhibit 5 gross life insurance and gross annuity reserves

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October 3, 2024

Rachel Hemphill,
Chair, NAIC Life Actuarial (A) Task Force (LATF)

Dear Chair Hemphill:

Thank you for the opportunity to provide comments on the Life Actuarial (A) Task Force (LATF) AAT for Reinsurance Actuarial Guideline Draft exposure. I write as a representative of the Cayman International Reinsurance Companies Association (CIRCA). Founded in October 2020, CIRCA is now made up of over 60 members. The association is dedicated to promoting collaboration, advocating for regulatory excellence, and driving educational initiatives in the Cayman Islands' reinsurance sector. I have taken the liberty of including an Appendix to this letter that provides information about the Cayman Islands Monetary Authority (CIMA) which we feel is helpful additional context when reviewing our feedback.

CIRCA has been closely following the discussions occurring at LATF regarding asset adequacy testing for reinsurance and the development of the current exposure. After review from our members and ongoing discussions with interested parties, CIRCA has developed initial feedback below for the requested initial exposure, Section 2, Scope and Sections 5.C and 7, Aggregation.

Section 2, Scope

According to the exposure, LATF is contemplating applying either a narrow or broad scope to the Actuarial Guideline. CIRCA encourages LATF to adopt a narrow scope, as outlined in Option 1. Also, our members suggest including a provision that would allow for entities that provide disclosures comparable to VM-30 to their regulator be out of scope for the Actuarial Guideline. Specifically, if an assuming reinsurer provides to their regulator a technical document which is consistent with the methodology, nature, and overall purpose of the VM-30 Actuarial Opinion and Memorandum Requirements, then the reinsurance ceded to that reinsurer should be excluded from the scope of this Actuarial Guideline proposal.

As currently drafted, the Actuarial Guideline exposure appears to focus on situations where the reserves set by the assuming reinsurer are materially lower than the U.S. Statutory Reserve ceded by the ceding company. CIRCA contends that what matters to the ceding company is the level of contractually obligated assets they have unfettered access to in order to satisfy the ceded policyholder obligations. Therefore, CIRCA recommends that the Actuarial Guideline exclude from its scope transactions where the contractually obligated assets supporting the ceded risk are no less than the ceded U.S. Statutory Reserve. This would include Modified Coinsurance or Coinsurance Funds Withheld where those assets remain in the ceding company's possession and on their balance sheet or Coinsurance supported by a reserve credit trust compliant with NAIC Model 785.

If such transactions are not fully excluded, we recommend that the focus of analysis of the transaction by the Appointed Actuary be on the committed asset level, reflecting any overcollateralization contractually provided by the reinsurer, available to the ceding company

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and not the stated reserve for the risk held by the reinsurer assuming another accounting basis. If the contractually required collateral is used in place of that stated reinsurer reserve in the provided Attribution Analysis spreadsheet, the result would be a total volume of supporting assets greater than or equal to the reserve which CIRCA believes would result in the transaction posing a low risk.

Sections 5.C and 7, Aggregation

CIRCA members believe that any aggregation requirements set out in the Actuarial Guideline exposure should be consistent with those applicable to the aggregation requirements outlined in VM-30 and relevant actuarial guidance. LATF should apply consistent aggregation requirements for their disclosures, regardless of whether the reinsurance transaction is ceded to a domestic or offshore reinsurer.

The testing should include all contractual resources for a transaction, including the reserves held by the reinsurer, coinsurance funds withheld, comfort trusts and any other form of NAIC Model 785 compliant contractual support. Ceding companies often negotiate overcollateralization as an additional layer of protection so CIRCA would also recommend assets supporting the overcollateralization to be available in any AAT analysis of the ceded business.

Other Comments

Also, both Primary Securities and Other Securities as described in AG 48 (4D and 4E, respectively) should be included as "Acceptable Assets" in support of policyholder obligations, consistent with permissible investments in the relevant regulator's state. For reference, in AG 48 Section 4E, Other Securities are defined to be: "Any asset, including any asset meeting the definition of Primary Security, acceptable to the Commissioner of the ceding insurer's domiciliary state." On this point, CIRCA would like to highlight that ceding companies negotiate investment guidelines with the reinsurer as a protection to meet their policyholder obligations. Assets held on the ceding company's balance sheet under Modified Coinsurance or Funds Withheld will be such that the company is compliant in total under the domiciliary state's investment limitations. Reserve credit trusts supporting Coinsurance transactions are even more restrictive, limiting the assets in the trust to SVO-rated, cash or cash equivalents, letters of credit from a qualified institution, or other assets as specifically authorized by the ceding company's domiciliary commissioner. All assets supporting the ceded business are held in the U.S.

As stated above, CIRCA appreciates the opportunity to provide comments to LATF and thanks you for your consideration. We welcome any opportunity to discuss these and any other points further as the Task Force deems appropriate.

Sincerely,

David C. Self

Chair of Board of Directors
Cayman International Reinsurance Companies Association.

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CIRCA

Appendix – The Cayman Islands Monetary Authority

The Cayman Islands Monetary Authority (CIMA) is the primary regulator and supervisor of the financial services industry in the Cayman Islands. In its supervisory role, CIMA is responsible for monitoring the activities of its domestic and international licenses through integrated risk-based supervisory approach of onsite and offsite supervision. CIMA has a long history of international cooperation and leadership in international regulatory policymaking and standard setting. CIMA is a founding member of the International Association of Insurance Supervisors (IAIS), and member of its Reinsurance task force responsible for the creation of the international reinsurance regulatory standards (ICP 13). CIMA has been a member of the International Organization of Securities Commissions (IOSCO) since 2009 and participates in international initiatives with the NAIC, Organization for Economic Cooperation and Development (OECD), Financial Action Task Force (FATF) and International Monetary Fund (IMF).

The provision of assistance to overseas regulatory authorities is one of CIMA's principal functions. Such international cooperation takes place primarily through the exchange of information, facilitated through Memorandums of Understanding ("MOUs"), other agreements and through CIMA's active participation in international forums. CIMA has 70+ bilateral and multilateral cooperation arrangements with international regulatory authorities, including an MOU with the NAIC and direct MOUs with other state regulators. CIMA is also a signatory of the IAIS Multilateral Memorandum of Understanding which allows CIMA to cooperatively exchange information with other signatories.

According to Section 9(1)(a) of the Insurance Act and the Actuarial Valuations Rules and Statement of Guidance, each Cayman Islands licensed life and annuity reinsurer is required to provide CIMA with an annual Actuarial Valuation Report that is compliant with the requirements of the IAIS. The Actuarial Valuation Report is a detailed test of solvency, requiring an actuarial analysis of the valuation of the assets and liabilities as well as capital adequacy of the company. Various stress testing that reflects the risks of the business must be included in the analysis. This Report is prepared by the Appointed Actuary and reviewed by the Peer Reviewing Actuary. Both roles must be approved by CIMA, at the time of the licensing of the company and for any ongoing changes within the roles. The criteria used by CIMA when determining whether to recognize or approve an actuary are set out in the CIMA Regulatory Policy on The Recognition and Approval of an Actuary.

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PETER GOULD

September 19, 2024

Life Actuarial (A) Task Force
NAIC

Re: Reinsurance Asset Adequacy Testing Concepts - https://content.naic.org/sites/default/files/inline-files/Straw%20Man%20Draft%20-%20AG%20ReAAT%20-%20LATF%20081124.pdf

Dear Members of the LATF:

I am a retiree and am writing to comment as a consumer and annuity contract owner with skin in the game. My wife and I depend on Guaranteed Lifetime Withdrawal Benefits from Roth IRA variable annuities for a considerable portion of our retirement income. We did not purchase annuities as speculative investments.

As an annuity owner, the insurer's obligations to me are spelled out in my contracts. However, there are no provisions in my contracts that protect me or provide me rights to prevent my insurer from becoming insolvent or unable to meet their contractual obligations to me. **Consumers rely entirely on state regulators** to adopt and enforce regulations that **proactively and effectively** prevent impairment of insurers' solvency, inability of insurers to honor their contractual obligations to policyowners and failures of insurers.

With respect to reinsurance and counterparty transactions by which risk is transferred to a third party, I'm totally dependent on state regulators to ensure that the invested assets of the reinsurer are adequate to support the ceded reserves so that the money is there when I submit a claim.

Reinsurance and counterparty transactions frequently result in substantial reductions to Total Asset Requirements (TAR). Without your oversight and regulation, these practices increase the likelihood that I will outlive my insurer and that my contractual benefits (bought with my hard-earned dollars remitted as premiums) will not be paid to me when I need them. I don't want to be left "holding the bag", like the 92,000 PHL Variable Life policy owners.

I strongly support the broadest, most in-depth scope for these rules as possible. To that end, I offer the following comments on scope of the Straw Man Draft - AG ReAAT - LATF 081124.pdf:

1. Effective Date - To me, this is a component of scope and I support making the changes applicable to December 31, 2024 Annual Statements. Delaying the effective date until 2025 will be detrimental to consumers as it will facilitate an increase of the already exponential rate by which insurers are moving business offshore to sidestep US reserve requirements and arbitrage regulation and enforcement.

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2. Scope - to cast the widest net of consumer protection, I support option 2, modified as follows: "This Guideline shall apply to all life insurers with combined reserve credit, funds withheld, and modified coinsurance reserve in excess of the lesser of: $1 million or 5% of ceding company gross Exhibit 5 gross life insurance plus gross annuity reserves."

   In addition, these rules should apply to all treaties/ceded business regardless of establishment date. There's no reason to compromise consumer protection by giving a free pass to older arrangements. Given the huge amount of reinsurance already in place and its exponential growth, it's essential to cover all such arrangements. Prior comments have suggested that it may be too difficult to assemble and analyze the data. Given the systemic risk, the incremental cost to provide this information pales in comparison to the cost of an insurer liquidation.

Thanks for your consideration of my comments and the work that you do to protect consumers.

Yours truly,

Peter Gould

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Re-AAT Comments

John Robinson FSA, FCA, MAAA

August 26, 2024

LATF,

Thank you for the opportunity to comment on this document, which I believe is very important. The conversation started from the observation that if an insurer has modco reinsurance, in which case, it has both the assets and liabilities on their books, then the insurer should perform CFT on this block for the same reasons that it performs CFT for the other reserves on its books. The conversation has clearly gone a long way from there, and I am thankful for the progress.

Comment 1: Concerning Section 2, "Scope":

1. Option 1, Statement 2(b): "2% of ceding company gross Exhibit 5 gross life insurance plus gross annuity reserves."

   Comment: This statement, as written, can be interpreted in two ways:
   (2% of ceding company gross Exhibit 5 gross life insurance) plus (gross annuity reserves).

   Or

   2% of (ceding company gross Exhibit 5 gross life insurance plus gross annuity reserves)

   Please re-write to make it clearer which interpretation applies. Note that this phrase occurs several times, including in Option 2.

Comment 2: Concerning the choice between Option 1 and Option 2:

I am concerned that Option 1 can be defeated by the insurer simply increasing the number of counterparties participating in the reinsurance of a block of business.

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Comment 3a: Definition of "Deficient Block"

This is a minor wordsmith: Instead of "When a block of business shows negative…", say "A block of business that shows negative…"

Comment 3b: Definition of "Sufficient Block"

This is a minor wordsmith: Instead of "When a block of business shows positive…", say "A block of business that shows positive…"

Comment 4: Definition of "Pre-reinsurance reserve"

The use of the phrase "in the absence of the reinsurance transaction" suggests that the term applies in the context of a single transaction between the insurer and reinsurer. Please assess whether the use of the term in the document is consistent with this interpretation. I suggest you apply the same consideration to the use of the terms "Total Reserve" and "Reserve Decrease".

Comment 5: Definition of "Attribution Analysis"

This is a minor wordsmith: Since the pre-reinsurance reserve is defined to be a US statutory reserve, the phrase "U.S. statutory" in the definition of "Attribution Analysis" can be deleted.

Comment 6: Requirements

I am unclear as to what work the document requires. The Scope section identifies which companies are subject to the provisions, not which treaties are to be analyzed. The closest I can come to Requirements is Section 5A, which suggests (but does not state explicitly) that the insurer is required to perform some form of asset adequacy analysis on the Total Reserve. If the Total Reserve only pertains to a single transaction, as mentioned above, then this implies that the insurer must perform a stand-alone analysis for each transaction. I suggest you add a "Requirements" paragraph.

Thank you 😊

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rrc risk&regulatory CONSULTING

Memo

To: Rachel Hemphill, FSA, MAAA, FCAS, Life Actuarial Task Force

From: Patricia Matson, FSA, MAAA, Partner, RRC
Ben Leiser, FSA, MAAA, Director, RRC

Date: October 3, 2024

Subject: RRC Comments Regarding LATF's Reinsurance AAT Actuarial Guideline Draft Exposure

Background

The Life Actuarial Task Force (LATF) is requesting comments on the AAT for Reinsurance Actuarial Guideline Draft ("the Exposure"). LATF has asked that comments regarding the Scope and Aggregation sections of the Exposure be provided by October 3rd. Originally, comments on the Scope section were due by September 19th, and we submitted a comment letter on September 19th. Since both Scope and Aggregation will be discussed on the October 10th LATF call, we have included in this comment letter our previously submitted comments as well as comments on Aggregation. RRC intends to provide further comments on the full Exposure by the comment deadline.

RRC appreciates the opportunity to offer our comments. Should you have any questions, we would be glad to discuss our comments with you and Task Force members.

We appreciate the work LATF has undertaken to address what we believe is a critical industry issue, namely the significant use of reinsurance, including offshore reinsurance, to provide US insurers with material reserve and capital relief.

RRC has assisted regulators in reviewing a variety of reinsurance transactions that result in material reductions in the total asset requirement (TAR) backing the policyholder obligations. We understand that while these transactions are executed for a variety of appropriate business and financial strategies, we also believe that in some cases they can result in reserves or capital that are reduced to a level that raises questions about their appropriateness from a policyholder protection perspective.

General Comments

We believe that when an insurer makes a promise to its direct policyholders, it is critical for the insurer to set operational and financial standards that will enable it to meet that promise. One such standard would be to ensure there are sufficient assets to pay future claims. This does not change when the insurer chooses to reinsure the business.

Based on this important promise, in a case in which an insurer uses reinsurance to reduce reserve and capital requirements that it views as overly conservative, we believe it would be reasonable to expect the insurer to continue to hold *adequate* reserves and capital, based on US statutory requirements. Based on the overall statutory framework, reserve adequacy has tended to be viewed as the level that would be sufficient under moderately adverse conditions (which may equate to an 85% confidence level). Capital would then cover conditions beyond moderately adverse, up to a higher confidence level (such as 95%).

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Therefore, we believe that a goal of the Exposure (which we recognize is focused on reserves) should be to set guardrails so that reserve financing transactions do not result in those reserves declining below a level that would be sufficient to cover policyholder obligations with approximately 85% confidence (or under moderately adverse conditions) based on the US statutory framework. This seems to be a fundamental minimum, under US statutory guidance, to meet policyholder protection while still allowing for the use of reinsurance to finance reserves.

RRC Comments on Scope Section

With respect to the two options laid out in the Exposure, RRC is in favor of "Option 1: Narrow scope, some analysis expected for all treaties in the scope." Our rationale for this is to address the areas of concern while avoiding creating significant work for Appointed Actuaries and regulators that does not materially address the areas of concern.

Based on our experience, it appears to be a relatively small subset of all reinsurance transactions that result in a material reduction in TAR. Therefore, we are in favor of limiting the scope of the new guidance to reinsurance transactions that result in such material reduction (or may result in such reduction in the future).

We are in favor of using a size threshold as laid out in the Exposure.

We agree with exempting treaties in situations in which the reinsurer is required by law to provide a VM-30 memorandum, since such treaties are unlikely to result in a significant reduction in TAR.

We agree with including any treaty that presents significant collectability risk. Potential approaches to defining such risk are:

1. Credit rating (however, we don't believe that this alone is sufficient)
2. Solvency position (e.g. the reinsurer's capital exceeds the regulatory intervention threshold in its jurisdiction)
3. Delays in payment on the reinsurance agreement that exceed a defined period such as 180 days

We also note that in the case of significant collectability risk, an appropriate reserve would need to take into account the potential need for the cedant to re-establish the full U.S. Statutory reserve if the reinsurer were to default. For example, if the U.S. Statutory reserve is materially higher than an 85th percentile reserve set solely based on the projected underlying asset and liability cash flows, and the reinsurer defaults, the cedant would have to hold the full statutory reserve. This should be considered by the cedant's Appointed Actuary in their asset adequacy assessment.

LATF may want to consider exempting from scope treaties that meet the following criteria, since such treaties are unlikely to result in a significant reduction in TAR:

1. The treaty does not involve business with material investment risk (for example, YRT treaties)
2. The current and projected future reserves that will be held by the reinsurer are not materially less than those required under the U.S. Statutory framework

RRC Comments on Aggregation Section

Based on our experience, the transactions that are generating regulatory concern are those in which the insurance company achieves a significant reduction in TAR. In other words, the treaty is entered into for the express purpose of reducing reserves and/or capital. While such a transaction may be done for good business reasons, we strongly believe that there should not be adverse impacts on policyholder protection. Therefore, we believe that the assets available to cover future policyholder obligations should

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remain at a level that aligns with overall statutory principles. As described above, this would imply that the reserves backing the transferred business would still be set at approximately an 85% confidence level, and capital at a 95% confidence level. Therefore, we believe that standalone testing of the adequacy of the assets backing reserves for the transferred business is appropriate. Such testing would be used to ensure that the assets backing the reserves post-transaction are still adequate to cover policyholder obligations under moderately adverse conditions. This seems like an appropriate minimum standard, and would still allow companies to free up capital in situations in which formulaic statutory reserves are viewed as excessive (i.e. materially greater than an 85% confidence level). In other words, we do not support aggregation across treaties, counterparties, or with retained blocks of business.

While we recognize that current asset adequacy testing (AAT) allows for aggregation of business, the purpose of AAT is as a backstop test to ensure that the formulaic statutory reserves (which are intended to be conservative) continue to be sufficient. Therefore, the testing allows for aggregation of deficient blocks (i.e. blocks that have booked statutory reserves that are below the 85% confidence level) with sufficient ones as long as "the assets or cash flows from the blocks are available to support the reserves" (per ASOP 22, *Statements of Actuarial Opinion Based on Asset Adequacy Analysis for Life Insurance, Annuity, or Health Insurance Reserves and Other Liabilities*). We believe that in a situation in which an insurance company is proactively seeking surplus relief through a reinsurance treaty (typically because reserves are believed to be overly conservative), it is reasonable to expect that the post-transaction reserves continue to be sufficient on a standalone basis.

Thank you for the opportunity to provide comments on this important topic. We can be reached at 860-305-0701/tricia.matson@riskreg.com or 201-870-7713/ben.leiser@riskreg.com if you or other members have any questions.

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Missouri prefers the narrow and specific scope under Option 1 and will offer the following comments:

2A:

a) We need to take out the reference to VM-30. Exempting reinsurance transactions to US reinsurers through this VM-30 reference creates an unlevel playing field for covered agreement reinsurers and could run afoul of the covered agreement. By removing the VM-30 reference we are focusing only on the reinsurance transaction itself regardless of the location of the reinsurer.

b) The size factors are very small so we suggest increasing them and adding a catch all (5) for small companies that might have transactions that otherwise not hit the transaction size but still be material to them. The revision is summarized below:

	MO's revised Scope				Original Scope	
	reserve credit ($M)	% of GR			reserve credit ($M)	% of GR
1	5000			1	5000	
2	1000	5		2	1000	2
3	500	10		3	100	10
4	100	20		4	10	20
5		50				

c) Reserve credit is determined irrespective of the amount of fund withheld. We suggest remove the reference to fund withheld in the scope criteria.

2B: We suggest deleting the verbiage in B(1) and B(2), which appears to be redundant. LATF can add additional guidance to significant collectability risk as it sees fit.

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2. Scope

OPTION 1: Narrow scope, some analysis expected for all treaties in the scope

This Guideline shall apply to all life insurers with:

A. Reinsurance ceded to entities ~~that are not required to submit a VM-30 memorandum to US state regulators in~~ for treaties established 1/1/2016 or later that meet any of the criteria determined ~~by~~ for each counterparty in subsections (1) through (4~~5~~) below:

(1) In excess of $5 billion of combined reserve credit ~~or funds withheld or~~ and~~-~~modified coinsurance reserve ceded

(2) Combined reserve credit~~, funds withheld~~, and modified coinsurance reserve ceded in excess of:

(a) $1 billion and

(b) ~~2~~5% of ceding company ~~gross~~ Exhibit 5 gross life insurance plus gross annuity reserves

(3) Combined reserve credit~~, funds withheld~~, and modified coinsurance reserve ceded in excess of:

(a) $~~1~~500 million and

(b) 10% of ceding company ~~gross~~ Exhibit 5 gross life insurance plus gross annuity

reserves

(4) Combined reserve credit, ~~funds withheld~~, and modified coinsurance reserve in excess of:

(a) $100 million and

(b) 20% of ceding company ~~gross~~ Exhibit 5 gross life insurance plus gross annuity reserves

(5) Combined reserve credit~~, funds withheld~~, and modified coinsurance reserve ceded in excess of 50% of ceding company ~~gross~~ Exhibit 5 gross life insurance plus gross annuity reserves

B. Reinsurance ceded to entities, regardless of treaty establishment date, that results in significant reinsurance collectability risk

~~(1) For year-end 2025, significant reinsurance collectability risk is determined according to the judgment of the ceding company's Appointed Actuary~~

~~(2) For year-end 2026, [placeholder for more objective guidance?]~~

~~OPTION 2: Broader scope for the AG, details on whether analysis is expected is contained in the Analysis sections~~

~~This Guideline shall apply to all life insurers with combined reserve credit, funds withheld, and modified coinsurance reserve in excess of: $10 million or 20% of ceding company gross Exhibit 5 gross life insurance plus gross annuity reserves.~~

Response to Straw Man Draft for Reinsurance AAT Actuarial Guideline

Document: Straw Man Draft - AG ReAAT - LATF 081124.pdf (naic.org)
Document Date: 8/11/2024

Date of response: 9/6/2024
Author: Aaron Ziegler, FSA, CERA, MAAA
Title: Chief Actuary and Appointed Actuary – Illinois Mutual Life Insurance Company
Email: ATZiegler@illinoismutual.com

To: Scott O'Neal: soneal@naic.org

Note: My response below represents solely my own opinion. No part of my response should be deemed to represent the opinions of Illinois Mutual nor the opinions of the other actuaries at Illinois Mutual.

I thank you for your time and efforts and the ability to make comments on this exposure draft.

Request:

The request for commentary was broken into a few parts:

1. For **Section 2, Scope**, please provide related comments by **Sep. 19** to allow for discussion at a Sep. 26 meeting of LATF.
2. For **Sections 5.C and 7, Aggregation**, please provide related comments by **Oct. 3** to allow for discussion at a Oct. 10 meeting of LATF.
3. Comments on the **remaining sections** are requested by **Oct. 11**.

Part 1 – Section 2 scope

The scope is broken down into two separate sections:

1. Option 1: Narrow scope, some analysis expected for all treaties in the scope
2. Option 2: Broad scope

For option 1 –
Part A: The description states that is applies for reinsurance "ceded to entities that are not required to submit a VM-30". Maybe better would be simply to state whether the reinsurer is an "admitted" reinsurer.

I would like to see some guidance here regarding what is NOT in scope. To me: highly rated reinsurers who are "admitted reinsurers" should be excluded from the scope.

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I urge caution regarding the thresholds defined in 1-4. There may be certain instances where a 5% reserve credit is too large and risky whereas a 30% reserve credit might be stable and reasonable.

Part B: I applaud the wording here. “Significant reinsurance collectability risk” … “according to the judgement of the ceding company’s Appointed actuary.”
This is excellent phrasing each insurer (and correspondingly reinsurer) are unique. It’s important to leverage the expertise and judgement of the Appointed actuary to determine whether there is “significant collectability risk.”

For option 2
Option 2 is too broad and brings in TOO many “plain vanilla” reinsurance agreements (co-insurance on term policies) where there has been very small amounts of risk to the industry for the last 50+ years. I urge the regulators to proceed with caution when painting with a broad brush. The general tendency over the last number of years is to create onerous regulation which does little to add to the strength of the industry.

In particular, small insurance companies often have large reinsurance credits on a percentage basis. This is not necessarily a bad thing! Small companies get the benefit of experience and stability from highly rated reinsurers. Moreover, the ability for small companies to be in the market and compete with large companies benefits the consumer with lower and more competitive prices.

Suggested “Option 3” for scope
In general, the appointed actuary is responsible for the credit worthiness and reliability of the reinsurers that the company is transacting with. The wording of Option1.B is excellent, why not start there to define scope? If, in the opinion of the appointed actuary all reinsurance agreements are out of scope, a small writeup / explanation from the appointed actuary describing the thought process in the AOMR would be a reasonable request for this regulation.

Part 2 – 5C and 7, Aggregation

The regulators need to be extremely careful here. There are a number of things going on in the details which may not be aptly considered.

While 5E suggests that the actuary may use “simplifications”, I humbly ask the regulators to recognize that asset adequacy testing (AAT) is not (typically) performed on a seriatim basis (i.e. policy by policy and reinsurance agreement by reinsurance agreement). As it is, AAT is performed using a model and approximations.

On this front, many insurance companies have model point compression (lumping more than one policy together) and the process for modeling reinsurance is rarely done on a treaty by treaty basis. This is done for a number of reasons:

1. When the model points are compressed, if 5% of the business in the model point is reinsured, then the model will reimburse 5% of the benefits. It’s possible that some of these

policies in the singular model point were reinsured at 100% and some may not have been reinsured at all. Overall – the impact to the company is immaterial.

2. Even if we side-step model point compression and look instead at a singular policy – it is common for a company to share the reinsurance with more than one reinsurance company. When the financial benefits of this is modeled ["Modeled" is an important key word as this should be understood as "estimated" or "approximated"] more often than not, a simple calculation is made for a singular reinsurance benefit in the model (even though it may come from more than 1 reinsurance company).

Why is this done? It's a model! Models are simplifications of reality. Run time, computation time, analysis time are all very expensive. Actuaries use judgement to make simplifications and efficiencies.

Is it a concern that a single policy might be reinsured by more than 1 reinsurance company but is not modeled that way? No. In fact, this is conservative! It is rare that a highly-rated reinsurer goes bankrupt, but it is even more rare that MULTIPLE highly rated reinsurers go bankrupt. So, by modeling "split company reinsurance" through a simple mechanism in a model is conservative.

Additionally, as a follow-up here, 5E suggests that the actuaries can use "modeling efficiency techniques if the appointed actuary can demonstrate that the use of such techniques does not make the analysis results more favorable." This language is borrowed from the existing valuation manual, VM20. This is easier said than done. Reworded, this sentence suggests that in order to prove that you can use modeling efficiencies – you must model without the efficiencies first and then you can use the efficiencies. These things are not always possible. I urge the regulators to rely upon the opinion of the Appointed Actuary and his/her judgement on these matters.

Now, with this said, my comments heretofore have been primarily focused on plain-vanilla reinsurance contracts. If, however, the reinsurance agreements were highly complex and asset intensive – then perhaps a more rigorous approach to reinsurance modeling would be warranted. I recognize the importance of this and the risk of such an agreement, but I share my thoughts with the regulators because I want to make sure that the regulation does not paint with too broad of a brush putting unnecessary burden – especially on small company actuaries and simple reinsurance arrangements.

Part 3 - Comments on other sections

Section 6 describes an attribution analysis for "relevant treaties." I've mentioned before, up above, but it bears repeating that plain-vanilla reinsurance is often not modeled on a treaty by treaty basis in actuarial AAT models. The analysis described, may be worthwhile for the risky and asset intensive reinsurance agreements, but regarding simple YRT or coinsurance arrangements on simple level term policies – this would be onerous and would not provide the regulators with useful information.

Section 8.A states: "If cash flow testing is performed, present New York 7 results." Some companies are not subject to New York and therefore may not run the NY7 scenarios. Moreover, VM30 does not require nor define what the "New York 7" scenarios are. It does not seem appropriate to inherently require the NY7 scenarios through this backdoor amendment regarding reinsurance. If the regulators desire to have a fixed set of scenarios – this should be requested in VM30 directly not independently required here.

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A question at the beginning of the document is of keen interest to me:
"Should these requirements not apply to reinsurance treaties established prior to a certain date? … [this] may leave out a few substantial treaties of interest."
Given that the regulators are already apparently aware of certain concerns with some treaties, why go the route of creating a new actuarial guideline instead of just going directly to those companies of concern? The regulators already have the authority to do this.

This is a similar problem that regulators faced when dealing with ULSG in the early 2000's. Instead of using the regulatory powers to discipline actuaries who were creating products simply to sidestep reserve requirements, AG38 was amended and reamended ad nauseum. We must be careful not to over-regulate the industry because of a few bad actors.

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October 3, 2024

Rachel Hemphill, Chair
Fred Andersen
Life Actuarial Task Force
c/o Scott O'Neal, soneal@naic.org

RE: Asset Adequacy Testing for Reinsurance: Comments on Scope

Dear Rachel and Fred,

The Reinsurance Association of America (RAA) appreciates the opportunity to provide input on the Life Actuarial Task Force's (LATF) AG Reinsurance Asset Adequacy Testing (AAT) Straw Man Draft 1 proposal. The Reinsurance Association of America (RAA) is the leading 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 and insurance-linked securities (ILS) fund managers and market participants that are engaged in the assumption of property/casualty risks. The RAA represents its members before state, federal and international bodies.

The RAA appreciates LATF's ongoing consideration of industry input, and we remain committed to providing LATF feedback on its efforts. We also applaud LATF and the NAIC for its enhanced coordination on workstreams impacting reinsurance. As requested, this comment letter is restricted to comments on Scope as set forth in Section 2 of the AG ReAAT Straw Man Draft 1 proposal (the " Guideline").

"Asset Intensive" Reinsurance Transactions

In general, we support a narrow scope for the proposed Guideline. A narrower scope enables regulators to focus their attention and resources only on the "asset intensive" transactions for which regulators have expressed collectability, reserving, and asset quality concerns. To narrow the scope, we propose defining an "asset intensive" reinsurance transactions using the chart in Section 2.f. of Appendix A-791 which identifies life insurance products that have significant asset/investment risk including credit quality, reinvestment, and disintermediation risk.

In doing so, the Guideline would apply to asset intensive reinsurance transactions but not to transactions without significant asset risk such as transactions reinsuring term life business, yearly renewable transactions reinsuring only mortality or morbidity risks, and non-proportional reinsurance transactions such as catastrophic and stop-loss coverage.

Once the asset intensive reinsurance transactions are identified, the proposed thresholds in

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Scoping Option 1 could be applied to determine which asset intensive reinsurance transactions are subject to the Guideline.

Retroactive v. Prospective Application

LATF has discussed whether the Guideline should apply to existing asset intensive transactions. In our view, application of the Guideline to existing asset intensive transactions should be limited, applying only to material transactions with effective dates on or after January 1, 2020. Materiality could be determined based upon the size of the transaction relative to the ceding companies' net reserves, capital and surplus or some other financial measure.

Modified Coinsurance or Coinsurance with Funds Withheld Arrangements

Scoping Option 1 of the proposed Guideline provides scoping thresholds with respect to funds withheld and modified coinsurance agreements. In our view, the Guideline should contain an exemption for modified coinsurance or coinsurance with funds withheld arrangements where the total modco and funds withheld assets held by the ceding company equal or exceed the total US statutory reserve ceded under the reinsurance contract. These assets are held by, and on the books of, the ceding company, and the ceding company has control over these assets.

LATF has expressed concern over the transparency to regulators of the assets backing the ceded reserves in asset intensive reinsurance transactions. The Statutory Accounting Principles Working Group (SAPWG) has exposed a proposal (Ref #2024-07) requiring the identification of funds withheld and modified coinsurance assets supporting reinsurance transactions. Under the proposal, ceding companies would identify these assets on a new addendum to Schedule S in the life annual statement blank resulting in full transparency of these assets to regulators. If these assets cover the US statutory reserve, there should be no concern requiring additional scrutiny.

Assets Pledged as Collateral and Meeting the Requirements for Credit for Reinsurance

Section 3 of the NAIC Credit for Reinsurance Model Law allows as an asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an unauthorized reinsurer. The reduction is in the amount of funds held by the ceding insurer or on behalf of the ceding insurer in a credit for reinsurance trust, as security for the payment of the reinsurer's obligation. The security must held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified U.S. financial institution. The security may be in the form of:

A. Cash;

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B. Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets;

C. Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified U.S. financial institution; or

D. Any other form of security acceptable to the commissioner.

In our view, the Guideline should allow a credit or offset against the scope thresholds for funds withheld assets, assets in trust, or qualifying letters of credit issued by qualified US Financial Institutions so long as those assets meet the requirements for credit for reinsurance because those assets are held by, under the control of, and on the books of the ceding company.

Additionally, if the SAPWG proposal regarding the identification of funds withheld and modified coinsurance assets supporting reinsurance transactions is adopted, these assets will be identified and fully transparent to regulators.

Transactions Subject to Regulatory Approval

Certain reinsurance transactions are subject to regulatory approval by the ceding company's domiciliary regulator. Those reinsurance transactions include transactions subject to various state laws and certain affiliated transactions. We believe those transactions should be exempt from the Guideline because they are subject to regulatory approval, and during the approval process, the domiciliary regulator has the discretion to impose requirements such as cash flow testing of the reinsurance transaction as a condition to approving the transaction.

Regulators have expressed concerns regarding affiliated transactions but we are unaware of the nature of the concerns. Perhaps further discussions would be helpful in identifying those concerns. In our view, consideration should be given to these existing regulatory requirements for certain reinsurance transactions to avoid unnecessary duplication with respect to such transactions.

Reinsurance Ceded to a Reinsurer filing a VM-30 Report

The Guideline exempts reinsurance transactions ceded to a reinsurer that files a VM-30 Report. While we do not object to this exemption, the exemption practically limits the Guideline to reinsurance transactions ceded to offshore reinsurers and perhaps, onshore captive reinsurers. LATF indicated the purpose of the Guideline is to gather information. Gathering information only on offshore reinsurance transactions likely does not violate the Covered Agreements between the US and EU and the US and the UK (Covered Agreements). However, if, after gathering this information, additional requirements are imposed on

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transactions between US ceding companies and offshore reinsurers located in the EU or UK, those additional requirements likely would violate the Covered Agreements. Furthermore, applying additional requirements to reinsurance agreements between US ceding companies and Reciprocal Reinsurers located in Reciprocal Jurisdictions would violate the spirit and intent of the laws and regulations adopted by all states regarding Reciprocal Jurisdictions and Reciprocal Reinsurers.

Perhaps LATF should consider an exemption for reinsurers that file a report that is equivalent to a VM-30 Report. The Guideline could identify the requirements for determining whether a report is equivalent to a VM-30 Report.

Conclusion

We urge a solution that is narrowly tailored to effectively address the concerns identified by regulators, ensuring the collectability of reinsurance. Implementation of overly broad regulatory requirements that duplicate existing regulatory tools risks the loss of needed reinsurance protection and the resulting opportunity to close the protection gap. Adding regulations that create friction and costs may discourage effective risk management through reinsurance without commensurate benefits.

The RAA continues to support LATF's work to find an appropriate solution that addresses the problem without severely disincentivizing the deployment of reinsurance capacity. Ensuring that the scope of this Guideline is appropriately tailored is a crucial first step in this process.

Sincerely,

Karalee C. Morell

Karalee C. Morell
SVP and General Counsel

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RAA

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Draft: 10/24/24

Life Actuarial (A) Task Force
E-Vote
October 9, 2024

The Life Actuarial (A) Task Force conducted an e-vote that concluded Oct. 9, 2024. 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); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Ann Gillespie represented by Vincent Tsang (IL); Vicki Schmidt represented by Nicole Boyd (KS); Robert L. Carey represented by Marti Hooper (ME); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Margaret Garrison (NE); D.J. Bettencourt represented by Jennifer Li (NH); Justin Zimerman 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); and Jon Pike represented by Tomasz Serbinowski (UT).

1. Adopted its 2025 Proposed Charges

The Task Force conducted an e-vote to consider adoption of its 2025 proposed charges. Li made a motion, seconded by Chupp, to adopt the Task Force's 2025 proposed charges (Attachment Three-A). 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/2024-3-Fall/LATF Calls/10 09/Oct 09 Minutes.docx

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Draft: 9/23/24
Adopted by the Executive (EX) Committee and Plenary, ___ __, ____
Adopted by the Life Insurance and Annuities (A) Committee, ___ __, ____
Adopted by the Life Actuarial (A) Task Force, 10/9/2024

2025 Proposed Charges

LIFE ACTUARIAL (A) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Life Actuarial (A) Task Force** will:
   A. Work to keep reserve, reporting, and other actuarial-related requirements current. This includes principle-based reserving (PBR) and other requirements in the *Valuation Manual*, actuarial guidelines, and recommendations for appropriate actuarial reporting in blanks. Respond to charges from the Life Insurance and Annuities (A) Committee and referrals from other groups or committees, as appropriate.
   B. Report progress on all work to the Life Insurance and Annuities (A) Committee and provide updates to the Financial Condition (E) Committee on matters related to life insurance company solvency. This work includes the following:
      i. Work with the American Academy of Actuaries (Academy) and the Society of Actuaries (SOA) to develop new mortality tables for valuation and minimum nonforfeiture requirements for life insurance and annuities, as appropriate.
      ii. Provide recommendations for guidance and requirements for accelerated underwriting (AU) and other emerging underwriting practices, as needed.
      iii. Work with the SOA on the annual development of the Generally Recognized Expense Table (GRET) factors.
      iv. Provide recommendations and changes to other reserve and nonforfeiture requirements to address issues as appropriate, and provide actuarial assistance and commentary to other NAIC committees relative to their work on actuarial matters.
      v. Work with the selected vendor to develop and implement the new generator of economic scenarios (GOES) for use in regulatory reserve and capital calculations.
      vi. Monitor international developments regarding life and health insurance reserving, capital, and related topics. Compare and benchmark these with PBR requirements.
      vii. Coordinate with the Reinsurance (E) Task Force on actuarial items related to reinsurance.

2. The **Experience Reporting (A) Subgroup** will:
   A. Continue the development of the experience reporting requirements within the *Valuation Manual*. Provide input on the process regarding the experience reporting agent, data collection, and subsequent analysis and use of experience submitted.

3. The **Generator of Economic Scenarios (GOES) (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor that the economic scenario governance framework is being appropriately followed by all relevant stakeholders involved in scenario delivery.
   B. Review material GOES updates, either driven by periodic model maintenance or changes to the economic environment, and provide recommendations.

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

C. Regularly review key economic conditions and metrics to evaluate the need for off-cycle or significant GOES updates, and maintain a public timeline for GOES updates.
D. Support the implementation of the GOES for use in statutory reserve and capital calculations.
E. Develop and maintain acceptance criteria that reflect history as well as plausibly more extreme scenarios.

4. The **Life and Annuity Illustration (A) Subgroup** will:
   A. Consider changes to *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold on or After December 14, 2020* (AG 49-A), as needed. Provide recommendations for the consideration of changes to the *Life Insurance Illustrations Model Regulation* (#582) to the Task Force, as needed.
   B. Consider any guidance, actions, or recommendations that may be necessary to regulate annuity illustration practices.

5. The **Longevity Risk (E/A) Subgroup** of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group will:
   A. Provide recommendations for recognizing longevity risk in statutory reserves and/or risk-based capital (RBC), as appropriate.

6. The **Variable Annuities Capital and Reserve (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor the variable annuities (VA) reserve framework and RBC calculation, and determine if revisions need to be made.
   B. Develop and recommend appropriate changes, including those to improve the accuracy and clarity of VA capital and reserve requirements and reporting.

7. The **Valuation Manual (VM)-22 (A) Subgroup** will:
   A. Recommend requirements for non-variable (fixed) annuities in the accumulation and payout phases for consideration by the Task Force, as appropriate. Continue working with the Academy on a PBR methodology for non-variable annuities.

NAIC Support Staff: Scott O'Neal/Jennifer Frasier

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Draft: 10/25/24

Life Actuarial (A) Task Force
Virtual Meeting
September 12, 2024

The Life Actuarial (A) Task Force met Sept. 12, 2024. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Mark Fowler represented by Sanjeev Chaudhuri (AL); Lori K. Wing-Heier represented by Sharon Comstock (AK); Ricardo Lara represented by Ahmad Kamil and Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Holly W. Lambert 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 and John Rehagen (MO); Eric Dunning represented by Margaret Garrison (NE); D.J. Bettencourt represented by Jennifer Li (NH); Justin Zimerman 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 an Update on AAT for Reinsurance on a Potential Inquiry to Inform Scope Discussions

Andersen provided background on the exposure of the asset adequacy testing (AAT) for reinsurance Actuarial Guideline, noting that distinct comment periods for comments relevant to respective sections had been specified. Regarding the comment period for the scope section, Andersen stated that the comment deadline would be pushed back to Oct. 3 to allow for an inquiry to take place with a series of insurance organizations with large treaties. Andersen said that the inquiry would look for feedback on whether AAT would be necessary for all large treaties or if a subset of large but lower risk treaties would not need testing.

2. Adopted 2024 VM-20 HMI and FMI Rates

Marianne Purushotham (Society of Actuaries—SOA) provided background on the development of the 2024 Valuation Manual (VM)-20, Requirements for Principle-Based Reserves for Life Insurance historical and future mortality improvement (HMI and FMI) rates.

Chupp made a motion, seconded by Reedy, to adopt the 2024 VM-20 HMI and FMI rates (Attachment Four-A). The motion passed unanimously.

3. Adopted its Summer National Meeting Minutes

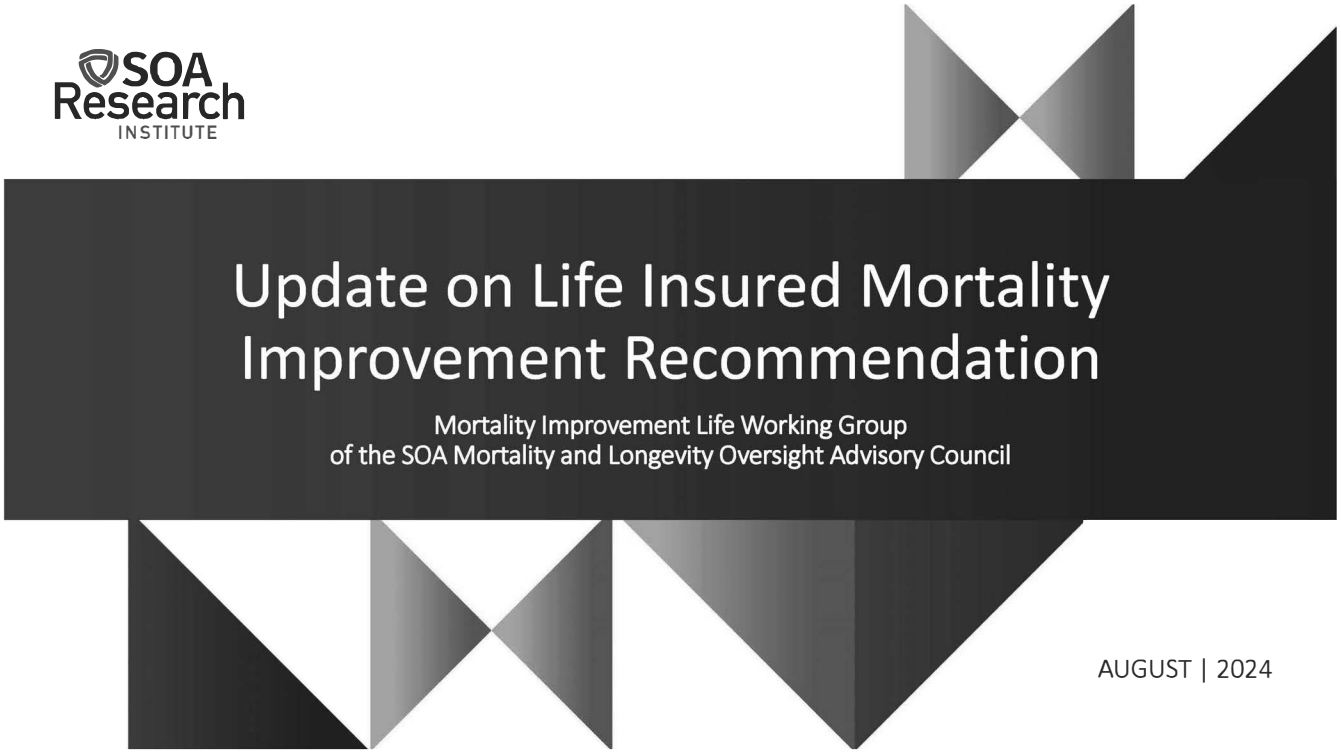
Chupp noted three editorial issues with the Task Force's Summer National Meeting minutes packet.

Chupp made a motion, seconded by Weber, to adopt the Task Force's Summer National Meeting minutes with his suggested editorial changes (*see NAIC Proceedings – Summer 2024, Life Actuarial (A) Task Force*). The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.

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SOA Research INSTITUTE

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Agenda

- Historical Mortality Improvement (HMI) 2024 Recommendation
- Future Mortality Improvement (FMI) 2024 Recommendation
- Next Steps
  - Future update on recommended approach for estimating a life insured population MI basis

HMI 2024

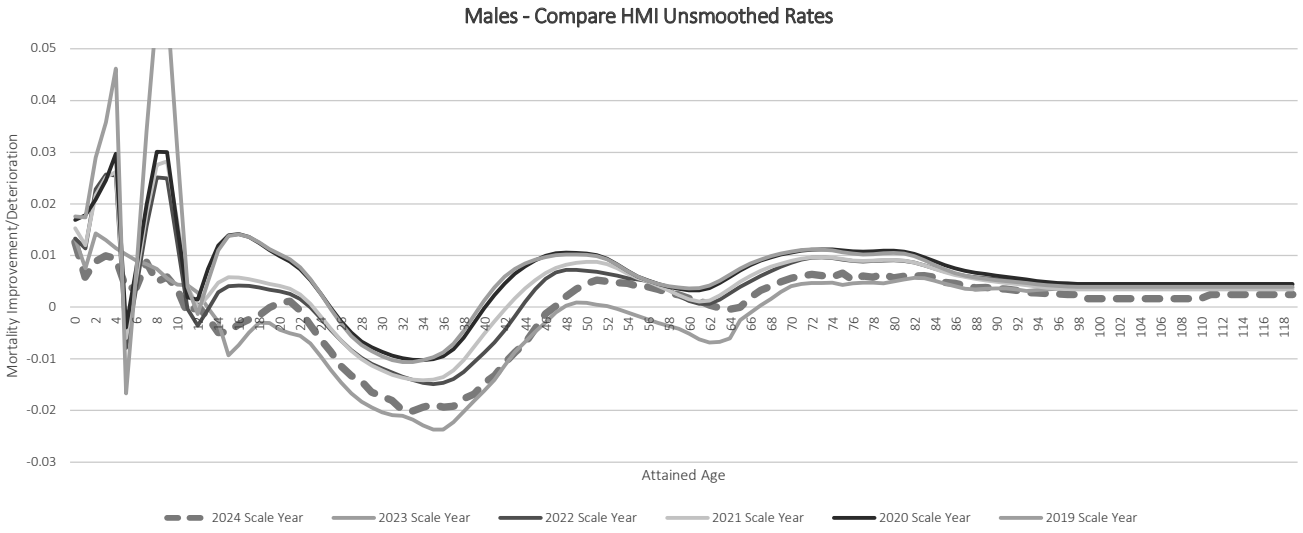
- HMI by attained age and gender
  - General population data - Social Security Administration (SSA)
  - No insured lives adjustment

- HMI unsmoothed scale = average of historical and future components
  - Historical component = 10 years ending in 2022
    - No adjustment made to historical data for COVID impact (moving back to pre COVID standard methodology for 2024)
    - Geometric average – only reflects end points of historical period (2012/2022)
  - Future component = geometric average of SSA Intermediate Projection
    - 20 years – year end 2024-2044

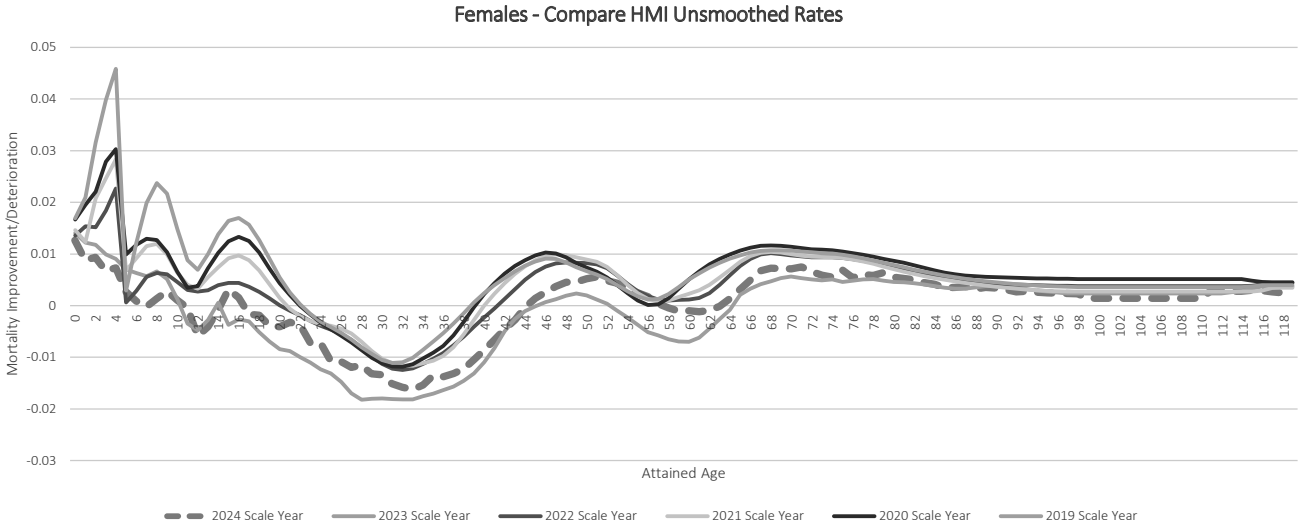
- HMI Smoothed Scale
  - Averaging applied to smooth within age groups
  - 0-20, 30-40, 45-60, 65-84, 90+

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2024 HMI Unsmoothed Scale Comparison to Prior Years

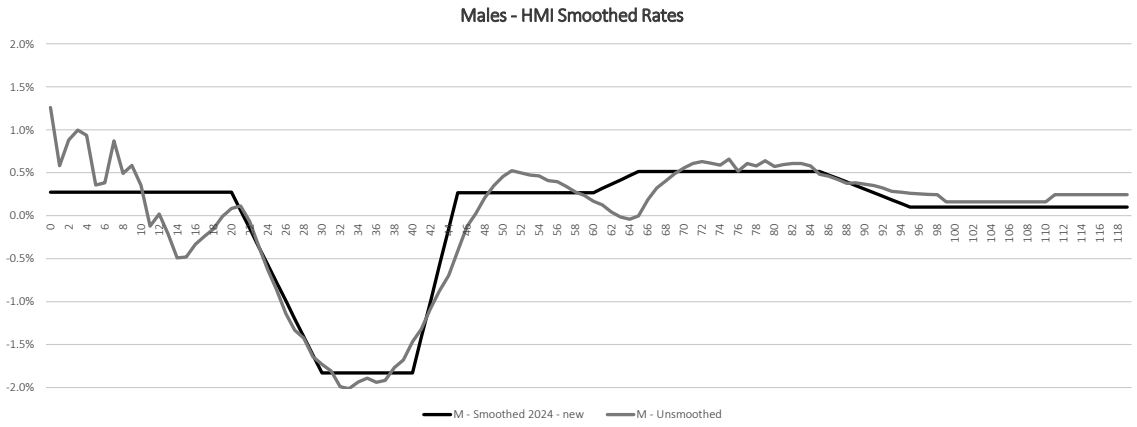


2024 HMI Unsmoothed Scale Comparison to Prior Year Published Scales



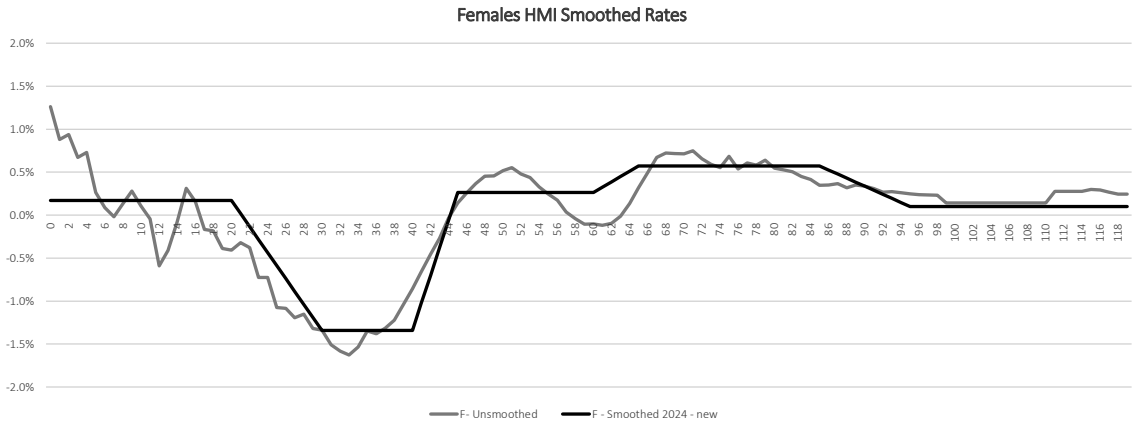
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2024 HMI Smoothed Scale



Same age groupings for females and males so there is some constraint in the averaging ranges, accident and opioid impact and dip continues, age 65 dip

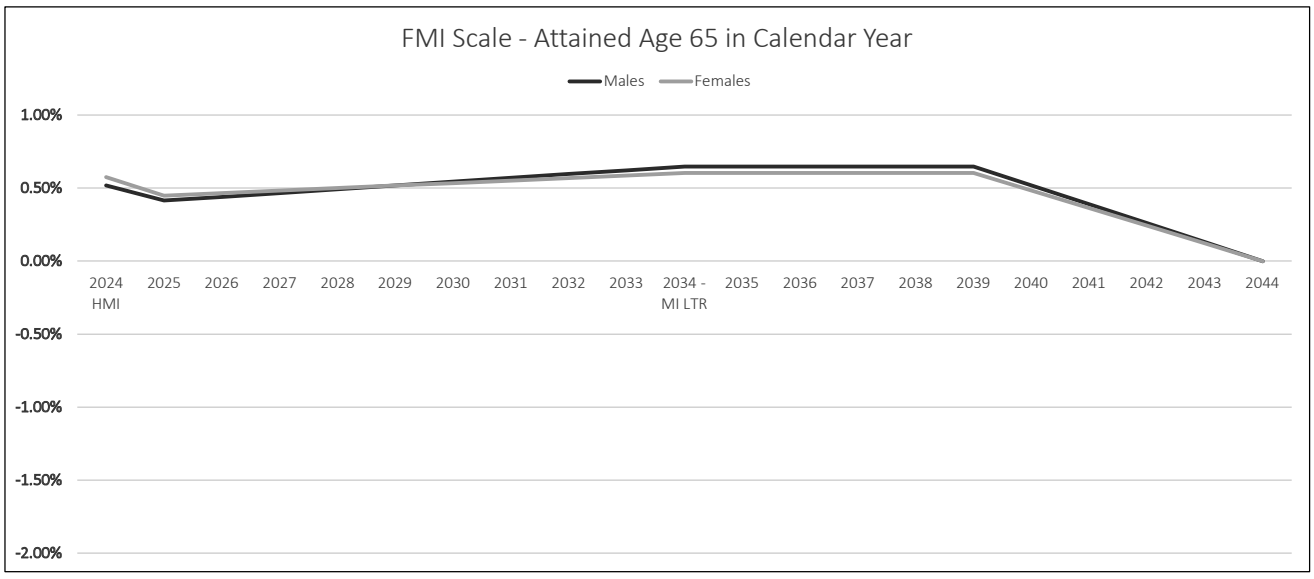
2024 HMI Smoothed Scale



FMI 2024

- FMI by attained age and gender
- 20 years of future improvement (MI rates grade to zero at reserve projection year 20)
- For attained ages where HMI for 2024 is positive – apply standard methodology – example is age 65
- Standard Methodology
  - Grade linearly from 2024 HMI Smoothed Scale to long term mortality improvement rate (LTMIR) over the first 10 reserve projection years
    - LTMIR based on Social Security Administration projected mortality improvement between 10 and 15 years from the valuation year
  - Remain level at LTMIR for next 5 reserve projection years
  - Grade linearly to zero FMI for remaining 5 reserve projection years
  - Margin = reduction in base FMI rates of 25%

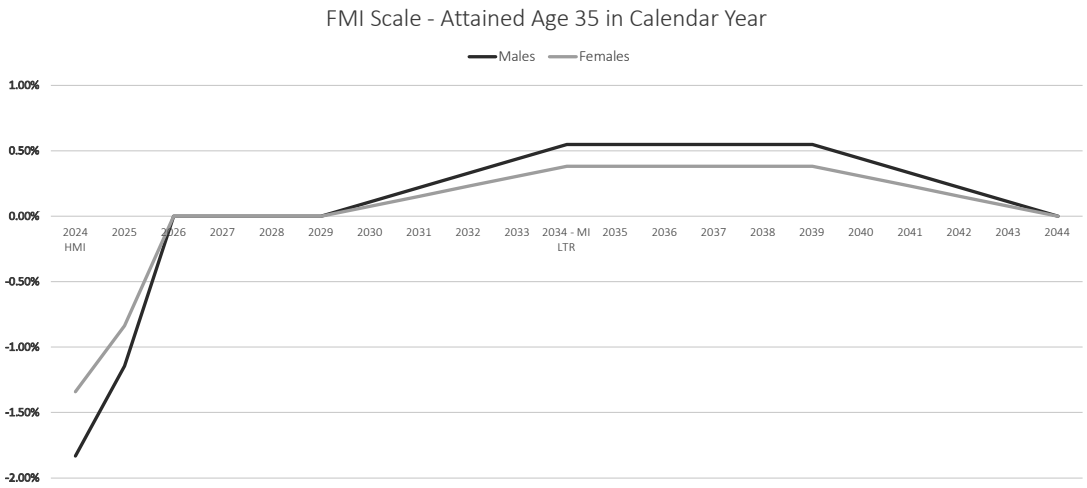
2024 FMI Scale with Margin – Age 65



FMI 2024

- For attained ages where HMI for 2024 remains negative (ages 22- 48 for males, 18-44 for females) – apply past methodology of adjusting to positive mortality improvement at LTMIR over time – example is age 35
- For 2024, adjustment to positive mortality improvement used the following approach:
  - Reach zero improvement level at reserve projection year 2026
  - Remain at zero mortality improvement to year 2029
  - Grade to LTMIR at 2034
  - Remain level at LTMIR to 2039
  - Grade linearly to zero improvement at 2044

2024 FMI Scale with Margin – Age 35 – **REVISED 8/19/24**



MI Recommendation – Fully Underwritten Business

- Where we started
  - Assumption that there was too much noise in the industry experience data on insured lives to be used to measure insured MI results
  - Reviewed SOA general population socioeconomic decile work
    - Is there a decile that can be used as a proxy for the life insurance population?
- Initial Considerations
  - Is there a new baseline level of MI post-pandemic?
  - Should the impact of COVID be included/excluded? If excluded, method of exclusion?
  - How much do drug/opioid and smoking status impact the insurance population?
    - Drug/opioid issue (may be more important for key concentration of insured ages)
    - Smoker/nonsmoker differential

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MI Recommendation - Fully Underwritten Business Update

- Peer review of MI Analysis Tool & Predictive Models completed
- Continue investigation of patterns in insured versus general population experience generated by MI analysis tool

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Contact Information

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Corporate Vice President, Research Data Services
LLGlobal/LIMRA
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Draft: 9/27/24

Life Actuarial (A) Task Force
Virtual Meeting
September 5, 2024

The Life Actuarial (A) Task Force met Sept. 5, 2024. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Mark Fowler represented by Sanjeev Chaudhuri (AL); Lori K. Wing-Heier represented by Sharon Comstock (AK); Ricardo Lara represented by Ahmad Kamil and Thomas Reedy (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); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung and John Rehagen (MO); D.J. Bettencourt 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 the 2025 GRET Recommendation

Yanacheak made a motion, seconded by Andersen, to adopt the 2025 Generally Recognized Expense Table (GRET) recommendation (Attachment Five-A). The motion passed unanimously.

2. Adopted APF 2024-11 (Revisions to Life PBR Exemption)

Hemphill introduced amendment proposal form (APF) 2024-11, which would revise the *Valuation Manual* life principle-based reserve (PBR) exemption to account for changes made to the NAIC's annual statement blanks. Hemphill also noted a typo correction suggested by Boston in Valuation Manual (VM) Section II, 1.G.2.e, where "group life certificate" should actually be referred to as "group life contract" for consistency. Hemphill said this would not require a re-exposure of APF 2024-11, as it strictly corrected a typo. Carmello said that a further tweak might need to be made to VM Section II, 1.G.2.e and other references in the VM to individual life contracts issued under a group life contract so that it reads "group life certificates issued under a group life contract." Yanacheak agreed.

Hemphill stated that instead, both potential editorial revisions should be a takeaway, as she wanted to confer with Mary-Bahna Nolan (Willis Towers Watson), who had worked on the original language addressing group life contracts under VM-20, Requirements for Principle-Based Reserves for Life Products, to understand the reasoning for the current terminology.

Chupp made a motion, seconded by Reedy, to adopt APF 2024-11 (Attachment Five-B). The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.

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TO: Rachel Hemphill, Chair, Life Actuarial (A) Task Force

FROM: Pete Miller, ASA, MAAA, Experience Study Actuary, Society of Actuaries (SOA) Research Institute
Tony Phipps, Chair, SOA Research Institute Committee on Life Insurance Company Expenses

DATE: August 1, 2024

RE: 2025 Generally Recognized Expense Table (GRET) – SOA Research Institute Analysis

Dear Ms. Hemphill:

As in previous years, the Society of Actuaries Research Institute expresses its thanks to NAIC staff for their assistance and responsiveness in providing Annual Statement expense and unit data for the 2025 GRET analysis for use with individual life insurance sales illustrations. The analysis is based on expense and expense-related information reported on each company's 2022 and 2023 Annual Statements. This project has been completed to assist the Life Actuarial Task Force (LATF) in considering potential revisions to the GRET that could become effective for the calendar year 2025. This memo describes the analysis and resultant findings.

NAIC staff provided Annual Statement data for life insurance companies for calendar years 2022 and 2023. This included data from 749 companies in 2022 and 745 companies in 2023. This decrease resumes the trend of small decreases from year to year. Of the total companies, 378 were in both years and passed the outlier exclusion tests and were included as a base for the GRET factors (379 companies passed similar tests last year).

Approach Used

The methodology for calculating the recommended GRET factors based on this data is similar to that in the last several years. The methodology was last altered in 2015. The changes made then can be found in the recommendation letter sent to LATF on July 30, 2015.

To calculate updated GRET factors, the average of the factors from the two most recent years (2022 and 2023 for those companies with data available for both years) of Annual Statement data was used. For each company, an actual-to-expected (A/E) ratio was calculated. Companies with ratios that fell outside predetermined parameters were excluded. This process was completed three times to stabilize the average rates. The boundaries of the exclusions have been modified from time to time; however, there were no adjustments made this year. Unit expense seed factors (the seeds for all distribution channel categories are the same), as shown in Appendix B, were used to compute total expected expenses. Thus, these seed factors were used to implicitly allocate expenses between acquisition and maintenance expenses, as well as among the three acquisition expense factors (on a direct of ceded reinsurance basis).

Companies were categorized by their reported distribution channel (four categories were used as described in Appendix A included below). There remain a significant number of companies for which no distribution channel was provided, as no responses to the annual surveys have been received from those companies. The characteristics of these companies vary significantly, including companies not currently writing new business or whose major line of business is not individual life insurance. Any advice or assistance from LATF in future years to increase the response rate to the surveys of companies that submit Annual Statements to reduce the number of companies in the "Other" category would be most welcomed. The intention is to continue

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surveying the companies in future years to enable the enhancement of this multiple distribution channel information.

Companies were excluded from the analysis if in either 2022 or 2023, (1) their A/E ratios were considered outliers, often due to low business volume, (2) the average first year and single premium per policy were more than $40,000, (3) they are known reinsurance companies or (4) their data were not included in the data supplied by the NAIC. To derive the overall GRET factors, the unweighted average of the remaining companies' A/E ratios for each respective category was calculated. The resulting factors were rounded, as shown in Table 1.

The Recommendation

The above methodology results in the proposed 2025 GRET values shown in Table 1. To facilitate comparisons, the current 2024 GRET factors are shown in Table 2. Further characteristics of the type of companies represented in each category are included in the last two columns in Table 1, including the average premium per policy issued and the average face amount ($000s) per policy issued.

To facilitate comparisons, the current 2024 GRET factors are shown in Table 2. Further characteristics of the type of companies represented in each category are included in the last two columns in Table 2, including the average premium per policy issued and the average face amount ($000s) per policy issued.

TABLE 1
PROPOSED 2025 GRET FACTORS, BASED ON AVERAGE OF 2022/2023 DATA

DESCRIPTION	Acquisition per Policy	Acquisition per Unit	Acquisition per Premium	Maintenance per Policy	Companies Included	Average Premium Per Policy Issued During Year	Average Face Amt (000) Per Policy Issued During Year
Independent	204	$1.10	51%	61	147	3,008	241
Career	227	1.20	57%	68	86	2,739	218
Direct Marketing	239	1.30	59%	72	24	465	119
Niche Marketing	131	0.70	33%	39	27	649	12
Other*	159	0.90	40%	48	94	869	81
* Includes companies that did not respond to this or prior year surveys					378		

TABLE 2
CURRENT 2024 GRET FACTORS, BASED ON AVERAGE OF 2021/2022 DATA

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

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In previous recommendations, an effort was made to reduce volatility in the GRET factors from year to year by limiting the yearly change in GRET factors to about ten percent of the prior value. The changes from the 2024 GRET were reviewed to ensure that a significant change was not made in this year's GRET recommendation.

All GRET factors the Direct Marketing distribution channel and the Acquisition per Unit factor for Career experienced changes greater than ten percent, so the factors for these lines were capped at the ten percent level (or slightly above/below 10% due to rounding of the factor) from the corresponding 2024 GRET values. This volatility occurred due to an increasing median A/E ratio for each distribution channel, which allowed for additional companies with higher A/E ratios to be included in the calculation that were previously dropped. Final GRET A/E medians increased for all distribution types with the largest changes in the Career and Direct Marketing sections.

The average premium per policy issued during the year saw a decrease of 518 from last year to this year, accompanying this is a 4,262 policy decrease in policies issued from last year to this year. This increase in A/E medians is due to the 6.4% increase in the average face amount per policy issued for all distribution types.

Usage of the GRET

This year's survey, responded to by each company's Annual Statement correspondent, included a question regarding whether the 2024 GRET table was used in its illustrations by the company. Last year, 44% of the responders indicated their company used the GRET for sales illustration purposes, which is much higher than previous years, typically around 31-35% of companies indicate their usage of GRET. This year, 34% of responding companies indicated they used the GRET in 2024 for sales illustration purposes. The range covered all distribution methods, including 20% for Independent, 63% for Career, 80% for Direct Marketing, and 17% for Niche Marketers. Based on the information received over the last several years, the variation in GRET usage appears to be in large part due to the relatively small sample size and different responders to the surveys.

We hope LATF finds this information helpful and sufficient for consideration of a potential update to the GRET. If you require further analysis or have questions, please contact Pete Miller at 847-706-3566.

Kindest personal regards,

Pete Miller, ASA, MAAA
Experience Studies Actuary
Society of Actuaries Research Institute

Tony Phipps, FSA, MAAA
Chair, SOA Research Institute Committee on
Life Insurance Company Expenses

Appendix A – Distribution Channels

The following is a description of distribution channels used in the development of recommended 2023 GRET values:

1. Independent – Business written by a company that markets its insurance policies through an independent insurance agent or insurance broker not primarily affiliated with any one insurance company. These agencies or agents are not employed by the company and operate without an exclusive distribution contract with the company. These include most PPGA arrangements.

2. Career – Business written by a company that markets insurance and investment products through a sales force primarily affiliated with one insurance company. These companies recruit, finance, train, and often house financial professionals who are typically referred to as career agents or multi-line exclusive agents.

3. Direct Marketing – Business written by a company that markets its own insurance policies direct to the consumer through methods such as direct mail, print media, broadcast media, telemarketing, retail centers and kiosks, internet, or other media. No direct field compensation is involved.

4. Niche Marketers – Business written by home service, pre-need, or final expense insurance companies as well as niche-market companies selling small face amount life products through a variety of distribution channels.

5. Other – Companies surveyed were only provided with the four options described above. Nonetheless since there were many companies for which we did not receive a response (or whose response in past years' surveys confirmed an "other" categorization (see below), values for the "other" category are given in the tables in this memo. It was also included to indicate how many life insurance companies with no response (to this survey and prior surveys) and to indicate whether their exclusion has introduced a bias into the resulting values.

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Appendix B – Unit Expense Seeds

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

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

2006-2010 (AVERAGE) CLICE STUDIES:

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

CURRENT UNIT EXPENSE SEEDS:

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

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Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

   Identification:
   Rachel Hemphill, Texas Department of Insurance

   Title of the Issue:
   Update the Life PBR Exemption as needed due to changes made to the annual statement blanks.

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 Section II, Subsection 1.G

   January 1, 2025 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.)

   Valuation Manual Section II, Subsection 1.G

Exemption premium is determined as follows:

a. The amount reported in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 2 ("Individual Life"), line 20.1; plus
b. The portion of the amount in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 2 ("Individual Life"), line 20.2 assumed from unaffiliated companies; minus
c. Amounts included in either (a) or (b) that are associated with industrial policies, credit life policies, guaranteed issue insurance policies and/or preneed life insurance policies; minus
d. Amounts included in either (a) or (b) that represent transfers of reserves in force as of the effective date of a reinsurance assumed transaction; plus
e. Amounts of premium for individual life certificates issued under a group life certificate that meet the conditions defined in VM-20, Section 1.B, and that are not included in either (a) or (b).

Guidance Note:
Definitions of industrial life insurance, preneed, and guaranteed issue life insurance policy are in VM-01. The definition of credit life insurance is in Section II, Subsection 5.B.

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

   This APF is to coordinate with Blanks updates that have been made. Specifically, in Exhibit 1, Part 1 there is now an "individual" column rather than an "ordinary" column and the separate industrial and credit life columns were removed, by BWG 2022-14.

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EXHIBIT 1 – PART 1 – PREMIUMS AND ANNUITY CONSIDERATIONS FOR LIFE AND ACCIDENT AND HEALTH CONTRACTS

	1	Insurance										
		2	Ordinary 3	4	5	Group 6	7	Accident and Health 8	9	10	11	12
	Total	~~Industrial~~Individual Life	Group Life ~~Insurance~~	Individual Annuities	~~Credit Life (Group and Individual)~~ Group Annuities	~~Life Insurance~~ Accident & Health	~~Annuities~~ Fraternal	Group Other Lines of Business	~~Credit (Group and Individual)~~	~~Other~~	~~Aggregate of All Other Lines of Business~~	~~Fraternal (Fraternal Benefit Societies Only)~~
FIRST YEAR (other than single)												
1. Uncollected												
2. Deferred and accrued												
3. Deferred, accrued and uncollected:												
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)												
SINGLE												
10. Single premiums and considerations:												
10.1 Direct												
10.2 Reinsurance assumed												
10.3 Reinsurance ceded												
10.4 Net												
RENEWAL												
11. Uncollected												
12. Deferred and accrued												
13. Deferred, accrued and uncollected:												
13.1 Direct												
13.2 Reinsurance assumed												
13.3 Reinsurance ceded												
13.4 Net (Line 11 + Line 12)												
14. Advance												
15. Line 13.4 - Line 14												
16. Collected during year:												
16.1 Direct												
16.2 Reinsurance assumed												
16.3 Reinsurance ceded												
16.4 Net												
17. Line 15 + Line 16.4												
18. Prior year (uncollected + deferred and accrued - advance)												
19. Renewal premiums and considerations:												
19.1 Direct												
19.2 Reinsurance assumed												
19.3 Reinsurance ceded												
19.4 Net (Line 17 - Line 18)												
TOTAL												
20. Total premiums and annuity considerations:												
20.1 Direct												
20.2 Reinsurance assumed												
20.3 Reinsurance ceded												
20.4 Net (Lines 9.4 + 10.4 + 19.4)												

Dates: Received	Reviewed by Staff	Distributed	Considered
7/23/2024	A.F.		
Notes: APF 2024-11			

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Draft: 9/27/24

Life Actuarial (A) Task Force
Virtual Meeting
August 29, 2024

The Life Actuarial (A) Task Force met Aug. 29, 2024. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Mark Fowler represented by Sanjeev Chaudhuri (AL); Lori K. Wing-Heier represented by Sharon Comstock (AK); Ricardo Lara represented by Ahmad Kamil and Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Robert L. Carey represented by Marti Hooper (ME); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung and John Rehagen (MO); Eric Dunning represented by Margaret Garrison (NE); D.J. Bettencourt represented by Jennifer Li (NH); Adrienne A. Harris represented by Bill Carmello (NY); Judith L. French represented by Peter Weber (OH); Michael Humphreys represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT).

1. Exposed APF 2024-13 (IMR Clarification)

Hemphill provided background on amendment proposal form (APF) 2024-13, noting that it provides additional guidance on the treatment of negative interest maintenance reserves (IMRs).

Chupp made a motion, seconded by Weber, to expose APF 2024-13 for a 21-day public comment period ending Sept. 19. The motion passed unanimously.

2. Exposed APF 2024-14 (Surrender Charge Waivers)

Hemphill said APF 2024-14 addresses an issue raised by Task Force members who noted that they had seen increasing requests to expand the list of criteria for waiver of surrender charges on annuities. Hemphill further stated that there were questions of: 1) how material those waivers are; 2) whether there was any implication for valuations; and 3) how the surrender charge waivers were reflected in the valuation. Hemphill noted the issue was discussed among a small group of state insurance regulators who agreed to add reporting to better understand the materiality.

Chupp asked if a similar change should be made for the Valuation Manual (VM)-22, Requirements for Principle-Based Reserves for Non-Variable Annuities, draft. Hemphill said that the VM-22 (A) Subgroup will want to consider addressing the disclosure requirement in the VM-22 draft. Slutsker agreed with Hemphill and added that, where applicable, VM-22 and VM-21 should align. Hemphill noted that for VM-20, Requirements for Principle-Based Reserves for Life Products, the analogous waivers are usually addressed under the supplemental benefits and riders.

John Robinson (MN-Retired) noted the language in the APF did not specify the number of years of historical data that should be reported. He suggested a cover letter question regarding the number of years be included as part of the exposure. Hemphill noted the APF does not specify the number of years, intending for actuaries to use professional judgment, but agreed that a cover letter question could be included to request comments on the minimum number of years.

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Andersen made a motion, seconded by Reedy, to expose APF 2024-14 with the cover letter question suggested by Robinson for a 21-day comment period ending Sept. 19. 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/2024-3-Fall/LATF Calls/08 29/Aug 29 Minutes.docx

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November 15, 2024

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 NAIC's Executive (EX) Committee and Plenary at the Spring National Meeting on March 25. Regulators are reviewing the impact of the Guideline revisions on the market. 2025 charges for the Subgroup are being considered by the NAIC's Executive (EX) Committee and Plenary that would rename the Subgroup to be the "Life and Annuity Illustration (A) Subgroup" and expand its role into annuity illustrations.

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November 15, 2024

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 met October 18, 2024, to discuss potential changes to the Annual Statement Variable Annuity Supplement. Potential changes are being considered in response to the work being done at the Valuation Manual (VM)-22 (A) Subgroup. The VM-22 SG has developed an annual statement supplement for reporting non-variable annuities which provides information for non-variable annuity product reserves and VM-22 reserve components broken out into various product categories.

The chair described the current annual statement Variable Supplement and walked through a document that offered ideas for how that supplement could be made more useful if a similar structure to what the VM-22 SG was proposing was implemented. Following robust discussion, the chair incorporated many of the comments made on the call into a revised document and that version was exposed for 90 days, until January 21, 2025.

The VACR SG also discussed a plan for aligning the requirements in VM-21 to those in VM-22 where appropriate. There will likely be many improvements that can be made to VM-21 based on the work being done on VM-22. Any improvements are not intended to be substantial changes, but rather improved accuracy and clarity of wording in VM-21. Based on comments from the VM-22 SG vice chair, it was decided that there was still the potential for many changes to the draft VM-22 requirements, and it would be better to wait until it was more complete. The VACR SG will revisit the question in the first quarter of 2025.

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Draft: 11/1/24

Variable Annuities Capital and Reserve (E/A) Subgroup
Virtual Meeting
October 18, 2024

The Variable Annuities Capital and Reserve (E/A) Subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force met Oct. 18, 2024. The following Subgroup members participated: Pete Weber, Chair (OH); Thomas Reedy and Elaine Lam (CA); Fred Andersen (MN); William Leung (MO); Seong-min Eom (NJ); Bill Carmello and Michael Cebula (NY); and Rachel Hemphill (TX).

1. Discussed Potential Additions to the Variable Annuities Supplement in the Annual Statement

Weber started the meeting by walking through the *Valuation Manual* (VM)-22, Requirements for Principle-Based Reserves for Non-Variable Annuities, supplement draft. He pointed out that the prior year and current year reserves are broken out by different product types, and components of the reserve calculation are shown on the supplement draft. Weber recapped the two-part variable annuities (VA) supplement in the annual statement. He asked whether regulators want to see any changes to the current VA supplement, which can provide more useful information as they monitor the business.

Weber shared his initial thoughts on the potential additions to the VA supplement. First, he proposed to categorize the variable annuity guaranteed living benefit (VAGLB) products into five phases, including accumulation or withdrawal. Second, he showed a list of 10 product types that are related to the variable annuities and defined in VM-01, and none involved the guaranteed minimum death benefit (GMDB). Third, Weber posed a question on whether there is a need to reflect optimally efficient withdrawers that are possibly over or under. He questioned if the VA products in various combinations of VAGLB and GMDB should be shown either in one single row as the VM-22 supplement draft does or in two columns like the current VA supplement does. Fourth, Weber commented that a couple of very specific product types that are listed in the VM-21 standard projection amount (SPA) assumption section were not defined in the VM-01. He mentioned tax-qualified and non-qualified products and said the delineation drives SPA assumption. He also pointed out that the simple 403(b) contracts were not defined either. Lastly, Weber suggested considering the reporting format for the GMDB contracts that are valued under the alternative method, as well as the index-linked variable annuities. Weber said his goal is to expose his initial thoughts and gather comments.

Carmello said the five proposed product categorizations can be combined and merged into the existing 10 product types in VM-01. Reedy said this proposal is good because the granular categorization will sync up with the granularity of the policyholder behavior that is described in the VM-31 report. However, it should not be too granular. Weber responded that there is a balance between granularity and usefulness.

Brian Bayerle (American Council of Life Insurers—ACLI) said he liked what Carmello suggested especially with Reedy's feedback. He suggested the categorization should align as closely as possible with the company's existing reporting. Additionally, he said the feedback in response to the exposure should consider what data should be collected in terms of additional columns on the VA supplement.

Timothy Ritter (Jackson National Life Insurance Company) followed up on what Bayerle said and expressed his concern with the challenge when components of the VM-21 reserve calculation need to be split up between the proposed product categories. He said the final aggregated reserve is allocated back to the contract level, but the guidance for allocation to all the different components of the reserve calculation would not necessarily exist.

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Weber said he would have a chair exposure of a document within the next few days, which is based on his initial thoughts and also reflect the comments made so far. No Subgroup members opposed. Eom asked whether Weber wants to split the indexed-linked variable annuities to be more consistent with the VM-22 supplement draft. Weber said he needs to add it as a product category in the exposure.

2. Discussed a Plan for Aligning VM-21 and VM-22

Weber said he received an email from the chair of the American Academy of Actuaries (Academy) VA capital and reserve subcommittee asking whether there is any plan for the alignment between VM-21 and VM-22. He said the results of the field test and model office testing for VM-22 are coming up in the first quarter of 2025 and made a comment on potential wasted efforts as a result of starting the alignment too soon. Weber asked for thoughts from the Subgroup members on the timing and potential plan for reviewing VM-21 based on what the VM-22 (A) Subgroup has put together.

Lam, who is Vice Chair of the VM-22 (A) Subgroup, provided updates on VM-22. She expects there will be many changes to the VM-22 requirements based on the field test results. The VM-22 (A) Subgroup has started the work of identifying things that should be aligned between VM-21 and VM-22, as well as those things that should not be aligned. She suggested the Subgroup wait until the VM-22 requirements are more settled and finalized to start the alignment.

Bayerle asked whether changes could be made to VM-22 right after its implementation due to the alignment. Weber thought, in most cases, VM-21 would be changed to align with VM-22, which is one direction only. Lam said she agreed with Weber. She said the alignment would be largely around language. Weber said he does not envision major changes to VM-21 resulting from the alignment project.

Having no further business, the Variable Annuities Capital and Reserve (E/A) Subgroup adjourned.

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November 15, 2024

From: Fred Andersen, Chair
The Experience Reporting (A) Subgroup

To: Rachel Hemphill, Chair
The Life Actuarial (A) Task Force

Subject: The Report of the Experience Reporting (A) Subgroup to the Life Actuarial (A) Task Force

The Experience Reporting (A) Subgroup has not met since the Summer National Meeting. Upcoming projects include monitoring the plans for collecting life insurance mortality and policyholder behavior data using the NAIC as the statistical agent, starting to develop mandatory reporting of group annuity – pension risk transfer data, and continuing to work on evaluating actuarial aspects of accelerated underwriting.

An amendment proposal form (APF) was exposed regarding the mandatory reporting of group annuity – pension risk transfer business. The NAIC has identified additional individuals to work with the Experience Reporting (A) Subgroup to review and enhance this APF. The Subgroup plans to meet to begin this process in early December.

A working group has been formed to draft an APF to collect additional life data regarding simplified and accelerated underwriting. Work on this APF is currently ongoing.

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November 15, 2024

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 2024 Summer 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.

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November 15, 2024

From: Ben Slutsker, Chairperson
Elaine Lam, Vice Chairperson
The VM-22 (A) Subgroup

To: Rachel Hemphill, Chair
The Life Actuarial (A) Task Force

Subject: The Report of the VM-22 (A) Subgroup to the Life Actuarial (A) Task Force

The NAIC VM-22 (A) Subgroup has met multiple times since the NAIC Summer National Meeting. The group has addressed comments made in response to the latest exposure of the Additional Standard Projection Amount section of the VM-22 draft. In addition, various corrections and clarifications were made in response to questions that arose from participants during the VM-22 field test.

The VM-22 field test itself took place over July through September and all responses have now been collected by the NAIC and American Academy of Actuaries (Academy). Ernst & Young (E&Y) is also analyzing results and generating model office output. The Academy and E&Y will present more details on their progress after the conclusion of this VM-22 (A) Subgroup report to the Life Actuarial (A) Task Force (LATF).

There are now proposed drafts for VM-22 requirements, the Additional Standard Projection Amount, a new VM-V section, VM-31 disclosures, the VM-22 Supplement Blank, and various other edits to VM Section II, VM-01, and VM-G to accommodate a potential VM-22 principles-based reserving (PBR) adoption. All of these documents have been exposed, with subsequent changes made to address comments received during the exposure period.

That said, there are a few large items that remain for the Subgroup to address prior to finalizing its recommendation to LATF:

- Reinvestment Mix Guardrail: either (1) 50%/50% AA/A, (2) 5%/15%/80% UST/AA/A, or (3) 5%/15%/40%/40% UST/AA/A/BBB
- Stochastic Exclusion Ratio Test (SERT): setting the threshold percentage and mortality shocks
- Additional Standard Projection Amount assumptions: withdrawals and surrenders
- Longevity Reinsurance: k-factor method, ACLI proposal, or 2% of annual benefit floor
- Purpose of Additional Standard Projection Amount: (1) reserving floor or (2) disclosure-only

The Subgroup will continue to hold calls through December and the first half of 2025 to address these items, as well as provide a final chance to revisit key elements of the framework. VM-22 PBR is still on track for completion in mid-2025, with potential adoption in time for a 1/1/2026 effective date, and a three-year optional implementation period ending in 1/1/2029, after which requirements would become mandatory for non-variable annuity contracts on a prospective basis.

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Draft: 11/07/24

Valuation Manual (VM)-22 (A) Subgroup
Virtual Meeting
November 6, 2024

The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met Nov. 6, 2024. The following Subgroup members participated: Ben Slutsker, Chair (MN); Elaine Lam, Vice Chair (CA); Lei Rao-Knight (CT); Vincent Tsang (IL); Nicole Boyd (KS); William Leung (MO); Seong-min Eom (NJ); Bill Carmello (NY); Rachel Hemphill and Iris Huang (TX) and Craig Chupp (VA).

1. Adopted Preneed Annuity Exclusion Edits to the VM-22 Draft

Slutsker provided an overview of the proposed edits to VM-22, Principle-Based Reserves for Non-Variable Annuities by Homesteaders Life Company (Attachment Thirteen-A). Scott Michels (National Guardian Life Insurance Company—NGL) discussed NGL's support for the exposed language to exclude preneed annuity from VM-22 (Attachment Thirteen-B). Carmello said he supported excluding preneed annuities. Colin Masterson (American Council of Life Insurers—ACLI) said the ACLI supported the proposal.

Leung made the motion, seconded by Chupp, to adopt the recommended edits to exclude preneed annuities from VM-22 principle-based reserving requirements in the VM-22 draft. The motion passed.

2. Exposed Longevity Reinsurance Reserve Flooring Methodologies

Masterson (ACLI) provided an overview of the longevity reinsurance treaty (LRT) illustration, an example of the different approaches and responses to the comments (Attachment Thirteen-C). Masterson stated the ACLI supports an approach for LRT that would floor reserves at the treaty level and not reflect the k-factor. Masterson noted that the k-factor approach may accomplish state insurance regulators' goal to have positive reserves emerge sooner than anticipated with the ACLI proposal. However, if mortality assumptions change over time, the k-factor will create the undesired effect of significant jumps in reserves and profits. Masterson said the representative cell and assumptions in the illustration show zero reserves for several years under the ACLI proposal depending on the average age for the treaty, treaty structure, and product demographics, and positive reserves may emerge earlier. Eom presented an alternative to the ACLI proposal that floors treaties at a positive number rather than zero (Attachment Thirteen-D). Eom said for LRT the simple PBR approach (the present value of future benefit minus the present value of future premiums) can have negative results in early durations for a long time. Eom explained that the k-factor PBR reserves will fall short of the gross premium PBR reserves in later durations. Eom said the goal of this alternative treaty-floor proposal was to raise the reserves above zero in early durations without falling short of the gross premium PBR reserves in later durations. Eom recommended setting the reserve floor to 2% of the longevity reinsurance benefits payable within the next 12 months because a zero floor results in zero reserves for too long in early durations.

Eom made a motion, seconded by Lam, to expose the non-zero treaty-floor alternative longevity reinsurance reserve flooring proposal and the comparison of the different methodologies for a 32-day public comment period ending Dec. 9. The Subgroup agreed to expose the positive floor methodology.

Having no further business, the VM-22 (A) Subgroup adjourned.

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August 21, 2024

Benjamin Slutsker, Chair
Valuation Manual (VM)-22 (A) Subgroup
1100 Walnut Street, Suite 1000
Kansas City, MO 64106

Submitted via email to Benjamin Slutsker: Benjamin.slutsker@state.mn.us

RE: Preneed Annuities within VM-22

Dear Chair Slutsker:

Thank you for your engagement in the 2nd quarter of this year and for the opportunity to comment on preneed annuities within VM-22.

As we discussed, reserve requirements for life insurance policies exempt preneed life contracts from principle-based valuation (VM-20). The VM-22 draft provides requirements for Principle-Based Reserves for Non-Variable Annuities. Annuities are sold in the preneed market. This letter requests consideration of exempting preneed annuity contracts from principle-based valuation (VM-22), in line with that done for preneed life contracts.

To facilitate such an exemption, retaining the current reserve requirements for preneed annuities, the draft VM-22 could be updated as listed below.

Item D in Subsection 2: Annuity Products would include the following underlined text:

Minimum reserve requirements for non-variable annuity contracts issued on 1/1/2025 and later are those requirements as found in VM-22, with the exception of Preneed Annuities, Guaranteed Investment Contracts, Synthetic Guaranteed Investment Contracts, and other Stable Value Contracts which shall follow the requirements found in VM-A, VM-C, and VM-V. The minimum reserve requirements of VM-22 are considered PBR requirements for purposes of the Valuation Manual, and therefore are applicable to VM-G.

Additionally, VM-01: Definitions for Term in Requirements would include:

The term "Preneed Annuity" means any non-variable deferred annuity policy or certificate that is issued in combination with, in support of, an assignment to or as a

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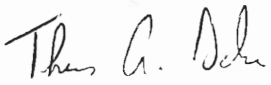
guarantee for a prearrangement for good and services to be provided at the time of and immediately following the death of the insured. Goods and services may include, but are not limited to, embalming, cremation, body preparation, viewing or visitation, coffin or urn, memorial stone, and transportation of the deceased. The status of the policy or contract as preneed insurance is determined at the time of issue in accordance with the policy form filing. (Note: Preceding definition taken from the Preneed Life Insurance Minimum Standards for Determining Reserve Liabilities and Nonforfeiture Values Model Regulation [#817].) The definition of preneed shall be subject to that definition of preneed in a particular state of issue if such definition is different in that state.

The wording within this definition follows that listed within the Valuation Manual for preneed life insurance.

Thank you again for your consideration of this enhancement to bring consistency with preneed life, recognizing the nature of preneed insurance in the context of principles-based valuation.

My contact information is listed within this letter should you have questions about this submission.

Sincerely,



Thomas A. Doruska

Cc Elaine Lam via email: Elaine.Lam@insurance.ca.gov

To whom it may concern:

National Guardian Life, a writer of Preneed Life and Annuity contracts, agrees with the proposal submitted by Thomas Doruska at Homesteaders Life Company. Both Preneed Life and Preneed Annuity contracts are issued in combination with, in support of, an assignment to or as a guarantee for a prearrangement for goods and services to be provided at the time of and immediately following the death of the insured. Because of this fact, these contracts do not typically experience dynamic policyholder behavior, and as such, we continue to support the exclusion of these contracts from Principles Based Reserving. We feel strongly that Preneed Life and Preneed Annuities should both have the exemption, as the same facts apply to both types of contracts.

Best Regards,

Scott Michels, FSA, MAAA
National Guardian Life Insurance Company (NGL)
(608) 209-5862 (cell)
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October 8, 2024

Ben Slutsker
Chair, NAIC Valuation Manual (VM)-22 (A) Subgroup (Subgroup)
Elaine Lam
Vice Chair, NAIC Valuation Manual (VM)-22 (A) Subgroup (Subgroup)

Re: VM-22 Longevity Risk Transfer (LRT) Exposure

Dear Chair Slutsker and Vice Chair Lam:

The American Council of Life Insurers (ACLI) appreciates the opportunity to provide feedback on the Subgroup's June 2024 exposure of their LRT proposal. ACLI would also like to take this time to express our immense gratitude towards NAIC staff, regulators, and other interested parties such as the American Academy of Actuaries and EY for their continued efforts as we move closer towards drafting a new VM chapter for fixed/non-variable annuities. Conceptually, we agree with the inclusion of LRT as a consideration within the updated VM-22 because it comprises similar insurance risks as annuity business; however, we have concerns regarding the proposed "K-Factor" approach and think it would be preferable to pivot to another methodology.

ACLI continues to support an approach for LRT that would floor reserves at the treaty-level and would not reflect a K-Factor. The ACLI proposal adequately reflects uncertainty within the margin for the prudent estimate mortality assumption, rather than developing a new reserving method not aligned with PBR. For LRT, premiums and expected benefits are based on the best estimate at inception (e.g., set equal), and the assuming company receives additional fees. In other words, premiums are scheduled and follow expected mortality (i.e., does not vary with experience). Over time, any deviations to mortality trend risk would be identified and reflected in the prudent estimate mortality assumption used to determine the benefit stream. The application of additional margins or haircuts (such as K-factors) to premiums would be unnecessary to meet statutory reporting objectives. Flooring reserves at the treaty-level would address regulator concerns regarding negative reserves and subsidizing within the Longevity Reinsurance Category.

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acli.com

At a recent meeting of the Subgroup, we heard regulators contemplate whether positive reserves should emerge sooner than what is anticipated with the ACLI proposal. Regulators also expressed interest in understanding LRT reserves from both the ceding company and assuming company perspective. ACLI has prepared an illustration of the mechanics of the K-Factor and ACLI proposal under different mortality scenarios as a way of providing regulators with more information on which to form their decisions. We note the following observations in this illustration:

- If experience emerges as expected, then the K-factor may accomplish the regulator's goal of smoothing profits. However, we note that if mortality assumptions change over time the K-factor creates significant jumps in reserves and profit. We do not believe this is the desired outcome for regulators or industry. The user can adjust the mortality shock and year of mortality shock in the input table to observe this dynamic.
- For LRT between two U.S. companies, we would generally expect the ceding company to receive a negative reserve credit under PBR. The ceding company reserve would reflect all reinsurance cash flows using prudent estimate assumptions, and the reserve would likely increase due to the fees paid. In the illustration for the ACLI proposal, since reserves reflect the administrative expense and are floored at zero for the assuming company, the total reserves early in the projection between both companies would likely be larger than the reserves previously held by the ceding company after the LRT transaction. This relationship of reserves for the ceding company and assuming company can be found in columns BC through BD on the 'Projections' tab.
- For the representative cell and assumptions, the illustration does not show reserves for several years under the ACLI proposal. Depending on the average age for the treaty, treaty structure, and product demographics, reserves may emerge earlier. The user can observe these variations by changing the inputs (date of birth, mortality table, fee %, mortality margin, etc.). For example, if the user changes the date of birth to an earlier date (i.e., 12/1/1950), positive reserves emerge earlier under the ACLI proposal.

We hope that our examples lay the groundwork for a thorough discussion to address the inclusion of LRT in the Valuation Manual.

Thank you once again for the consideration of our comments and if you have any questions related to this letter or the accompanying spreadsheet, please do not hesitate to reach out to ACLI staff.

Sincerely,



cc: Amy Fitzpatrick, NAIC

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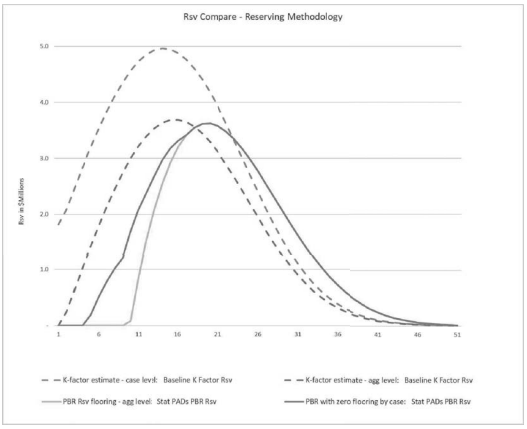
VM-22 Reserving

A New PBR Reserve Flooring Proposal

Why this approach is being proposed?

The PBR reserves for Longevity Reinsurance business are negative in the early years, which was considered undesirable. The LATF VM-22 working group analyzed multiple approaches to address this concern. These are discussed below:

1. Flooring the PBR reserves at zero (at contract or at aggregate book of business level).
   - The resulting PBR reserves incorporating the flooring at zero were still considered too low in the early durations staying at zero for too long per each contract– 10 years (depending on the business mix) or staying at zero or at a very low level when flooring in aggregate.
2. Using the K-factor methodology instead of PBR (with the K-factor calculated at case or at aggregate book of business level).
   - This can produce non-zero reserves in the early durations.
   - However, due to the artificial premium reshuffling (with the application of k-factor estimated at the issue), the K-factor based reserves will fall short of the gross premium PBR reserves in the later durations, which is not considered desirable.



Business mix:
- 50% each for new business and 5-year inforce
- 50% each of 100% retirees with older blue-collar contract and younger white-collar contract

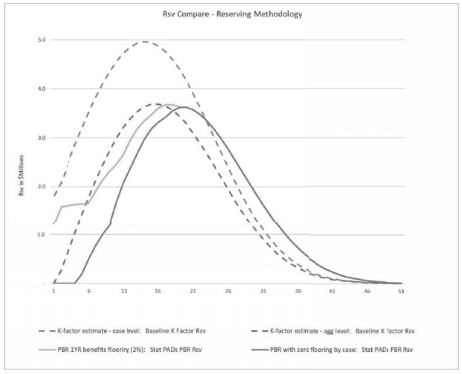
The proposed alternative builds on the zero flooring at contract level adjustment proposal, by raising the floor above zero for PBR reserves.

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The new flooring basis for PBR reserves

The goal of this new proposal is to raise the floor for PBR reserves above zero in the early durations, without creating reserve deficiencies in the later durations.

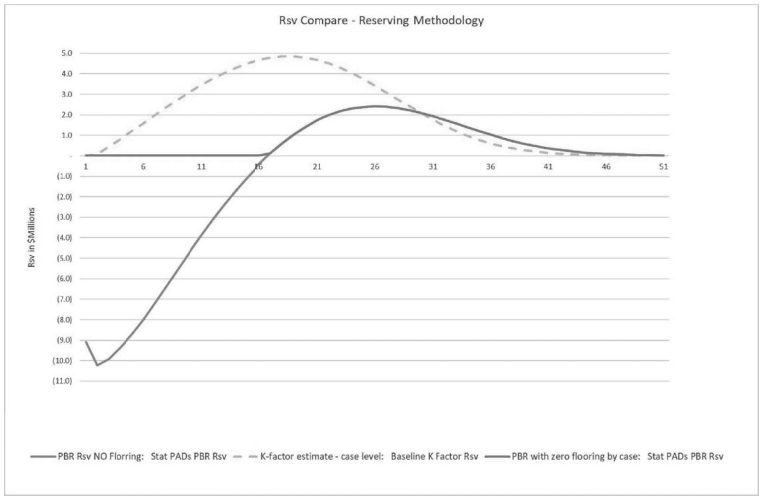
- The proposal is to express the floor for PBR reserves as a percentage of Longevity Reinsurance benefits payable within the next 12 months from the date of valuation.
  - Currently proposing flooring at 2% of the Longevity Reinsurance benefits payable within the next 12 months from the valuation date
- The proposed 2% floor could be described as the amount required to pre-fund approximately one week worth of the upcoming Longevity Reinsurance benefits payable (1/52 is 1.92% that is rounded up to 2%).
- The benefit amount is proposed as the basis for the floor rather than a more traditional premium basis due to the nature of the Longevity Reinsurance business.



Business mix:
- 50% each for new business and 5-year inforce
- 50% each of 100% retirees with older blue-collar contract and younger white-collar contract

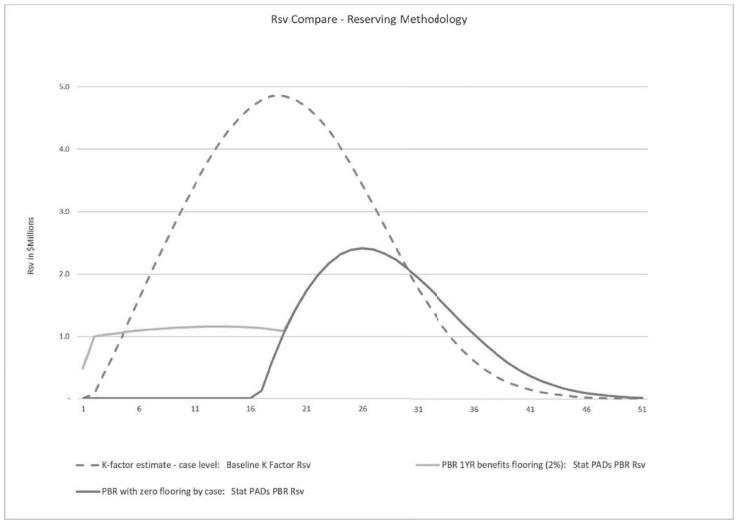
The proposed new floor solves the issue of the PBR reserves being too low for too long in the early durations, without creating reserve deficiencies in the later durations.

Sample Reserve Comparisons



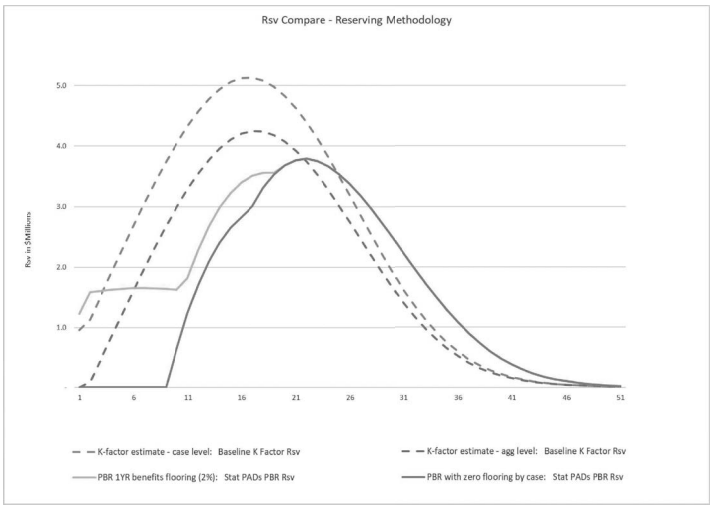
Business mix:
- 100% new business
- 100% younger white-collar contract

Sample Reserve Comparisons



Business mix:
- 100% new business
- 100% younger white-collar contract

Sample Reserve Comparisons



Business mix:
- 100% new business
- 50% each of 100% retirees with older blue-collar contract and younger white-collar contract

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Draft: 11/6/24

Valuation Manual (VM)-22 (A) Subgroup
Virtual Meeting
October 23, 2024

The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met Oct. 23, 2024. The following Subgroup members participated: Ben Slutsker, Chair (MN); Elaine Lam, Vice Chair (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); Nicole Boyd (KS); William Leung (MO); Bill Carmello (NY); Rachel Hemphill and Iris Huang (TX); Tomasz Serbinowski (UT) and Craig Chupp (VA).

1. Discussed VM-22 SPA Draft Comments

A. Unbuffered Amount Calculation for DR

Slutsker noted a question that has repeatedly surfaced: if a deterministic reserve (DR) is elected through the deterministic certification option, is it required to have a standard projection amount (SPA)? If so, what should be done with the buffer. Slutsker said the intention is that the SPA is required, and there should be clarification made in the draft to address how to calculate the buffer since there are no CTE70 and CTE65 calculations for a single scenario. Slutsker said the proposed edits to Section 6.B.4.a-b are to explicitly state that a single scenario reserve will be used for the DR. Chupp noted similar changes would also be needed in Section 6.A.1 and the main VM22, Requirements for Principle-Based Reserves for Non-Variable Annuities, draft. The Subgroup agreed to the clarifying edits to use require an SPA calculation for the DR.

Slutsker described two options in Section 6.B.4.c. for the buffer calculation. Option 1 is to have the buffer amount set using a single scenario that is calibrated to the CTE65 and has several advantages: 1) there is consistency with a currently drafted footnote in the proposed VM-22 Reserves Supplement; 2) there is more consistency with the stochastic reserve (SR) calculation; and 3) there is some flexibility in which valuation date to select the scenario that calibrates. Option 2 is to have no buffer for the DR which has the advantage of simplicity from a review and implementation basis. However, the disadvantages are inconsistency with the SPA for the SR and likely a higher resulting reserve.

David Reynolds (Legal and General) asked if the Subgroup had made the decision to use the ASPA as a component of the reserve or will it serve more as a disclosure item. Slutsker said for VM-21, Requirements for Principle-Based Reserves for Variable Annuities, it is part of the reserve and serves as a guardrail. However, Slutsker said that determination had not been made for VM-22. Under either direction, the calculation itself would be the same but there would be different impacts to the final reserve. This is planned to be discussed in early 2025. Slutsker recommended option 1 going forward and to include option 2 as part of the drafting note and include it in the next exposure to get comments. The Subgroup agreed to ask for clarifying comments on the next exposure and will use option 1 as the default with option 2 as an alternative in a drafting note.

B. Location of Mortality Requirements in SPA Section

Slutsker introduced the comment that noted there is mortality guidance for pension risk transfers (PRTs), single premium immediate annuities, longevity risk transfers and structured settlements in the guaranteed actuarial present value (GAPV) section. However, he said these products may not actually have a GAPV. The Subgroup agreed to move the mortality requirements from the GAPV section to Section 8 where the broader mortality requirements reside.

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C. Future Mortality Improvement in GAPV Calculation

Slutsker noted the issue arose from the field test regarding how far the improvement can be applied. Slutsker said the date in Section 6.C.3.e was confirmed to be 2022 (not 2021) by the Society of Actuaries (SOA) and the intent is that the GAPV would restrict the mortality movement beyond Dec. 31, 2022. Slutsker noted part of the reason it was put into VM-22 was for consistency with the fixed date in VM-21. Brian Bayerle (American Council of Life Insurers—ACLI) said leaving it as is for consistency to be arrived later would be fine. However, he said he is also OK with removing the static date. Carmello said he supported doing what the Subgroup deems appropriate considering the lack of rationale for it and consider updates to VM-21 later. Bruce Friedland (American Academy of Actuaries—Academy) suggested finding out more about the rationale and if that date needs to be moved in the future and when. The Subgroup agreed to remove the limitation in Section 6.C.3.e on mortality improvement to simply reference Section 6.C.8 and add a drafting note to receive comments.

D. Clarification of Valuation Date for Discounting

Carmello suggested that the definition of valuation date in Section 6.C.3.f should be the date the financial report is being developed. The Subgroup agreed to move forward with the edit.

E. ANB vs ALB

Slutsker noted the SOA was consulted during the field test and they identified that the assumptions as based on age nearest birthday (ANB) and both the factors and tables would need to be adjusted to convert to age last birthday (ALB). The Subgroup agreed to include a guidance note to clarify the draft based on the SOA feedback.

F. Structured Settlement Mortality Table Clarification

Slutsker noted there were questions if the definition of duration in Table 6.4 meant since issue or from the valuation date. The Subgroup agreed to change the term “duration” to “contract year” to align with the SOA confirmed interpretation that duration meant contract year.

G. Mortality Flooring for Group Annuities, International and Longevity Reinsurance Contracts

Bayerle said the issue is that the mortality flooring requirement at the company's prudent estimate is inconsistent with VM-21 and the intent of the SPA to catch assumption outliers. Bayerle noted there may be instances where an individual assumption could be greater or less than a company’s prudent estimate assumptions and should be consistent with the other assumptions within the SPA. Bayerle said performing this comparison negates the ability to decide whether the prudent best estimate might be an outlier in this case. The Subgroup agreed to remove the comparison to the company’s prudent best estimate and just use the 1994 Group Annuity Mortality (GAM) with Projection Scale AA since the comparison is already done in aggregate, and the more granular level comparison is not done elsewhere in the framework.

2. Discussed Comments Received on the VM-22 Draft

Slutsker outlined several areas of clarification that arose from the field test. Slutsker introduced one that noted the need for VM II. Section 2.C to better define the date for settlement options to be subject to VM-22 because the date could be: 1) the issue date of the settlement option; or 2) the issue date of the contract from which the settlement originated. Carmello recommended the issue date of the settlement option as currently written unless a company receives approval from its domestic regulator to do it another way. Slutsker agreed with Carmello that

the date of the settlement option makes sense but should be consistent with the current VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities. The Subgroup agreed to move forward to be consistent with VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities language.

Slutsker noted another clarification needed regarding the scope of funding agreements in VM-22. Slutsker said that if the funding agreements should be in the list of contracts out of scope in VM II. Section 2.D then a definition should be added to VM-01, Definitions for Terms in Requirements. Slutsker noted that the definition added to the draft was based on the definition in the annuity model regulation. Carmello suggested removing the specification of a group of contracts from the definition because that is already a group product. Katie Rook (Equitable) agreed with this change. The Subgroup agreed to exclude funding agreements from the scope of VM-22 and to make the edit to the definition to remove "group of."

Slutsker discussed why, under VM-22, the benefits that stem from variable annuity contracts, like guaranteed minimum income benefit (GMIB) annuitizations, are included in the accumulation reserving category while all other payout contracts like structured securities fall into the payout category even though the risk profiles are similar. Slutsker said the Subgroup discussed this on a prior call and the preliminary vote was to put a deferred annuity with an exhausted fund value in the accumulation category. Slutsker noted one option discussed was to put a deferred annuity in the payout annuity reserving category because it essentially becomes a payout annuity once the fund value is exhausted, but then it would be in a different category that cannot be aggregated with contracts that do not have the fund value exhausted even though they are the same contract types.

Slutsker said the other option discussed was to keep the deferred annuity with an exhausted fund value in the accumulation reserving category and keep it with the same contracts and do not switch categories. Bayerle said one of the reasons for keeping contracts in the same reserving category is due to the exclusion tests. Bayerle explained that it might be difficult for some companies to calculate the stochastic excusion ratio test (SERT) and set reserves if the reserving category switches as a result of fund exhaustion. Slutsker suggested that since this item was a close vote, it should have a drafting note to revisit later and point it out when the recommendation is made to the Life Actuarial (A) Task Force. Carmello suggested including other items that were close votes when the recommendation is made to the Task Force. The Subgroup agreed to move forward with this drafting note.

Slutsker introduced another comment regarding Section 4.D.1.a language asking the Subgroup to clarify that the starting asset amount should include an allocated pre-tax interest maintenance reserve (PIMR) as implied in the first paragraph of the section but is not mentioned as a component later in the same section. Hemphill and Carmello agreed the edit made sense. Hemphill noted that the Task Force made recent edits around PIMR and negative values and she questioned whether the PIMR discussion in the VM-22 draft was patterned off of VM-20 or VM-21. Hemphill said VM-20 needed an edit because the treatment needed to follow VM-30, Actuarial Opinion and Memorandum Requirements language. Slutsker said the Subgroup will follow up to ensure consistency with the recent changes to the *Valuation Manual* regarding PIMR.

Having no further business, the VM-22 (A) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/2024-3-Fall/VM-22 Calls/10 23/Oct23 VM22Minutes.docx

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Draft: 11/5/24

Valuation Manual (VM)-22 (A) Subgroup
Virtual Meeting
October 9, 2024

The VM-22 (A) Subgroup met Oct. 9, 2024. The following Subgroup members participated: Ben Slutsker, Chair (MN); Elaine Lam, Vice Chair (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); William Leung (MO); Seong-min Eom (NJ); Bill Carmello (NY); Rachel Hemphill and Iris Huang (TX); Tomasz Serbinowski (UT) and Craig Chupp (VA).

1. Discussed a Preneed Annuity Comment Letter

Tom Doruska (Homesteaders Life Company) presented proposed changes to the VM-22, Requirements for Principle-Based Reserves for Non-Variable Annuities, draft to remove preneed annuities from scope. He said that preneed annuities are simple fixed deferred annuities used to pay for goods and services related to a policyholder's death. Doruska noted these are typically small contracts under $10,000 in benefits without guaranteed living benefits (GLBs) and no guaranteed interest rate aside from nonforfeiture benefits. He noted that a distinction between preneed life insurance and preneed annuities is that preneed life insurance has specific preneed mortality tables and valuation formulas, while preneed annuities do not.

Serbinowski suggested the Subgroup consider whether to carve out simple products like this that have no guarantees even if the products are used outside of the preneed market to avoid defining preneed annuity. Doruska stated that the policyholder behavior for preneed annuity differs from other simple fixed deferred annuities because if a policyholder terminates their policy or accesses a partial surrender, those actions will disrupt their funeral plan.

Leung asked if the preneed annuity valuation method would default to the current Commissioner Annuity Reserve Valuation Method (CARVM). Doruska said the intent of the proposed language is to default to the current CARVM rules for these products. Carmello questioned whether contracts exempted from VM-22 should be allowed to use the principle-based reserving (PBR) rules even if they do not have to. Bruce Friedland (American Academy of Actuaries—Academy) said he thought blocks that would otherwise be exempt could go through PBR if a company is willing to go through all the requirements. Hemphill said that for life insurance, there is a distinction between products that are subject to the exemption tests and those that are not subject to VM-20, Requirements for Principle-Based Reserves for Life Products. Hemphill added that the Subgroup should be mindful that the optionality to do PBR or not for VM-22 may put a burden on companies regarding governance and VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation, documentation.

Slutsker said that the PBR framework was constructed on the premise that companies must go through the exclusion tests for a block of business or a product type to gain access to PBR. Therefore, if there is no exclusion test for a product, then there is no reporting. Carmello said it made sense to exempt this product outright rather than having some optionality of doing PBR and suggested that companies in the preneed space should comment on their concerns with the proposal. Leung made a motion, seconded by Yanacheak, to expose the preneed annuity comment letter for a 21-day public comment period ending Oct. 30. The motion passed.

2. Discussed SPA Exposure Comments

The Subgroup agreed to review each comment incorporated into the draft and accept the edits where there are no objections. Otherwise, it will discuss and request more information to revisit at a subsequent meeting.

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Brian Bayerle (American Council of Life Insurers—ACLI) noted there should be consistency across VM-21, Requirements for Principle-Based Reserves for Variable Annuities, and VM-22 regarding the inflation and base expense assumptions. He suggested the future inflation assumption in the current draft of 2% be updated to 2.5%. The Subgroup agreed to update Section 6.C.2.a and Section 6.C.2.c future inflation assumption to 2.5% to be consistent with both VM-21 and the historical inflation assumption of 2.5%.

Bayerle said the base maintenance expense assumption for the fixed indexed annuities in Table 6.1 are prescribed to be $100. He noted that while this is the same as for variable annuities (VA), the fee for fixed annuity contract would generally be expected to be significantly lower than the VA contract even though both have GLBs. Carmello suggested these assumptions should be based on the studies available, and it may be different from VA, but that that number may change over time. Yanacheak agreed with Carmello.

Slutsker noted that the assumptions in the VM-22 standard projection amount (SPA) draft came from a WTW presentation from the Subgroup's meeting on Nov. 30, 2022. Slutsker asked the ACLI to propose an expense assumption for the fixed indexed annuities. Bayerle agreed to take the request back to ACLI membership. The Subgroup will revisit this assumption during a future meeting.

Bayerle said the ACLI is looking for a clarification of "All other contracts" in Table 6.1 Base Maintenance Expense assumptions since many individuals may be covered on one policy for institutional products. Carmello said the intent was participants, not one contract or group, and suggested making an edit to clarify. The Subgroup agreed to put in a placeholder of "All other individual contracts or participants in a group contract" and add a drafting note until the assumption can be further addressed. Bayerle agreed to have ACLI membership review the assumption of $75 per participant in a group contract for appropriateness or propose an alternative. The Subgroup will revisit this assumption during a future meeting.

Slutsker said there had been some confusion regarding the application of the percent of account value expense assumption outlined in Section 6.C.2.b to products without account values. Carmello agreed with the ACLI proposal to proxy the account value as the present value of the benefit using the 10-year U.S. Treasury (UST10Y) at the valuation date to discount. The Subgroup agreed to move forward with this approach.

Slutsker said between the field test discussions and the ACLI comments, there is clarification needed for Section 6.C.3 regarding whether guaranteed minimum death benefits (GMDB) are included in the guaranteed actuarial present values (GAPV) definition because under VM-21, the GMDB is not included. Bayerle agreed to have ACLI membership work on proposed language to clarify this. The Subgroup will revisit this assumption during a future meeting.

Slutsker noted that the discussions during the field test and the ACLI comments identified clarifications needed for the calculation of integrated benefits in Section 6.C.3. The ACLI commented that for the future projection period, the survival factor appears to apply only to the living benefit and not the death benefit.

Angela McShane (EY) said the intent of the calculation is to discount both the death and living benefits each period. She also said the formula needs to be updated. Chris Conrad (American Academy of Actuaries—Academy) agreed. Linda Lankowski (RGA) said the correct notation depends on how the variables are defined in the formula. The Subgroup agreed to revisit this after appropriately defined notation is proposed.

Having no further business, the VM-22 (A) Subgroup adjourned.

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VM-22 Field Test Update and Model Office Results

NAIC Life Actuarial Task Force
November 15, 2024

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History

Since the 2022 final presentation of the reasonable assumptions for the standard projection amount, work has continued to develop the VM-22 field test

- ARCS drafted preliminary specifications for the field test, complete with a template for the collection of data in June 2022
- Draft preliminary specifications for public comment were exposed in Dec 2023
- Also in Dec 2023, the NAIC, Academy and the ACLI engaged EY to:
  - Assist all parties in the preparation for, conduct of, and analysis of the field test results; and
  - Develop a model office implementation of the VM-22 specifications, usings results from that model office to compare results with those from the field test and to assess products and/or scenarios which might be difficult for participants in the field test.
- EY reviewed preliminary draft specifications from ARCS, providing comments and suggestions to the NAIC, Academy and ACLI in Jan 2024
- Between Feb and June 2024, the NAIC, Academy, ACLI, and EY met weekly to review specifications and seek consensus.

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Current State

Analyzing the results of the field test and the model office analysis

On Aggregation of results from field test:

- Aggregation to allow public dissemination of results as anonymized (requires a minimum of 5 entities for each set of results)
- Limits on public dissemination still allow regulators to view results which do not meet aggregation minima and to view individual company responses
- Academy working closely with EY on producing aggregated results.
- Aiming to have preliminary aggregate results for a VM-22 work group meeting scheduled for December 18th
  - Will inform work group by November 30th if this will be possible.
- Full aggregated results available by early January.

Results submitted:

# of Entities or Groups with Baseline results: 20

# of Entities with results for:

SPIA	9	FDA w/ no WB	13	FIA w/ no WB	13
SSC	5	FDA w/ WB	4	FIA w/ WB	11
PRT	6				

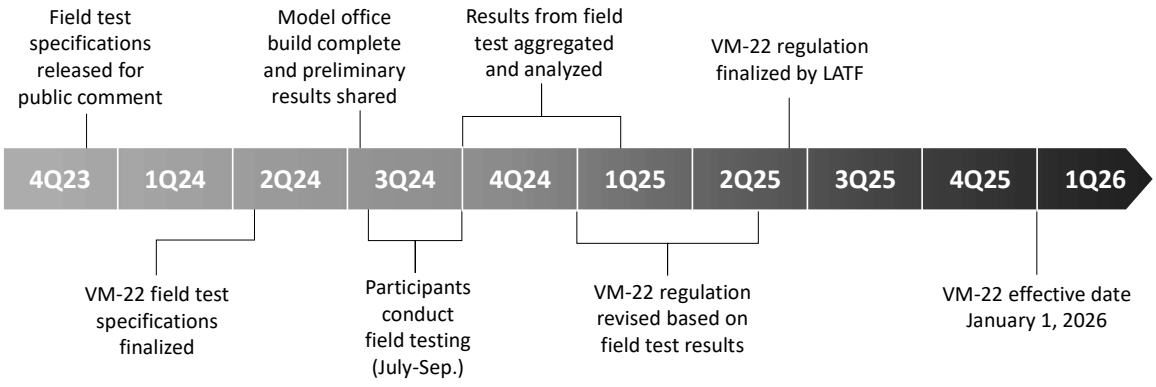
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EY to discuss Project Timeline and Model Office Results

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Target VM-22 Timeline

VM-22 field test timeline and key milestones are provided below:



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VM-22 Field Test Model Office: Life Actuarial Task Force

November 15, 2024

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Disclaimer

These model office results are based on the model specifications agreed upon by members of the NAIC, ACLI, and AAA. Results from actual companies participating in the field test will vary based on real product features, assumptions and distribution of inforce blocks.

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Overview of Model Office

EY developed a Moody's AXIS-based model office to support the field test

Overview

Model office specifications were finalized after rounds of discussions between EY, NAIC, ACLI and Academy personnel. The specifications were also refined as per feedback provided by ACLI member companies and ARCSC.

Objectives

- Produce results to analyze VM22 framework on a **representative set of products**, under various sensitivities and scenarios
- Provide **first cut of analysis** in advance of field test commencement, to get ahead of any unexpected test-related results or issues
- Perform further ad-hoc analysis and sensitivities to **lighten the load** on the number of runs being demanded of industry participants
- **Establish a forum** with industry participants while field test is in progress, to triage emerging issues and provide support
- Assess products, scenarios or projections **which may not be feasible** for participants in the field test

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VM-22 Impacts by Product

For the products modeled in the model office, deferred annuities with guaranteed living benefits had the largest decrease when moving from pre-PBR CARVM to VM-22.

Product	CARVM ($M)	SR ($M)	SPA ($M)	CSV ($M)	Final VM-22 reserve ($M)	Change from CARVM (%)
SPIA	530.6	512.4	500.5	N/A	512.4	(3.4%)
PRT	501.3	472.3	484.0	N/A	484.0	(3.5%)
FDA (no WB)	278.0	278.7	276.0	275.5	278.7	0.3%
FDA (WB)	1,055.3	808.7	836.7	765.7	836.7	(20.7%)
FIA (no WB)	281.1	289.3	294.0	279.3	294.0	4.6%
FIA (WB)	1,050.9	846.9	875.6	792.2	875.6	(16.7%)

* ***Important disclaimer for the FIA model office results***: the cost of the FIA hedges is currently accounted for via a spreadsheet topside for each scenario. The model currently incorporates the payoffs of the hedges, but not the costs. We have included the costs via topside, estimated as *option budget x AV / 12* (since there are annual resets), which are reflected in the results above and throughout this presentation. A system enhancement is in progress from the vendor.

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Payout Annuities Reserving Category: SPIA and PRT

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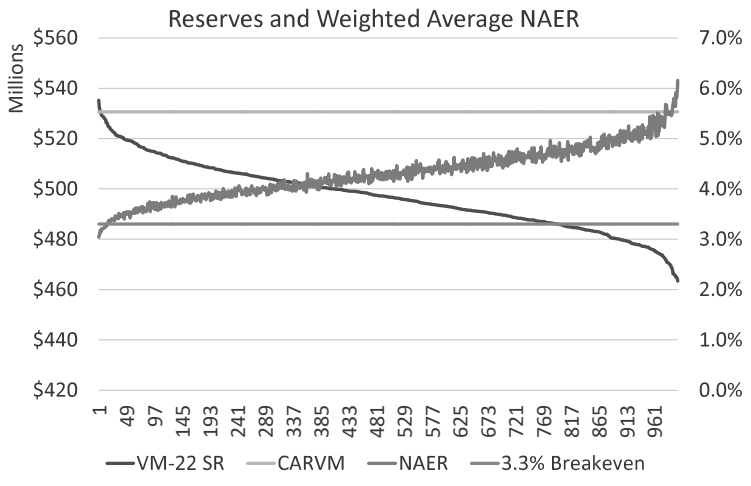
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SPIA: NAER Analysis

CARVM	SR	SPA	Final VM-22 Reserve	Change from CARVM
530.6	512.4	500.5	512.4	(3.4%)

Using an initial asset portfolio of 10- and 15-year bonds, weighted to produce a duration match with the liabilities, our model office produced a VM-22 reserve which was 3.4% lower than pre-PBR CARVM.

As part of the attribution of these results from current CARVM, we determined a "break-even" rate of 3.3%, by calculating a PV of benefits and expenses under the VM-22 scenarios that would equal the current CARVM reserve of $530.6m. The graph to the right shows the VM-22 reserves by scenario, compared with the weighted average earned rate. In nearly all 1,000 scenarios, the portfolio returns exceeded the break-even rate, driving the reduction in reserves under VM-22.



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PRT Results by Sub-block

CARVM	SR	SPA	Final VM-22 Reserve	Change from CARVM
501.3	472.3	484.0	484.0	(3.5%)

The PRT block in our model office consisted of three sub-blocks: structured settlements (SS), a retiree block and a deferred block. Overall, the results from PRT were similar to SPIA, but in looking deeper at the sub-block level, we see differences in the comparisons of results. This is a product where we expect to see more variance in results from the industry participants, depending on the characteristics of the specific blocks, which has started to be revealed with some of the early submissions for PRT.

Description	Metric	SR ($M)	SPA ($M)	CARVM ($M)	Change from CARVM(%)
SS	CTE 70	318.5	316.8	337.6	(5.7%)
Retired	CTE 70	114.7	124.3	120.5	3.1%
Deferred	CTE 70	39.5	43.1	43.2	(0.1%)
Total	**CTE 70**	**472.3**	**484.0**	**501.3**	**(3.5%)**

- The results presented above are for the three sub-blocks of PRT.
  - No changes were made to the starting asset portfolio, economic scenarios, or reinvestment strategy to vary by block
- Nearly all of the reserve reduction from CARVM came from the structured settlement (SS) block, due to the higher mortality rates used in our prudent margin assumptions and prescribed SPA assumptions
- The Retired block saw an increase in VM-22 Reserve from CARVM, driven by the higher SPA amount
- The total line shows the results from the aggregate baseline run shown in slide 5

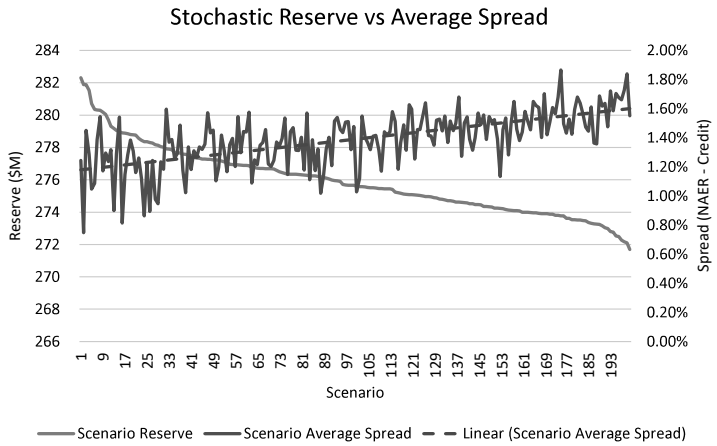
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Accumulation Annuities Reserving Category: FDA and FIA

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FDA without GLWB: Reserve Sensitivity by Weighted Average Spread

CARVM	SR	SPA	CSV	Final VM-22 Reserve	Change from CARVM
278.0	278.7	276.0	275.5	278.7	0.3%



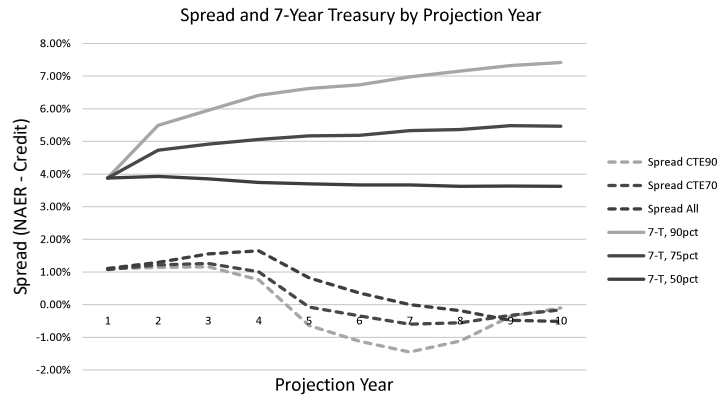
- For each of the 200 stochastic scenarios, the graph shows the VM-22 Stochastic Reserve (orange line) and average spread (blue line), where the average spread is calculated as the **weighted average NAER minus weighted average implied crediting rate**.
- This supports the intuition that larger reserves are correlated with compressed spreads as the scenario will require a larger beginning asset amount to support future cashflow needs.
- The relationship is more muted than seen on SPIA due to liabilities also being impacted by scenarios.

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FDA without GLWB: Weighted Average Spread versus 7-Year Treasury

CARVM	SR	SPA	CSV	Final VM-22 Reserve	Change from CARVM
278.0	278.7	276.0	275.5	278.7	0.3%

In the graph below, the solid lines represent the 7-year treasury rates, for all Conning scenarios, anchored on the 50th, 75th and 90th percentiles. Dashed lines represent the average spread earned on investments, calculated as the weighted average NAER minus weighted average crediting rate. Years 1-10 are shown as ~85% of the block has decremented by year 10.



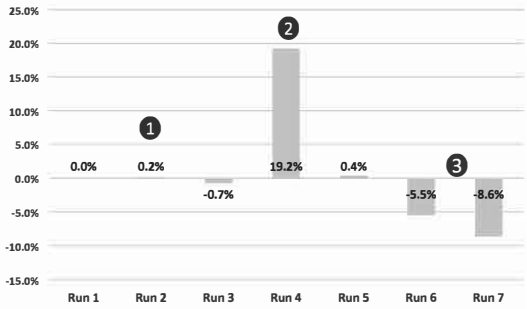
- The relationship shows higher CTEs are comprised of scenarios that observe worse (more negative) spreads, but also higher interest rates.
- The crediting rate formula for this representative product is the driver, as renewal credits equal 7-year Treasury minus 50 bps spread.
- The impact is also likely compounded by lower dynamic lapses when the crediting rate is outperforming the GMIR by greater margins.

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FDA with GLWB: CARVM vs. VM-22

CARVM	SR	SPA	CSV	Final VM-22 Reserve	Change from CARVM
1,055.3	808.7	836.7	765.7	836.7	(20.7%)

We performed a set of runs to understand the reserve differences from the current CARVM methodology to VM-22.



Commentary
Run 1: CARVM reserve using immediate withdrawals as only withdrawal path, and SPA mortality assumption ($885.1M)
Run 2: VM-22 SPA, with no lapses and 100% immediate withdrawals ($886.6M)
Run 3: CARVM reserve using immediate withdrawals and CARVM mortality assumption ($878.9M)
Run 4: CARVM reserve using perfect efficiency on withdrawals ($1,055.3M)
Run 5: VM-22 SPA with no lapses, and partial withdrawal utilization assumption ($888.3M)
Run 6: VM-22 SPA with assumed lapses and utilizations ($836.7M)
Run 7: VM-22 SR with assumed lapses and utilizations ($808.7M)

There are three key takeaways from this analysis:

1. When we remove the perfect efficiency from CARVM, remove lapses from SPA, and use the same mortality assumption in both, the reserve differences are only 0.2%.
2. The CARVM implicit assumption of perfect withdrawal efficiency is main driver of differences between VM-22 and current reserving methodology. CARVM reserves increased by 19% when all paths were modeled.
3. VM-22 lapses also lowered the reserve, as shown in the Run 5 and Run 6 results for SPA and SR, respectively.

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Reinvestment Guardrail Sensitivities

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VM-22 Reinvestment Guardrail Sensitivities

The impacts of testing alternative reinvestment guardrails resulted in lower reserves than the baseline 50/50 A/AA split. The table below shows the impact on the Stochastic Reserve for the following tests:

- **Baseline:** 50% AA, 50% A
- **Sensitivity 1:** 5% Treasury, 15% AA, 40% A, 40% BBB
- **Sensitivity 2:** 5% Treasury, 15% AA, 80% A

Product	Baseline ($M)	Sensitivity 1 ($M)	Difference from baseline	Sensitivity 2 ($M)	Difference from baseline
SPIA	512.4	512.6	0.0%	511.9	(0.1%)
PRT	472.3	471.7	(0.1%)	470.2	(0.5%)
FDA (no WB)	278.7	277.4	(0.5%)	277.9	(0.3%)
FDA (WB)	808.7	802.3	(0.8%)	806.5	(0.3%)
FIA (no WB)*	289.3	286.2	(1.1%)	288.0	(0.4%)
FIA (WB)*	846.9	839.9	(0.8%)	844.3	(0.3%)

* ***Important disclaimer for the FIA model office results***: the cost of the FIA hedges is currently accounted for via a spreadsheet topside for each scenario. The model currently incorporates the payoffs of the hedges, but not the costs. We have included the costs via topside, estimated as *option budget x AV / 12* (since there are annual resets), which are reflected in the results above and throughout this presentation. A system enhancement is in progress from the vendor.

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Stochastic Exclusion Ratio Test (SERT)

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Stochastic Exclusion Ratio Test results

The table below summarizes the results of the stochastic exclusion ratio test for each product included in the model office. The impact of applying a +/- 5% mortality margin did not materially impact the resulting ratio for all products.

Product	95% Mortality Factor	100% Mortality Factor	105% Mortality Factor
SPIA	3.6%	3.3%	3.1%
PRT	3.7%	3.4%	3.2%
FDA (no WB)	1.3%	1.3%	1.3%
FDA (WB)	2.1%	2.2%	2.3%
FIA (no WB)*	5.8%	5.8%	5.8%
FIA (WB)*	33.8%	33.7%	33.6%

* ***Important disclaimer for the FIA model office results***: the cost of the FIA hedges is currently accounted for via a spreadsheet topside for each scenario. The model currently incorporates the payoffs of the hedges, but not the costs. We have included the costs via topside, estimated as *option budget x AV / 12* (since there are annual resets), which are reflected in the results above and throughout this presentation. A system enhancement is in progress from the vendor.

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Next Steps for the VM-22 Field Test

- Field test results from participants have been received from all entities that were scheduled to submit
- Work is now in progress to aggregate and analyze participant results
- Additional model office sensitivity testing will be performed as necessary to support questions that arise from the field test participant results

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Appendix: Modeling Specifications

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SPIA Methods and Assumptions

The table below provides a summary of the assumptions and common model elements used in the development and testing of the model office's SPIA block.

Modeled Balance	Assumptions	Common Model Elements
Stochastic Exclusion Ratio Test (SERT)	• 95%, 100% and 105% of anticipated experience mortality assumption excluding margin as prescribed • Prudent estimate expenses (+5% margin) • 16 scenarios prescribed by the NAIC	• 50-year projection • Block of business consists of ~$500M current stat reserves (CARVM) • Greatest Present Value of Accumulated Deficiency (GPVAD) and Direct Iteration Method (DIM) reserving methods used for both exclusion testing and stochastic reserves
Stochastic Reserve (SR)	• 2012 IAM mortality table with 0.5% mortality improvement applied from 2012 up until each future projection year • Maintenance expense of $10 per contract with 2% annual inflation • Prudent margins for mortality and expenses • 200 and 1,000 scenario sets (random selection) from GOES scenario set #1*	
Standard projection amount (SPA)	• 2012 IAM mortality table with projection Scale G2 improvement factors applied from 2021 up until each future projection year • Maintenance expense of $50 per contract multiplied by 1.025^(valuation year – 2015) in the first projection year and increased by an annual inflation of 2% each year thereafter • 200 and 1,000 scenario sets from GOES scenario set	

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SPIA Product Features

The table below provides a summary of the product features, in-force distribution and actuarial assumptions modeled for SPIA:

Modeled Balance	Assumptions
Base Product	• Single premium at issue • 10 year certain payout annuity with life contingent payments thereafter
Riders	• None
In-force distribution	• 1,200 policies (600 male, 600 female) • 10 issue years of business (2014-2023), distributed equally across issue months • Issue ages 60 (10%), 65 (25%), 70 (35%), 75 (20%), 80 (10%)
Anticipated experience assumptions	• Mortality: 2012 IAM ANB • Mortality improvement: 0.5%, using 2012 as base year • Lapses: 0% • Partial Withdrawals: N/A • Annuitizations: N/A • Maintenance expenses: $10 per contract with 2% annual inflation

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PRT Product Features

The table below provides a summary of the product features, in-force distribution and actuarial assumptions modeled for PRT:

Modeled Balance	Assumptions
Base Product	• Three sub-blocks of business under PRT (to capture variations for SS and DIA) which can be reported and calculated separately or combined as needed: • 1) 80% retirees & 20% deferreds. For the deferreds, 75% take a lump sum prior to retirement and 25% annuitize (proxy for a deal where the carrier writes the contract prior to the plan conducting a termination) • 2) 90% retirees and 10% deferreds but 100% of the deferreds annuitize (proxy for a deal where the carrier writes the contract after the plan has already done a lump sum offering or a plan that does not offer lump sums at all) • 3) Younger age block (DIA and SS), with payments starting at specified age or duration
Riders	• None
In-force distribution	• 3,600 policies (1,800 male, 1,800 female) • 10 issue years of business (2014-2023), distributed equally across issue months • Issue ages 50 (3%), 55 (2%), 60 (15%), 65 (20%), 70 (20%), 75 (20%), 80 (20%)
Anticipated experience assumptions	• Mortality: 50/50 mix of blue and white collar mortality • Mortality improvement: None • Lapses: 0% • Partial Withdrawals: N/A • Annuitizations: Base case is all policies annuitize • Maintenance expenses: $61 per contract with 2% annual inflation and a 5% margin

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FDA and FIA Methods and Assumptions

The table below provides a summary of the assumptions and common model elements used in the development and testing of the model office's FDA and FIA blocks.

Modeled Balance	Assumptions	Common Model Elements
Stochastic Exclusion Ratio Test (SERT)	• 95%, 100% and 105% of anticipated experience mortality assumption excluding margin as prescribed • 16 scenarios prescribed by the NAIC	• 50-year projection • Greatest Present Value of Accumulated Deficiency (GPVAD) and Direct Iteration Method (DIM) reserving methods used for both exclusion testing and stochastic reserves
Stochastic Reserve (SR)	• 2012 IAM mortality table with 0.5% mortality improvement applied from 2012 up until each future projection year • Base lapses of 1%, 1%, 2%, 2%, 2%, 2%, 3%, 3%, 4%, 5%, 10% (ultimate rate – 10 year CDSC product) • Dynamic lapse factors based on rider ITM, from 50% to 150% • Maintenance expense equal to SPA assumption • Prudent margins for mortality, lapses, expenses • 200 and 1,000 scenario sets (via scenario picker) from GOES scenario set #1*	
Standard projection amount (SPA)	• 2012 IAM mortality table with projection Scale G2 improvement factors applied from 2012 up until each future projection year and prescribed Fx • Maintenance expense of $75 per contract multiplied by 1.025^(valuation year – 2015) in the first projection year and increased by an annual inflation of 2% each year thereafter, plus 7bps of projected AV for each year in the projection • 200 and 1,000 scenario sets from GOES scenario set	

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FDA (without GLWB) Product and Rider Features

The table below provides a summary of the product features, in-force distribution and actuarial assumptions modeled for FDAs (without GLWB):

Modeled Balance	Assumptions
Base Product	• Single premium at issue • 5-year surrender charge period (9%, 8.5%, 7.5%, 5.5%, 4%), with MVA • Free partial withdrawal of 10% • 1% minimum guarantee crediting rate • Crediting equal to 7-year treasury minus 50 bps spread; Crediting is reset at end of CDSC and then annually thereafter
Riders	• None
Commissions	• 5% of year 1 premium
In-force distribution	• 1,200 policies (600 male, 600 female) • 10 issue years of business (2014-2023), distributed equally across issue months and based on expected lapsation through valuation date • Issue ages 45 (5%), 50 (15%), 55 (20%), 60 (30%), 65 (25%), 70 (5%)
Anticipated experience assumptions	• Mortality: 2012 IAM ANB • Mortality improvement: 0.5%, using 2012 as base year • Base lapses: 1%, 1%, 2%, 2%, 4%, 40%, 10% (ultimate rate) • Dynamic lapses: Factor based on ITM, where ITM = Current Crediting Rate / Market Rate. If ITM <= 0.8, then Factor = 150%. If ITM >= 1.2, then Factor = 50%. Factor is interpolated between these points. • Partial Withdrawals: SPA prescribed assumption • Annuitizations: 0% • Maintenance expenses: SPA prescribed assumption

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FDA (with GLWB) Product and Rider Features

The table below provides a summary of the product features, in-force distribution and actuarial assumptions modeled for FDAs (with GLWB):

Modeled Balance	Assumptions
Base Product	• Single premium at issue • 10-year surrender charge period (9%, 8.5%, 7.5%, 6.5%, 5.5%, 4.5%, 3.5%, 3%, 2%, 1%), without MVA • Free partial withdrawal of 10% • 1% minimum guarantee crediting rate • Crediting equal to 7-year treasury minus 50 bps spread; Crediting is reset at end of CDSC and then annually thereafter
Riders	• GLWB rider with fees equal to 75 bps of BB • BB grows at 8% (simple interest) per year for 10 years or until withdrawals begin (whichever comes first)
Commissions	• 5% of year 1 premium
In-force distribution	• 1,200 policies (600 male, 600 female) • 10 issue years of business (2014-2023), distributed equally across issue months and based on expected lapsation through valuation date • Issue ages 50 (15%), 55 (25%), 60 (35%), 65 (20%), 70 (5%)
Anticipated experience assumptions	• Mortality: 2012 IAM ANB • Mortality improvement: 0.5%, using 2012 as base year • Base Lapses: 1%, 1, 2, 2, 2, 2, 3, 3, 4, 5, 10 (ultimate rate) • Dynamic Lapses: Factor from 50% to 150% when AV > 0; Factor = 0% when AV = 0; Factor based on ITM, where ITM = PV of WB payments divided by CSV. If ITM <= 0.8, then Factor = 150%. If ITM >= 1.2, then Factor = 50%. Factor is interpolated between those two points. • Partial Withdrawals: assume policyholders withdraw 100% of the MWP; wait periods distributed by duration and attained age • Annuitizations: 0% • Maintenance expenses: SPA prescribed assumption

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FIA (without GLWB) Product and Rider Features

The table below provides a summary of the product features, in-force distribution and actuarial assumptions modeled for FDAs (without GLWB):

Modeled Balance	Assumptions
Base Product	• Single premium at issue • 5-year surrender charge period (9%, 8.5%, 7.5%, 5.5%, 4%), with MVA • Free partial withdrawal of 10% • Option budget equal to 7-year treasury minus 50 bps spread, with 1-year cap crediting based on S&P index
Riders	• None
Commissions	• 5% of year 1 premium
In-force distribution	• 1,200 policies (600 male, 600 female) • 10 issue years of business (2014-2023), distributed equally across issue months and based on expected lapsation through valuation date • Issue ages 45 (5%), 50 (15%), 55 (20%), 60 (30%), 65 (25%), 70 (5%)
Anticipated experience assumptions	• Mortality: 2012 IAM ANB • Mortality improvement: 0.5%, using 2012 as base year • Base lapses: 1%, 1%, 2%, 2%, 4%, 40%, 10% (ultimate rate) • Dynamic lapses: Factor based on ITM, where ITM = Current Crediting Rate / Market Rate. If ITM <= 0.8, then Factor = 150%. If ITM >= 1.2, then Factor = 50%. Factor is interpolated between these points. • Partial Withdrawals: SPA prescribed assumption • Annuitizations: 0% • Maintenance expenses: SPA prescribed assumption

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FIA (with GLWB) Product and Rider Features

The table below provides a summary of the product features, in-force distribution and actuarial assumptions modeled for FIAs (with GLWB):

Modeled Balance	Assumptions
Base Product	• Single premium at issue • 10-year surrender charge period (9%, 8.5%, 7.5%, 6.5%, 5.5%, 4.5%, 3.5%, 3%, 2%, 1%), without MVA • Free partial withdrawal of 10% • Option budget equal to 7-year treasury minus 50 bps spread, with 1-year cap crediting based on S&P index
Riders	• GLWB rider with fees equal to 75 bps of BB • BB grows at 8% (simple interest) per year for 10 years or until withdrawals begin (whichever comes first)
Commissions	• 5% of year 1 premium
In-force distribution	• 1,200 policies (600 male, 600 female) • 10 issue years of business (2014-2023), distributed equally across issue months and based on expected lapsation through valuation date • Issue ages 50 (15%), 55 (25%), 60 (35%), 65 (20%), 70 (5%)
Anticipated experience assumptions	• Mortality: 2012 IAM ANB • Mortality improvement: 0.5%, using 2012 as base year • Base Lapses: 1%, 1, 2, 2, 2, 2, 3, 3, 4, 5, 10 (ultimate rate) • Dynamic Lapses: Factor from 50% to 150% when AV > 0; Factor = 0% when AV = 0; Factor based on ITM, where ITM = PV of WB payments divided by CSV. If ITM <= 0.8, then Factor = 150%. If ITM >= 1.2, then Factor = 50%. Factor is interpolated between those two points. • Partial Withdrawals: assume policyholders withdraw 100% of the MWP; wait periods distributed by duration and attained age • Annuitizations: 0% • Maintenance expenses: SPA prescribed assumption

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NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS



Update on GOES Field Test and GOES (E/A) Subgroup Report

Mike Yanacheak, Chair, GOES (E/A) Subgroup
Scott O'Neal

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Agenda

1. GOES Field Test Update
2. GOES (E/A) Subgroup Key Discussion Topics
   a) Model Governance
   b) Negative Rates, UST Flooring
   c) Equity Calibration
   d) SERT Scenarios
   e) Scenario Selection
   f) Initial Yield Curve Fitting
3. Next Steps



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Status of Field and Model Office Testing

- There were five required runs using the new GOES field test scenario sets. The runs tested the latest calibration of the GOES as of year-end 2023, other alternative Treasury starting conditions, and included an equity market drop sensitivity.
- There were also seven optional field test runs that included additional Treasury, bond, and equity sensitivities along with a scenario set that used an alternative initial yield curve fitting methodology.
- Participants tested revised set of scenarios calibrated according to regulator-defined acceptance criteria, and confidential, participant-to-regulator discussions were held between July and October.
- Variable annuity and life model office testing results were presented in June and August, respectively to provide public disclosure of the impacts to reserves and capital. Many field test participants highlighted the value of the model office testing and were able to relate the results to that of their own field testing.

Required Field Test Runs:

Field Test Run	Scenario Sets	Inforce
Baseline	Scenario set(s) the company used for 12/31/23 statutory reporting of reserves and RBC	As of 12/31/23
#1 - GOES	Conning scenarios as of 12/31/23	As of 12/31/23
#2 – Low-Rate Shock	Conning scenarios with a starting UST yield curve as of 3/9/20 but with 12/31/23 starting credit spreads.	As of 12/31/23 but modified as necessary for a different starting UST yield curve.
#3 – Up Rate Shock	Conning scenarios with a starting UST yield curve as of 10/31/89 but with 12/31/23 starting credit spreads.	
#4 – Normal Yield Curve	Conning scenarios with a starting UST yield curve as of 12/31/04 but with 12/31/23 starting credit spreads.	
#5 – Down Equity Shock	Same as #1	As of 12/31/23 but modified for a 25% drop in equity markets.

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GOES (E/A) Subgroup: Key Discussion Topics

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Model Governance

- Field test participants frequently commented on the need for a robust model governance framework.
- The monthly delivery of scenarios, periodic model updates, and documentation were all cited by participants as needing robust governance and controls.
- **A Draft GOES Model Governance Framework was exposed by the GOES (E/A) Subgroup for public comment on September 25th. The comment period was extended to Friday, November 22nd.**

GOES Model Governance Framework

GOES Model	Scenario Delivery	Ongoing Maintenance	Ancillary Tools
Validation and Statistics	Documentation	Training Materials	Support

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Negative UST Rates and Flooring

- Participants commented that the frequency and severity of negative interest rates was too severe - even with a generalized fractional floor (GFF) applied to control both the frequency and severity of negative UST rates in the field test scenarios.
- The American Council of Life Insurers (ACLI) has recommended a refined version of the GFF, the dynamic GFF, be applied. This version of the floor greatly reduces the frequency of negative interest rates.
- **State insurance regulators are considering the ACLI's proposal, and the potential to vary the parameters of the dynamic GFF to achieve different levels of negative UST rate frequencies.**

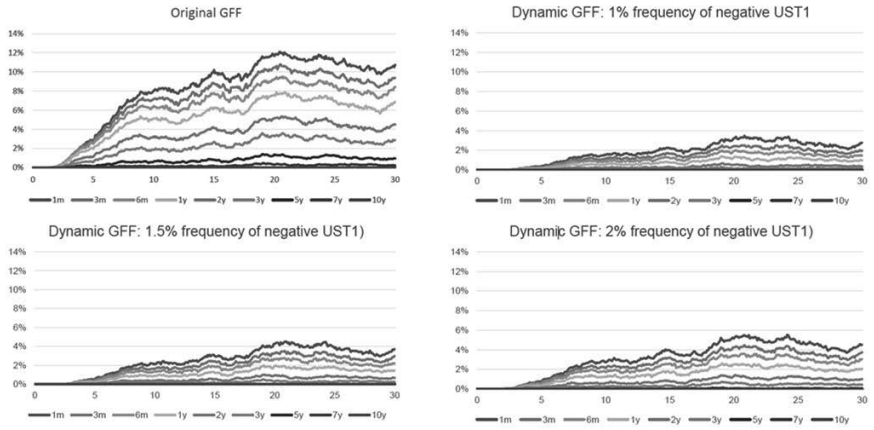
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Dynamic GFF UST Flooring Alternatives



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Source: American Council of Life Insurers

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Equity Calibration

- Equity model acceptance criteria were developed by the American Academy of Actuaries based on the results of reasonably calibrated alternative models. Regulators specified that the acceptance criteria be based on the average of the models.
- The accumulated equity returns of the GOES field test scenarios in the left tail were lower than the average target but were within the acceptable range produced by the alternative models and satisfied the acceptance criteria overall.
- **An alternative equity model calibration proposed by the ACLI is being considered by state insurance regulators that has lower percentile GWFs closer to the targets. If desired by regulators, Conning could also alter their existing calibration to bring the lower percentile GWFs to be closer to the targets.**

	Targets						Simulated						Ratio					
Percentiles	1	5	10	20	30	50	1	5	10	20	30	50	1	5	10	20	30	50
0	0.46	0.25	0.22	0.25	0.29	0.46	0.49	0.21	0.14	0.08	0.17	0.26	1.08	0.87	0.64	0.29	0.57	0.57
1	0.70	0.58	0.60	0.79	1.15	2.82	0.70	0.55	0.53	0.63	0.94	2.17	1.00	0.95	0.88	0.79	0.82	0.77
5	0.82	0.80	0.91	1.36	2.20	6.38	0.82	0.79	0.88	1.29	2.03	5.47	1.00	1.00	0.96	0.95	0.92	0.86
10	0.88	0.93	1.12	1.81	3.08	9.78	0.88	0.92	1.11	1.74	2.93	8.81	1.00	0.99	0.99	0.96	0.95	0.90
15	0.92	1.02	1.28	2.18	3.84	12.94	0.93	1.02	1.28	2.10	3.73	11.91	1.00	1.00	1.00	0.96	0.97	0.92
25	0.99	1.18	1.54	2.81	5.26	19.23	0.99	1.18	1.55	2.80	5.17	18.42	1.00	1.01	1.01	1.00	0.98	0.96
30	1.01	1.24	1.66	3.12	6.01	22.79	1.01	1.25	1.67	3.13	5.89	22.02	1.00	1.00	1.00	1.00	0.98	0.97
50	1.09	1.48	2.15	4.47	9.23	39.98	1.10	1.49	2.17	4.48	9.28	39.64	1.01	1.01	1.01	1.00	1.01	0.99
70	1.17	1.74	2.71	6.30	14.12	68.89	1.18	1.76	2.75	6.36	14.09	69.20	1.01	1.01	1.02	1.01	1.00	1.00
75	1.19	1.82	2.89	6.93	15.88	80.22	1.20	1.83	2.92	6.96	15.89	80.89	1.01	1.01	1.01	1.00	1.00	1.01
85	1.25	2.02	3.36	8.69	21.06	115.31	1.26	2.03	3.40	8.62	21.02	115.56	1.01	1.01	1.01	0.99	1.00	1.00
90	1.28	2.15	3.71	10.09	25.20	147.92	1.30	2.17	3.76	9.97	25.08	145.91	1.01	1.01	1.01	0.99	1.00	0.99
95	1.34	2.37	4.30	12.33	33.19	210.72	1.36	2.39	4.38	12.30	32.53	211.90	1.01	1.01	1.02	1.00	0.98	1.01
99	1.45	2.82	5.64	18.18	53.74	397.23	1.47	2.83	5.68	17.53	50.56	394.09	1.01	1.00	1.01	0.96	0.94	0.99
100	1.76	4.20	8.98	42.03	140.72	1676.94	1.82	4.29	9.32	38.28	120.07	2292.44	1.03	1.02	1.04	0.91	0.85	1.37

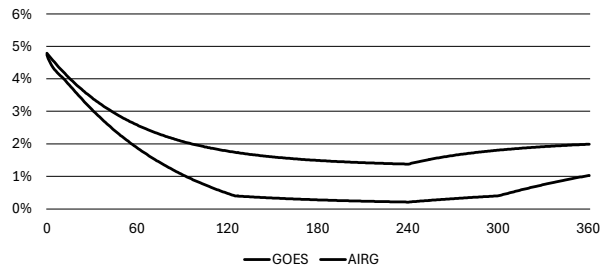
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2024 NATIONAL MEETING FALL / DENVER NAIC

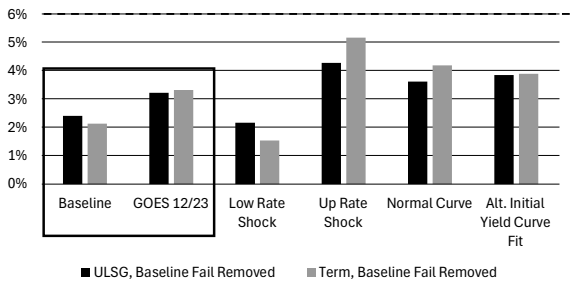
VM-20 SERT and Deterministic Reserve Scenarios

- VM-20 Stochastic Exclusion Ratio Test (SERT) scenarios are used to determine whether companies need to run the stochastic reserve for a given life model segment. The deterministic reserve scenario (1 of the 16 SERT scenarios) is also used to determine one of the VM-20 reserve components.
- Field test participants generally noted the increased conservatism/volatility of the field test SERT scenarios compared to the AIRG.
- Considering participants that passed the SERT in their baseline run, the average SERT ratio remained below the passing threshold (6%) for the field test participants. However, there were participants that failed the SERT in some field test runs that passed in the baseline.
- **The GOES (E/A) Subgroup exposed questions on the SERT and DR scenarios for public comment period ending Nov. 14 th.**

Scenario 12 (DR Scenario), 1YR UST, 12/31/23



Select* GOES 2024 Field Test Participant Average SERT Ratios by VM-20 Reserving Category



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*Field Test model segments where the SERT was failed in the baseline were removed from this chart

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2024 NATIONAL MEETING FALL / DENVER NAIC

Initial Yield Curve Fitting and Scenario Selection

Initial Yield Curve Fitting

- As part of the 2024 GOES Field Test, Conning's initial yield curve fitting methodology was used in the majority of the scenarios. An optional scenario set with an alternative initial yield curve fitting methodology proposed by the ACLI was also included in the field test.
- A number of 2024 GOES field test participants noted a preference for the ACLI proposed method.
- **This topic was discussed on the 10/9 call of the GOES (E/A) Subgroup, but a decision has not yet been made on which method to utilize going forward.**

Scenario Selection

- As part of the 2024 GOES Field Test, participants used an Excel-based tool developed by Conning to select scenario subsets.
- The tool allows users to select scenarios based on a 20-year UST significance measure or a Gross Wealth Factor from the Large Cap fund. All users get the same scenarios for a given number and method.
- Participants were able to successfully use the tool to create subsets, but limited feedback was received otherwise.
- **This topic was discussed on the 10/16 call of the GOES (E/A) Subgroup, but a decision on whether to utilize the tool has not yet been made.**

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Next Steps

Continue Work of GOES (E/A) Subgroup

- The GOES (E/A) Subgroup will resume meetings in December 2024.
- A schedule of planned meeting topics will be distributed to members, interested regulators, and interested parties ahead of the planned meetings in December.
- Model office testing is planned for any revisions to the GOES determined by the GOES (E/A) Subgroup to estimate the reserve and capital impacts.

Adoption of GOES

- The Life Actuarial (A) Task Force will need to adopt related Valuation Manual amendments by mid-year 2025 and the Life RBC (E) Working Group will need to adopt blanks changes by mid-year 2026 for the generator to be effective for reserve and capital calculations in 2026.
- Work will begin early in 2025 on an amendment proposal form (APF) to modify the Valuation Manual for GOES, followed by work on changes to the Life RBC Blanks.

*Model governance program and documentation will be revised and enhanced on an ongoing basis

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Draft: 11/5/24

Generator of Economic Scenarios (GOES) (E/A) Subgroup
Virtual Meeting
October 16, 2024

The GOES (E/A) Subgroup of Life Risk-Based Capital (E) Working Group and Life Actuarial (A) Task Force met Oct. 16, 2024. The following Subgroup members participated: Mike Yanacheak, Chair (IA); Pete Weber, Vice Chair (OH): Ted Chang (CA); Scott Shover (IN); Ben Slutsker (MN); William Leung (MO); Bill Carmello (NY); Rachel Hemphill (TX); and Craig Chupp (VA).

1. Discussed SERT Scenario Feedback

Scott O'Neal (NAIC) presented feedback from Field Test II participants on stochastic exclusion ratio test (SERT) Scenarios (Attachment Eighteen-A). Weber said that the Subgroup had the option of simply adjusting the SERT passing threshold or altering the SERT scenarios, but he was unsure of unintended consequences that could arise from adjusting the threshold. Hemphill proposed changing the threshold as the expedient next step, followed by working to improve the SERT scenarios at a later date. She suggested options like certification methods for incorrect failures and supporting documentation for unexpected passes. Slutsker said that he was not concerned about false failures due to the current VM-20, Requirements for Principle-Based Reserves for Life Insurance, certification method's three-year lookback flexibility to non-flexible premium products. He proposed reducing volatility for nonmaterial secondary guarantees under 20 years by allowing the certification method for those products to use a lookback period of three-years rather than the currently prescribed. Connie Tang (Retired) inquired about data supporting which scenarios caused failures. O'Neal noted some data from the 2024 field test was available. However he said it was inconsistent between runs and participants and required further research. Colin Masterson (American Council of Life Insurers—ACLI) asked if the ACLI could distribute the material for more feedback, and Yanacheak agreed. Yanacheak responded that this item could be included in an exposure to formally receive feedback on.

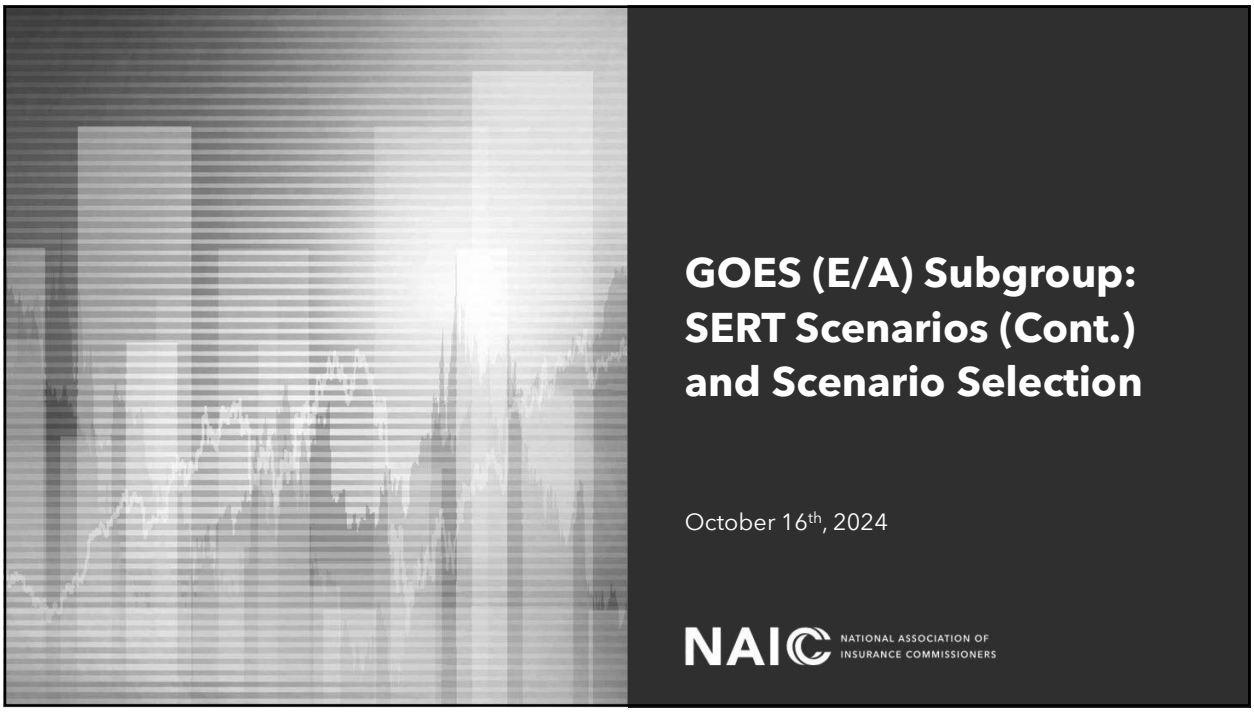
O'Neal continued the presentation with a discussion of the feedback on the deterministic reserve (DR) scenario. Tang noted that feedback on the conservatism of the DR scenario was more related to the calibration of the underlying stochastic scenarios, which Steve Strommen (Blufftop LLC) supported. Strommen added that the current calibration included a "low for long" criterion that was significantly more severe than any observed behavior, leading to intentionally harsher low scenarios. O'Neal, noting that the 20-year UST DR scenario was less extreme than the one-year UST DR scenario, asked whether companies were more concerned with the longer maturity DR scenarios or the shorter maturity DR Scenarios. Tang said it could vary depending on a company's products and investment strategies. Yanacheak asked O'Neal to provide more data and charts on the different maturity Treasury DR scenarios, to which O'Neal responded could be provided in the exposure.

2. Discussed Scenario Selection

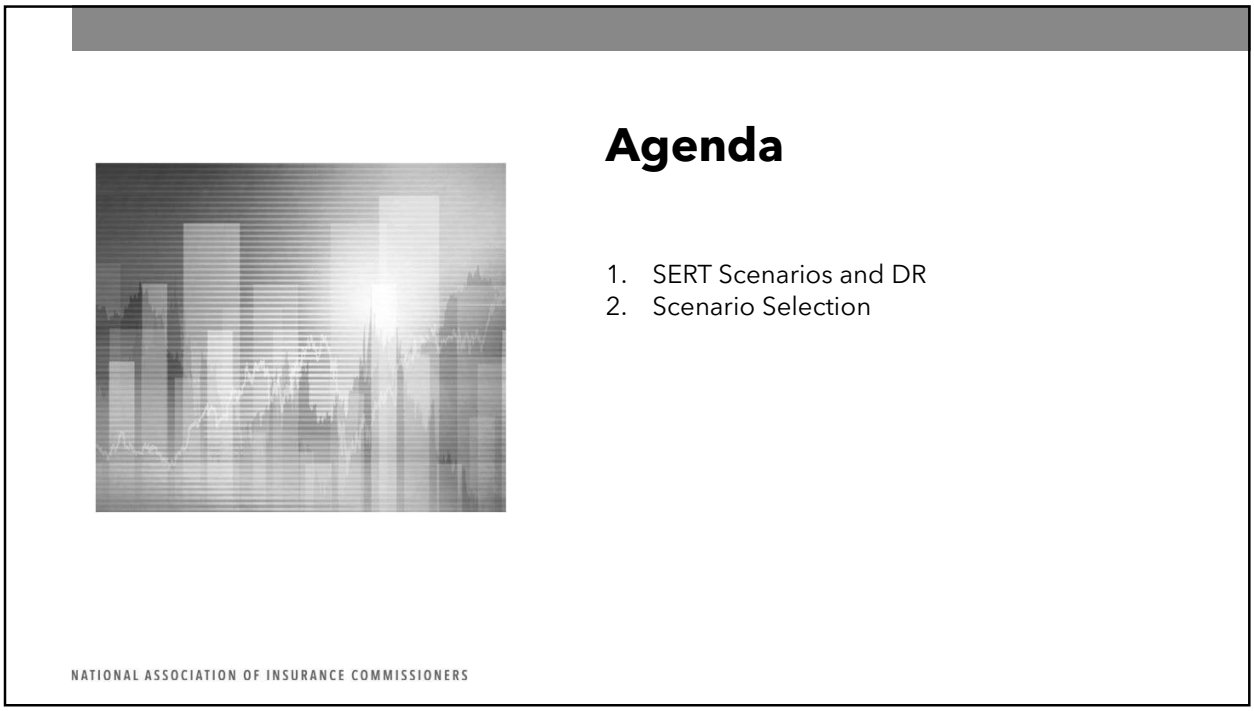
O'Neal introduced the Excel-based scenario selection tool used in the 2024 field test, developed by Conning. O'Neal asked the Subgroup if the tool meets regulatory and industry needs. Carmello inquired if companies would get the same scenarios with identical parameters and inputs, and O'Neal affirmed this. Hemphill noted the *Valuation Manual* required a robust demonstration that any scenario reduction techniques do not materially lower or bias the reserve. Chang supported adding language to the *Valuation Manual* requiring companies to provide reasoning or seek approval if they change their scenario selection methodology between valuations. Having no further business, the GOES (A) Subgroup adjourned.

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Field Test Participant Feedback: SERT Scenarios and DR

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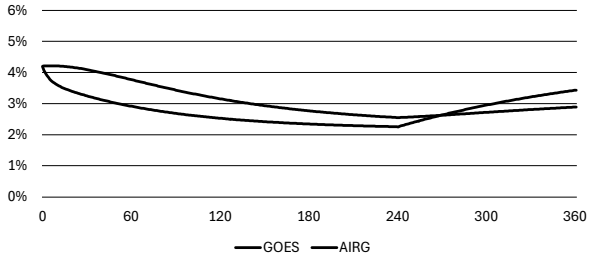
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SERT Scenarios

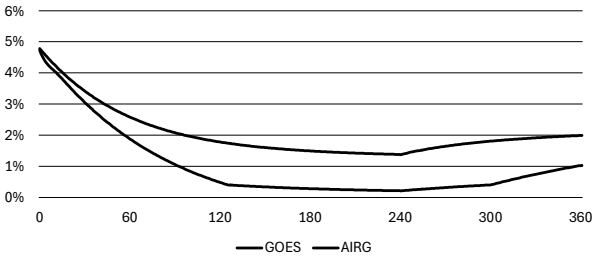
Participant Feedback:

- Recalibrate the SERT scenarios to be less extreme; Consider increasing the SERT passing threshold above 6% to address conservatism in the SERT scenarios.
- [One participant's Term model segment passed the SERT, but company calculated an SR that was in excess of both their DR and NPR for the baseline and field test scenarios. This was a new SR model for them.]
- Calibration of deterministic scenario for valuation is beyond moderately adverse.

Scenario 12 (DR Scenario), 20YR UST, 12/31/23



Scenario 12 (DR Scenario), 1YR UST, 12/31/23



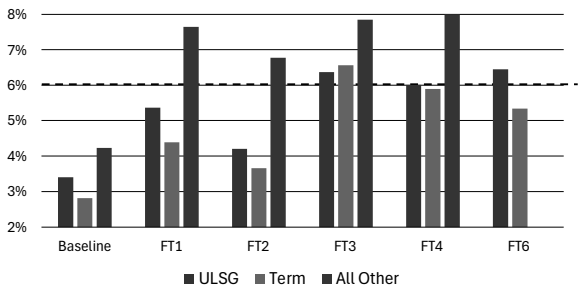
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2024 Field Test Participant SERT Results

- For the 12/31/23 GOES FT1 scenarios compared to the Baseline (AIRG) SERT scenarios:
  - The average SERT ratio increased across all VM-20 reserving categories, and
  - Each reserving category saw one participant's model segment that had passed with the Baseline fail with the GOES SERT scenarios.
- The average SERT ratio across each reserving category was significantly impacted by increases to the model segment that failed with the Baseline
- FT3 ("Up Rate Shock") saw the most model segments fail, particularly in the term model segment.
- No additional "All Other" model segments failed the field test SERT scenarios

Average Participant SERT Ratio by Reserving Category



Number of Passing Participant Model Segments/Total Participant Model Segments

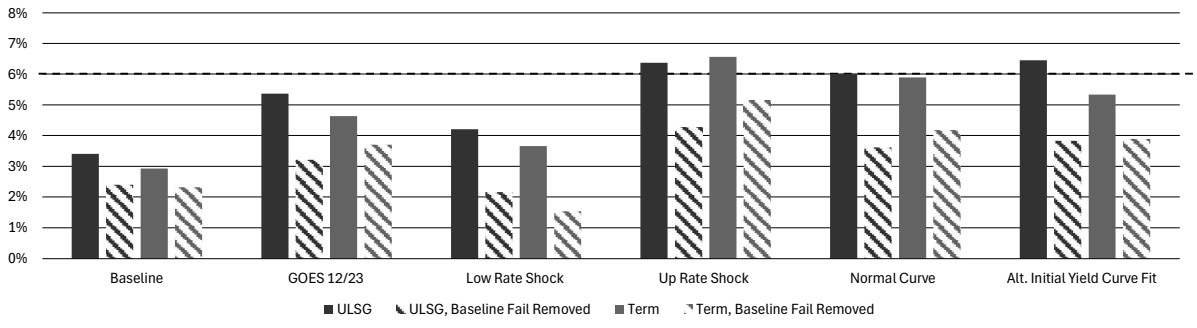
VM-20 Reserving Category	Baseline	FT1 12/31/23	FT2 Low Rate Shock	FT3 Up Rate Shock	FT4 Normal Yield Curve	FT6 Alt. Initial Yield Curve Fit
ULSG	6/7	5/7	6/7	4/7	5/7	4/6
Term	10/11	8/10	7/8	3/7	5/7	5/7
All Other	4/5	4/5	4/5	4/5	4/5	

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2024 Field Test Participant SERT Results, continued

- For the Term and ULSG reserving categories, when the model segment that is failing in the baseline is removed:
  - the average SERT ratios go down significantly.
  - the average SERT ratio is never above the passing threshold.
- There were not enough participants to show for the "All Other" VM-20 Reserving Category



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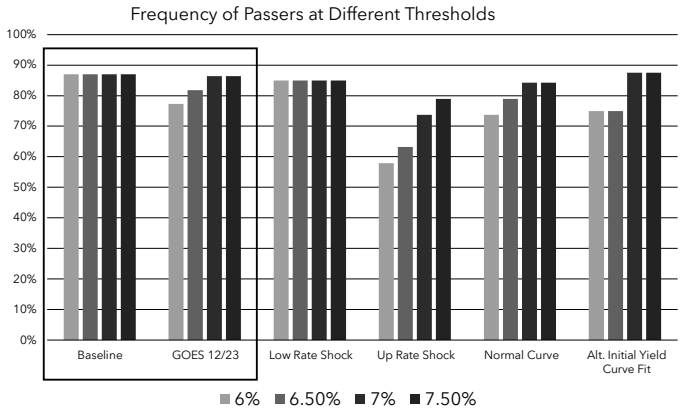
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2024 Field Test Participant SERT Results, continued

- 87% of the field test participants' model segments passed the SERT in their baseline YE23 run with a 6% threshold. This number dropped to 77% for the FT1 YE23 scenarios. Increasing the threshold to 7% brings the participant passing rate back up to a similar level.
- 58% of the FT3 (Up Rate Shock) field test participant model segments passed the SERT at the 6% threshold, increasing to up to ~80% if the threshold is increased to 7.5%. Note, we do not have comparative data on the frequencies of participants that would pass using the FT3 starting yield curve and AIRG SERT scenarios.
- **Question:** Should an adjustment be made to the threshold for passing the SERT scenarios, or some other modification?

Frequency of Passing SERT by Field Test Run
All VM-20 Reserving Categories



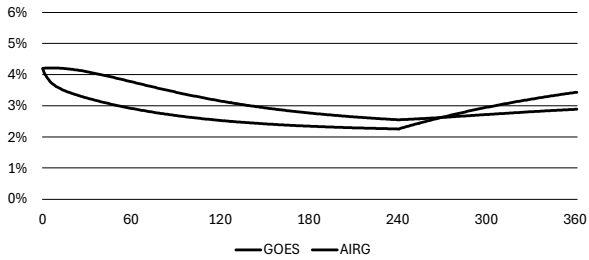
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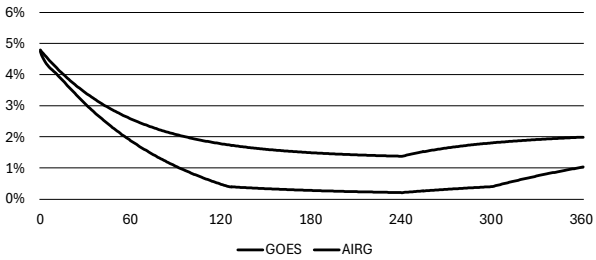
DR Scenario

Scenario 12 – Deterministic scenario for valuation
There are uniform downward shocks each month for 20 years, sufficient to get down to the one standard deviation point (84%) on the distribution of 20-year shocks. After 20 years, shocks are zero.
Questions:
1. Should the same formula for the DR scenario be used in the GOES scenarios?
2. What information would be needed to make a decision (e.g. model office testing of different options)?

Scenario 12 (DR Scenario), 20YR UST, 12/31/23



Scenario 12 (DR Scenario), 1YR UST, 12/31/23



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Scenario Selection

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Scenario Selection - Background

- One of the components of the Academy Interest Rate Generator which needs to be replaced is the Scenario Picker Tool. This tool creates subsets (i.e., 50, 200, 500, and 1000 scenarios) from the full set of 10,000 scenarios, which can be used to reflect the full distribution.
- Currently, if a scenario subset is used in reserve calculations, VM-20 prescribes use of the scenario picker tool but VM-21 does not. Applicable VM language is shown below.
- VM-31 contains requirements for companies to demonstrate their compliance with applicable VM-20 and VM-21 language.

VM-20 Section 7.G.2:

c. Use of fewer scenarios rather than a higher number of scenarios is permissible as a model efficiency technique provided that:
   i. The smaller set of scenarios is generated using the scenario picker tool provided within the prescribed scenario generator, and
   ii. The use of the technique is consistent with Section 2.G.

d. The number of scenarios required to comply with Section 2.G will depend on the specific nature of the company's assets and liabilities and may change from time to time. Compliance with Section 2.G would ordinarily be tested by comparing scenario reserves of a simpler model or a representative subset of policies, run using the reduced scenario set, with the scenario reserves of the same subset or simpler model run using the larger scenario set.

VM-21 Section 8.F:

1. For straight Monte Carlo simulation (with equally probable "paths" of fund returns), the number of scenarios should typically equal or exceed 1,000. **The appropriate number will depend on how the scenarios will be used and the materiality of the results. The company should use a number of scenarios that will provide an acceptable level of precision.**
2. Fewer than 1,000 scenarios may be used provided that the company has determined through prior testing (perhaps on a subset of the portfolio) that the CTE values so obtained materially reproduce the results from running a larger scenario set.
3. Variance reduction and other sampling techniques are intended to improve the accuracy of an estimate more efficiently than simply increasing the number of simulations. Such methods can be used provided the company can demonstrate that they do not lead to a material understatement of results. Many of the techniques are specifically designed for estimating means, not tail measures, and could in fact reduce accuracy (and efficiency) relative to straight Monte Carlo simulation.
4. The above requirements and warnings are not meant to preclude or discourage the use of valid and appropriate sampling methods, such as Quasi Random Monte Carlo (QRMC), importance sampling or other techniques designed to improve the efficiency of the simulations (relative to pseudo-random Monte Carlo methods).

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Scenario Selection

Excel-based Scenario Selection Tool Used in 2024 Field Test:

- For the 2024 GOES Field Test, an excel based scenario selection tool was utilized by participants to determine their scenario subsets from the 10k set.
- The tool is able to select scenario subsets based off of the 20-year UST significance measure or equity GWFs from the Large Cap fund. Both values are calculated from the relevant scenario set by Conning and included as a separate input for use in the tool.
- As currently configured, the tool allows the user to select any number of scenarios up to 1,000.
- The user can also specify whether spot rates, coupon yields, or both should be output.

Question: Does this tool meet the needs of regulators and the industry?

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Draft: 11/6/24

Generator of Economic Scenarios (GOES) (A) Subgroup
Virtual Meeting
October 9, 2024

The GOES (A) Subgroup of Life Actuarial (A) Task Force met Oct. 9, 2024. The following Subgroup members participated: Mike Yanacheak, Chair (IA); Pete Weber, Vice Chair (OH); Ted Chang (CA); Wanchin Chou (CT); Ben Slutsker (MN); Seong-min Eom (NJ); Bill Carmello (NY); and Rachel Hemphill (TX).

1. Discussed Initial Yield Curve Fit and SERT Scenario Field Test Participant Feedback

Scott O'Neal (NAIC) walked through a presentation (Attachment Nineteen-A) on feedback from the 2024 GOES field test participants on initial yield curve fitting and stochastic exclusion ratio test (SERT) scenarios. After O'Neal's discussion of the initial yield curve fitting, Brian Bayerle (American Council of Life Insurers—ACLI) presented an alternative methodology. Bayerle said that Conning's current approach prioritizes the short end of the curve when fitting the Treasury model against the initial yield curve. Bayerle emphasized the importance of avoiding overstating or understating modeled rates to prevent non-economic volatility in reserves and capital. Yanacheak inquired about any industry concerns with the ACLI's approach, and Bayerle responded that the ACLI has not encountered any opposition to the alternative proposal. Yanacheak then asked about the large fitting errors in the shorter maturities and their potential impact on reserves and capital. Bayerle responded that due to the faster mean reversion of the shorter end of the curve, rates are expected to realign within a year and, therefore, should have a small impact.

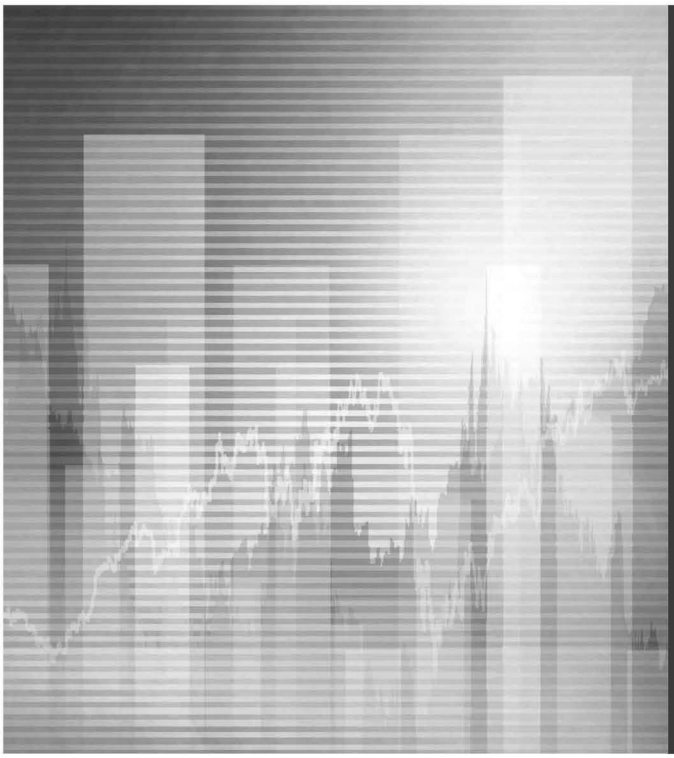
Dan Finn (Conning) presented on the Initial Treasury Fit Approach and alternative calibrations in the GEMS model (Attachment Nineteen-B). Iouri Karpov (Prudential) noted that his concern was with how the fitting errors played out in the projected scenarios and not necessarily the fitting errors at the start of the projection. Karpov also noted that Conning's approach put too much weight on fitting shorter maturities, which he felt was not appropriate given life insurers' typical investments in longer maturity assets. Weber commented that targeting longer tenors is logical given insurers' longer investment portfolios, a view that Randall McCumber (Lincoln Financial Group) supported. Chang noted that the performance of the two fitting methodologies would be dependent on the starting yield curve. Yanacheak noted that this topic would need additional discussion during a future Subgroup meeting.

O'Neal concluded the presentation of feedback from GOES 2024 field test participants on SERT scenarios, highlighting passing ratios across products subject to VM-20, Requirements for Principle-Based Reserves for Life Products. O'Neal said that participants suggested that the SERT scenarios, and in particular the deterministic reserve (DR) scenario, were too adverse.

Having no further business, the GOES (A) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/2024-3-Fall/GOES SG Calls/Oct 9/October 9 Minutes.docx

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GOES (E/A) Subgroup: Initial Yield Curve Fit and SERT Field Test Participant Feedback

October 9th, 2024

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Agenda

Discussion of Field Test Participant Feedback on:

1. Initial Yield Curve Fitting
2. SERT Scenarios

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Field Test Participant Feedback: Initial Yield Curve Fitting

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Initial Yield Curve Fitting Methodology

Participant Feedback:

- Preference for alternative baseline.
- Adopt initial yield curve method used in the alternative baseline as the standard approach with exact method for error term runoff.
- Use ACLI's initial curve fitting methodology.

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Field Test Participant Feedback: SERT Scenarios

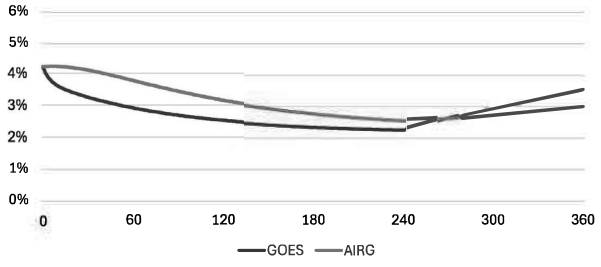
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SERT Scenarios

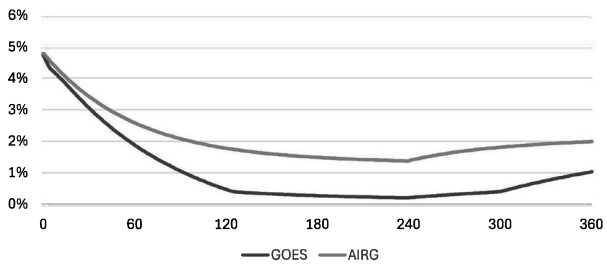
Participant Feedback:

- Recalibrate the SERT scenarios to be less extreme; Consider increasing the SERT passing threshold above 6% to address conservatism in the SERT scenarios.
- [One participant's Term model segment passed the SERT, but company calculated an SR that was in excess of both their DR and NPR for the baseline and field test scenarios. This was a new SR model for them.]
- Calibration of deterministic scenario for valuation is beyond moderately adverse.

Scenario 12 (DR Scenario), 20YR UST, 12/31/23



Scenario 12 (DR Scenario), 1YR UST, 12/31/23

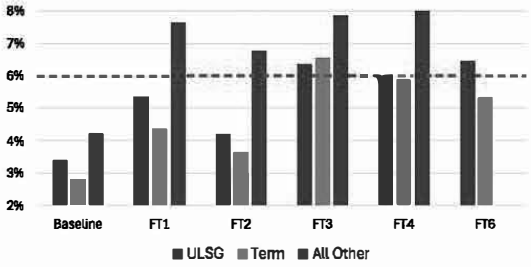


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2024 Field Test Participant SERT Results

- For the 12/31/23 GOES FT1 scenarios compared to the Baseline (AIRG) SERT scenarios:
  - The average SERT ratio increased across all VM-20 reserving categories, and
  - Each reserving category saw one participant's model segment that had passed with the Baseline fail with the GOES SERT scenarios.
- The average SERT ratio across each reserving category was significantly impacted by increases to the model segment that failed with the Baseline
- FT3 ("Up Rate Shock") saw the most model segments fail, particularly in the term model segment.
- No additional "All Other" model segments failed the field test SERT scenarios

Average Participant SERT Ratio by Reserving Category



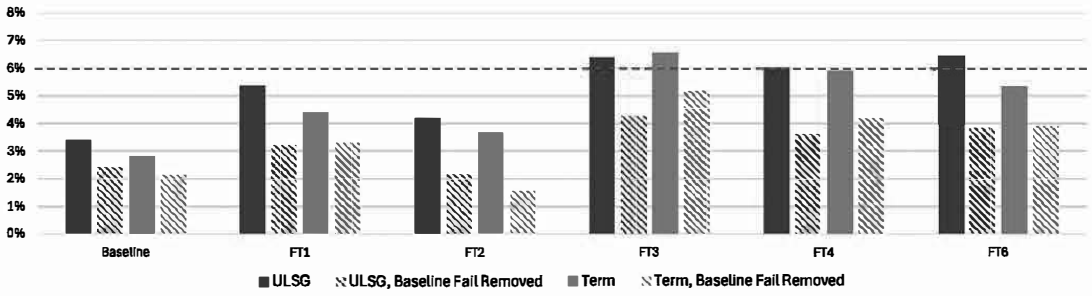
Number of Passing Participant Model Segments/Total Participant Model Segments

VM-20 Reserving Category	Baseline	FT1 12/31/23	FT2 Low Rate Shock	FT3 Up Rate Shock	FT4 Normal Yield Curve	FT6 Alt. Initial Yield Curve Fit
ULSG	6/7	5/7	6/7	4/7	5/7	4/6
Term	8/9	8/9	7/8	3/7	5/7	5/7
All Other	4/5	4/5	4/5	4/5	4/5	

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2024 Field Test Participant SERT Results, continued

- For the Term and ULSG reserving categories, when the model segment that is failing in the baseline is removed:
  - the average SERT ratios go down significantly.
  - the average SERT ratio is never above the passing threshold.
- There were not enough participants to show for the "All Other" VM-20 Reserving Category



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2024 Field Test Runs

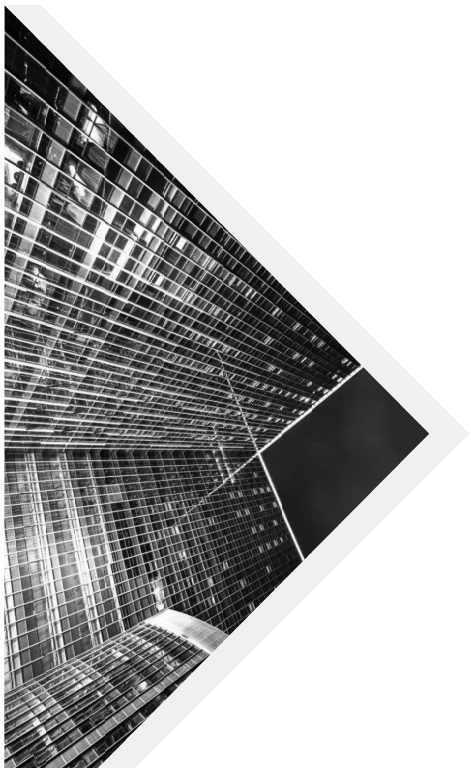
Field Test Run	Scenario Sets	Inforce Assets and Liabilities	Comparison Scenario Set
Baseline Already exists; no new runs needed.	Scenario set(s) the company used for 12/31/23 statutory reporting of reserves and RBC**	As of 12/31/23**	N/A
Field Test 1	Conning scenarios as of 12/31/23**	As of 12/31/23**	Baseline
Field Test 2 – Low Rate Shock	Conning scenarios with a starting UST yield curve as of 3/9/20 but with 12/31/23 starting credit spreads.	As of 12/31/23, but modified as necessary for a different starting UST yield curve.*	Field Test 1
Field Test 3 – Up Rate Shock	Conning scenarios with a starting UST yield curve as of 10/31/89 but with 12/31/23 starting credit spreads.		Field Test 1
Field Test 4 – Normal Yield Curve	Conning scenarios with a starting UST yield curve as of 12/31/04 but with 12/31/23 starting credit spreads.		Field Test 1
Field Test 5 – Down Equity Shock (VM-21/C3P2 and VUL business only)	Conning scenarios as of 12/31/23 (same as Field Test 1)	As of 12/31/23, but modified for a 25% drop in equity markets.*	Field Test 1
OPTIONAL Field Test 6 – Alternative Initial Yield Curve Fit	Conning scenarios as of 12/31/23 with alternative initial yield curve fitting methodology that emphasizes longer maturities.	As of 12/31/23	Field Test 1

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2024 Field Test Runs (continued)

Field Test Run	Scenario Sets	Inforce Assets and Liabilities	Comparison Scenario Set
OPTIONAL Field Test 7 – High Credit Spread	Conning scenarios as of with 12/31/23 starting interest rate conditions and starting corporate bond spread environment as of 12/31/2008	As of 12/31/23, but modified as necessary for a different starting corporate bond spread environment*	Field Test 1
OPTIONAL Field Test 8 – Low Credit Spread	Conning scenarios as of with 12/31/23 starting interest rate conditions and starting corporate bond spread environment as of 12/31/2021	As of 12/31/23, but modified as necessary for a different starting corporate bond spread environment*	Field Test 1
OPTIONAL Field Test 9 – Extreme Up Rate with Inversion	Conning scenarios with a starting UST yield curve as of 3/31/80 but with 12/31/23 starting credit spreads.	As of 12/31/23, but modified as necessary for a different starting UST yield curve.*	Field Test 1
OPTIONAL Field Test 10 – Low Equity/Low Interest	Conning scenarios with a starting UST yield curve as of 3/9/20 but with 12/31/23 starting credit spreads.	As of 12/31/23, but modified for a 25% drop in equity markets.*	Field Test 1
OPTIONAL Field Test 11 – Low Equity/High Interest	Conning scenarios with a starting UST yield curve as of 10/31/89 but with 12/31/23 starting credit spreads.	As of 12/31/23, but modified for a 25% drop in equity markets.*	Field Test 1
OPTIONAL Field Test 12 – Up Equity Shock	Conning scenarios as of 12/31/23**	As of 12/31/23, but modified for a 25% increase in equity markets.*	Field Test 1

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Initial Treasury Fit Discussion

Academy Economic Scenarios Work Group
Weekly Meeting

May 10, 2024

Initial Treasury Fit Approach

Standard GEMS® approach

- Select 3 Pivot Tenors: 3-Month and 2 others that adjust each month
- Other 2 are selected to minimize gap between Fitted and Actual Spot Curves

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Adjustments for First Field Test

Concern was raised about 1-Month Yield

- Extrapolated from 3-Month
- Could cause unexpected movements in Equity Returns
- So, Conning switched fixed Pivot from 3-Month to 1-Month

Fitting process applies to unfloored spot rates

- Take actual Spot Rates
- Calculate rate needed to produce this result after flooring
  - E.g., in Dec 2021 runs, 6 bps Yield for 3-Month Treasury gets converted to -1.3%
- Fit these "unfloored" Spot Rates
- Tends to over emphasize short rates in these situations
- So, Conning switched to using Par Yields

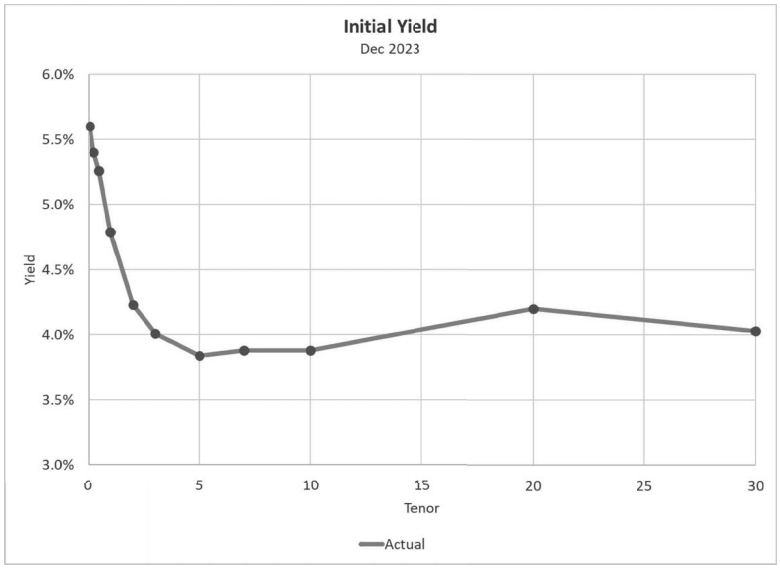
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2

Impact on December 2023 Fitting

Unusual initial curve

- Inverted out to 10-Year
- Sharply increases to 20-Year
- Drops back down for 30-Year



Prepared by Conning, Inc. Source: U.S. Department of the Treasury (2024)

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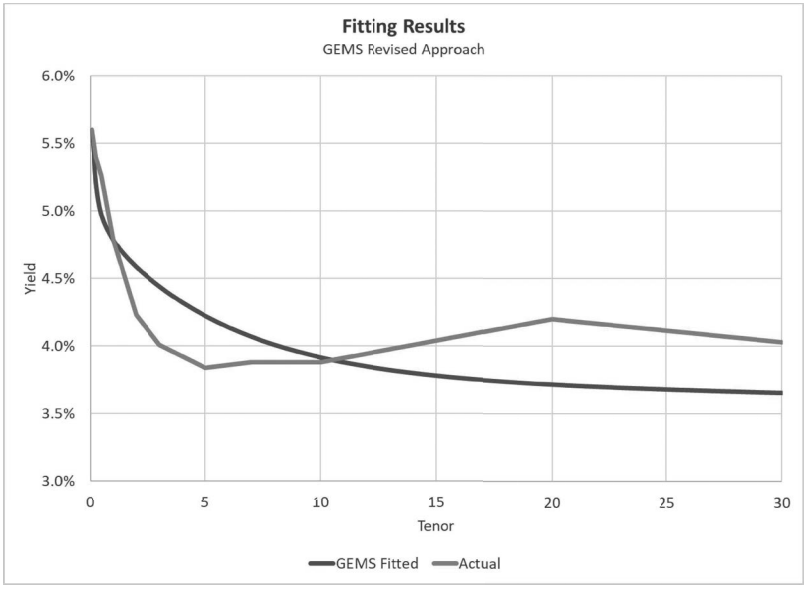
Impact on December 2023 Fitting

Unusual initial curve

- Inverted out to 10-Year
- Sharply increases to 20-Year
- Drops back down for 30-Year

GEMS® revised approach

- Selects 1- and 10-Year Pivots
- Balances being above in mid range with being below on long end



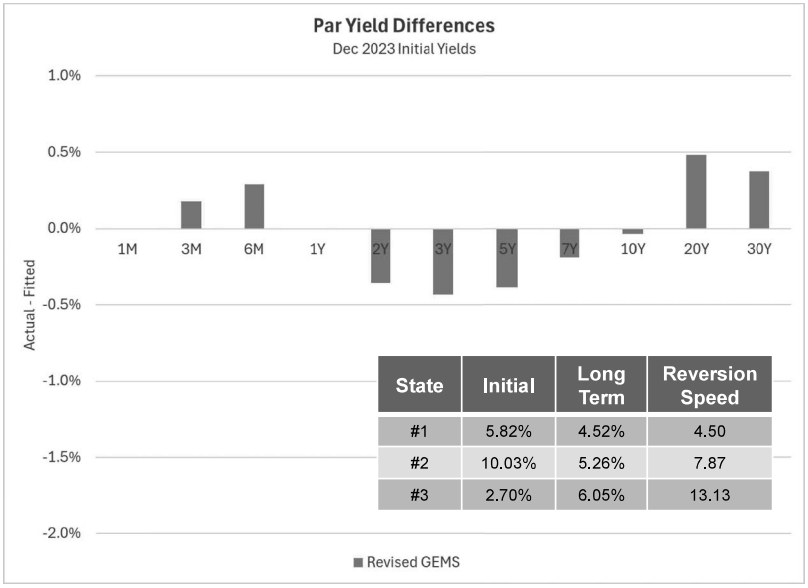
Prepared by Conning, Inc. Sources: U.S. Department of the Treasury (2024), GEMS® Economic Scenario Generator scenarios.,

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Impact on December 2023 Fitting – State Variables

Unusual initial curve

- Leads to unusual initial values
- Mix of above and below target values
- Relatively large mismatch between Fitted and Actual



State	Initial	Long Term	Reversion Speed
#1	5.82%	4.52%	4.50
#2	10.03%	5.26%	7.87
#3	2.70%	6.05%	13.13

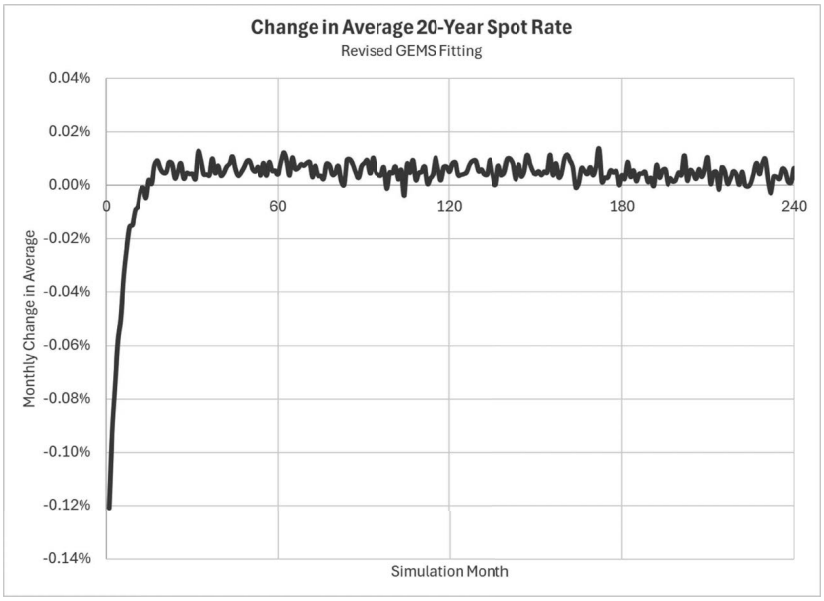
Prepared by Conning, Inc. Source: GEMS® Economic Scenario Generator scenarios.

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Impact on December 2023 Fitting – State Variables

Unusual initial curve

- Leads to unusual initial values
  - Mix of above and below target values
  - Relatively large mismatch between Fitted and Actual
- Creates potential for non-linear movements in averages



Prepared by Conning, Inc. Source: GEMS® Economic Scenario Generator scenarios.

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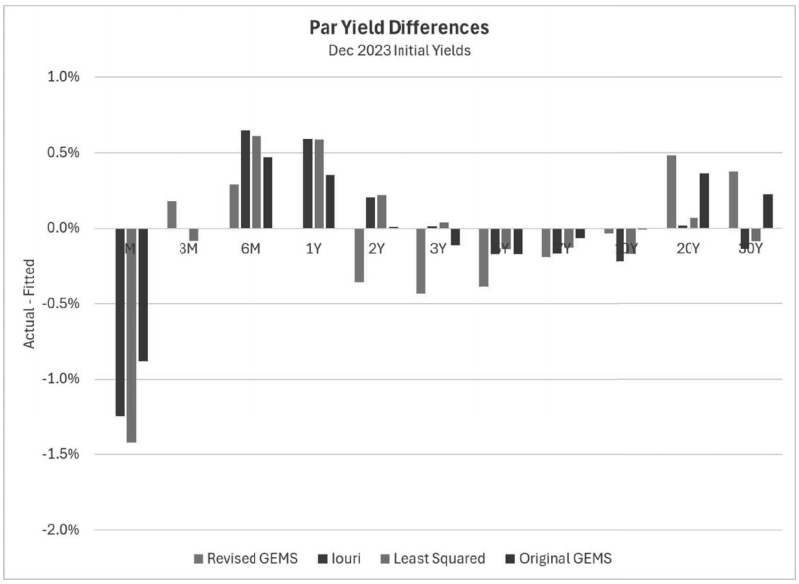
Impact on December 2023 Fitting – Alternative Methods

Compared three other methods

- Original Conning approach
- Least Squares Fitting
- Proposal from Iouri Karpov

Observations

- Removal of 1-Month from fitting creates mismatch for all
- Tradeoffs for the rest of the curve include a better fit or the long end and a worse fit for the short end



Prepared by Conning, Inc. Source: GEMS® Economic Scenario Generator scenarios.

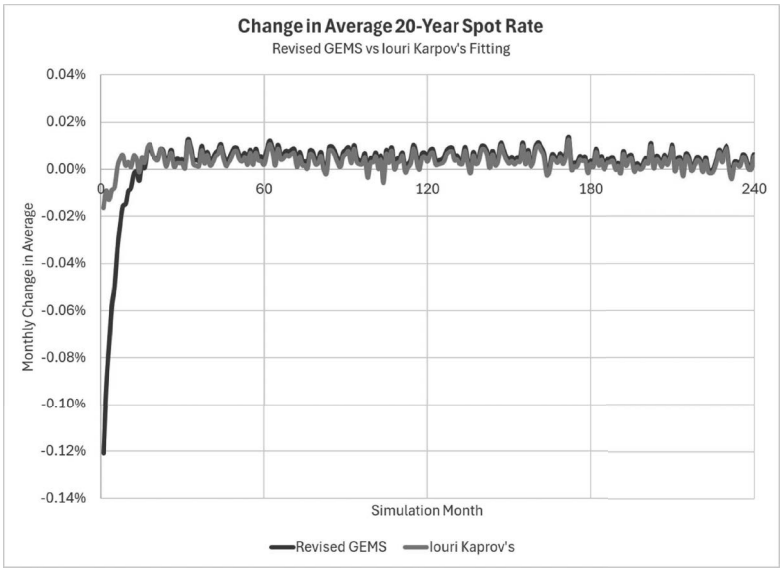
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Impact on December 2023 Fitting – Average Yields

Different fits create different behaviors

- Iouri Karpov's calibration has a better initial fit on 20-Year reduced swings in averages



Prepared by Conning, Inc. Source: GEMS® Economic Scenario Generator scenarios.

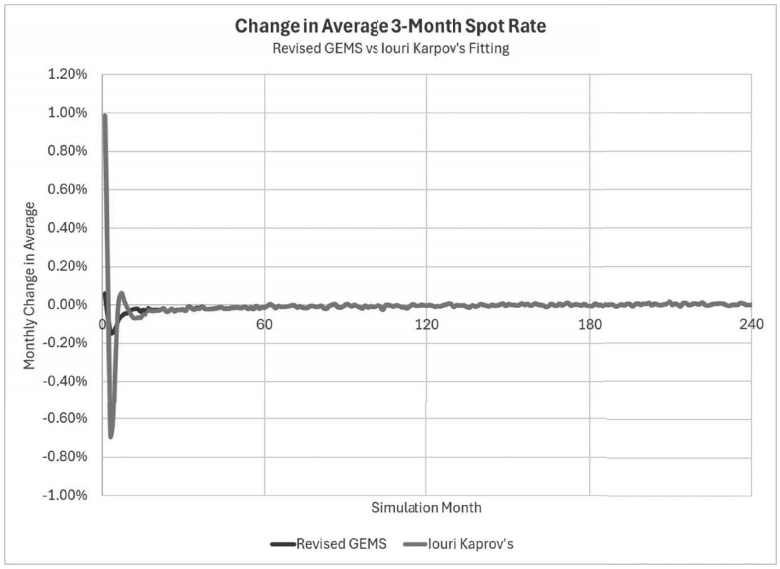
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Impact on December 2023 Fitting – Average Yields

Different fits create different behaviors

- Iouri Karpov's calibration has a better initial fit on 20-Year reduced swings in averages
- The tradeoff is huge swings for the short end of the curve



Prepared by Conning, Inc. Source: GEMS® Economic Scenario Generator scenarios.

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Draft: 11/6/24

Generator of Economic Scenarios (GOES) (E/A) Subgroup
Virtual Meeting
October 2, 2024

The GOES (A) Subgroup of the Life Risk-Based Capital (E) Working Group and Life Actuarial (A) Task Force met Oct. 2, 2024. The following Subgroup members participated: Mike Yanacheak, Chair (IA); Pete Weber, Vice Chair (OH); Ted Chang (CA); Wanchin Chou (CT); Philip Barlow (DC); Scott Shover (IN); Ben Slutsker (MN); William Leung (MO); Seong-min Eom (NJ); Bill Carmello (NY); and Rachel Hemphill (TX).

1. Discussed Field Test Participant Feedback on the UST, Equity, and Corporate Models

Scott O'Neal (NAIC) walked through a presentation (Attachment Twenty-A) highlighting feedback on the U.S. Department of the Treasury (Treasury Department), equity, and corporate models from field test participants. After discussion of feedback from participants on the level of negative interest rates present in the Treasury Department scenarios, Brian Bayerle (American Council of Life Insurers—ACLI) delivered a presentation on the ACLI's proposed dynamic generalized fractional floor (GFF). Yanacheak inquired whether the ACLI had identified any unintended consequences, to which Bayerle responded that they had not observed any.

Dan Finn (Conning) noted that while the proposal would reduce the frequency of negative rates, he anticipated a minimal impact on reserves due to the small magnitude of shifts to the rates. Hal Pedersen (American Academy of Actuaries—Academy) raised a concern about potential distortions in returns, particularly among different tenors of bond returns in a low-interest environment. He warned that this could render certain asset classes unattractive and create disincentives to invest in short-term tenors. Carmello asked if it would be possible to make the approach arbitrage-free. Pedersen replied that there is no straightforward solution to remove these distortions. Pedersen noted that while adopting a shadow rate model could be a potential approach, it would require significant effort from Conning.

Iouri Karpov (Prudential) commented that the ACLI's proposed approach closely resembles the current method and would impact only a small subset of rates below 40 basis points (bps). Karpov added that the potential unintended consequences would likely be no greater than those under the current structure, given the similarity of the proposed floor to the original GFF. Weber echoed Karpov's sentiment, noting that the observed phenomenon is already present in the current model. Weber, Eom, and Carmello voiced support for the dynamic GFF alternative approach in curbing the prevalence of negative rates. However, for the long term, they said there is a need to revisit and think about revising the current Treasury model to address the incentive or lack of to invest in certain asset classes.

After O'Neal walked through feedback on the equity model, Carmello stated that he felt that the equity calibration was appropriately conservative and recommended no changes. Hemphill noted that the Subgroup did not prioritize the portion of the gross wealth factor (GWF) acceptance criteria for the minimum and maximum due to the wide range of results seen in maximums and minimums across the reference models that were used in the development of the criteria. Bayerle (ACLI) then presented an alternative equity model calibration recommended by the ACLI that had closer alignment to the lower percentiles of the equity GWF acceptance criteria. Bayerle (ACLI) then presented an alternative equity model calibration that had closer alignment to the lower percentiles of the equity GWF acceptance criteria. Hemphill asked that Conning perform a review of the ACLI's alternative equity calibration for discussion during a later Subgroup meeting.

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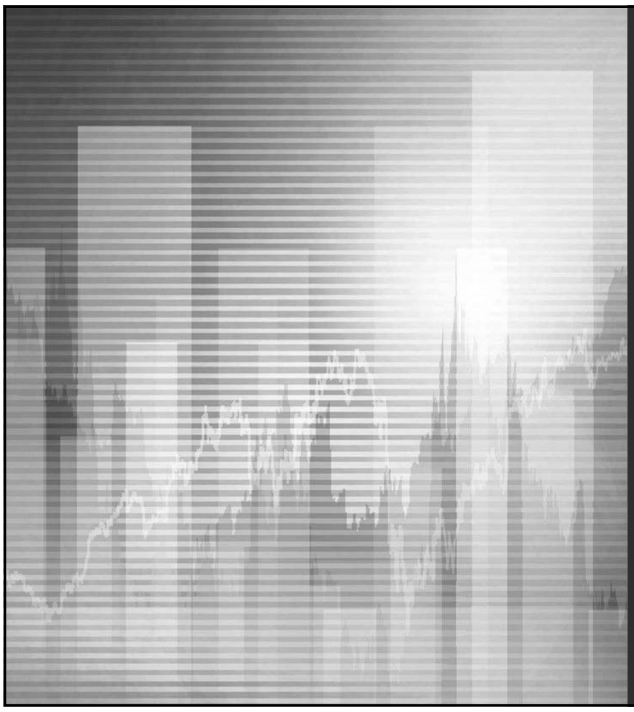
O'Neal concluded the presentation on corporate model feedback, addressing concerns about the lack of active strategies compared to the passively managed bond funds in the Conning model. Yanacheak encouraged other companies with similar concerns to voice them through the Subgroup, ACLI, or the Academy. Pederson urged state insurance regulators to consider what the appropriate corporate model should be moving forward—whether to maintain the current model or simplify it for easier documentation. Connie Tang (Retired) acknowledged that while the GEMS corporate model may be robust, further understanding is necessary to fully evaluate its effectiveness.

Having no further business, the GOES (A) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/2024-3-Fall/GOES SG Calls/Oct 2/October 2 Minutes.docx

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GOES (E/A) Subgroup: Feedback from Field Test Participants

Model Calibration and UST Flooring

October 2nd, 2024

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Agenda

1. Model and Calibration Feedback:
   a) US Treasury
   b) Equity
   c) Corporate

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US Treasury Model Field Test Participant Feedback

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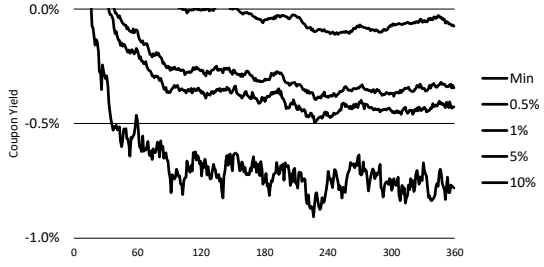
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UST Scenario Feedback – Negative Rates

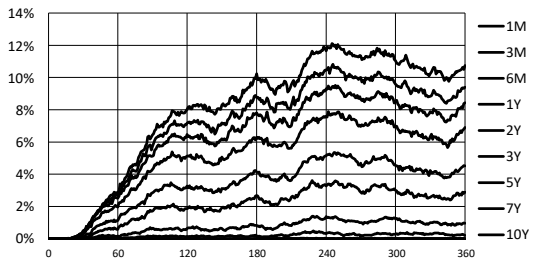
Participant Feedback:

- GEMS has a much higher occurrence of negative rates in the 90-day treasury than historical rates (1981 to present) or the prior scenario generator
- Adjust interest rate model to ensure rates are not excessive especially at the tails
- Conning scenario sets seem to be overly conservative in the tails compared to the prepackaged C3P1 RBC scenario set
- Recalibrate interest rate model to reduce frequency of negative and high interest rates

1 YR UST Negative Rate Percentiles – 10K Scenarios, 12/31/23



Negative UST Frequencies by Maturity – 10K Scenarios, 12/31/23



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UST Scenario Feedback – UST Flooring

Participant Feedback:

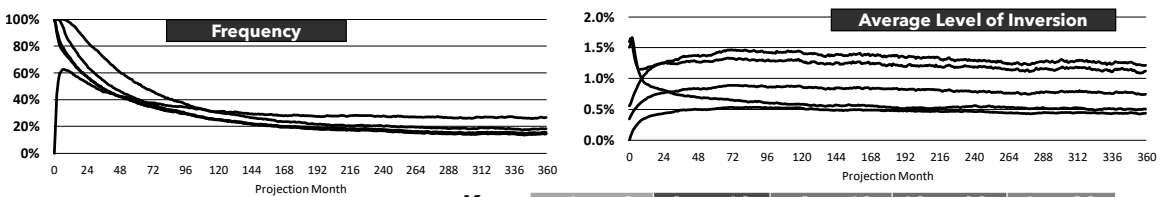
- Generalized Fractional Floor (GFF) has shortcomings due to its blunt approach such as distorted yield curve shapes, unrealistic term premiums and lack of arbitrage-free scenario sets. We suggest exploring the Shadow Floor from the first field test or potential changes to the GFF.
- A dynamic Generalized Fractional Floor (GFF) is a better option to control the distribution of negative rates.
  - Recently developed enhancements to the GFF effectively control the frequency and severity of extreme low/negative short-term rates and better target the associated Academy's criteria.
    - Extends existing GFF definition by dynamically adjusting GFF factors to target the desired rate level at a given tail severity (e.g. target 0% UST1 at 1% tail in steady state).
    - Applies post scenario generation and requires minimal model updates.

UST Scenario Feedback – Other

Participant Feedback:

- **Interest Rate Volatility:**
  - Volatility is higher in GEMS than the prior scenario but is slightly lower than historical (1981-present)
  - We ask the NAIC to consider if the resulting measured interest rate volatility is reasonable vs. observable history for a moderately adverse CTE 70 Best Efforts reserve and CTE 98. Perhaps could use historical volatility plus a margin for CTE Best efforts instead of directly sourcing from the GOES generator which is elevated to meet interest rate scenario acceptance criteria.
- **Yield Curve Inversions:**
  - Inverted yield curves in GEMS occur 16-24% of the time [depending on starting conditions] compared to 9% in the prior scenario and 10% in history
  - …higher/more inverted rates reduced base contract fee revenues from lower bond fund returns in early years compared to [scenarios participant used in their baseline].

Inversion Statistics, 12/31/23



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Equity Model Field Test Participant Feedback

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E1.T Large Capitalization Equity Gross Wealth Factors

	Targets						Simulated						Ratio					
Percentiles	1	5	10	20	30	50	1	5	10	20	30	50	1	5	10	20	30	50
0	0.46	0.25	0.22	0.25	0.29	0.46	0.49	0.21	0.14	0.08	0.17	0.26	1.08	0.87	0.64	0.29	0.57	0.57
1	0.70	0.58	0.60	0.79	1.15	2.82	0.70	0.55	0.53	0.63	0.94	2.17	1.00	0.95	0.88	0.79	0.82	0.77
5	0.82	0.80	0.91	1.36	2.20	6.38	0.82	0.79	0.88	1.29	2.03	5.47	1.00	1.00	0.96	0.95	0.92	0.86
10	0.88	0.93	1.12	1.81	3.08	9.78	0.88	0.92	1.11	1.74	2.93	8.81	1.00	0.99	0.99	0.96	0.95	0.90
15	0.92	1.02	1.28	2.18	3.84	12.94	0.93	1.02	1.28	2.10	3.73	11.91	1.00	1.00	1.00	0.96	0.97	0.92
25	0.99	1.18	1.54	2.81	5.26	19.23	0.99	1.18	1.55	2.80	5.17	18.42	1.00	1.01	1.01	1.00	0.98	0.96
30	1.01	1.24	1.66	3.12	6.01	22.79	1.01	1.25	1.67	3.13	5.89	22.02	1.00	1.00	1.00	1.00	0.98	0.97
50	1.09	1.48	2.15	4.47	9.23	39.98	1.10	1.49	2.17	4.48	9.28	39.64	1.01	1.01	1.01	1.00	1.01	0.99
70	1.17	1.74	2.71	6.30	14.12	68.89	1.18	1.76	2.75	6.36	14.09	69.20	1.01	1.01	1.02	1.01	1.00	1.00
75	1.19	1.82	2.89	6.93	15.88	80.22	1.20	1.83	2.92	6.96	15.89	80.89	1.01	1.01	1.01	1.00	1.00	1.01
85	1.25	2.02	3.36	8.69	21.06	115.31	1.26	2.03	3.40	8.62	21.02	115.56	1.01	1.01	1.01	0.99	1.00	1.00
90	1.28	2.15	3.71	10.09	25.20	147.92	1.30	2.17	3.76	9.97	25.08	145.91	1.01	1.01	1.01	0.99	1.00	0.99
95	1.34	2.37	4.30	12.33	33.19	210.72	1.36	2.39	4.38	12.30	32.53	211.90	1.01	1.01	1.02	1.00	0.98	1.01
99	1.45	2.82	5.64	18.18	53.74	397.23	1.47	2.83	5.68	17.53	50.56	394.09	1.01	1.00	1.01	0.96	0.94	0.99
100	1.76	4.20	8.98	42.03	140.72	1676.94	1.82	4.29	9.32	38.28	120.07	2292.44	1.03	1.02	1.04	0.91	0.85	1.37

The Large Capitalization (S&P 500) equity fund gross wealth factors (GWFs) are largely aligned with the targets across the bulk of the percentile GWF distribution over the projected durations. The first percentile does show some differences, with lower returns over time in the latest equity calibration compared to the targets.

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Equity Model Feedback

Participant Feedback:

- Recalibrate equity scenarios to more closely match American Academy of Actuaries gross wealth factor calibration targets in the tail.
- The GOES equity path shows greater volatility compared to the AIRG.
- Extremely low tail equity calibration should be revisited.
- Adjust equity calibration to bring tail GWFs more in line with updated AAA criteria (ACLI proposal).
- Use Run 6 equity calibration from the field test one as basis and make further adjustments to the parameters to better align with the Academy's criteria.
- GOES uses a Stochastic Volatility with Jumps which produces fatter tails.
- [The lack of an Equity-Treasury linkage is] punitive to companies that fair value hedge guarantees only

GOES Equity Gross Wealth Factors (GWFs)

SP500	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr
Min	0.49	0.21	0.14	0.08	0.17
1.0%	0.70	0.55	0.53	0.63	0.93
2.5%	0.77	0.68	0.71	0.96	1.39
5.0%	0.82	0.79	0.88	1.29	2.02
10.0%	0.88	0.92	1.11	1.74	2.93
25.0%	0.99	1.18	1.55	2.80	5.17
50.0%	1.10	1.49	2.17	4.48	9.28
75.0%	1.20	1.83	2.92	6.96	15.89
90.0%	1.30	2.17	3.76	9.97	25.08
95.0%	1.36	2.39	4.38	12.31	32.53
97.5%	1.41	2.60	4.98	14.51	40.74
99.0%	1.47	2.83	5.69	17.54	50.60
Max	1.82	4.29	9.32	38.28	120.07

AIRG Equity GWFs

SP500	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr
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

GOES/AIRG Equity GWF Ratio

SP500	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr
Min	120%	68%	54%	22%	44%
1.0%	100%	88%	81%	76%	76%
2.5%	101%	94%	92%	87%	82%
5.0%	100%	98%	95%	91%	90%
10.0%	100%	99%	99%	95%	95%
25.0%	100%	102%	103%	102%	101%
50.0%	101%	103%	104%	105%	105%
75.0%	101%	101%	102%	102%	104%
90.0%	100%	98%	99%	98%	100%
95.0%	99%	97%	99%	95%	95%
97.5%	98%	96%	96%	93%	89%
99.0%	97%	92%	92%	86%	84%
Max	95%	90%	79%	57%	51%

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Corporate Model Field Test Participant Feedback

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Corporate Model Feedback

Participant Feedback:

- GOES Corporate bond fund excess return reflects both:
  - low risk-adjusted excess return relative to other asset classes and various historical periods of observed performance
  - much higher volatilities vs. observed Barclays Agg Corporate Bond index historical volatilities.
- We believe the elevated volatility of the Corporate bond fund is due to both the elevated interest rate volatility noted previously as well as potentially additional volatility from modeling downgrade-driven spread widening and forced sales in the GOES Corporate Model methodology
- We understand GOES Bond Fund Modelling is based on modeling Passive bond fund strategies (e.g. Indices) which dampens the return profile. This may result in GOES understating the net spread earned on Active Bond Funds.
  - In periods of high stress, Passive or Index Bond Funds have strict credit quality targets to adhere to which can force buys and sells at inopportune times. Consider the following:
    - In a highly volatile market, if bonds are downgraded, then Passive Bond Fund managers must sell these downgraded bonds to conform to their AAA/AA target (for example)
    - This distressed sale will generate losses as fund managers must incur the mark-to-market loss from the downgrade
    - Active fund managers are not forced to sell in such environments and instead can strategically purchase more bonds at higher yields, while holding downgraded bonds to maturity

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Draft: 10/28/24

Generator of Economic Scenarios (GOES) (E/A) Subgroup
Virtual Meeting
September 25, 2024

The GOES (E/A) Subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force met Sept. 25, 2024. The following Subgroup members participated: Mike Yanacheak, Chair (IA); Peter Weber, Vice Chair (OH); Ted Chang (CA); Wanchin Chou (CT); Ben Slutsker (MN); William Leung (MO); Seong-min Eom (NJ); Bill Carmello (NY); Rachel Hemphill (TX); and Craig Chupp (VA).

1. Discussed Upcoming Meetings and its 2026 Project Plan

Yanacheak provided an overview of the Subgroup's planned meeting topics leading up to the Fall National Meeting. He also gave an overview of the project plan for implementation in 2026. Connie Tang (Retired) asked if any deliverables were targeted for completion ahead of the Fall National Meeting. Yanacheak responded that he was more focused on hitting a quality standard rather than a specific deadline for various components of the project but that the Subgroup would work diligently to meet its objectives in a timely fashion.

2. Exposed the GOES Model Governance Framework

Yanacheak highlighted the importance of setting a strong model governance framework that defined clear roles for state insurance regulators, the NAIC, Conning, the insurance industry, and other interested parties. Pat Allison (NAIC) then walked through the draft model governance framework.

Chou asked if the draft document would be exposed. Yanacheak responded that he intended to do a chair exposure of the draft model governance framework. After additional discussion, Yanacheak noted that he would expose the document for a 40-day public comment period ending Nov. 4.

Having no further business, the GOES (E/A) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/2024-3-Fall/GOES SG Calls/09 25/Sept 25 Minutes.docx

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ACLI
Financial Security for Life

ACLI Equity Calibration Proposal

November 15, 2024

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ACLI

Background

- Prior to the 2024 GOES field test (FT2), ACLI identified that equity calibrations were meaningfully more severe for the tail distribution in the longer time horizon than the Academy's criteria
- Specifically, Gross Wealth Factor (GWF) targets at higher durations (20+ years) in the right (low return) tails were lower than targets with monthly returns more severe than history.
- ACLI has concerns developed a calibration as one way to address this issue, while also addressing Conning comments about correlations and jump processes in an early proposal.

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Key Enhancements

- Enhanced jump process parametrization, better aligned with historical equity returns (Slide 4)
- Tail short-term (monthly) returns better aligned with historical data (Slides 5-6)
- Tail long-term returns (GWF over 10+ years) better aligned with adopted acceptance criteria (Slide 8)
- ACLI calibration follows a repeatable ground-up process, directly tied to historical data using MLE calibration (Appendix)

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Parameter Comparison to GEMS FT2 Baseline

	ACLI Proposed			
	Large	Mid	Small	Aggressive
mu0	0.0723	0.0408	0.0556	0.1233
mu1	0.5744	2.0910	1.5311	-0.2500
alpha	0.0196	0.0307	0.0308	0.0191
beta	0.9519	1.1310	0.9408	0.4800
sigma	0.1254	0.1409	0.1409	0.1587
mu_jump	-0.1500	-0.2184	-0.2355	-0.1990
sigma_jump	0.0584	0.0476	0.0480	0.0678
lambda_jump	4.9442	4.6774	3.8906	3.6347
correlation	-0.4563	-0.6661	-0.6275	-0.3105
initial vol	0.1435	0.1648	0.1809	0.1997
theta	0.0206	0.0272	0.0327	0.0399
Avg. Jump Freq.	0.1019	0.1270	0.1273	0.1449
% Jump Variance	11.4%	18.9%	18.3%	13.8%

	GEMS FT2			
	Large	Mid	Small	Aggressive
mu0	0.0825	0.0882	0.0909	0.1058
mu1	0.0926	0.0020	0.0012	0.0186
alpha	0.0058	0.0048	0.0051	0.0086
beta	0.4627	0.2927	0.3141	0.3303
sigma	0.0747	0.0358	0.0520	0.0408
mu_jump	-0.0525	-0.0420	-0.0696	-0.0504
sigma_jump	0.0575	0.0575	0.0575	0.0595
lambda_jump	139.5882	113.4168	112.9784	128.7243
correlation	-0.4770	-0.5263	-0.4951	-0.4805
initial vol	0.1117	0.1283	0.1272	0.1615
theta	0.0125	0.0164	0.0162	0.0261
Avg. Jump Freq.	1.7419	1.8656	1.8288	3.3580
% Jump Variance	45.8%	36.5%	47.9%	43.9%

Avg. Variance: $\theta = {}^{\alpha}/_{\beta}$

Est. Jump Freq (annual) $= \theta\lambda$

Est. Variance due to Jumps:
$V_{jump} = \theta\lambda(\mu_{jump}^2 + \sigma_{jump}^2)$

% of Variance due to Jumps:
$$\frac{V_{jump}}{\theta + V_{jump}}$$

ACLI calibration key differences vs. GEMS FT2:

- ACLI parameters derived using historical MLE calibration, with subsequent adjustments to alpha and mu0 parameters to align to historical variance and Sharpe ratio of ~28.1% across all indices.
- **Jumps: lower frequency but higher severity, accounting for 10-20% of return variance compared to 40-50% of variance under FT2**
- Variance: higher mean reversion of the variance process
- Risk Premium Coefficient (mu1): larger coefficients and possible negatives.

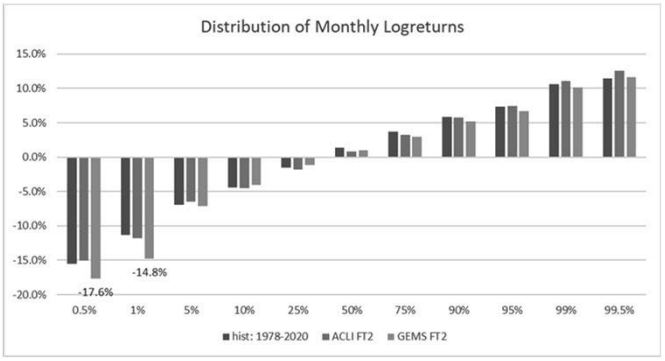
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Distribution of Monthly Logreturn: Large Cap

	hist: 1978-2020	hist: 1992-2020	ACLI FT2	GEMS FT2	FT1 Run6
min	-24.2%	-18.4%	-62.1%	-69.1%	-52.9%
0.5%	-15.5%	-13.8%	-15.0%	-17.6%	-12.8%
1%	-11.4%	-11.4%	-11.8%	-14.8%	-10.5%
5%	-7.0%	-7.2%	-6.5%	-7.1%	-6.1%
10%	-4.4%	-4.5%	-4.5%	-4.1%	-4.3%
25%	-1.5%	-1.6%	-1.8%	-1.1%	-1.7%
50%	1.4%	1.3%	0.8%	1.0%	0.7%
75%	3.7%	3.4%	3.2%	3.0%	3.0%
90%	5.8%	5.6%	5.7%	5.2%	5.6%
95%	7.3%	7.0%	7.4%	6.7%	7.3%
99%	10.6%	9.2%	11.0%	10.2%	11.1%
99.5%	11.4%	10.4%	12.5%	11.6%	12.6%
max	12.6%	12.1%	33.6%	32.1%	31.6%



- Modeled monthly logreturns based on 10k scenarios and 50yrs of projection.
- FT2 baseline scenarios exaggerate severity of tail monthly returns, which also translate into long term GWF severity (see following slides)
- ACLI calibration amply recovers the distribution of historical monthly returns which includes 1987 Black Monday, Financial Crisis, and the Pandemic of 2020.

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Distribution of Monthly Logreturn: All Indices

ACLI Scenarios (estimated)	large	mid	small	aggressive
min	-62.1%	-69.7%	-76.0%	-81.1%
0.5%	-15.0%	-21.6%	-23.4%	-23.0%
1%	-11.8%	-15.4%	-16.9%	-18.2%
5%	-6.5%	-7.5%	-8.3%	-9.3%
10%	-4.5%	-5.2%	-5.8%	-6.3%
25%	-1.8%	-2.1%	-2.3%	-2.3%
50%	0.8%	0.9%	1.0%	1.0%
75%	3.2%	3.8%	4.1%	4.1%
90%	5.7%	6.6%	7.3%	7.7%
95%	7.4%	8.5%	9.4%	10.2%
99%	11.0%	12.5%	13.8%	15.9%
99.5%	12.5%	14.2%	15.6%	18.3%
max	33.6%	39.6%	44.6%	56.7%

FT2 Baseline Scenarios	large	mid	small	aggressive
min	-69.1%	-53.5%	-70.1%	-63.7%
0.5%	-17.6%	-16.7%	-19.9%	-21.6%
1%	-14.8%	-14.1%	-16.9%	-18.4%
5%	-7.1%	-7.3%	-8.7%	-10.6%
10%	-4.1%	-4.8%	-5.1%	-6.9%
25%	-1.1%	-1.8%	-1.5%	-2.5%
50%	1.0%	1.0%	1.2%	1.3%
75%	3.0%	3.5%	3.6%	4.7%
90%	5.2%	5.9%	6.0%	7.7%
95%	6.7%	7.4%	7.6%	9.7%
99%	10.2%	10.6%	11.0%	13.6%
99.5%	11.6%	12.0%	12.3%	15.2%
max	32.1%	33.7%	30.7%	35.2%

historical 78-2020	large	mid	small	aggressive
min	-24.2%	-30.6%	-33.8%	-31.8%
0.5%	-15.5%	-24.0%	-24.0%	-25.2%
1%	-11.4%	-16.8%	-20.1%	-18.9%
5%	-7.0%	-7.5%	-8.2%	-9.7%
10%	-4.4%	-4.8%	-5.8%	-6.6%
25%	-1.5%	-1.7%	-2.1%	-2.2%
50%	1.4%	1.5%	1.7%	1.8%
75%	3.7%	4.2%	4.5%	4.5%
90%	5.8%	6.6%	7.3%	7.6%
95%	7.3%	8.2%	8.5%	10.3%
99%	10.6%	12.9%	13.3%	13.6%
99.5%	11.4%	13.7%	14.4%	15.3%
max	12.6%	15.6%	18.1%	19.9%

ACLI Monthly Logreturn (10k scenarios, 50yrs)	large	mid	small	aggressive
mean (annual)	7.3%	8.1%	8.6%	9.1%
st.dev (annual)	15.3%	18.3%	20.0%	21.6%
skew	-0.60	-0.96	-0.90	-0.68
kurtosis	6.48	8.06	7.69	7.17
Sharpe Ratio*	28.1%	28.1%	28.1%	28.2%
* assumes Rf = 3%				

GEMS FT2 Monthly Logreturn (10k scenario, 50yrs)	large	mid	small	aggressive
mean (annual)	7.2%	7.5%	7.6%	8.3%
st.dev (annual)	15.2%	16.1%	17.7%	21.6%
skew	-1.25	-0.81	-1.25	-0.81
kurtosis	8.29	5.79	7.32	5.14
Sharpe Ratio*	27.9%	28.2%	25.9%	24.8%
* assumes Rf = 3%				

Historical Monthly Logreturn (1978-2020)	large	mid	small	nasdaq
mean (annual)	11.2%	11.9%	11.6%	10.8%
st.dev (annual)	15.2%	18.2%	19.9%	21.5%
skew	-0.88	-1.18	-1.18	-0.94
kurtosis	6.00	7.84	7.51	6.04
Sharpe Ratio*	34.1%	32.4%	27.9%	22.1%
* assumes Rf = 6%				

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Index Return Correlations: Realized vs. Historical

ACLI Scenarios (estimated)	Large	Mid	Small	Aggrsv.
Large	100%			
Mid	91%	100%		
Small	87%	97%	100%	
Aggrsv.	85%	87%	88%	100%

FT2 Baseline Scenarios	Large	Mid	Small	Aggrsv.
Large	100%			
Mid	88%	100%		
Small	87%	92%	100%	
Aggrsv.	81%	80%	80%	100%

Historical 1978-2020	Large	Mid	Small	Aggrsv.
Large	100%			
Mid	91%	100%		
Small	87%	98%	100%	
Aggrsv.	86%	89%	90%	100%

Table 10: Historic Correlations for Monthly Log Returns

	S&P500	MSCI-EAFE $USD	U.S. SmallCap	Aggressive Equity	Money Market	U.S. ITGVT	U.S. LTCORP
S&P500	1						
MSCI-EAFE $USD	0.560	1					
U.S. SmallCap	0.759	0.447	1				
Aggressive Equity	0.595	0.488	0.579	1			
Money Market	−0.046	−0.059	−0.053	0.002	1		
U.S. ITGVT	0.137	0.091	0.042	−0.064	0.113	1	
U.S. LTCORP	0.280	0.171	0.164	−0.005	0.026	0.822	1

- ACLI realized return correlations reasonably recover historical levels, and exceed those embedded in FT Baseline scenarios
- Both modeled and historical correlation between select indices is high, and well in excess of levels assumed in AIRG (see table to the left). This assumption would reflect a greater severity of systemic equity risk across all indices.

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GWF Comparison vs. AAA Criteria: ACLI and FT2 Baseline

ACLI Large Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.49	0.17	0.16	0.19	0.21	0.54
0.5%	0.67	0.51	0.48	0.62	0.89	2.13
1.0%	0.70	0.57	0.58	0.76	1.15	2.75
5.0%	0.82	0.78	0.90	1.36	2.23	6.17
10.0%	0.88	0.92	1.11	1.82	3.05	9.48
25.0%	0.98	1.17	1.54	2.81	5.11	18.81
50.0%	1.09	1.47	2.14	4.44	9.20	39.45
75.0%	1.19	1.82	2.89	6.92	15.79	79.76
90.0%	1.29	2.16	3.70	9.99	25.22	148.83
95.0%	1.34	2.40	4.33	12.50	33.40	209.78
99.0%	1.47	2.91	5.62	19.04	52.86	415.11
99.5%	1.51	3.12	6.26	22.26	66.31	512.63
Max	1.83	4.70	10.85	43.13	168.19	1,514.65

AAA Criteria (Avg. GWF)	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.46	0.25	0.22	0.25	0.29	0.46
0.5%						
1.0%	0.70	0.58	0.60	0.79	1.15	2.82
5.0%	0.82	0.80	0.91	1.36	2.20	6.38
10.0%	0.88	0.93	1.12	1.81	3.08	9.78
25.0%	0.99	1.18	1.54	2.81	5.26	19.23
50.0%	1.09	1.48	2.15	4.47	9.23	39.98
75.0%	1.19	1.82	2.89	6.93	15.88	80.22
90.0%	1.28	2.15	3.71	10.09	25.20	147.92
95.0%	1.34	2.37	4.30	12.33	33.19	210.72
99.0%	1.45	2.82	5.64	18.18	53.74	397.23
99.5%						
Max	1.76	4.20	8.98	42.03	140.72	1,676.94

ACLI / AAA Criteria	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	1.07	0.70	0.72	0.73	0.72	1.19
0.5%						
1.0%	1.00	0.99	0.97	0.96	1.00	0.97
5.0%	1.00	0.99	0.98	1.00	1.01	0.97
10.0%	1.00	1.00	0.99	1.01	0.99	0.97
25.0%	1.00	1.00	1.00	1.00	0.97	0.98
50.0%	1.00	1.00	1.00	0.99	1.00	0.99
75.0%	1.00	1.00	1.00	1.00	0.99	0.99
90.0%	1.00	1.00	1.00	0.99	1.00	1.01
95.0%	1.00	1.01	1.00	1.01	1.01	1.00
99.0%	1.01	1.03	1.00	1.05	0.98	1.05
99.5%						
Max	1.04	1.12	1.21	1.03	1.20	0.90

GEMS FT2 Large Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.49	0.21	0.14	0.08	0.17	0.26
0.5%	0.66	0.47	0.42	0.50	0.69	1.45
1.0%	0.70	0.55	0.53	0.63	0.93	2.07
5.0%	0.82	0.79	0.88	1.29	2.02	5.50
10.0%	0.88	0.92	1.11	1.74	2.93	8.83
25.0%	0.99	1.18	1.55	2.80	5.17	18.47
50.0%	1.10	1.49	2.17	4.48	9.28	39.71
75.0%	1.20	1.83	2.92	6.96	15.89	80.47
90.0%	1.30	2.17	3.76	9.97	25.08	148.39
95.0%	1.36	2.39	4.38	12.31	32.53	207.89
99.0%	1.47	2.83	5.69	17.54	50.60	413.34
99.5%	1.52	2.99	6.39	19.81	59.40	504.06
Max	1.82	4.29	9.32	38.28	120.07	2,292.47

AAA Criteria (Avg. GWF)	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.46	0.25	0.22	0.25	0.29	0.46
0.5%						
1.0%	0.70	0.58	0.60	0.79	1.15	2.82
5.0%	0.82	0.80	0.91	1.36	2.20	6.38
10.0%	0.88	0.93	1.12	1.81	3.08	9.78
25.0%	0.99	1.18	1.54	2.81	5.26	19.23
50.0%	1.09	1.48	2.15	4.47	9.23	39.98
75.0%	1.19	1.82	2.89	6.93	15.88	80.22
90.0%	1.28	2.15	3.71	10.09	25.20	147.92
95.0%	1.34	2.37	4.30	12.33	33.19	210.72
99.0%	1.45	2.82	5.64	18.18	53.74	397.23
99.5%						
Max	1.76	4.20	8.98	42.03	140.72	1,676.94

ACLI / AAA Criteria	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	1.08	0.87	0.64	0.29	0.57	0.57
0.5%						
1.0%	1.00	0.95	0.88	0.79	0.81	0.73
5.0%	1.00	1.00	0.96	0.95	0.92	0.86
10.0%	1.00	0.99	0.99	0.96	0.95	0.90
25.0%	1.00	1.01	1.01	1.00	0.98	0.96
50.0%	1.01	1.01	1.01	1.00	1.01	0.99
75.0%	1.01	1.01	1.01	1.00	1.00	1.00
90.0%	1.01	1.01	1.01	0.99	1.00	1.00
95.0%	1.01	1.01	1.02	1.00	0.98	0.99
99.0%	1.01	1.00	1.01	0.96	0.94	1.04
99.5%						
Max	1.03	1.02	1.04	0.91	0.85	1.37

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ACLI

GWF Comparison vs. FT2 Baseline: Large and Mid Cap

Revised ACLI

Large Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.49	0.17	0.16	0.19	0.21	0.54
0.5%	0.67	0.51	0.48	0.62	0.89	2.13
1.0%	0.70	0.57	0.58	0.76	1.15	2.75
5.0%	0.82	0.78	0.90	1.36	2.23	6.17
10.0%	0.88	0.92	1.11	1.82	3.05	9.48
25.0%	0.98	1.17	1.54	2.81	5.11	18.81
50.0%	1.09	1.47	2.14	4.44	9.20	39.45
75.0%	1.19	1.82	2.89	6.92	15.79	79.76
90.0%	1.29	2.16	3.70	9.99	25.22	148.83
95.0%	1.34	2.40	4.33	12.50	33.40	209.78
99.0%	1.47	2.91	5.62	19.04	52.86	415.11
99.5%	1.51	3.12	6.26	22.26	66.31	512.63
Max	1.83	4.70	10.85	43.13	168.19	1,514.65

Mid Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.43	0.20	0.13	0.16	0.22	0.56
0.5%	0.59	0.47	0.45	0.60	0.96	2.25
1.0%	0.65	0.55	0.55	0.78	1.20	3.15
5.0%	0.79	0.77	0.89	1.45	2.42	8.06
10.0%	0.86	0.90	1.13	1.94	3.58	12.70
25.0%	0.98	1.19	1.62	3.19	6.28	26.97
50.0%	1.11	1.55	2.35	5.29	11.95	60.44
75.0%	1.23	1.95	3.26	8.53	21.37	131.06
90.0%	1.33	2.36	4.26	12.86	35.90	253.99
95.0%	1.38	2.63	5.01	16.24	47.87	379.55
99.0%	1.50	3.20	6.74	25.05	82.19	774.76
99.5%	1.55	3.41	7.23	29.42	100.00	996.64
Max	1.86	4.93	12.60	58.24	352.44	2,777.67

FT2

Large Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.49	0.21	0.14	0.08	0.17	0.26
0.5%	0.66	0.47	0.42	0.50	0.69	1.45
1.0%	0.70	0.55	0.53	0.63	0.93	2.07
5.0%	0.82	0.79	0.88	1.29	2.02	5.50
10.0%	0.88	0.92	1.11	1.74	2.93	8.83
25.0%	0.99	1.18	1.55	2.80	5.17	18.47
50.0%	1.10	1.49	2.17	4.48	9.28	39.71
75.0%	1.20	1.83	2.92	6.96	15.89	80.47
90.0%	1.30	2.17	3.76	9.97	25.08	148.39
95.0%	1.36	2.39	4.38	12.31	32.53	207.89
99.0%	1.47	2.83	5.69	17.54	50.60	413.34
99.5%	1.52	2.99	6.39	19.81	59.40	504.06
Max	1.82	4.29	9.32	38.28	120.07	2,292.47

Mid Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.53	0.30	0.20	0.12	0.09	0.19
0.5%	0.66	0.51	0.47	0.54	0.75	1.58
1.0%	0.71	0.57	0.57	0.68	0.97	2.34
5.0%	0.82	0.78	0.88	1.27	2.08	5.91
10.0%	0.87	0.91	1.08	1.75	3.01	9.32
25.0%	0.98	1.16	1.53	2.82	5.41	20.27
50.0%	1.09	1.49	2.19	4.66	10.01	45.25
75.0%	1.21	1.88	3.06	7.43	17.70	96.94
90.0%	1.32	2.29	4.04	11.14	29.41	184.11
95.0%	1.38	2.56	4.75	14.16	39.00	271.15
99.0%	1.52	3.11	6.58	21.35	64.22	547.74
99.5%	1.57	3.27	7.08	24.13	76.76	745.84
Max	1.88	4.36	10.50	60.24	168.30	1,839.70

Revised ACLI / FT2

Large Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.99	0.80	1.14	2.47	1.26	2.09
0.5%	1.02	1.09	1.14	1.24	1.29	1.47
1.0%	1.00	1.04	1.10	1.21	1.24	1.33
5.0%	1.00	0.99	1.02	1.06	1.10	1.12
10.0%	1.00	1.00	1.00	1.05	1.04	1.07
25.0%	0.99	0.99	0.99	1.00	0.99	1.02
50.0%	0.99	0.99	0.98	0.99	0.99	0.99
75.0%	0.99	0.99	0.99	0.99	0.99	0.99
90.0%	0.99	1.00	0.98	1.00	1.01	1.00
95.0%	0.99	1.00	0.99	1.02	1.03	1.01
99.0%	1.00	1.03	0.99	1.09	1.04	1.00
99.5%	0.99	1.04	0.98	1.12	1.12	1.02
Max	1.01	1.10	1.16	1.13	1.40	0.66

Mid Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.81	0.67	0.66	1.27	2.46	2.88
0.5%	0.90	0.93	0.96	1.12	1.28	1.43
1.0%	0.92	0.95	0.97	1.15	1.24	1.35
5.0%	0.96	0.98	1.01	1.14	1.16	1.36
10.0%	0.98	0.99	1.04	1.11	1.19	1.36
25.0%	1.00	1.03	1.06	1.13	1.16	1.33
50.0%	1.01	1.04	1.07	1.14	1.19	1.34
75.0%	1.01	1.04	1.06	1.15	1.21	1.35
90.0%	1.01	1.03	1.05	1.15	1.22	1.38
95.0%	1.00	1.03	1.05	1.15	1.23	1.40
99.0%	0.99	1.03	1.02	1.17	1.28	1.41
99.5%	0.99	1.04	1.02	1.22	1.30	1.34
Max	0.99	1.13	1.20	0.97	2.09	1.51

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ACLI

GWF Comparison vs. FT2 Baseline: Small Cap and Aggressive

Revised ACLI

Small Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.39	0.15	0.10	0.12	0.21	0.39
0.5%	0.57	0.41	0.40	0.53	0.80	1.90
1.0%	0.62	0.49	0.49	0.70	1.12	2.85
5.0%	0.76	0.73	0.85	1.39	2.40	8.13
10.0%	0.84	0.87	1.09	1.92	3.54	13.60
25.0%	0.97	1.19	1.63	3.30	6.78	30.89
50.0%	1.11	1.59	2.46	5.86	13.84	78.25
75.0%	1.25	2.06	3.57	9.99	26.65	184.34
90.0%	1.36	2.56	4.82	15.81	48.08	397.94
95.0%	1.43	2.89	5.82	20.92	66.09	609.89
99.0%	1.57	3.57	7.99	33.97	118.70	1,352.69
99.5%	1.63	3.84	8.84	39.59	140.37	1,740.91
Max	1.91	5.57	15.56	94.36	680.18	5,728.16

Aggressive	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.37	0.07	0.04	0.04	0.02	0.01
0.5%	0.56	0.31	0.24	0.28	0.37	0.77
1.0%	0.60	0.38	0.33	0.40	0.56	1.32
5.0%	0.74	0.63	0.68	1.03	1.70	5.34
10.0%	0.82	0.81	0.96	1.65	2.92	10.73
25.0%	0.96	1.18	1.61	3.30	6.91	31.97
50.0%	1.11	1.65	2.66	6.79	16.57	101.05
75.0%	1.27	2.22	4.10	12.80	37.38	303.97
90.0%	1.42	2.83	5.82	21.68	73.93	741.62
95.0%	1.51	3.26	7.22	29.39	107.63	1,237.20
99.0%	1.70	4.40	10.52	53.22	215.88	3,004.52
99.5%	1.83	4.80	12.01	68.58	271.59	3,958.46
Max	2.62	9.91	24.87	158.33	1,000.18	20,311.70

FT2

Small Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.45	0.16	0.12	0.07	0.07	0.16
0.5%	0.61	0.42	0.38	0.38	0.56	1.02
1.0%	0.66	0.52	0.48	0.50	0.72	1.54
5.0%	0.79	0.72	0.79	1.13	1.67	4.63
10.0%	0.85	0.87	1.02	1.58	2.63	8.09
25.0%	0.97	1.15	1.51	2.72	5.14	19.31
50.0%	1.10	1.51	2.23	4.71	10.22	46.50
75.0%	1.23	1.94	3.18	7.90	19.41	108.70
90.0%	1.34	2.36	4.28	12.30	32.48	222.35
95.0%	1.41	2.66	5.11	15.62	43.45	324.38
99.0%	1.54	3.30	6.96	23.83	76.17	713.21
99.5%	1.58	3.52	7.61	27.12	90.62	936.46
Max	1.84	5.99	15.46	56.38	183.63	3,135.58

Aggressive	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.42	0.24	0.12	0.05	0.06	0.10
0.5%	0.59	0.39	0.33	0.33	0.44	0.88
1.0%	0.63	0.45	0.41	0.45	0.62	1.31
5.0%	0.76	0.66	0.72	0.99	1.59	4.48
10.0%	0.82	0.81	0.95	1.50	2.54	8.36
25.0%	0.95	1.12	1.48	2.81	5.51	22.91
50.0%	1.11	1.56	2.39	5.49	12.74	67.17
75.0%	1.27	2.13	3.77	10.49	28.50	191.25
90.0%	1.43	2.80	5.55	17.95	56.55	470.39
95.0%	1.52	3.26	6.88	24.71	80.40	808.50
99.0%	1.71	4.33	10.21	43.81	164.57	2,022.47
99.5%	1.77	4.71	11.99	51.65	206.30	2,855.67
Max	2.24	7.32	22.45	120.23	540.32	22,014.52

Revised ACLI / FT2

Small Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.86	0.95	0.86	1.82	3.11	2.41
0.5%	0.93	0.98	1.05	1.38	1.43	1.87
1.0%	0.94	0.93	1.02	1.41	1.55	1.85
5.0%	0.97	1.00	1.07	1.23	1.44	1.76
10.0%	0.99	1.00	1.07	1.21	1.35	1.68
25.0%	1.00	1.04	1.08	1.21	1.32	1.60
50.0%	1.01	1.05	1.10	1.24	1.35	1.68
75.0%	1.02	1.07	1.13	1.26	1.37	1.70
90.0%	1.02	1.08	1.13	1.29	1.48	1.79
95.0%	1.02	1.09	1.14	1.34	1.52	1.88
99.0%	1.02	1.08	1.15	1.43	1.56	1.90
99.5%	1.03	1.09	1.16	1.46	1.55	1.86
Max	1.04	0.93	1.01	1.67	3.70	1.83

Aggressive	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.88	0.29	0.31	0.81	0.31	0.05
0.5%	0.94	0.80	0.74	0.85	0.86	0.88
1.0%	0.94	0.83	0.79	0.90	0.90	1.00
5.0%	0.98	0.94	0.95	1.04	1.07	1.19
10.0%	1.00	1.00	1.02	1.10	1.15	1.28
25.0%	1.01	1.05	1.09	1.17	1.25	1.40
50.0%	1.01	1.05	1.11	1.24	1.30	1.50
75.0%	1.00	1.04	1.09	1.22	1.31	1.59
90.0%	1.00	1.01	1.05	1.21	1.31	1.58
95.0%	0.99	1.00	1.05	1.19	1.34	1.53
99.0%	1.00	1.02	1.03	1.21	1.31	1.49
99.5%	1.03	1.02	1.00	1.33	1.32	1.39
Max	1.17	1.35	1.11	1.32	1.85	0.92

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ACLI

GWF Comparison vs. FT1 Run 6: Large and Mid Cap

Revised ACLI

Large Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.49	0.17	0.16	0.19	0.21	0.54
0.5%	0.67	0.51	0.48	0.62	0.89	2.13
1.0%	0.70	0.57	0.58	0.76	1.15	2.75
5.0%	0.82	0.78	0.90	1.36	2.23	6.17
10.0%	0.88	0.92	1.11	1.82	3.05	9.48
25.0%	0.98	1.17	1.54	2.81	5.11	18.81
50.0%	1.09	1.47	2.14	4.44	9.20	39.45
75.0%	1.19	1.82	2.89	6.92	15.79	79.76
90.0%	1.29	2.16	3.70	9.99	25.22	148.83
95.0%	1.34	2.40	4.33	12.50	33.40	209.78
99.0%	1.47	2.91	5.62	19.04	52.86	415.11
99.5%	1.51	3.12	6.26	22.26	66.31	512.63
Max	1.83	4.70	10.85	43.13	168.19	1,514.65

Mid Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.43	0.20	0.13	0.16	0.22	0.56
0.5%	0.59	0.47	0.45	0.60	0.96	2.25
1.0%	0.65	0.55	0.55	0.78	1.20	3.15
5.0%	0.79	0.77	0.89	1.45	2.42	8.06
10.0%	0.86	0.90	1.13	1.94	3.58	12.70
25.0%	0.98	1.19	1.62	3.19	6.28	26.97
50.0%	1.11	1.55	2.35	5.29	11.95	60.44
75.0%	1.23	1.95	3.26	8.53	21.37	131.06
90.0%	1.33	2.36	4.26	12.86	35.90	253.99
95.0%	1.38	2.63	5.01	16.24	47.87	379.55
99.0%	1.50	3.20	6.74	25.05	82.19	774.76
99.5%	1.55	3.41	7.23	29.42	100.00	996.64
Max	1.86	4.93	12.60	58.24	352.44	2,777.67

FT1 Run 6

Large Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.43	0.14	0.13	0.31	0.23	0.54
0.5%	0.67	0.50	0.51	0.66	0.95	2.22
1.0%	0.71	0.57	0.59	0.79	1.20	2.97
5.0%	0.83	0.80	0.92	1.41	2.32	6.91
10.0%	0.89	0.94	1.14	1.85	3.20	10.25
25.0%	0.99	1.19	1.58	2.90	5.41	19.96
50.0%	1.09	1.50	2.17	4.55	9.49	41.20
75.0%	1.19	1.82	2.90	6.83	15.89	80.13
90.0%	1.28	2.15	3.66	9.85	24.35	144.23
95.0%	1.33	2.34	4.22	12.01	31.70	198.49
99.0%	1.43	2.75	5.37	17.19	52.06	349.38
99.5%	1.47	2.94	5.97	19.75	61.17	455.82
Max	1.79	3.97	9.38	33.26	135.23	1,089.03

Mid Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.36	0.07	0.10	0.21	0.17	0.49
0.5%	0.59	0.47	0.49	0.61	0.91	2.42
1.0%	0.65	0.53	0.57	0.77	1.18	3.40
5.0%	0.80	0.77	0.90	1.47	2.56	8.37
10.0%	0.87	0.93	1.15	2.00	3.64	13.33
25.0%	0.99	1.22	1.66	3.25	6.58	28.51
50.0%	1.11	1.56	2.37	5.39	12.23	63.08
75.0%	1.22	1.95	3.26	8.62	21.73	132.37
90.0%	1.32	2.33	4.26	12.57	35.30	256.01
95.0%	1.38	2.60	4.95	15.66	46.52	369.93
99.0%	1.49	3.09	6.36	23.02	77.92	752.74
99.5%	1.53	3.40	6.98	26.70	90.74	945.65
Max	1.81	4.38	9.80	44.43	281.03	3,564.58

Revised ACLI / FT1 Run 6

Large Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	1.12	1.24	1.23	0.60	0.92	1.01
0.5%	1.00	1.04	0.95	0.94	0.93	0.96
1.0%	0.99	0.99	1.00	0.96	0.96	0.92
5.0%	0.99	0.98	0.97	0.97	0.96	0.89
10.0%	0.99	0.98	0.97	0.99	0.95	0.92
25.0%	0.99	0.98	0.98	0.97	0.94	0.94
50.0%	1.00	0.98	0.99	0.97	0.97	0.96
75.0%	1.00	1.00	1.00	1.01	0.99	1.00
90.0%	1.01	1.01	1.01	1.01	1.04	1.03
95.0%	1.01	1.03	1.03	1.04	1.05	1.06
99.0%	1.03	1.06	1.05	1.11	1.02	1.19
99.5%	1.03	1.06	1.05	1.13	1.08	1.12
Max	1.02	1.18	1.16	1.30	1.24	1.39

Mid Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	1.18	2.72	1.35	0.74	1.26	1.12
0.5%	1.00	1.00	0.93	0.99	1.05	0.93
1.0%	1.00	1.03	0.97	1.01	1.02	0.93
5.0%	0.98	0.99	1.00	0.99	0.94	0.96
10.0%	0.99	0.97	0.98	0.97	0.98	0.95
25.0%	0.99	0.98	0.98	0.98	0.95	0.95
50.0%	1.00	0.99	0.99	0.98	0.98	0.96
75.0%	1.00	1.00	1.00	0.99	0.98	0.99
90.0%	1.01	1.01	1.00	1.02	1.02	0.99
95.0%	1.00	1.01	1.01	1.04	1.03	1.03
99.0%	1.01	1.04	1.06	1.09	1.05	1.03
99.5%	1.01	1.00	1.04	1.10	1.10	1.05
Max	1.03	1.13	1.29	1.31	1.25	0.78

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ACLI

GWF Comparison vs. FT1 Run 6: Small Cap and Aggressive

Revised ACLI

Small Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.39	0.15	0.10	0.12	0.21	0.39
0.5%	0.57	0.41	0.40	0.53	0.80	1.90
1.0%	0.62	0.49	0.49	0.70	1.12	2.85
5.0%	0.76	0.73	0.85	1.39	2.40	8.13
10.0%	0.84	0.87	1.09	1.92	3.54	13.60
25.0%	0.97	1.19	1.63	3.30	6.78	30.89
50.0%	1.11	1.59	2.46	5.86	13.84	78.25
75.0%	1.25	2.06	3.57	9.99	26.65	184.34
90.0%	1.36	2.56	4.82	15.81	48.08	397.94
95.0%	1.43	2.89	5.82	20.92	66.09	609.89
99.0%	1.57	3.57	7.99	33.97	118.70	1,352.69
99.5%	1.63	3.84	8.84	39.59	140.37	1,740.91
Max	1.91	5.57	15.56	94.36	680.18	5,728.16

Aggressive	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.37	0.07	0.04	0.04	0.02	0.01
0.5%	0.56	0.31	0.24	0.28	0.37	0.77
1.0%	0.60	0.38	0.33	0.40	0.56	1.32
5.0%	0.74	0.63	0.68	1.03	1.70	5.34
10.0%	0.82	0.81	0.96	1.65	2.92	10.73
25.0%	0.96	1.18	1.61	3.30	6.91	31.97
50.0%	1.11	1.65	2.66	6.79	16.57	101.05
75.0%	1.27	2.22	4.10	12.80	37.38	303.97
90.0%	1.42	2.83	5.82	21.68	73.93	741.62
95.0%	1.51	3.26	7.22	29.39	107.63	1,237.20
99.0%	1.70	4.40	10.52	53.22	215.88	3,004.52
99.5%	1.83	4.80	12.01	68.58	271.59	3,958.46
Max	2.62	9.91	24.87	158.33	1,000.18	20,311.70

FT1 Run 6

Small Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.30	0.04	0.05	0.11	0.16	0.29
0.5%	0.56	0.38	0.39	0.47	0.72	1.87
1.0%	0.61	0.47	0.46	0.65	1.03	2.82
5.0%	0.77	0.73	0.85	1.37	2.43	8.05
10.0%	0.85	0.90	1.12	1.93	3.57	13.73
25.0%	0.98	1.22	1.68	3.36	7.01	31.57
50.0%	1.12	1.61	2.48	5.86	13.85	77.20
75.0%	1.24	2.03	3.51	9.72	25.82	171.67
90.0%	1.35	2.47	4.61	14.55	43.08	346.14
95.0%	1.41	2.73	5.41	18.50	58.08	515.80
99.0%	1.53	3.40	7.06	27.78	99.82	1,082.56
99.5%	1.59	3.73	7.76	32.36	118.72	1,473.17
Max	1.93	5.23	12.00	66.21	449.09	4,322.95

Aggressive	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	0.27	0.04	0.04	0.04	0.02	0.06
0.5%	0.54	0.28	0.22	0.21	0.31	0.57
1.0%	0.60	0.35	0.30	0.32	0.43	1.01
5.0%	0.74	0.61	0.63	0.93	1.58	4.82
10.0%	0.82	0.79	0.93	1.50	2.73	10.29
25.0%	0.97	1.17	1.59	3.22	6.72	32.53
50.0%	1.12	1.67	2.69	6.83	16.71	103.80
75.0%	1.27	2.29	4.26	13.29	39.46	324.43
90.0%	1.41	2.92	6.24	23.51	79.89	862.78
95.0%	1.50	3.42	7.59	32.14	120.89	1,449.71
99.0%	1.67	4.37	11.21	55.41	252.27	3,687.17
99.5%	1.75	4.68	12.92	68.95	320.91	4,996.51
Max	2.25	9.52	23.82	219.21	1,104.92	24,015.57

Revised ACLI / FT1 Run 6

Small Cap	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	1.32	3.53	2.06	1.08	1.32	1.34
0.5%	1.02	1.08	1.02	1.13	1.11	1.02
1.0%	1.01	1.04	1.08	1.09	1.08	1.01
5.0%	1.00	1.00	1.00	1.02	0.99	1.01
10.0%	0.99	0.97	0.97	0.99	0.99	0.99
25.0%	0.99	0.98	0.97	0.98	0.97	0.98
50.0%	1.00	0.99	0.99	1.00	1.00	1.01
75.0%	1.01	1.01	1.02	1.03	1.03	1.07
90.0%	1.01	1.04	1.05	1.09	1.12	1.15
95.0%	1.01	1.06	1.08	1.13	1.14	1.18
99.0%	1.02	1.05	1.13	1.22	1.19	1.25
99.5%	1.03	1.03	1.14	1.22	1.18	1.18
Max	0.99	1.07	1.30	1.43	1.51	1.33

Aggressive	1 Yr	5 Yr	10 Yr	20 Yr	30 Yr	50 Yr
Min	1.36	1.64	0.93	0.99	1.05	0.08
0.5%	1.03	1.12	1.10	1.34	1.19	1.35
1.0%	0.99	1.08	1.09	1.27	1.30	1.31
5.0%	1.00	1.03	1.07	1.11	1.07	1.11
10.0%	1.00	1.02	1.04	1.10	1.07	1.04
25.0%	0.99	1.01	1.01	1.03	1.03	0.98
50.0%	1.00	0.99	0.99	0.99	0.99	0.97
75.0%	1.00	0.97	0.96	0.96	0.95	0.94
90.0%	1.00	0.97	0.93	0.92	0.93	0.86
95.0%	1.01	0.95	0.95	0.91	0.89	0.85
99.0%	1.02	1.01	0.94	0.96	0.86	0.81
99.5%	1.04	1.03	0.93	0.99	0.85	0.79
Max	1.17	1.04	1.04	0.72	0.91	0.85

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Appendix

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Appendix A: Calibration and Parameters

	Large	Mid	Small	Aggressive
mu0	0.0723	0.0408	0.0556	0.1233
mu1	0.5744	2.0910	1.5311	-0.2500
alpha	0.0196	0.0307	0.0308	0.0191
beta	0.9519	1.1310	0.9408	0.4800
sigma	0.1254	0.1409	0.1409	0.1587
mu_jump	-0.1500	-0.2184	-0.2355	-0.1990
sigma_jump	0.0584	0.0476	0.0480	0.0678
lambda_jump	4.9442	4.6774	3.8906	3.6347
correlation	-0.4563	-0.6661	-0.6275	-0.3105
initial vol	0.1435	0.1648	0.1809	0.1997
theta	0.0206	0.0272	0.0327	0.0399
Avg. Jump Freq.	0.1019	0.1270	0.1273	0.1449
% Jump Variance	11.4%	18.9%	18.3%	13.8%
MLE Sum LL	914	838	788	756
MLE Avg. LL	1.8	1.7	1.6	1.5

Equity return assumed to be independent of short rate, i.e. follows constant mean return, implying the short rate as part of total return is effectively set to zero.

Model parameters calibrated to monthly historical data using generalized MLE:

- Large Cap: S&P total return index from 8/1978 to 12/2020, based on data provided by Link Richardson from a combination of sources
- Mid Cap: Willshire Mid Cap from 8/1978 to 12/2020 , sourced from FRED
- Small Cap: Willshire Small Cap from 8/1978 to 12/2020 , sourced from FRED
- Aggressive: NASDAQ Composite from 3/1971 to 12/2020 , sourced from FRED

Adjustments / Targeting

- MLE calibration included a 12% cap on jump frequency, to better align with historical correlations. Note that this frequency was subject to variance adjustment below.
- Large Cap drift coefficient, mu0, was adjusted by -.0383 to align with 8.75% average target proposed by NAIC in the original AIRG specification
- Mid, Small, and Aggressive alpha (variance target) parameter was adjusted to align with historical relationship to Large Cap returns
- Mid, Small and Aggressive, had mu0 adjusted to align with the Sharpe Ratio of 28.1% implied in the Large Cap scenarios, and assuming a risk-free rate of 3%.

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Appendix B: Constructing the Correlation Matrix

	Large Var	Large Ret	Mid Var	Mid Ret	Small Var	Small Ret	Aggr. Var	Aggr. Ret
Large Var	1.0000							
Large Ret	-0.4563	1.0000						
Mid Var	0.8172	-0.5429	1.0000					
Mid Ret	-0.4995	0.9405	-0.6661	1.0000				
Small Var	0.7667	-0.4927	0.9642	-0.6193	1.0000			
Small Ret	-0.4840	0.9004	-0.6505	0.9816	-0.6275	1.0000		
Aggr. Var	0.7889	-0.3309	0.8026	-0.3917	0.7996	-0.3890	1.0000	
Aggr. Ret	-0.3857	0.8931	-0.4965	0.9196	-0.4713	0.9276	-0.3105	1.0000

Correlation matrix based on historical data from 8/1978 to 12/2020:

- Variance/Return, or skew, correlation for each individual index based on each specific MLE
- Cross index Variance/Variance explicitly calculated using filtered historical Heston variance based on calibrated parameters
- Cross-skew correlation computed based on same filtered variances as above, but scaled to align with MLE-based correlation coefficients
- Cross index Return/Return explicitly calculated based on historical data, and subsequently adjusted by +3% for all coefficients except Mid/Small to adjust for the noise from the jump process.

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Appendix C: Notes on Proposed Calibration

- ACLI proposal calibrated to the history by using Maximum Likelihood Estimation (MLE) with additional adjustments to make sure appropriate relationship across model indices.
- Equity returns do not reflect explicit linkage to short rates, and the returns/volatilities have been adjusted to reflect reasonable historical relationships. No additional adjustments are required.
- Modeled ACLI results are based on externally implemented GEMS proxy model based on publicly disclosed model details. Proposed parameters must be run directly through GEMS software to confirm intended outcomes and for possible minor refinements.

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Equity Calibration Comparsion

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1

Two Alternative Calibrations

Modified GEMS Calibration

a) Based on standard GEMS calibration approach
b) Adjusted for NAIC's mean and standard deviation targets
c) Basis for Field Test #2 runs

ACLI's Proposed Calibration

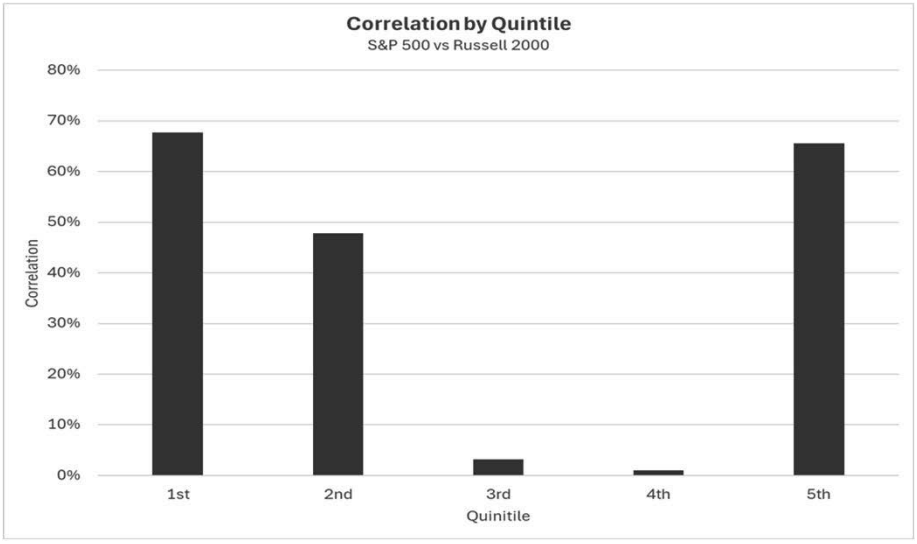
a) Based on Run #6 from Field Test #1
b) Adjusted to address some of Conning's previous concerns

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Previous Concern: Tail Correlation

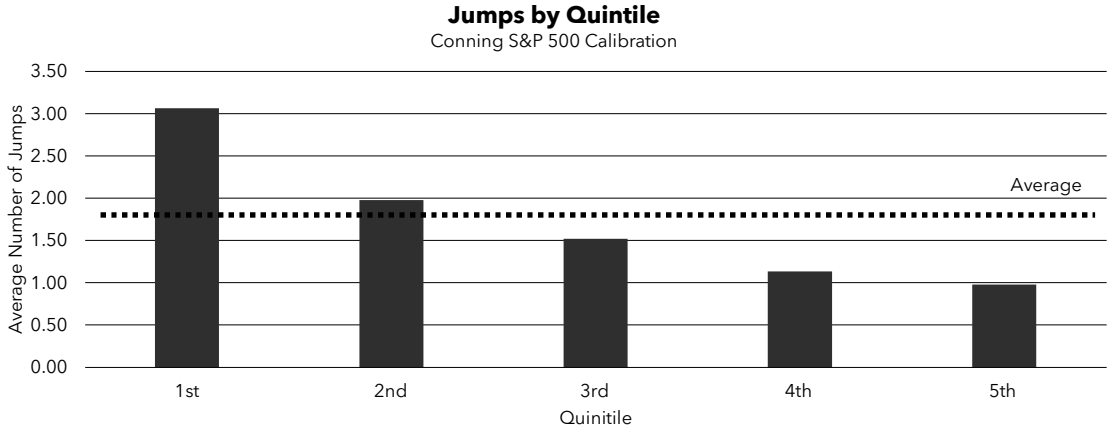


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Previous Concern: Tail Correlation

Focus on Impact of Jumps



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Previous Concern: Tail Correlation

Way to achieve this in GEMS

a) Correlation between Variances

Calibration	Mid Cap	Small Cap	US Aggressive Equity
Conning	0.8920	0.8530	0.9360
ACLI	0.8172	0.7667	0.7889

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Previous Concern: Tail Correlation

Way to achieve this in GEMS

a) Correlation between Variances
b) Correlations between Jump Losses
c) Similar Jump Frequencies
- Frequency is linked to Variance: Expected Frequency = Jump Intensity * Current Variance
- Variance reverts to α / β
- So, want Long-Term Frequency (= Jump Intensity * α / β) to be similar

Calibration	Large Cap	Mid Cap	Small Cap	US Aggressive Equity
Conning	1.7419	1.8656	1.8288	3.3580
ACLI	0.1019	0.1270	0.1273	0.1449

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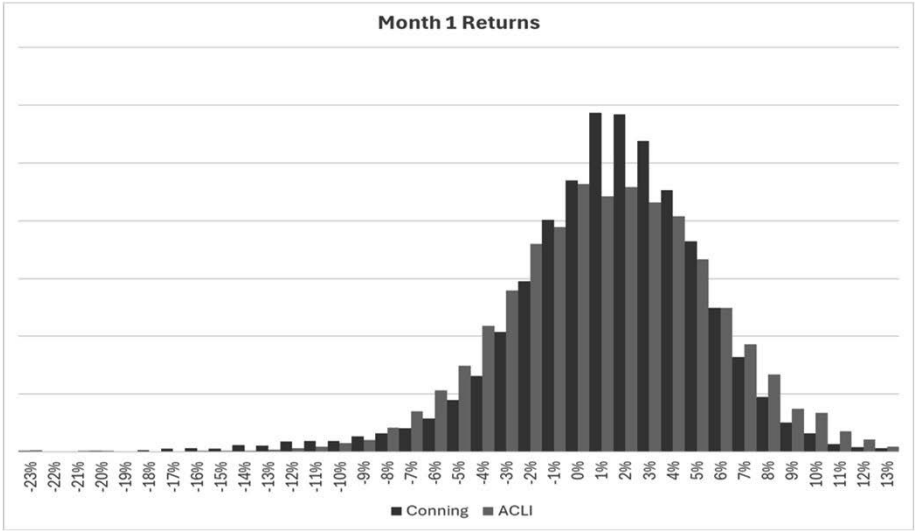
Alternative Calibrations: Large Cap Parameter Comparison

Parameters	Conning	ACLI
Fixed Return	0.0825	0.0723
Risk Premium Coefficient	0.0926	0.5744
Alpha	0.0058	0.0196
Beta	0.4627	0.9519
Sigma	0.0747	0.1254
Jump Intensity	139.5882	4.9442
Jump Mean	-0.0525	-0.1500
Jump Sigma	0.0575	0.0584

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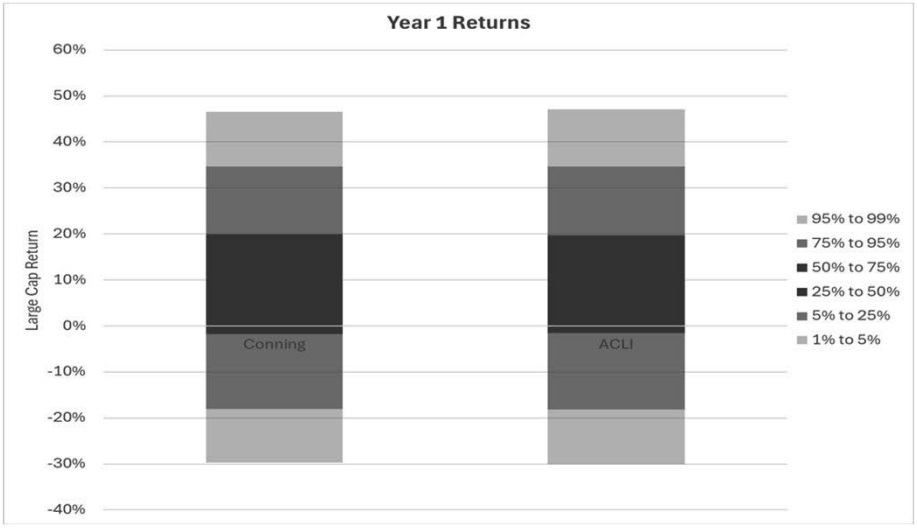
Alternative Calibrations: First Month Returns



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Alternative Calibrations: First Year Returns



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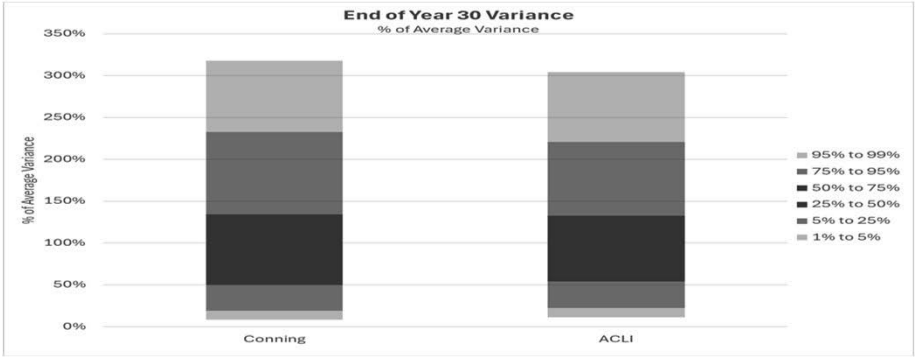
Alternative Calibrations: Changes over Time

Evolution only Impacted by Variance

- Core volatility is completely independent

Impact of Variance

- Is it variable?



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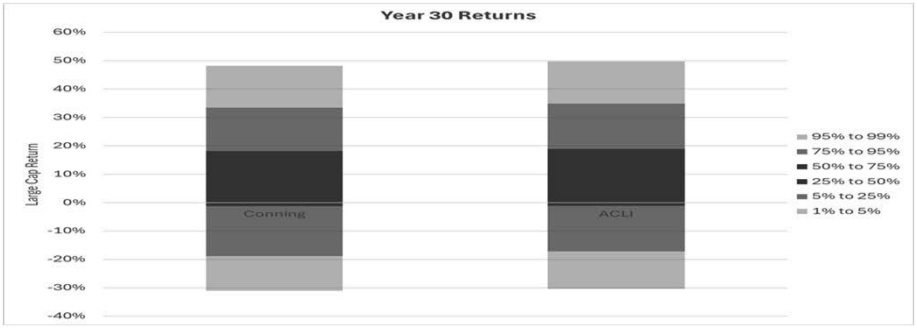
Alternative Calibrations: Changes over Time

Evolution only Impacted by Variance

- Core volatility is completely independent

Impact of Variance

- Is it variable?
- Does that variability impact return?



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Alternative Calibrations: Changes over Time

Evolution only Impacted by Variance

- Core volatility is completely independent

Impact of Variance

- Is it variable?
- Does that variability impact return?
- How does it impact serial correlation?

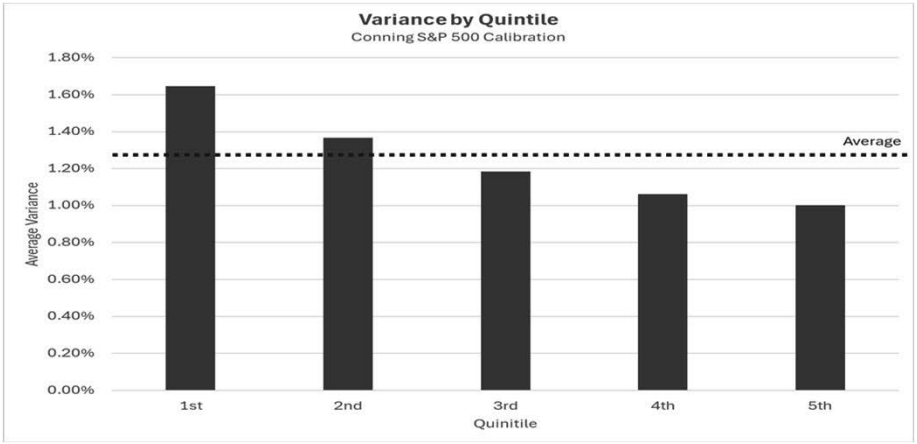
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Alternative Calibrations: Impact on Serial Correlation

Impact is Complicated

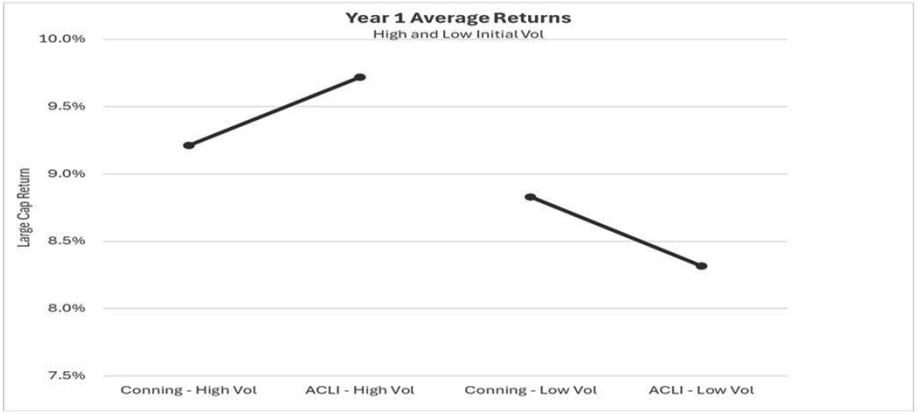
- Like Jumps, Variance increases with bad returns



Alternative Calibrations: Impact on Serial Correlation

Impact is Complicated

- Like Jumps, Variance increases with bad returns
- Large Risk Premium Coefficient makes Average Return very susceptible to changes in Variance

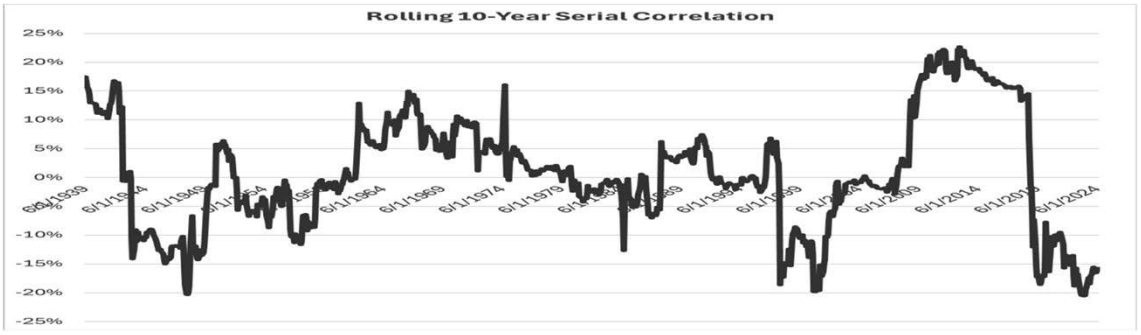


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Alternative Calibrations: Impact on Serial Correlation

Impact is Complicated

- Like Jumps, Variance increases with bad returns
- Large Risk Premium Coefficient makes Average Return very susceptible to changes in Variance
- Changes the sign of Serial Correlation
  - Conning's Year 1 vs Year 2 is +2%
  - ACLI's is -3%



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Financial Security for Life

ACLI Dynamic Generalized Fractional Floor (GFF) Proposal

November 15, 2024

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Generalized Fractional Floor (GFF)

- In 2021, discussions began to introduce a flooring mechanism to the Generator.
- The 3-factor CIR model, coupled with the low-for-long criteria, can be challenged to simultaneously produce high historical rates (1980s) without producing extremely negative and volatile short rates.
- To address this challenge, several floor proposals were discussed, ultimately resulting in reflecting a GFF in the Generator.
- While the GFF produced some improvements, the frequency of negatives is still quite severe.

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Dynamic GFF

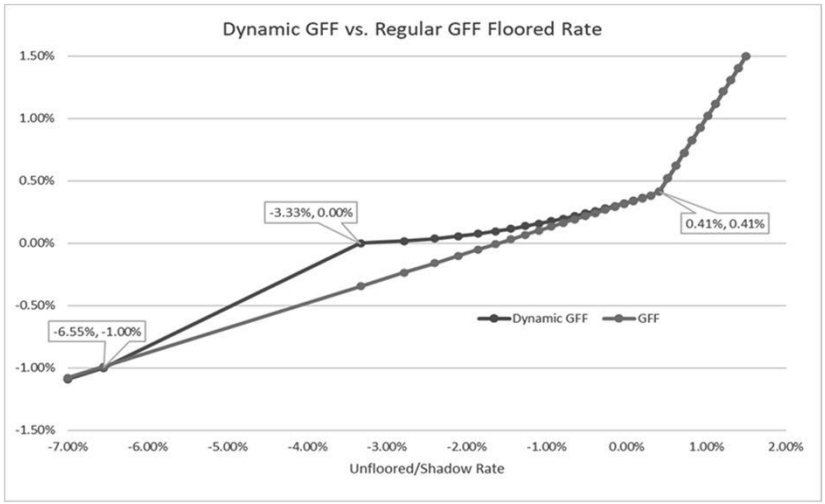
- ACLI is proposing a dynamic GFF to provide flexibility to more precisely calibrate the appropriate level of modeled negative rates in terms of both frequency and severity.
- In addition to the Current GFF terms, would need to define:
  - Minimum floored rate (-1% which aligns with the current GOES scenarios and targeting criteria);
  - The desired frequency of the negative rates in the steady state distribution (1% which aligns with the Academy worse than history criteria)
- Once these are defined, the floor formula parameters would be set based on how these two criteria interact with the relevant unfloored (shadow) rate distribution

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Resulting steady-state (years 80+) floored rates as of 12/31/2023 (FT2 Baseline):



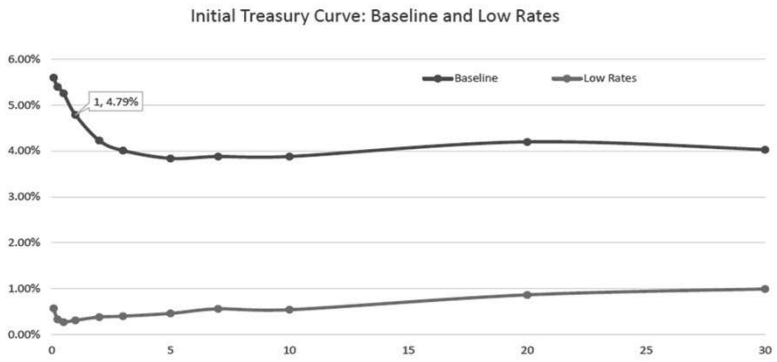
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Initial Treasury Curve: Baseline (12/2023) and Low Rates (3/2020)

- Distribution of negative rates is sensitive to starting conditions
- The next slides compare negative rate distributions between current and dynamic GFF on these valuation dates used in FT2

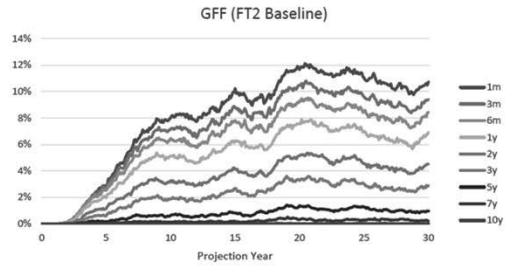


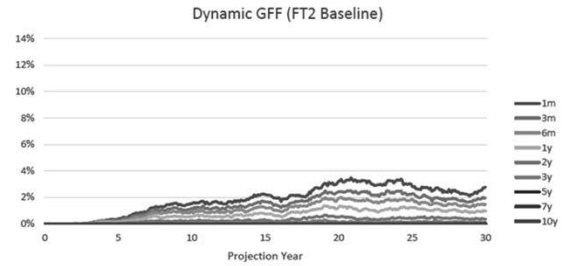
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Frequency of Negative Rates: Baseline FT2 Scenarios (first 30 years of the projection)





Frequency of Negative 1yr Rate by Projection Year

Proj. Year	GFF	Dynamic GFF
1	0.0%	0.0%
2	0.1%	0.0%
5	2.0%	0.2%
10	5.1%	0.5%
20	7.6%	1.3%
30	6.9%	1.0%

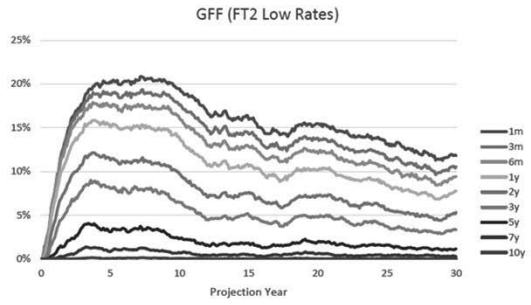
- Under current GFF up to 12% of 1-month rates, and 8% of 1-year rates fall below 0% in the Baseline scenarios
- Dynamic GFF significantly mitigates frequency of negative rates in the projection.
- Frequency of negative rates is diminished in the early years due to high starting rates (UST 1yr = 4.79%)

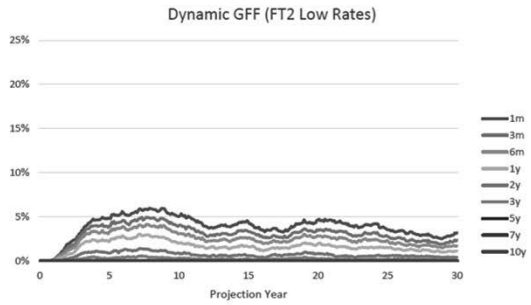
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Frequency of Negative Rates: Low Rates FT2 Scenarios ((first 30 years of the projection)





Frequency of Negative 1yr Rate by Projection Year

Proj. Year	GFF	Dynamic GFF
1	6.7%	0.1%
2	12.1%	0.7%
5	15.1%	2.2%
10	13.8%	2.1%
20	10.2%	2.0%
30	7.8%	1.1%

- Current GFF produces up to 20% of 1-month rates, and 15% of 1-year rates below 0% in the Low Rate scenarios
- Dynamic GFF significantly mitigates frequency of negative rates in the projection. Note that the frequency of negative rates is higher compared to the Baseline scenario set under both flooring methods, since the initial curve is 3%+ lower.

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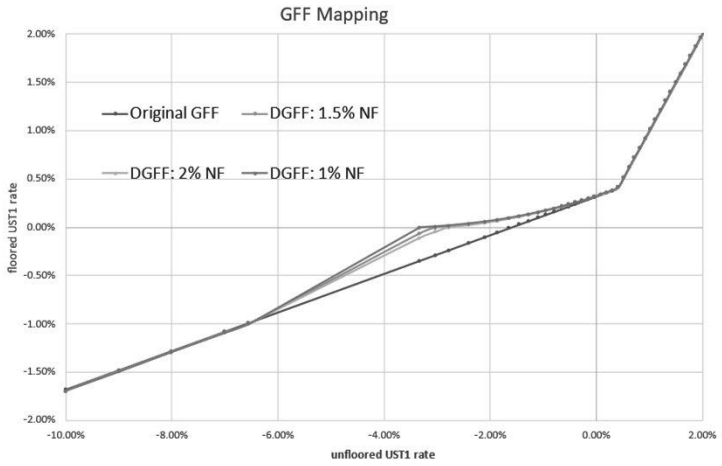
Alternatives

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Dynamic GFF Alternatives: impact of flooring



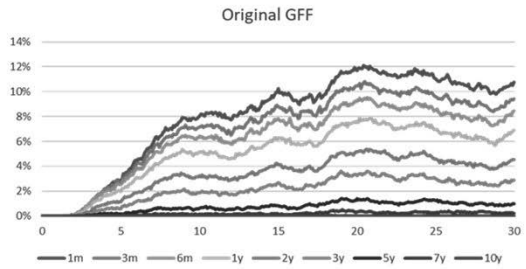
- Original GFF maps unfloored rate of -1.6% to 0%, effectively targeting 6-7% frequency of negative UST1
- Dynamic GFF allows for targeting of any desired frequency of negative UST1 by adjusting the unfloored rate level that maps to 0%
  - 1% frequency: unfloored rate of -3.33%
  - 1.5% frequency: unfloored rate of -3.03%
  - 2% frequency: unfloored rate of -2.79%
- Resulting flooring gets closer to original GFF as the desired frequency of negative UST1 is increased.

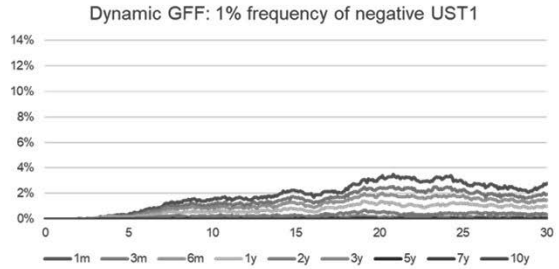
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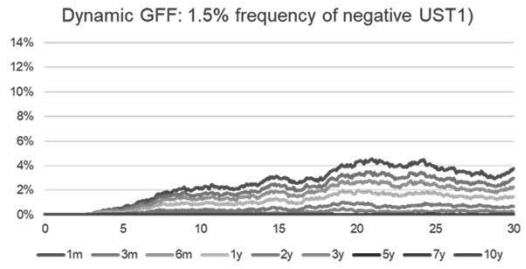
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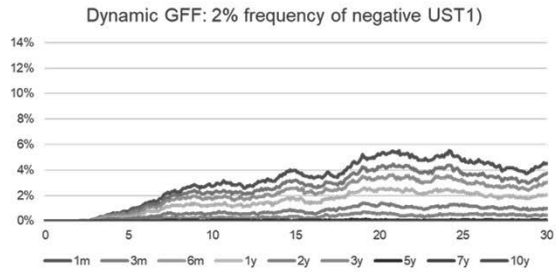
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Baseline FT2 Scenarios







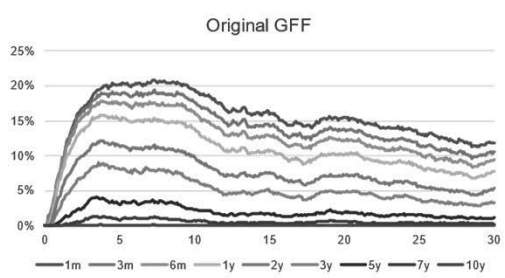


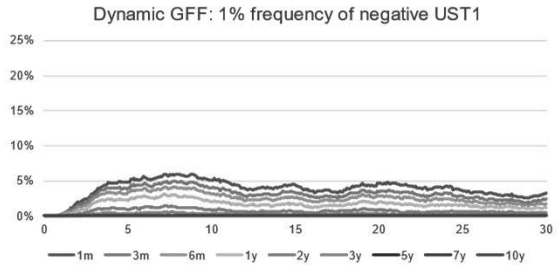
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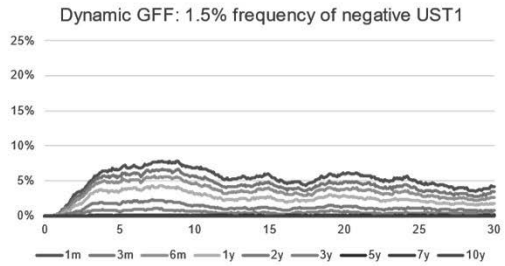
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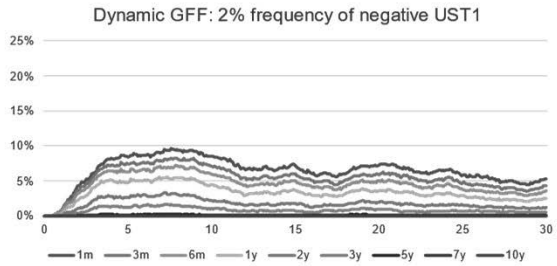
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Low Rate FT2 Scenarios









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Low Tail Distribution in Steady State (80-100yrs of the projection)

Original GFF

	1m	3m	6m	1y	2y	3y	5y	7y	10y
min	-1.3%	-1.2%	-1.1%	-1.0%	-0.8%	-0.7%	-0.5%	-0.4%	-0.2%
0.5%	-0.6%	-0.6%	-0.5%	-0.4%	-0.3%	-0.2%	-0.1%	0.1%	0.2%
1%	-0.5%	-0.5%	-0.4%	-0.3%	-0.2%	-0.1%	0.0%	0.1%	0.3%
2%	-0.4%	-0.3%	-0.3%	-0.2%	-0.1%	0.0%	0.1%	0.2%	0.3%
3%	-0.3%	-0.3%	-0.2%	-0.2%	-0.1%	0.0%	0.2%	0.3%	0.4%
4%	-0.3%	-0.2%	-0.2%	-0.1%	0.0%	0.1%	0.2%	0.3%	0.6%
5%	-0.2%	-0.2%	-0.1%	-0.1%	0.0%	0.1%	0.3%	0.4%	0.7%
6%	-0.2%	-0.1%	-0.1%	0.0%	0.1%	0.2%	0.3%	0.4%	0.9%
7%	-0.1%	-0.1%	0.0%	0.0%	0.1%	0.2%	0.3%	0.5%	1.1%
8%	-0.1%	0.0%	0.0%	0.1%	0.2%	0.2%	0.4%	0.7%	1.2%
9%	0.0%	0.0%	0.0%	0.1%	0.2%	0.3%	0.4%	0.8%	1.3%
10%	0.0%	0.0%	0.1%	0.1%	0.2%	0.3%	0.5%	0.9%	1.4%

Dynamic GFF: 1% frequency of negative UST1

	1m	3m	6m	1y	2y	3y	5y	7y	10y
min	-1.3%	-1.2%	-1.1%	-1.0%	-0.7%	-0.5%	-0.2%	0.0%	0.0%
0.5%	-0.3%	-0.3%	-0.2%	-0.1%	0.0%	0.0%	0.1%	0.1%	0.2%
1%	-0.2%	-0.1%	-0.1%	0.0%	0.0%	0.0%	0.1%	0.2%	0.3%
2%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.1%	0.2%	0.2%	0.3%
3%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%	0.3%	0.4%
4%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.2%	0.3%	0.6%
5%	0.0%	0.0%	0.1%	0.1%	0.1%	0.2%	0.3%	0.4%	0.7%
6%	0.0%	0.1%	0.1%	0.1%	0.1%	0.2%	0.3%	0.4%	0.9%
7%	0.1%	0.1%	0.1%	0.1%	0.2%	0.2%	0.3%	0.5%	1.1%
8%	0.1%	0.1%	0.1%	0.1%	0.2%	0.3%	0.4%	0.7%	1.2%
9%	0.1%	0.1%	0.1%	0.2%	0.2%	0.3%	0.4%	0.8%	1.3%
10%	0.1%	0.1%	0.1%	0.2%	0.2%	0.3%	0.5%	0.9%	1.4%

Steady State (80-100yrs) Tail: Dynamic GFF

	1m	3m	6m	1y	2y	3y	5y	7y	10y
min	-1.3%	-1.2%	-1.1%	-1.0%	-0.8%	-0.6%	-0.3%	-0.1%	0.0%
0.5%	-0.4%	-0.3%	-0.2%	-0.2%	0.0%	0.0%	0.1%	0.1%	0.2%
1%	-0.3%	-0.2%	-0.1%	-0.1%	0.0%	0.0%	0.1%	0.2%	0.3%
2%	-0.1%	-0.1%	0.0%	0.0%	0.0%	0.1%	0.2%	0.2%	0.3%
3%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%	0.3%	0.4%
4%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.2%	0.3%	0.6%
5%	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%	0.3%	0.4%	0.7%
6%	0.0%	0.0%	0.1%	0.1%	0.1%	0.2%	0.3%	0.4%	0.9%
7%	0.0%	0.1%	0.1%	0.1%	0.2%	0.2%	0.3%	0.5%	1.1%
8%	0.1%	0.1%	0.1%	0.1%	0.2%	0.2%	0.4%	0.7%	1.2%
9%	0.1%	0.1%	0.1%	0.2%	0.2%	0.3%	0.4%	0.8%	1.3%
10%	0.1%	0.1%	0.1%	0.2%	0.2%	0.3%	0.5%	0.9%	1.4%

Dynamic GFF: 2% frequency of negative UST1

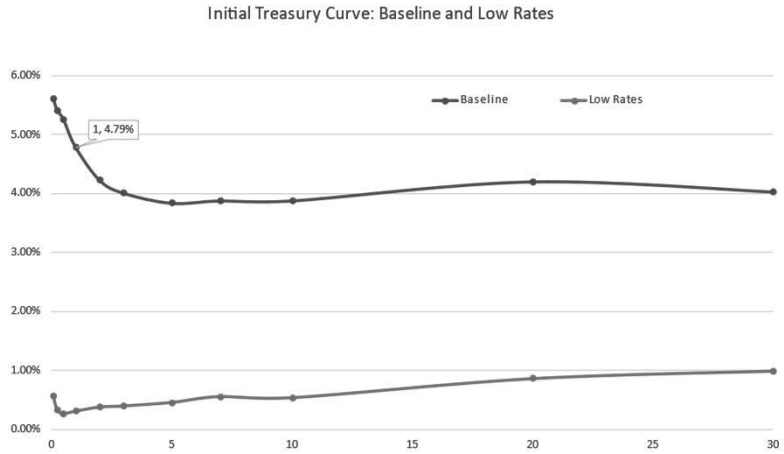
	1m	3m	6m	1y	2y	3y	5y	7y	10y
min	-1.3%	-1.2%	-1.1%	-1.0%	-0.8%	-0.6%	-0.3%	-0.1%	0.0%
0.5%	-0.4%	-0.4%	-0.3%	-0.2%	-0.1%	0.0%	0.1%	0.1%	0.2%
1%	-0.3%	-0.2%	-0.2%	-0.1%	0.0%	0.0%	0.1%	0.2%	0.3%
2%	-0.2%	-0.1%	-0.1%	0.0%	0.0%	0.1%	0.2%	0.2%	0.3%
3%	-0.1%	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%	0.3%	0.4%
4%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%	0.3%	0.6%
5%	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%	0.3%	0.4%	0.7%
6%	0.0%	0.0%	0.1%	0.1%	0.1%	0.2%	0.3%	0.4%	0.9%
7%	0.0%	0.1%	0.1%	0.1%	0.2%	0.2%	0.3%	0.5%	1.1%
8%	0.1%	0.1%	0.1%	0.1%	0.2%	0.2%	0.4%	0.7%	1.2%
9%	0.1%	0.1%	0.1%	0.2%	0.2%	0.3%	0.4%	0.8%	1.3%
10%	0.1%	0.1%	0.1%	0.2%	0.2%	0.3%	0.5%	0.9%	1.4%

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Initial UST Treasury Curves: FT2 Baseline and Low Rates



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Tail Distribution of 1yr Spot Rate under FT2 GEMS Scenarios

percentile	Floored (GFF)	Unfloored
min	-0.99%	-6.55%
1%	-0.35%	-3.33%
1.5%	-0.29%	-3.03%
2%	-0.24%	-2.79%
3%	-0.16%	-2.40%
4%	-0.10%	-2.11%
5%	-0.05%	-1.86%
6%	-0.01%	-1.64%
7%	0.03%	-1.45%
8%	0.07%	-1.27%
9%	0.10%	-1.10%
10%	0.13%	-0.94%

- Steady state distribution of 1yr Spot rate based on baseline FT2 GEMS scenarios, and years 80 to 100 of the projection.
- Unfloored/Shadow rates calculated by inverting the GFF formula to solve for the implied unfloored rates.
- Unfloored rates at given severity can be used directly to target the frequency of negative rates in the distribution.
- Example: to target 1.5% negative rate frequency in the steady state, set parameter s_0 = -3.03%

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Appendix

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Current Generalized Fractional Floor (GFF)

$$rate(s) = max(\kappa + m\ (s - \kappa), s)$$

- Where:

  $\boldsymbol{s}$ is the natively modeled shadow, or unfloored, rate

  $\boldsymbol{rate(s)}$ is the floored rate as a function of the shadow rate s and the GFF parameters κ and *m*

  $\boldsymbol{\kappa}$ is the threshold parameter – shadow rates below this threshold are subject to the fractional flooring

  $\boldsymbol{m}$ is the constant fraction parameter which applies to the difference $s - \kappa$. Setting *m=0* would imply simple flooring at k, while *m=1* would imply no flooring as *rate(s) = s*

- For purposes of GOES, GFF parameters are set to: $\kappa = .004$ and $m = .2$, and the floor applies to the continuous spot rates generated by a 3-factor CIR model

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Proposed Dynamic Generalized Fractional Floor (GFF)

$$rate(s) = max(\kappa + m(s)\ (s - \kappa), s)$$

$$m(s) = m_0 + max(min(s, \kappa) - s_0, 0)\ R_0 - max(s_0 - max(s, s_{min}), 0)\ R_{min}$$

- Where:

  $\bar{m}$ is the terminal fraction level that applies when $s = \kappa$; subject to constraint $\bar{m} < \frac{2\kappa}{\kappa - s_0}$

  $m_0 = \frac{\kappa}{\kappa - s_0}$ is the fraction that ensures $rate(s_0) = 0$

  $R_0 = \frac{\bar{m} - m_0}{\kappa - s_0}$

  $m_{min} = \frac{\kappa - rat\ _{min}}{\kappa - s_{min}}$ is the fraction that ensures $rate(s_{min}) = rate_{min}$

  $R_{min} = \frac{m_0 - m_{min}}{s_0 - s_{min}}$

- We assume m(s) can be recast as a piecewise linear function, based on additional targets to explicitly control for (i) frequency of negative rates and (ii) minimum floored rate boundary

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Recipe for Setting Dynamic GFF Parameters

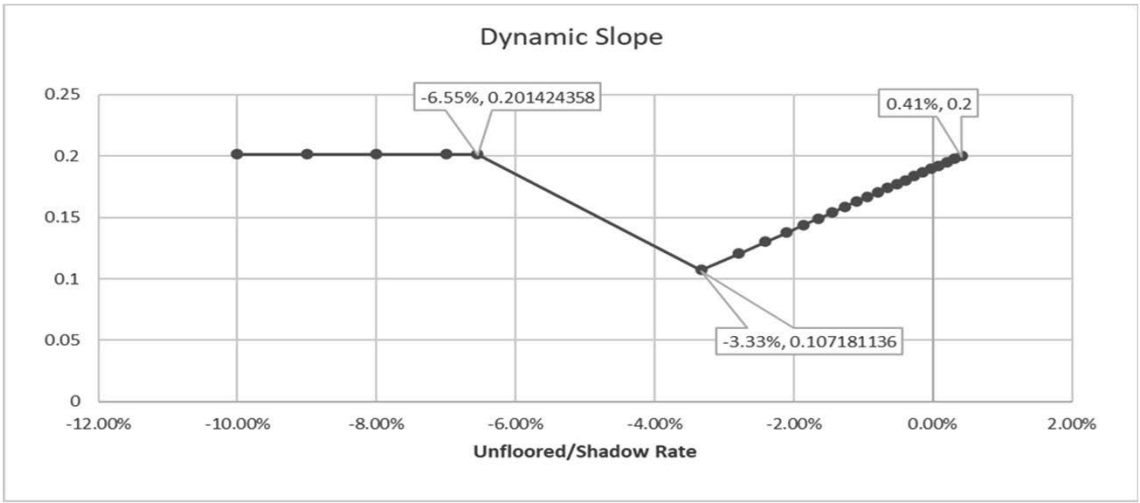
1. Start with the core GFF parameters, $\kappa = .004$ and $\bar{m} = .2$
2. Produce the target distribution of shadow rates as basis for targeting: include tail percentile levels such as minimum, 1%, 2%, etc. and pick the desired short rate tenor, such as 1yr.
3. Target negative frequency: s_0 = -3.3% which is the 1st percentile of the 1yr shadow rate distribution in years 81-100 (steady state) FT2 baseline scenarios. Note that this could also be set to 1.5% or 2% tail levels, to allow for more negative rates in the distribution.
4. Check to see if $\bar{m}$ satisfies the constraint (which it does), and lower accordingly.
5. Set the low-rate boundary (the ultimate floor): $s_{min} = -6.55\%$ (minimum shadow rate in FT2 scenarios) and $rate_{min} = -1\%$. Any other suitable level, like -1.5% would also work. Note that the FT2 baseline scenario 1yr spot rate bottoms out at ~ -1% as well.

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This parameterization results in the following dynamic fraction $m(s)$;
The fraction $m(s)$ linearly grades from $\bar{m}$ to m_0 at s=-.0333, to m_{min} at s = .0655 as intended.



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Update on Life Insured Mortality Improvement Recommendation

Mortality Improvement Life Working Group
of the SOA Mortality and Longevity Oversight Advisory Council

NOVEMBER| 2024

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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.

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Agenda

- Discuss Life Mortality Improvement (MI) Initial Recommendation for Fully Underwritten Business
- MI recommendation for Limited Underwriting Business
  - Considering applicability of planned new VM 51 underwriting data elements for limited underwriting study (underway)

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MI Recommendation – Fully Underwritten Business

Where we started …..

- Difficult to measure true life insured MI due to "noise" in the industry experience data for insured lives
  - Changes in underwriting definitions, changes in risk class structure, changes in market/distribution focus over time
- Reviewed SOA general population socioeconomic decile work
  - Is there a decile that that can be used as a proxy for the life insurance population?
- Predictive modeling approach considered

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MI Recommendation – Fully Underwritten Business
Overview of Work (2024)

- Predictive modeling work
  - To identify and quantify the primary factors impacting mortality improvement results in the insured population data
- MI analysis tool developed

Excel-based tool that allows for normalization of data for factors identified in predictive modeling work

  - Allows for better understanding of true biometric mortality improvement levels
  - Allows for comparison to general population deciles



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MI Recommendation – Fully Underwritten Business
Predictive Modeling

- Goal: Determine the primary factors impacting insured mortality improvement
- Data: 2011-2017 fully insured mortality data provided by SOA
- Separate models developed by product
  1. Term business – excluding post level term
  2. Post level term business only
  3. Permanent products
- Results: confirmed subgroup's hypothesis that the primary industry-related factors impacting MI for insured population include:
  - Face amount distribution
  - Risk class
  - Plan of insurance
  - Issue year era
  - Duration

The same primary factors were identified across products, but there are differences by product in order of factor importance.

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MI Recommendation – Fully Underwritten Business
MI Analysis Tool

- Data Sources
  - General population data from socioeconomic decile study
  - Insured data from SOA based on the NAIC/NYDFS data calls (2009-2019 period)
    - Includes all fully underwritten business issued standard (no substandard)
- Methodology
  - Insured mortality experience is normalized across years for factors having greatest effect
  - Currently can only normalize for one factor at a time
  - Informed by predictive modeling work
- Results
  - Normalized insured data was compared to population data
  - Normalized insured data appears reasonably consistent with population trends



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Preliminary Life MI Recommendation

	Options Considered	Initial Recommendation
Basis for Measuring Improvement	1. Fully underwritten insured mortality experience (after normalization) 2. General population decile chosen to represent insured 3. Combination of both	Combination of both – normalized insured data to measure MI for primary insured ages (25-80), different approach for oldest and youngest ages
Subset of Insured Historical Data for Measuring MI	1. Experience Period Subset (full period available 2009-2019) 2. Unismoke, smoker distinct, or all data 3. Post level term 4. Conversion business 5. Survivorship business	1. 2011-2019 2. Smoker distinct only 3. Excluded post level term 4. Conversion included (no means to exclude) 5. Survivorship excluded
Methodology	1. MI calculation basis (face amt/policy count) 2. Factors for variations in scale (gender, attained age, smoker status, risk class, select vs ultimate) 3. Smoothing approach 4. COVID adjustments if needed 5. Impact of opioid and mental health crises 6. Risk margin approach	1. Policy count 2. Gender and attained age only 3. TBD 4. COVID adjustments TBD 5. Included in both insured and general population data 6. Risk margin considerations TBD

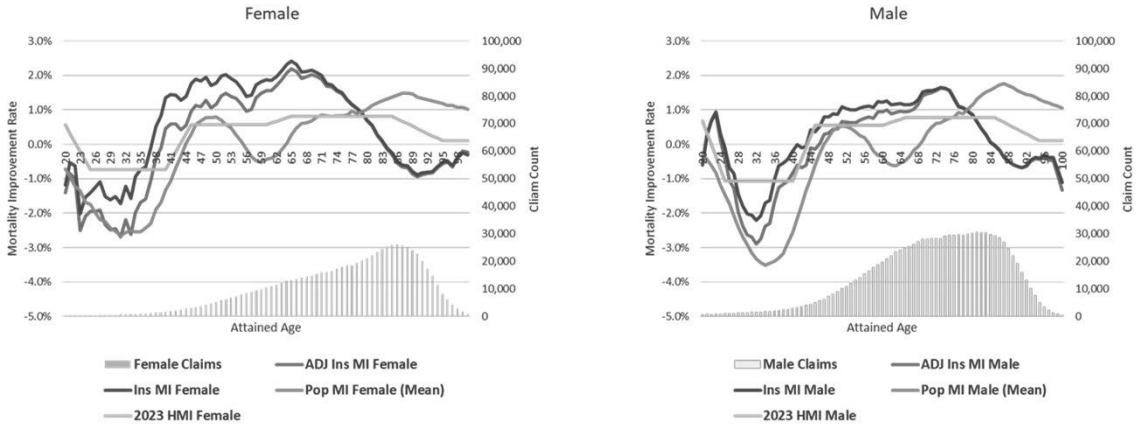
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MI Recommendation – Fully Underwritten Business Mortality Improvement Rates

Policy Count Basis – 2011-2019
Normalized for Face Amount, Ages 20 and older

Term and Permanent Combined



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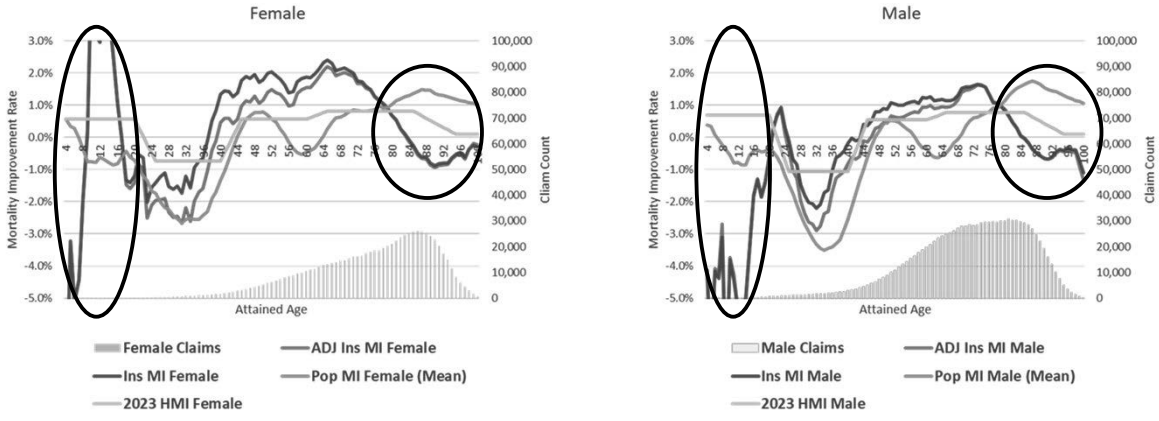
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MI Recommendation – Fully Underwritten Business Mortality Improvement Rates

Policy Count Basis – 2011-2019
Normalized for Face Amount, All Ages

Term and Permanent Combined

Need combination of insured and general population data at youngest and oldest ages.

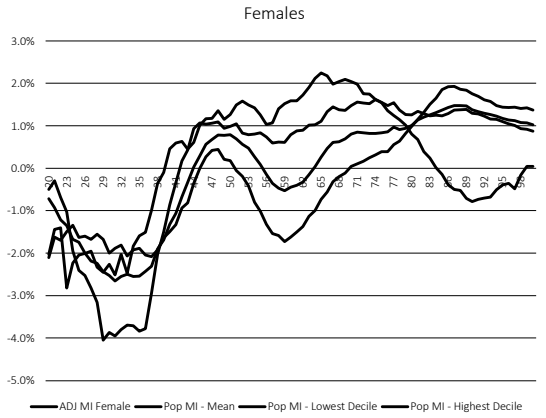


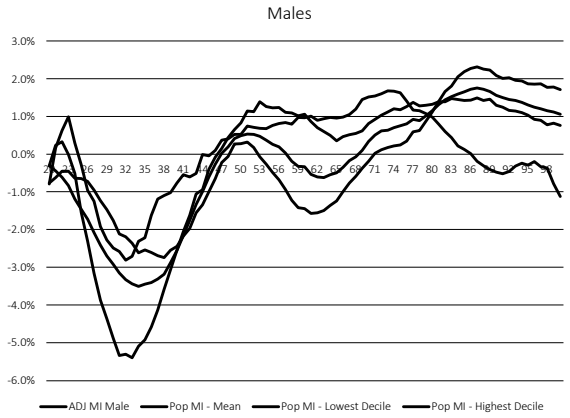
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MI Recommendation – Fully Underwritten Business Mortality Improvement Rates

Policy Count Basis – 2011-2019
Normalized for Face Amount, Ages 20 and older
Term and Permanent Combined



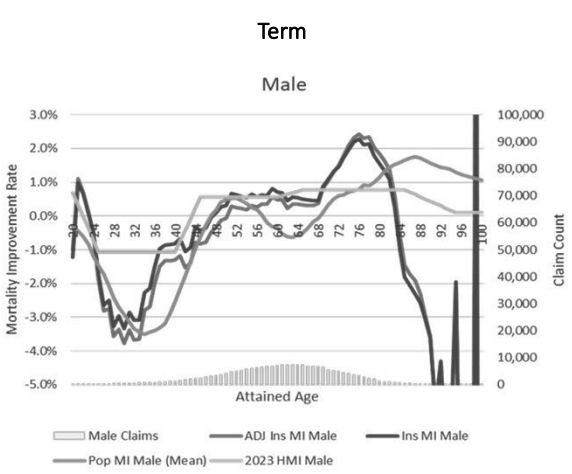


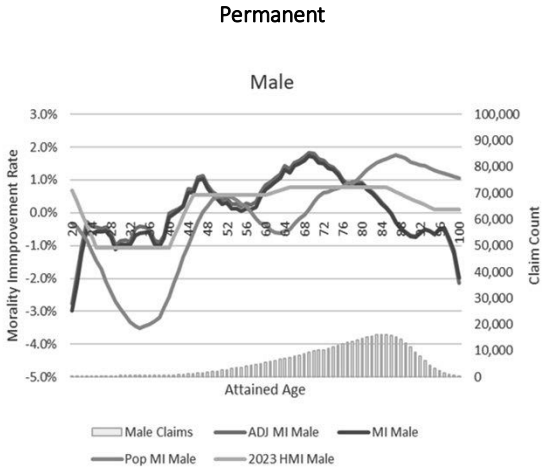
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MI Recommendation – Fully Underwritten Business Mortality Improvement Rates

Policy Count Basis
Normalized for Face Amount, Ages 20 and older
Term vs Perm - Male





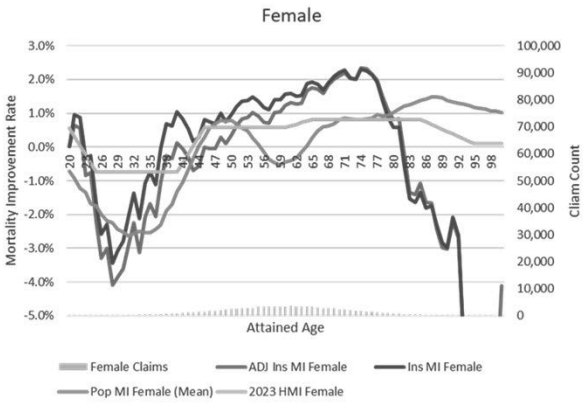
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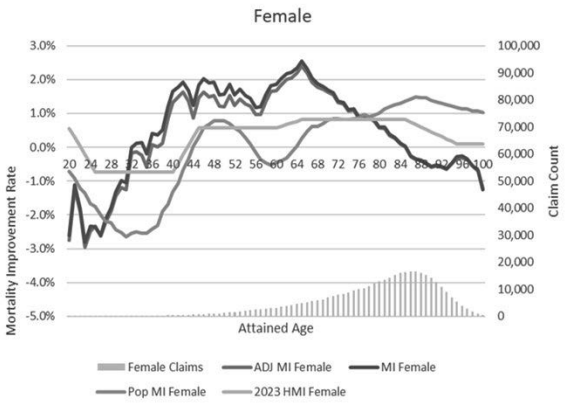
MI Recommendation – Fully Underwritten Business Mortality Improvement Rates

Policy Count Basis
Normalized for Face Amount, Ages 20 and older
Term vs Perm - Female

Term



Permanent



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MI Recommendation - Fully Underwritten Business
Next Steps

- Consider practical issues involved with using insured mortality data directly (lags in data, regular updates will be needed)
  - Ex. use of population data by age between updates of actual data
- Additional considerations to be addressed – COVID, margins, other
- Work with NAIC staff on impact testing using model office

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Contact Information

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Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
Rachel Hemphill, Texas Department of Insurance

Title of the Issue:
Add reporting on waiver of surrender charges.

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.F.3.f, January 1, 2025 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.)

f. Lapses and Full Surrenders – Description and listing of lapse or full surrender rates, including:

i. For contracts with VAGLBs, two comparisons of actual to expected lapses where "expected" equals (1) anticipated experience assumptions used in the development of the SR; and (2) the assumptions used in the development of the additional standard projection amount, and the "actual" is separated by logical blocks of business, duration (e.g., during and after surrender charge period), ITM (consistent with dynamic assumptions), and age (to the extent that age affects the election of benefits lapse). These data shall be separated by experience incurred in the past year, the past three years, and all years.

ii. If experience for contracts without VAGLBs is used in setting lapse assumptions for contracts with in-the-money or at-the-money VAGLBs, then a detailed explanation of the appropriateness of the assumption and a demonstration of the relevance of the experience to the business.

iii. A listing of all conditions under which surrender charges may be waived (e.g., financial hardship, home displacement, etc.), historical data showing how frequently surrender charges are waived, and a description of how such features are reflected in the valuation.

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

During a Compact Product Standards Committee meeting, it was noted that there have been requests from industry to expand the list of criteria for waiver of surrender charges on annuities (financial hardship, home displacement, etc.). Reporting is being added to assess the materiality of these waivers and any potential valuation implications.

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Updates on Actuarial Guideline 53

Fred Andersen, FSA, MAAA
11/15/2024

AG 53 provides uniform guidance for the asset adequacy testing applied to life insurers and is effective for reserves reported with respect to the Dec. 31, 2022, and subsequent annual statutory financial statements. A statement of actuarial opinion on the adequacy of the reserves and assets supporting reserves after the operative date of the Valuation Manual is required under Section 3B of the NAIC Standard Valuation Law (#820) and VM-30 of the Valuation Manual. Section 14A of Model #820 provides that actuarial opinions and related documents, including an asset adequacy analysis, are confidential information, while Section 14B provides that such confidential information may be shared with other state regulatory agencies and the NAIC. The asset adequacy analyses required under AG 53 reviewed in the preparation of this report were shared with the Valuation Analysis (E) Working Group and the NAIC in accordance with these requirements and continue to remain confidential in nature.

1

Notice Regarding Confidentiality

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Agenda

1. Summary of Reviews
2. Discussion on model rigor
3. Potential Next Steps and Reminders

AG 53 provides uniform guidance for the asset adequacy testing applied to life insurers and is effective for reserves reported with respect to the Dec. 31, 2022, and subsequent annual statutory financial statements. A statement of actuarial opinion on the adequacy of the reserves and assets supporting reserves after the operative date of the Valuation Manual is required under Section 3B of the NAIC Standard Valuation Law (#820) and VM-30 of the Valuation Manual. Section 14A of Model #820 provides that actuarial opinions and related documents, including an asset adequacy analysis, are confidential information, while Section 14B provides that such confidential information may be shared with other state regulatory agencies and the NAIC. The asset adequacy analyses required under AG 53 reviewed in the preparation of this report were shared with the Valuation Analysis (E) Working Group and the NAIC in accordance with these requirements and continue to remain confidential in nature.

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Net yield / net spread reviews - follow up from last year (year-end 2022)

- Identified outlying net yield assumptions for 14 companies
- Several of them agreed with our recommendations and were taken off the outlier list
- Some did not agree and remained on the list

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Net yield / net spread reviews – this year

- We continue to engage with last year's outliers that did not agree with our recommendations
- We also identified several additional companies that were not outliers last year but are this year
- Responses are currently being reviewed
- Not intended to be a safe harbor for non-outlying companies

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Identification of outliers

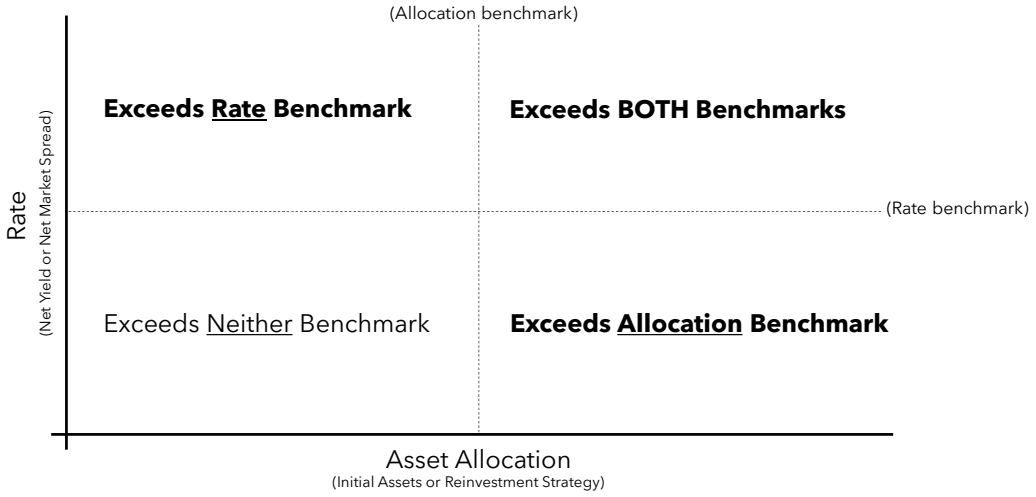
- Tended to be companies with an asset type with high assumed net yields / net spreads and substantial allocations
- Particular concerns: reinvestments or initial assets that last a long time assumed to earn excessive net yields
- Upcoming graph:
  - Benchmarks as focus for comparison
  - Outliers tend to be well outside benchmarks
    - And well outside NY Special Considerations and VM-20 yield and spread maximums or guidance

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Scatter Plot Quadrants Used to Assess Concern



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Potential next steps after two years of reviews

Possibility A: Enough companies are cooperative, we can further address outliers

Possibility B: Optimistic assumptions are a more widespread concern and LATF may need to consider assumption guardrails

- Too early to tell on scenario A or B
- Early favorable responses towards Possibility A
    - Will provide updates at future LATF meetings

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Model rigor

- Are models capturing key risks associated with Projected High Net Yield Assets?
- Section 4.B. of AG 53 contains expectations
- 2 choices:
  - Have a model that captures the risks associated with high yield assets OR
  - Apply conservatism such that any non-capturing of risk does not lead to more favorable results

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Model rigor

- Many companies attribute a vast majority of their assets' excess spread to illiquidity
- Section 4.B.i.(b) of AG 53:
  - "Asset cash flows should be appropriately projected to reflect anticipated liquidity under adverse conditions. If such model aspects are not developed, sufficient additional conservatism to reflect this risk shall be applied."
- Expectation that, if higher yield is assumed due to illiquidity, risk resulting from illiquidity should be accounted for
  - In modeling OR
  - Through added conservatism
- Will be area of focus

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Additional review aspects

- Reinsurance collectability
  - Monitoring, analysis, mitigation
  - Reliability of any perceived protections?
- Payment in Kind
- Tranche-level analysis

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YE 2024 Guidance Document

- Payment in Kind
  - Appointed Actuary should describe interactions with investment department re: development of PIK metrics
- Verify consistency with VM-30 assumptions
- Simplifications should not lead to more favorable results

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Reinsurance Asset Adequacy Testing

Fred Andersen, FSA, MAAA
11/15/2024

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Agenda

1. Discuss sequence of areas of focus
2. Scope – status or past and current items
3. Aggregation - comments & discussion
4. Discuss options for content of Actuarial Guideline
5. Case studies
6. Comments on other topics
7. Potential next steps

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Upcoming plan

1. Potential sequence
   - Focus on affiliated transactions now (perhaps now through January)
   - Then focus on non- affiliated specific issues such as any lack of data
2. Note that affiliated will likely need a special definition for purposes of this Guideline
   - Probably stricter than the 10% ownership definition

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Status of scope topics – progress previously made

- Broad or narrow scope?
  - **Narrow, determined 10/10/24**
- Restrict consideration of cash-flow testing (CFT) requirements to asset intensive reinsurance
  - **Yes, have placeholder definition to discuss**
- Application to transactions as of certain dates
  - **Likely going with bifurcation of affiliated (wider scope of dates) and non-affiliated (narrower scope of dates)**
- Exclude from scope if assuming company files a VM-30 report
  - **A lot of support but issues to work through later**

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Status of scope topics – new concepts

- Potential for lesser analysis for certain non-affiliated treaties with substantial risk protections
  - **Initial concept to consider, details need to be worked out**
- Reliance on reports similar to VM-30 / AG 53
  - **Likely a high bar, need transparency on assumptions**
  - **How is moderately adverse determined, including all key risks, incl. complex assets?**
  - **Availability of data, non-affiliated versus affiliated**
- Size
  - **Add up reserve credits (where there's no VM-30) when considering scope?**

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Aggregation

- Aggregation ok within counterparties (multiple treaties with a single assuming company)?
- Consideration of line of business restrictions

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Options for Actuarial Guideline content

- Option 1:
  - Anticipate the concerns we'll find in reinsurance asset adequacy testing that we should attempt to address in the 2025 adoption of AG ReAAT.
- Option 2:
  - Mainly receive disclosure for YE 2025 (reasons for reserve decreases, reserve adequacy testing in some form), ID concerns at that point.
  - And then figure out how to address those concerns, potentially through prescriptive measures

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Case study - Background

- Relevant information for each case (differentiated on the next slide):
  1. Fixed income annuities with guaranteed living benefits GLBs
     - US Stat (CARVM) reserve is $100 Million
  2. Post-reinsurance reserves are 80% of pre-reinsurance reserves, $80 Million
     - Reason: lower efficiency than in CARVM of policyholder selection of GLBs
  3. US RBC: $5 Million
  4. US Total Asset Requirement (TAR) = $105 Million
  5. Bermuda affiliate
  6. Coinsurance with funds withheld
  7. "Funds withheld amount = US Stat reserves"

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Setting up each case

- Case study #1
  - On US basis = $100 M US Stat reserves backed by primary security
    - + $0 capital & surplus
  - On Bermuda basis = $80 M economic reserves
    - + $20 M surplus
- Case study #2
  - $80 M primary security, $20 M other security

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Attribution analysis background

- Focus on affiliated transactions for this discussion
  - Presumably data would be available
- Start with Pre-Reinsurance Reserve (US stat for life, known as CARVM for annuities)
  - (ACLI comment re: start with best estimate)
- Reserve adjustment from US stat due to assumption differences from baseline:
  - Policyholder behavior and mortality / longevity assumptions
  - Investment return assumptions versus US stat discount rate
  - Other, including:
    - Removal of CSV floor
    - Market value vs. book value
    - Moderately adverse to best estimate

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Case studies – attribution analysis

- Both cases:
  - Pre-reinsurance reserve: $100
    - Deduction for policyholder behavior inefficiency: $20
    - Deduction for different in investment return assumptions: $0
    - Other deductions: $0
  - Post-reinsurance reserve supported with primary security: $80

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Cash-flow testing background

- Starting assets = amount of post-reinsurance reserve supported by primary security
  - Could be book value then marked to market; or market value
- Project liability cash flows (cash surrenders, annuitizations, death benefits, premiums, expenses)
- And asset cash flows (bond coupons, par, proceeds from asset sales, other asset cash flows)
  - Offset by investment expenses, defaults, reduced cash flows due to under-performance
- Cash flows are projected across multiple risk-free rate scenarios such as NY 7
- Assumptions on: asset returns, reinvestments, policyholder behavior, mortality, expenses, other
- Assumptions and scenarios should be consistent with those applied in the cedant's AAT approach
  - Including margins reflecting moderately adverse conditions

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Cash-flow testing background, 2

- Result is present value of surplus
  - This surplus metric is only related to the block of business cash flows, not company surplus
  - If negative, could be indicator of need for additional AAT reserves

Case studies – cash-flow testing

- Both cases:
  - Starting assets = $80, amount of post-reinsurance reserve supported by primary security

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Cash flow testing details

- Should New York 7 risk-free rate scenarios be analyzed and disclosed?
- AG 53-like net yield and net spread exposure should also help with analysis of asset risk
- AG 53 model rigor considerations re: analyzing all key asset risks, including illiquidity
- Consider development of a template to facilitate more efficient submissions and reviews

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Additional comments and next steps

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SOCIETY OF ACTUARIES RESEARCH UPDATE TO LATF

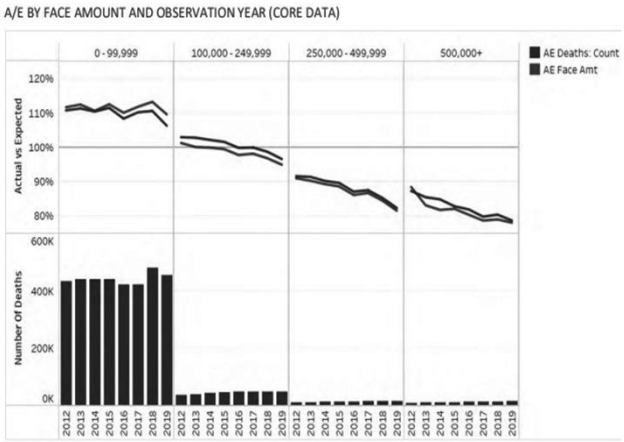
November 16, 2024

R. Dale Hall, FSA, MAAA, CERA, CFA
Managing Director of Research

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Individual Life Insurance Mortality Experience Report



- https://www.soa.org/resources/research-reports/2024/ilec-mort-2012-19/
- Actual versus Expected mortality experience for observation period 2012-2019
- Expected mortality 2015 Valuation Basic Table (2015 VBT) using the base Relative Risk table (RR 100)
- Data validation effort in conjunction with NAIC

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Experience Studies Update

Experience Studies PRO

SOA Research INSTITUTE + LIMRA Navigate With Confidence

- Upcoming Study Releases
- Transition to Industry Subscription Model for 2025
- Target Studies for 2025

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Additional Life Research

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Experience Studies

Project Name	Objective	Link/Expected Completion Date
2024 Life Mortality Improvement	Develop AG38 mortality improvement assumptions for YE 2024	https://www.soa.org/resources/research-reports/2024/ind-live-mort-ag38/
2015-22 Fixed Rate Deferred Surrender Study - Report	Complete a study of fixed rate deferred annuity surrender rates.	https://www.soa.org/resources/experience-studies/2024/15-22-frds/
ILEC Mortality Experience Report Update for 2012 - 2019	Draft a report updating the ILEC mortality experience reporting for 2019	https://www.soa.org/resources/research-reports/2024/ilec-mort-2012-19/
Economic Scenario Generator - 2024 Update	Update the AAA Economic Scenario Generator Annually.	https://www.soa.org/resources/tables-calcs-tools/research-scenario/
2015-21 Universal Life Premium Persistency Study - Report	Analyze the premium persistency for universal life products - Data collection and validation phase	https://www.soa.org/resources/experience-studies/2024/15-21-ulpp-ulls/
Group Life COVID-19 Mortality Survey Update - 2Q24 Report	Complete an update on a mortality study assessing the impact of COVID-19 on Group Life Insurance.	https://www.soa.org/resources/experience-studies/2024/group-life-covid19-mort-survey/
GRET for 2025 - Create Factors	Develop the Generally Recognized Expense Table (GRET) for 2025	https://www.soa.org/resources/research-reports/2024/2025-gret-recommendation/
2000-2022 U.S. Historical Population Mortality Rates	Publish unsmoothed SSA-Style historical mortality rates for 2000-2021	https://www.soa.org/resources/research-reports/2024/us-historical-mortality/
2009-2015 Individual Life Experience Committee Lapse and Mortality Study	Study mortality and lapse experience in the database of 2009-2015 individual life experience data and release a report with the findings.	12/5/2024
2015-2022 Whole Life/Term Lapse and Surrender - Report	Complete a study of Whole Life/Term Lapse and Surrender	12/5/2024
Predictive Analytics Framework	The theme is around the sharing and warehousing of PA tools and information, similar to a data science environment.	10/25/2024
US Population Mortality Observations: Updated with 2022 Experience	Explore observations from the release of the 2022 U.S. population mortality data.	11/21/2024
2021-22 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.	11/7/2024
2013-2021 Group Life Experience Study	Complete a study of 2013-2021 group term life mortality experience.	11/21/2024
Term Conversion Incidence and Post-Conversion Mortality and Lapse Experience - Report	Conduct a mortality and lapse experience study on the converted life insurance policies.	12/1/2025

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Practice Research

Project Name	Objective	Link/Expected Completion Date
Mortality and Race	Summarize available literature on mortality and race and discuss actuarial aspects.	https://www.soa.org/resources/research-reports/2024/mortality-and-race-and-ethnicity-us/
Maternal Mortality	Study maternal mortality in US and compare to other countries	https://www.soa.org/resources/research-reports/2024/maternal-mort-lit-review/
Comparison of 2015 VBT to Socioeconomic decile mortality	Examine life insurance VBT vs NCHS mortality by socioeconomic category.	POG is incorporating this into MIM-2021 Tools for 2024 update release.
Using Behavioral Science to Improve Consumers' Comprehension and Appreciation of Life Insurance Products - RGA	Test and improve the life insurance communication using BE	https://www.soa.org/resources/research-reports/2024/behavioral-science-rga/
Redesigning the Life Insurance Underwriting Journey with Behavioral Economics - Scor	Test BE wording for underwriting questions to improve honesty in answers and address under-disclosure of medical conditions	https://www.soa.org/resources/research-reports/2024/redesign-life-ins-underwriting/
Statistical Approaches for Imputing Race and Ethnicity	Outline the various approaches for statistically imputing race and ethnicity in the U.S. along with their strengths and weaknesses to help familiarize actuaries with these techniques.	https://www.soa.org/resources/research-reports/2024/stat-methods-imputing-race-ethnicity/
Review of Offshore Life and Annuity Jurisdictions Reinsurance Landscapes	Examine the offshore reinsurance landscapes	1/15/2025
ALM Practices	Conducts a survey of current ALM practices focused on various life insurance company products with attention paid to issues such as general account vs. separate account product distinctions.	1/15/2025
Fairness Metrics for Life Insurance	Identify and discuss a variety of quantitative metrics that could be used to evaluate fairness of life insurance products under different definitions of fairness.	2/28/2025
Mortality and Morbidity Impact of COVID-19 Beyond the Acute Phase	Study and quantify the excess death and excess morbidity impacts of the COVID-19 pandemic beyond the acute phase	11/21/2024
Expert Opinion on Impact of COVID-19 on Future Mortality - Survey 3	Survey panel of experts on short and mid term thoughts on future population and insured mortality	11/21/2024
U.S. Drug Abuse Epidemic: Past Present and Future	Create a resource that examines the evolution uf the U.S. drug epidemic and outlook of the impact on future mortality.	6/1/2025
Understanding Complex Assets	Examines the use of complex assets in the life and annuity industry compared to traditional public corporate bonds.	4/1/2025

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Life Practice Council Update

Life Actuarial (A) Task Force Meeting

November 16, 2024

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Recent Engagement

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Life Risk-Based Capital (E) Working Group

- Correlation in Capital Frameworks
- C-3 RBC Testing

Risk-Based Capital Investment Risk and Evaluation (E) Working Group

- CLO Comparable Attributes Project

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Recent Life Practice Council Activity

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Publications

- Life Underwriting and Risk Classification Subcommittee Comments to SCORI on Underwriting Survey
- Life Underwriting and Risk Classification Subcommittee Comments to Colorado on Proposed ACLI Regulation
- LPC Comments to LATF on Reinsurance Exposure Scope & Aggregation
- LPC Comments to LATF on Reinsurance Exposure

Academy Annual Meeting:

- Plenary Session with Commissioner Mais and NAIC CEO Gary Anderson; breakout life sessions on financial security (annuities and LTC) and solvency regulation (with Commissioner Houdek)

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Recent and Upcoming Academy Activity

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Webinars:

- Ethical Dilemmas Facing Health Actuaries: Insights and Case Studies
- VM-31 As Seen by Regulators (Dec 13)
- Other topics in December include capital markets (retirement focused), the annual professionalism session: Tales from the Dark Side, and surplus considerations for public pension plans

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Recent and Upcoming Academy Activity

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Publications

- Life: Life Perspectives, Summer/Fall 2024
- Health: The State of Long-Term Care
- Casualty: Insurance Fraud: Impacts on Premiums, Claim Costs, and the Public
- Retirement: Collective Defined Contribution Plans, Immigration and Social Security, Public Pension Plans: Evaluating Buyout Programs
- Risk Management: Big Data Terminology

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Coming Soon
Life and Health Valuation Law Manual

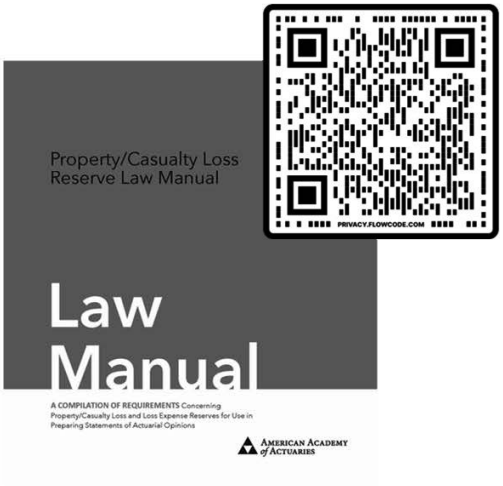
What's Inside?
- Current topics section outlining key valuation developments and specific state guidance;
- Current NAIC model laws and regulations that effect reserve calculations;
- A discussion of generally distributed interpretations; and
- Current actuarial guidelines from the NAIC *Financial Examiners Handbook*.



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Coming Soon
Property/Casualty Loss Reserve Law Manual

What's Inside?
- SAO requirements and the laws and regulations establishing those requirements;
- Annual statement instructions for the SAO for property/casualty, title loss, and loss expense reserves; and
- Other pertinent annual statement instructions.



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Plan ahead for these 2025 events



Investment Symposium
Spring 2025
New York, NY
Registration opening soon.



Life and Health Qualifications Seminar
Fall 2025
Arlington, Va.

www.actuary.org/calendar

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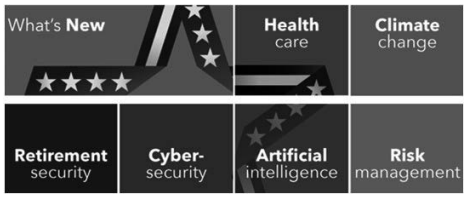
Other Resources

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Follow the Academy on LinkedIn

Check out the Academy's Policy Issues Clearinghouse, Actuarially Sound blog, and Academy Voices podcast

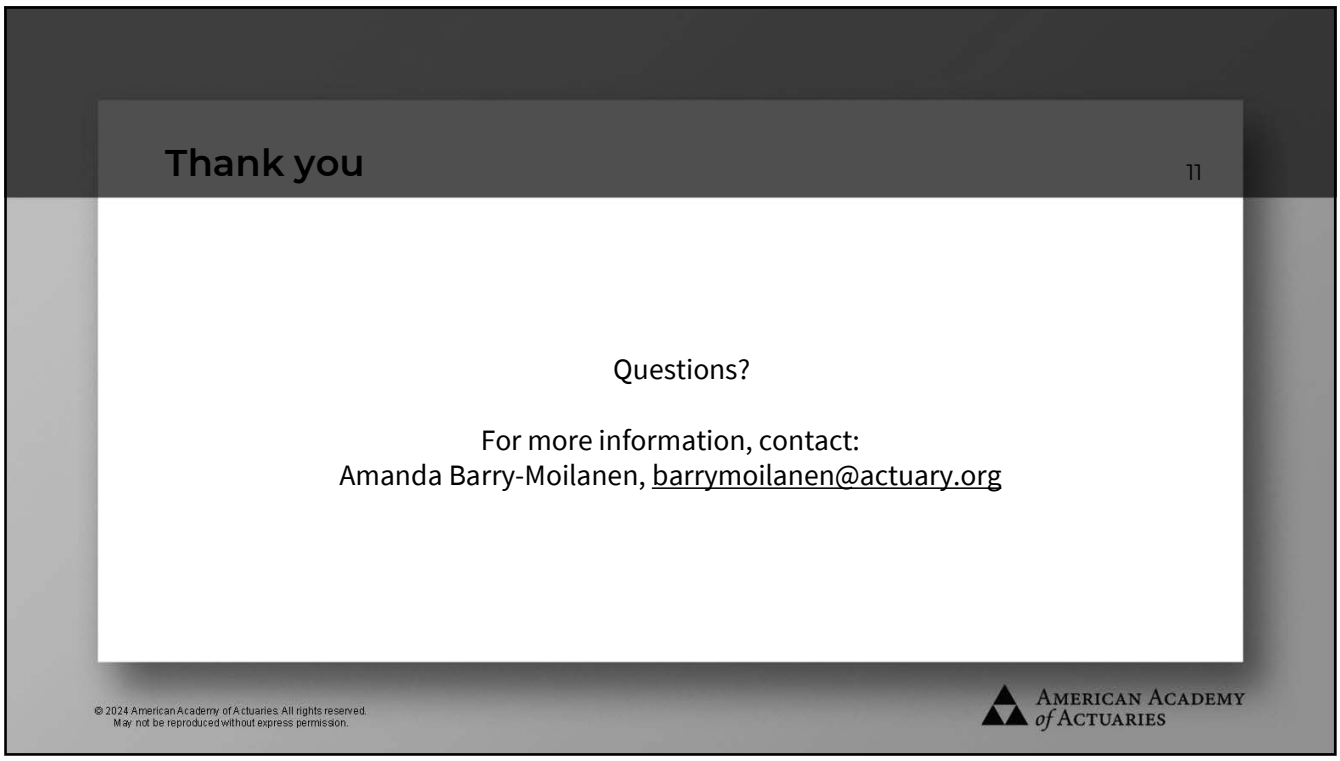




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Thank you
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Questions?
For more information, contact:
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American Academy of Actuaries Update on Life Actuary Knowledge Statement Request

Darrell Knapp
Tricia Matson
Linda Lankowski

November 16, 2024

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About the Academy

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AMERICAN ACADEMY of ACTUARIES

- The American Academy of Actuaries is a 20,000-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.

For more information, please visit:

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Agenda

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- Background
- Public Comment Response
- Next steps

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Background

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Request from LATF at 2023 Fall National Meeting

- LATF requested American Academy of Actuaries recommend knowledge statements for life actuaries signing certain Statements of Actuarial Opinion, including for actuaries serving as appointed actuaries, as illustration actuaries, and as qualified actuaries for principle-based reserves.
- The Academy shared drafts of knowledge statements for life and health appointed actuaries in Chicago during the Summer National Meeting.

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Public Comment Response

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- Following the public comment period, the Academy has offered a formal response to LATF.
- Any additional direction or requested modifications from LATF to adjust the drafted appointed actuary knowledge statements will be made prior to our final submission.
- Work continues on the qualified actuary knowledge statements (shared at this meeting) and on the illustration actuary knowledge statements (to be shared with LATF before year-end).

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Reminder—Important Considerations

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- The knowledge statements provided are recommendations in response to the LATF request.
- Knowledge statements are not a position of the Committee on Qualifications, and future use and modification of these recommendations are the responsibility of LATF.
- The knowledge statements focus on the additional knowledge that an actuary should have to perform specifically identified tasks. This does not include basic knowledge of actuarial mathematics, accounting, economics, and risk theory that all actuaries should have (primarily knowledge demonstrated prior to the associateship level in either the SOA or the CAS).
- Fulfillment of the knowledge statements does not imply an actuary is qualified to provide a given opinion. There are additional qualification requirements, and there may be additional knowledge required dependent on the topics covered under the opinion.
- An actuary should adhere to the "Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States" (USQS) and meet the continuing education (CE) requirements before issuing any statements of actuarial opinion.

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Qualified Actuary Knowledge Statements

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- With VM-22 not yet adopted, the regulators and interested parties may want to be aware that the drafted knowledge statements are focused on VM-20 and VM-21 actuaries. This is particularly important as it relates to VM-31 reports or the extent to which a Qualified Actuary is involved in setting Fixed Annuity reserves. The statements may need to be refined given any VM-xx updates, especially VM-22 updates.
- Since the knowledge statements are intended to cover both VM-20 and VM-21 Qualified Actuaries, regulators and interested parties should keep in mind that not every part of the draft will apply to every Qualified Actuary.
- LATF may want to consider knowledge statements for each individual VM chapter in the future, which could be addressed in the future by statements incorporated into the VM itself.

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Next Steps

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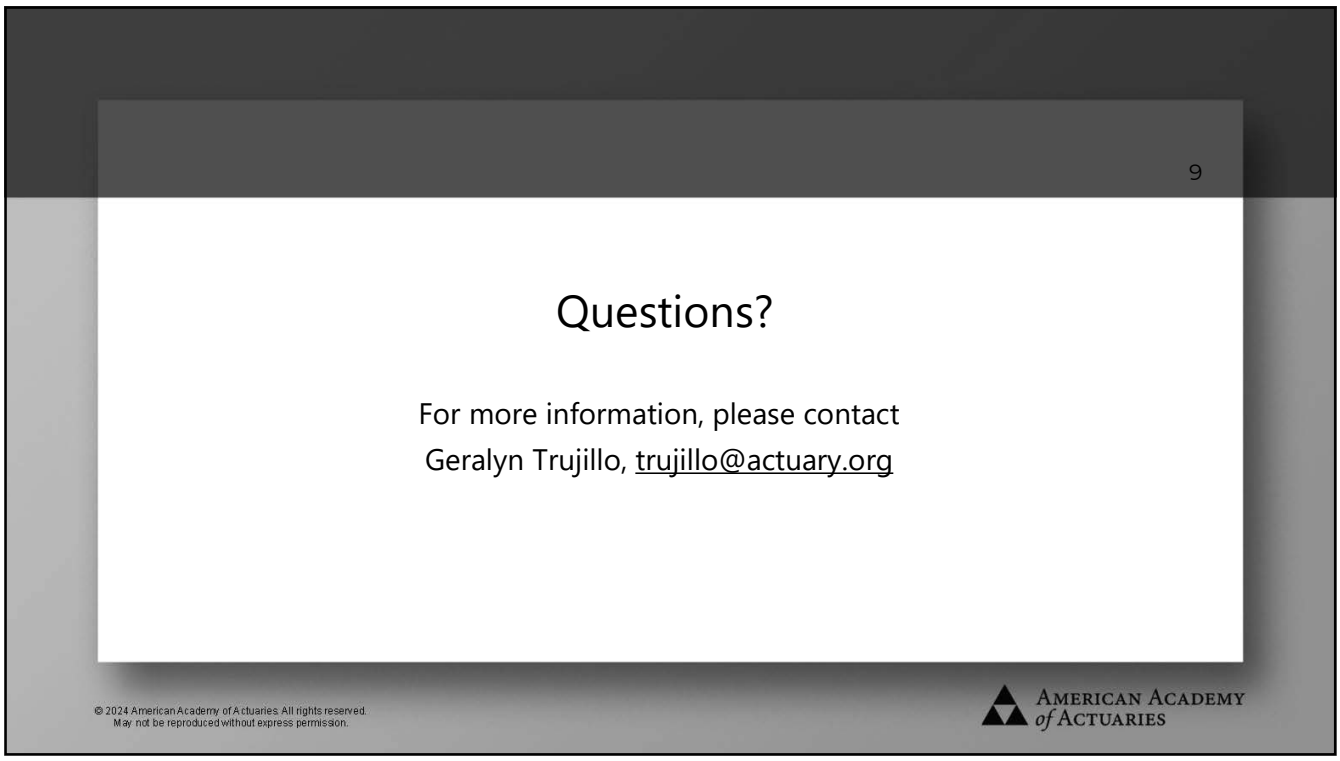
The completed drafts of all three knowledge statements will be submitted to LATF by the end of the year.

The Academy is happy to meet virtually with LATF to discuss the qualified actuary and the illustration actuary knowledge statements.

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Questions?
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Charitable Gift Annuities

Phil Purcell, CFRE, MPA/J.D.
President

Dave Ely, CFA
VP, Rates & Regulations

Shane Leib, FSA, MAAA
Actuary & Ex-Officio Director

November 18, 2024

1

The ACGA and their role

Charities formed the Committee on Gift Annuities in 1927 (now called the American Council on Gift Annuities)

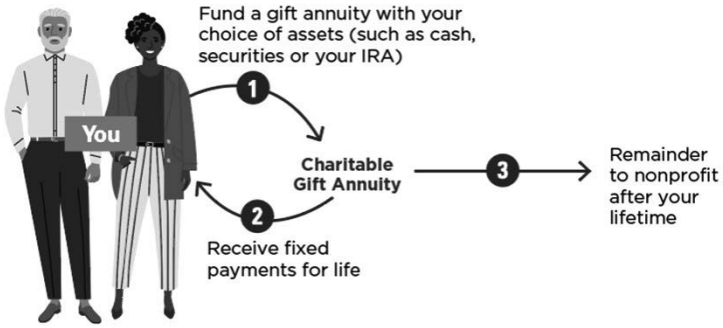
Purpose

Advocate: Promote good gifts for nonprofits and their donors	**Recommend payout rates**: Suggest maximum rates for charitable gift annuities	**Monitor regulations**: Interface with regulators and keep charities updated on state regulations	**Conduct research**: Conduct studies to help charities plan and analyze their gift annuity programs	**Educate**: Provide training and education to charities

2

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What is a Charitable Gift Annuity?



3

What is a Charitable Gift Annuity?

A charitable gift annuity (CGA) is a contract between a donor and a charity that provides:

- **Payments for life**: Payments can begin immediately or be deferred to a future date.
- **Tax benefits**: Donors can receive a partial tax deduction for their donation.
- **Annuity term**: The annuity ends when the donor dies, and the charity uses the remaining funds for its mission.

4

Charitable Gift Annuities are issued frequently

- Charitable gift annuities are the leading planned gift vehicle today
- 95% of gift activity
- 80% of dollar activity

5

Risks in Common with Traditional Payout Annuities

- Longevity Risk
- Interest Rate Risk
- Asset/Liability Mismatch
- Investment Risk
- Inflation
- Concentration Risk

6

Safeguards in Common with Traditional Annuities

- Minimum Ages and Amounts
- Reserve Pools
- Prudent Investing
- Reinsurance

7

Unique Challenges of Charitable Gift Annuities

- Gifts may be restricted which reduces the ability to aggregate individual risks
- Potentially heightened concentration risk for small pools.
- Inconsistent gift activity can concentrate inflation, interest rate, and market risks.

8

Unique Safeguards

- General assets of charities are also available to support annuity payments if original donated funds exhausted
- Payout rates are typically designed so that 50% of original payment is a charitable contribution at death (residuum)
- Annuitants may elect to forego future payments as an additional charitable contribution.
- ACGA provides expertise and guidance to members

9

How the ACGA supports charities



SUGGESTING PAYOUT RATES



STUDYING CGA MORTALITY EXPERIENCE



PERFORMING INDUSTRY SURVEYS/RESEARCH



REVIEWING OUR METHODOLOGIES REGULARLY



PROVIDING EDUCATIONAL OPPORTUNITIES VIA WEBCAST AND REGULAR CONFERENCES

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Suggesting Payout Rates

Since **1927**

Recognized by charities, donors, state insurance departments, and the Internal Revenue Service as being **actuarially sound**

Responsive to the **best interests of all parties** involved

Updated at least **semi-annually**

11

Details of payout rates

Typically, 60-70% of commercial payout annuity rates

- Driven by residuum and conservatism

Mortality Assumptions

- 45-55 blend of the 2012 IAR male and female mortality
- A change from 50-50

Expense Assumptions

- 100bp of MV of assets netted against investment return

Investment Return Assumption

- Mixture of treasury bonds (10y), treasury bills (90d), and equity
- Conservative equity return assumptions

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Mortality Study

2020 mortality study was largest ever

Over 50,000 active contracts which accounted for 31,703 unique lives

Five-year experience period 2015-2019

Data contributed by 31 organizations

Partnered with an external actuarial consulting firm

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Regular Methodology Review

- Engage actuaries and consultants to provide additional insights
- A general reassessment of the assumptions underlying the rates
  - Experience of charities issuing gift annuities
  - Current interest rates, the investment market environment
  - Mortality of annuitants
  - Expenses incurred in administering a gift annuity program
- Review of the payout rates relative to commercial SPIAs

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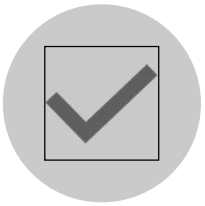
Education of members



REGULAR WEBINARS



BI-ANNUAL CONFERENCES



DISSEMINATION OF BEST PRACTICES

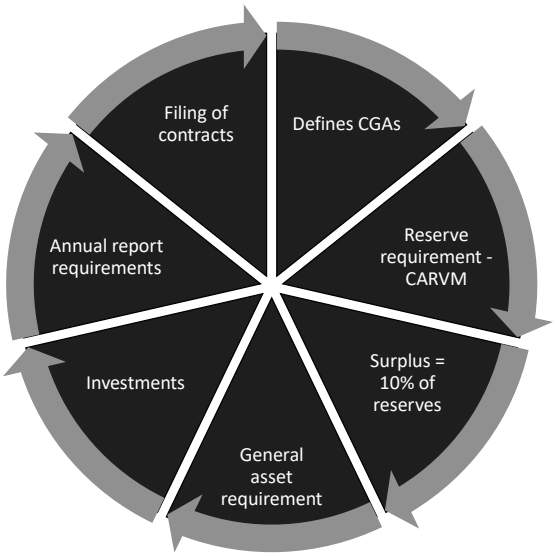
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Regulatory Requirements

What does my state require for charities issuing Charitable Gift Annuities?

16

Model 240 Overview



17

State by State Filing Requirements



18

1. State law requires segregated reserve, annual reporting, and/or detailed application (11):

State	Years in operation	Board resolution	Disclosure in agreement	Reserve required	Investment limitations	Other registrations
AL[1]	—	—	yes	yes	—	—
AR	5	yes	—	yes[2]	yes[3]	—
CA	10	yes	yes	yes[4]	yes[4]	—
FL	5	—	yes	yes[5]	yes	—
HI[6]	10 in HI	—	yes	yes	—[7]	—
MD	10 in MD	—	yes[8]	yes	—[7]	—
NJ	10	yes	—	yes	—[7]	yes[9]
NY	10	yes	—	yes	—[7]	—
ND	—	—	—	yes	—	—
TN	—	—	yes[8]	yes[10]	—[7]	—
WA[11]	3	—	—	yes	—[7]	yes[12]

NOTES:

[1] Regulated by Securities Dept. rather than Insurance
[2] May elect to segregate AR annuitants
[3] Prudent investor standard allowed
[4] CA annuitants only
[5] May elect to segregate FL annuitants
[6] Law requires $200,000 of assets in Hawaii
[7] Prudent investor standard
[8] If signed, or in separate signed document
[9] Registration with NJ Div. of Revenue and NJ Dept. of Law and Public Safety
[10] TN-only fund allowed but no longer mandated
[11] Organization must have $500,000 in unrestricted net assets
[12] Registration with WA Secretary of State

Source: PG Calc

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2. State law provides for exemption - Notification required (14):

State	Years in operation	Board resolution	Disclosure in agreement	Reserve required	Available assets	Other registrations
AK	3	—	yes	—	$300k	—
CT	3	—	yes	—	$300k	—
GA[13]	3	—	yes	—	$300k	—
ID	3	—	yes	—	$100k	—
IA	3	—	yes	—	$300k	—
MS	3	—	yes	—	$300k	yes[14]
MO	3	—	yes	—	$100k	—
NV	3	—	yes	—	$300k	—
NH[15, 16]	3	—	yes	yes	$300k	yes[17]
NM	3	—	yes	—	$300k[18]	—
NC	3	—	yes	—	$100k	—
OK[13]	3	—	yes	—	$100k	—
TX	3	—	yes	—	$100k	—
WV	3	—	yes	—	$300k	—

NOTES:

[13] Annual reporting: submission of audited financial statement
[14] Registration with MS Secretary of State (as charitable organization)
[15] Annual reporting: re-notification
[16] Annuity rates must not exceed ACGA suggested rates
[17] General registration with NH Dept. of Justice in some instances
[18] Either in unrestricted assets or reserve fund

Source: PG Calc

20

3. State law provides for exemption - No notification required (22):

State	Years in operation	Board resolution	Disclosure in agreement	Reserve required	Available assets	Other registrations
AZ	3	—	—[19]	—	$300k	—
CO	3	—	yes	—	—	—
DE	—	—	—	—	—	—
IL	20[20]	—	—	—	$2 mil.[20]	—
IN	—	—	—	—	—	—
KS	—	—	—	—	—	—
KY	—	—	—	—	—	yes[21]
LA	—	—	—	—	—	—
ME	5	—	—	—	—	yes[22]
MA	—	—	—	—	—	—
MI	—	—	—	—	—	—
MN	—	—	—	—	—	—
MT	3[20]	—	—	yes[20]	$100K[20,23]	—
NE	3	—	—	—	—	—
OR	5	—	—[24]	yes	$300k	—
PA	3	—	yes	—	$100k[25]	yes[26]
SC	5	—	—	—	—	—
SD	10	—	yes	—	$500k	yes[27]
UT	—	—	—	—	—	—
VA	3	—	yes	—	$100k	—
VT	3	—	yes	—	$300k	—
WI	3	—	yes[28]	—	—	—

NOTES:

[19] Detailed disclosure statement to donor prior to gift
[20] Waived if annuities reinsured
[21] Charities must file copy of Form 990 with KY Attorney General
[22] Registration with ME Secretary of State (qualified as foreign corporation)
[23] $100k in unrestricted assets or $300k net worth
[24] Content-specific written disclosure, in agreement or other document
[25] Plus one-half principal value of then outstanding annuities
[26] Certain charities must register with PA Dept. of State (general solicitation law)
[27] Registration with SD Secretary of State (qualified as foreign corporation)
[28] Language modified when law changed 4/18/14

Source: PG Calc

21

4. State law does not specifically address gift annuities (4):

DC, OH [29], RI, WY

NOTES:

[29] OH previously provided for an exemption from securities law under now rescinded administrative rule. OH Court of Appeals case decided in 2002 held gift annuities not subject to insurance regulation (OH Supreme Court declined to hear appeal).

- Source: PG Calc

22


Recent Activity
Partnering with New York Department of Financial Services

23

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee Nov. 19, 2024, Minutes....6-2
Consumer Information (B) Subgroup Oct. 18, 2024, Minutes (Attachment One)....6-8
Consumer Information (B) Subgroup Oct. 8, 2024, Minutes (Attachment One-A)....6-10
Consumer Information (B) Subgroup Aug. 29, 2024, Minutes (Attachment One-B)....6-11
Health Innovations (B) Working Group Oct. 15, 2024, Minutes (Attachment Two)....6-13
Health Insurance and Managed Care (B) Committee 2025 Proposed Charges (Attachment Three)....6-15
Committee Proposed Revisions to *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (Model #171) (Attachment Four)....6-17
Proposed Revisions to the Model #171 Adopted by the Committee (Attachment Five)....6-18

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Draft: 12/2/24

Health Insurance and Managed Care (B) Committee
Denver, Colorado
November 19, 2024

The Health Insurance and Managed Care (B) Committee met in Denver, CO, Nov. 19, 2024. The following Committee members participated: Anita G. Fox, Chair (MI); Grace Arnold, Co-Vice Chair (MN); Glen Mulready, Co-Vice Chair, and Andrew Schallhorn (OK); Trinidad Navarro (DE); John F. King (GA); Dean L. Cameron and Shannon Hohl (ID); Marie Grant (MD); D.J. Bettencourt (NH); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Jon Pike (UT); Mike Kreidler (WA); and Allan L. McVey (WV). Also participating were: Paul Lombardo (CT); Ann Gillespie (IL); Vicki Schmidt (KS); Robert Wake (ME); Mike Chaney (MS); Chrystal Bartuska (ND); Maggie Reinert (NE); Scott Kipper (NV); and Michael Wise (SC).

1. Adopted its Summer National Meeting Minutes

Commissioner McVey made a motion, seconded by Commissioner Mulready, to adopt the Committee's Aug. 15 (*see NAIC Proceedings – Summer 2024, Health Insurance and Managed Care (B) Committee*) minutes. The motion passed unanimously.

3. Adopted its Subgroup, Working Group, and Task Force Reports

Commissioner Arnold made a motion, seconded by Commissioner Navarro, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its Oct. 18 (Attachment One) minutes; 2) the Health Innovations (B) Working Group, including its Oct. 15 (Attachment Two) minutes; 3) the Health Actuarial (B) Task Force; 4) the Long-Term Care Insurance (B) Task Force; 5) the Regulatory Framework (B) Task Force; and 6) the Senior Issues (B) Task Force. The motion passed unanimously.

4. Adopted its 2025 Proposed Charges and its Task Forces' 2025 Proposed Charges

Director Fox said that prior to this meeting, NAIC staff distributed for comment and posted on the NAIC website the Committee's 2025 proposed charges (Attachment Three). She said the only substantive changes from its 2024 charges are the deletion of the charge related to the Long-Term Care Insurance (B) Task Force and the renaming of the Consumer Information (B) Subgroup to the Consumer Information (B) Working Group. Director Fox explained that as provided in its memorandum to the Committee, the Long-Term Care Insurance (B) Task Force recommends disbanding and moving its work to the Health Actuarial (B) Task Force and the Senior Issues (B) Task Force. Those changes are reflected in their 2025 proposed charges.

Director Fox said: 1) the Health Actuarial (B) Task Force adopted its 2025 proposed charges on Oct. 1; 2) the Regulatory Framework (B) Task Force adopted its 2025 proposed charges on Nov. 4; and 3) the Senior Issues (B) Task Force adopted its 2025 proposed charges on Oct. 21.

Commissioner McVey made a motion, seconded by Director Cameron, to adopt the Committee's 2025 proposed charges, the Health Actuarial (B) Task Force's 2025 proposed charges, the Regulatory Framework (B) Task Force's 2025 proposed charges, and the Senior Issues (B) Task Force's 2025 proposed charges. The motion passed unanimously.

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5. Adopted the Revisions to the Model #171

Schallhorn said the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) and its companion model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*), were identified in 2014 as needing to be revised because of the federal Affordable Care Act (ACA). He said the Regulatory Framework (B) Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup in 2016 to revise Model #170 and Model #171. The Subgroup completed its work on Model #170 in late 2018. The full NAIC membership adopted the Model #170 revisions in February 2019.

Schallhorn said Model #170 revisions removed provisions for certain types of health insurance products that would not be permitted because of the requirements of the ACA, leaving only those products considered excepted benefits and therefore, not subject to the ACA's requirements. He explained that excepted benefit products, such as accident-only plans and specified disease plans, are medically underwritten and subject to preexisting condition exclusions. He said the Subgroup also added short-term, limited-duration (STLD) plans to Model #170 because there was no other vehicle available to add those products, and the Subgroup did not want to create a new NAIC model for them.

Schallhorn said the revisions to Model #171 were revised for consistency with the revised Model #170. He said the revisions also add standards for STLD plans. He added that because the Subgroup did not want to dictate what benefits and coverages these plans must include, the standards specify that STLD must provide the benefits and coverages required by the state. He said the revisions also clarify provisions on consumer disclosure and outline of coverage requirements making them much more understandable for consumers, including requiring specific language stating that these plans are supplemental and are not intended to be major medical coverage.

Schallhorn said the Accident and Sickness Insurance Minimum Standards (B) Subgroup adopted the revisions on Oct. 17, and the Regulatory Framework (B) Task Force adopted the revisions on Nov. 4. He said that prior to adopting the Model #171 revisions, the Task Force discussed a provision in the model permitting health carriers to exclude mental health and substance use benefits from coverage. He explained that during this discussion, Task Force members and others emphasized that these are excepted benefit products, not major medical coverage and that this provision is optional. As such, he said the states can require such coverage if they feel it is appropriate. In addition, as already noted, for STLD plans, the benefits and coverages for these plans are tied to the state's requirements. If a state requires these plans to include mental health and substance use benefits, then the plan must include the coverage.

Director Fox said that prior to this meeting, NAIC staff distributed proposed revisions to drafting notes in Model #171 (Attachment Four) to address concerns expressed with the optional provision in Section 7D—Prohibited Policy Provisions. She said this language is a compromise and makes it clear that states should carefully consider whether to permit mental health and substance use coverage exclusions for STLD plans and disability income protection policies given the importance of such coverage. She noted, however, that these are excepted benefits products, not comprehensive, major medical coverage. She said the proposed revisions also add similar language to a drafting note in Section 8H—Short-Term, Limited-Duration Health Insurance Coverage.

Commissioner Humphreys said he appreciates the Subgroup's work on the Model #171 revisions, which include many good consumer protections. He also appreciates the suggested proposed revisions to the drafting notes. He said Pennsylvania is challenged particularly by the idea that STLD plans can exclude mental health coverage. Given this, he plans to abstain when voting.

Commissioner Mulready noted the Accident and Sickness Insurance Minimum Standards (B) Subgroup's painstaking work over the past six-plus years in crafting the revisions and the dedication, collaboration, and

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compromise among the stakeholders—state insurance regulators, industry, and consumers—to end up with a consensus product. He also noted that these are excepted benefit products, which are medically underwritten, not comprehensive, major-medical coverage. He also noted that the model establishes minimum standards meaning this is a floor. States can and have gone further. Commissioner Mulready said he would be voting in favor of adopting the proposed revisions.

Acting Commissioner Grant said she shares Commissioner Humphreys' concerns, but she plans to vote in favor of adopting the proposed revisions because the model sets minimum standards, and the proposed revisions to the drafting notes emphasize the flexibility the states have to go further. She said Maryland already has gone further than the existing model. She also expressed appreciation for the work that has gone on over the years. Commissioner McVey expressed support for the proposed revisions. He acknowledged the Accident and Sickness Insurance Minimum Standards (B) Subgroup's painstaking work over the past six years. He also noted that the model sets minimum standards and states can go further.

Lucy Culp (The Leukemia & Lymphoma Society—LLS) expressed appreciation for the Accident and Sickness Insurance Minimum Standards (B) Subgroup's work over the past six years. She urged Committee members to vote in favor of adopting the proposed revisions because the proposed revisions include many important consumer protections and, overall, improve the existing model. She said that as states consider adopting the revised model, the NAIC consumer representatives look forward to working with each state to remove the permitted exclusions as the state considers appropriate. Culp said the NAIC consumer representatives support the proposed revisions to the drafting notes as a compromise to alert the states to carefully consider and think through what is appropriate for their market with respect to these permitted exclusions.

Commissioner Kreidler made a motion, seconded by Commissioner Mulready, to adopt the revisions to Model #171, including the suggested revisions to Section 7D and Section 8H (Attachment Five). The motion passed with the following states voting in favor of the motion: Delaware, Georgia, Idaho, Maryland, Michigan, Minnesota, New Hampshire, Oklahoma, Oregon, Utah, Washington, and West Virginia. Pennsylvania abstained.

6. Heard a Presentation on the Use of AI to Conduct Utilization Management Research

Culp and Lauren Seno (NORC at the University of Chicago—NORC) provided an overview of a report prepared by NORC in collaboration with the NAIC consumer representatives focused on health. Culp noted the Committee's previous discussions on prior authorization. She said that, given these discussions, the NAIC consumer representatives believe it is important to look at how artificial intelligence (AI) is being used by health insurance companies in utilization management (UM) decision-making.

Before discussing the report's key findings, Seno first defined the terms used as the foundation of the report—AI, which is the catch-all term referring to technologies that enable computers and machines the ability to mirror human learning and decision-making, and natural language processing (NLP) and machine learning (ML). She said for purposes of the report: 1) NLP is a form of AI that allows computers to understand, interpret, and generate human language, and 2) ML refers to the ability of computer systems to learn and adapt beyond their initial instructions.

Seno discussed the report's key findings: 1) health plans are leveraging the ability of AI to make UM decisions, specifically to respond to prior authorization requests; 2) stakeholders see immense opportunities in such use, but warn that proper safeguards are missing today and need to be in place to protect consumers; and 3) some states have begun to regulate the development and use of AI in health insurance, but they have not been able to keep up with the proliferation of the use of AI itself. She discussed how health plans see AI as a means potentially to: 1) reduce administrative burden, 2) allow clinical reviewers to work at the top of their license, and 3) speed

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approvals. She said the research into this area focused on the three primary ways health plans are using AI in UM—administrative-only AI, decision-making AI, and AI learning model.

Seno said that as AI tools are developed and deployed to make coverage decisions, concerns arise. She said that in the absence of a comprehensive regulatory framework for the use of AI in health insurance, stakeholders have started to identify the potential risks that may adversely affect care delivery and health outcomes. Those potential risks include: 1) tools trained by biased data sets, 2) algorithms developed with misaligned incentives, and 3) ML systems developing their own processes. She said that as AI in UM develops, the state regulatory landscape has been uneven in its ability to keep up with advancements. Seno highlighted three states—California, Colorado, and Utah—that have developed their own approaches on how to best regulate this evolving environment. She also noted organizations that have developed frameworks on how AI should be used and regulated in health insurance practices, including the NAIC, the National Health Law Program (NHeLP), AHIP, and the American Medical Association (AMA).

Culp said that in looking at the report's key findings, the NAIC consumer representatives have these recommendations to address the use of AI in UM decision-making: 1) transparency, both to regulators and consumers, is a crucial component of AI oversight; 2) transparency is critical to hold health plans accountable, and when appropriate, liable for the harm caused by the integration of AI into UM activities; and 3) regulators need to ensure health insurers place humans with the appropriate clinical training and authority at the center of decisions that impact patient care. Accessible appeals processes must be considered a right for all consumers. She urged state insurance regulators to act now because the rapid expansion of AI tools in health insurance demands immediate regulatory attention to protect consumers from potential harm and discrimination.

7. Heard a Presentation from the CIPR on Small Group Market Trends

Kelly Edmiston (Center for Insurance Policy and Research—CIPR) discussed small group market trends. He discussed current insurance requirements for small businesses under the ACA. He said cost is the primary challenge for small group businesses. He said that prior to the ACA, small-group market insurance was largely risk-rated. Small businesses have smaller populations over which to pool risk and spread fixed costs. Edmiston noted, however, that there were thriving markets for small business health insurance, so the problem was not so much obtainability as cost. He said that although the ACA required insurers to accept every small employer that applies for coverage and all its employees, guaranteed issue does not guarantee affordability.

Edmiston discussed how employer-provided health insurance premiums have risen dramatically over the past few years and how the percentage of small employers offering health insurance to their employees has declined. He also discussed how the percentage share of what employees pay at small businesses has increased, particularly as compared to employees at large businesses.

Edmiston discussed small business insurance options, such as: 1) purchasing commercial health insurance or 2) self-insuring. He discussed the basics of both options, including the additional risk for small employers opting for self-funded coverage. He also highlighted firms with self-funded health insurance plans by size. Edmiston also discussed level-funded plans as a type of self-funded plan designed for small- and medium-sized businesses. He noted that small firms are taking up level-funded plans in large numbers.

Edmiston discussed additional small business health insurance options—health reimbursement arrangements (HRAs) and the ACA's Small Business Health Options Program (SHOP). He noted the increasing popularity of HRAs as either individual coverage HRAs (ICHRAs) for small businesses with 50 or more employees and qualified small employer HRAs (QSEHRAs) for small businesses with fewer than 50 employees.

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Commissioner King said he would like to learn more ICHRAs and would like to discuss it with Edmiston following the meeting. He said Georgia is considering looking at using ICHRAs as an option as part of its state-based health insurance exchange. Edmiston agreed to discuss the issue in more detail later. Acting Commissioner Grant asked Edmiston if the CIPR has some of the data he presented broken down by state. Edmiston said he believes the CIPR can get this information broken down by state, particularly the premium data. Acting Commissioner Grant said she is most interested in obtaining data by state related to the take-up rate of level-funded plans and stop-loss products. Edmiston said he would pull this information together. Hohl said Idaho is interested in any information the CIPR has or could obtain on the benefits provided under these types of self-funded plans, particularly ones with stop-loss coverage.

Commissioner Kreidler asked about the impact of association health plans (AHPs). He explained that AHPs have devastated Washington's small group market to the extent that it does not have small group employers in its state-based health insurance exchange. He asked about the extent to which the CIPR has seen this issue in its research, particularly with the impact of adverse selection and AHPs in the small group market. Edmiston said it is possible there is such a problem when the AHPs cherry-pick the good risks. He said the CIPR will research the issue and get back to the Committee.

Director Fox asked about cost drivers in the small group market and small employers limiting their coverage to employee-only coverage, not family coverage. Edmiston said as far as cost drivers are concerned, the CIPR has not seen anything different in the small group market from the large group market. He said the CIPR has seen some shifts in coverage in the small group market to employee-only coverage but not in large numbers. Commissioner Mulready said he would like some information on the breakdown of prescription drug cost by premium in the small group market. Commissioner Humphreys said he agreed with Commissioner Kreidler's comments on AHPs and potential cherry-picking. He suggested that the Committee examine this more in 2025. He also suggested that the CIPR look at captive insurance. Given the number of CIPR research requests, Director Fox suggested that Committee members send their requests to her and NAIC staff. She said she would circulate the requests and have the Committee rank them to prioritize the CIPR's research. Wake volunteered the Employee Retirement Income Security Act (ERISA) (B) Working Group to assist the Committee in this research and its discussions.

8. Heard an Update from the CCIIO on its Recent Activities

Jeff Wu (Center for Consumer Information and Insurance Oversight—CCIIO) updated the Committee on the CCIIO's recent activities of interest. His update included a discussion of three main areas: 1) the current 2025 open enrollment period, 2) recent regulatory activity, and 3) a new grant-funding opportunity.

Wu said the current open enrollment period for 2025 began Nov. 1 and ends Jan. 15, 2025. He said that after last year's record-breaking season, the CCIIO has continued to make changes to healthcare.gov to improve the consumer shopping experience by making it easier to understand plan options all around the country. He said the CCIIO has continued to fund large-scale outreach, advertising, and enrollment assistance. He said the CCIIO appreciates the efforts of the NAIC and state insurance regulators in assisting the CCIIO in getting the word out to consumers about their open enrollment opportunities and awareness around the availability of affordable plans. Wu noted that due to the enhanced premium subsidies, four out of five healthcare.gov customers will find health care coverage for $10 a month or less.

Wu said that in May, the federal Centers for Medicare & Medicaid (CMS) published a final rule that allows Deferred Action for Childhood Arrivals (DACA) participants to enroll for health care coverage through the health insurance exchanges or through the ACA's Basic Health Program (BHP). He said that as this year's open enrollment is occurring, there are still a few states continuing their Medicaid unwinding process. He said the CMS' priority is to ensure that those individuals who are no longer eligible for coverage under Medicaid or the federal Children's Health Insurance Program (CHIP) find access to other coverage, whether through the health insurance

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marketplaces or other forms of coverage. Wu also discussed the CMS' efforts and steps taken to address the issue and consumer complaints about agents making unauthorized plan switches. He said he believes that to date, the CCIIO has remedied about 99.7% of all the complaints that it is receiving. He said the CMS is working to update its health insurance marketplace systems to prevent unauthorized switches. Wu thanked the Committee and the Improper Marketing of Health Insurance (D) Working Group for assisting the CMS and the CCIIO in addressing these issues.

Wu said the CMS recently released a funding opportunity for states on the federal health insurance marketplace interested in updating their essential health benefits (EHB) benchmarks. He said the goal of the EHB-Benchmark Plan Modernization Grant for States is to help defray some of the costs of analysis involved in undertaking the process. To be eligible for funding, the state must have a federal health insurance exchange as of Jan. 1, 2026. He said the CMS encourages states to submit a letter of intent for planning purposes, but the letter of intent is optional. States that opt to submit a signed letter of intent should do so electronically by Dec. 15. Grant applications are due Jan. 15, 2025. He said the CMS hopes to award grants in March 2025.

Wu discussed a few federal rules, such as the recently finalized mental health parity rule and the recently issued Notice of Benefit and Payment Parameters for 2026 proposed rule. He said over the past few years, there have been some issues related to accessing preventive care services and the treatments related to those services. He said the CCIIO believes part of the problem relates to coding. As such, the CCIIO recently issued guidance for health plans and health care providers on coding for preventive care services.

Director Fox thanked Wu for the update. She said to the extent it can do so, the NAIC and its members and other stakeholders would urge the CCIIO to issue as soon as possible final rules and/or guidance it has been promising this year on: 1) preventive care services; 2) co-payment accumulators; and 3) implementation of the ACA's 1557 final rules.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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Draft: 10/23/24

Consumer Information (B) Subgroup
Virtual Meeting
October 18, 2024

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Oct. 18, 2024. The following Subgroup members participated: David Buono, Chair (PA); T.J. Patton, Vice Chair (MN); Debra Judy (CO); Michelle Baldock and Matthew Pickett (IL); Alex Peck (IN); Terri Smith (MD); Jeana Thomas, Amy Hoyt, and Jo LeDuc (MO); Jill Kruger (SD); Vickie Trice (TN); and Christina Keeley (WI). Also participating was: Susan Jennette (DE).

1. Considered Adoption of its Oct. 8 and Aug. 29 Minutes

Buono noted that the Subgroup's draft Oct. 8 and Aug. 29 minutes were posted on the Subgroup's web page and circulated with this meeting's announcement. During those meetings, the Subgroup discussed recommended amendments to the Affordable Care Act (ACA) frequently asked questions (FAQ) up to question 90.

Thomas made a motion, seconded by Kruger, to adopt the Subgroup's Oct. 8 (Attachment One-A) and Aug. 29 (Attachment One-B) minutes. The motion passed.

2. Discussed Recommended Amendments to the ACA FAQ

Buono thanked the Subgroup for its work on the Oct. 8 call. The draft circulated prior to today's call includes the revisions already adopted by the Subgroup and a few suggested edits discussed on the Oct. 8 call.

NAIC staff walked through the document, and the Subgroup adopted the edits suggested on the previous call. Beginning with question 90, the Subgroup considered the remaining possible revisions. Patton asked about the group size threshold under the Medicare secondary payer rules. Jennette provided a link to information, and the Subgroup recommended that staff edit the document to include the link and clearer information.

Erin Miller (Community Catalyst) suggested including language, noting that the answers provided in the document are subject to change. The Subgroup agreed. Miller also suggested adding the latest requirements on providing a Social Security number on the applications. The Subgroup agreed.

After considering the proposed edits, Patton recommended that NAIC staff make the changes suggested on this call and circulate them to Subgroup members for an electronic vote. The Subgroup agreed.

Buono reminded the Subgroup that open enrollment begins Nov. 1, and this document will be circulated to all departments of insurance (DOIs) as soon as it is approved so they can add state-specific information and use it to answer consumer questions. Jennette suggested that it also be circulated to State Health Insurance Assistance Programs (SHIPs).

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3. Discussed the Subgroup's Next Steps

Buono asked Subgroup members to provide their priorities for the upcoming guides the Subgroup will develop. Patton suggested using Survey Monkey to solicit suggestions. NAIC staff were asked to look into using such a tool.

Having no further business, the Consumer Information (B) Subgroup adjourned.

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Draft: 10/14/2024

Consumer Information (B) Subgroup
Virtual Meeting
October 8, 2024

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Oct. 8, 2024. The following Subgroup members participated: David Buono, Chair (PA); T.J. Patton, Vice Chair (MN); Anthony L. Williams (AL); Debra Judy (ID); Jeana Thomas (MO); Jill Kruger (SD); and Christina Keeley (WI). Also participating was: Susan Jennette (DE).

1. Discussed Recommended Amendments to the ACA FAQ

Buono thanked the regulators who volunteered to review the Affordable Care Act (ACA) FAQ and provided recommendations for updating the document. He also thanked other interested parties who provided constructive edits. He noted that NAIC staff had incorporated the number updates, grammatical corrections, and clarifying language that was submitted, but there were still several amendments to walk through.

Most of the edits recommended by commenters were accepted by the Subgroup, but a few require further discussion. For question 10, it was suggested that language be added noting that certain low-income persons have a year-round special enrollment period. For question 24, it was recommended that information on how to file a complaint be added with a link to Consumer Information (B) Subgroup guidance. For question 29, adding information on state balance billing laws was suggested. For question 34, the Subgroup agreed to strike "with subsidies" from the question. For question 40, additional information on health savings accounts (HSAs) and providing clearer information on how they work was recommended. It was suggested that question 16 be split into two questions: 1) where to go for help; and 2) where to go to enroll. It was recommended that throughout the document, the term "Producers (agents/broker)" be used. There was discussion about adding more information on unauthorized producer activity.

The Subgroup stopped at question 90. NAIC staff were instructed to incorporate the edits approved during the meeting and provide an updated draft with the suggested new language discussed. The Subgroup will meet again in a few weeks to finish walking through the document beginning at question 90 and consider the amendments suggested during this meeting.

Having no further business, the Consumer Information (B) Subgroup adjourned.

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Draft: 9/11/24

Consumer Information (B) Subgroup
Virtual Meeting
August 29, 2024

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Aug. 29, 2024. The following Subgroup members participated: David Buono, Chair (PA); Michelle Baldock (IL); Alex Peck (IN); Terri Smith (MD); Jeana Thomas (MO); Donna Dorr (OK); Jill Kruger (SD); Jennifer Ramcharan and Vickie Trice (TN); and Christina Keeley (WI). Also participating was: Susan Jennette (DE).

1. Discussed the Need for Volunteers to Review the ACA FAQ

Buono reminded Subgroup members and interested parties that one of the Subgroup's responsibilities is to ensure that the NAIC's Frequently Asked Questions (FAQ) About Health Care Reform is updated each year before the Open Enrollment Period begins so state insurance regulators have accurate information to answer consumers' questions.

A copy of the FAQ, with dates and dollar amounts updated by NAIC staff, was circulated with the invitation to today's meeting. Buono walked through the document and asked for volunteers to take the lead in reviewing each section. Suggested edits are due Sept. 20. State insurance regulators volunteered and were appointed for each section of the FAQ.

2. Discussed the Use of Current NAIC Guides Developed by the Subgroup

Buono noted that the Subgroup has been busy and has developed great information for consumers, including how to shop for insurance, how prior authorization and claims reviews work, and how they can appeal insurer decisions. He asked whether state insurance regulators even know this information is available since states are distributing it to consumers.

A few states said they use the materials for training, while others said they send it to consumers. Several states said they did not know about the information until they joined the Subgroup, and it was noted that it is hard to find on the NAIC website.

Brenda J. Cude (University of Georgia) suggested that the Subgroup distribute the materials to state public information officers (PIOs) and discuss them at zone meetings. Katie Dzurec (Examination Resources LLC) recommended reaching out to the Insurance Regulatory Examiners Society (IRES) Education Committee.

Buono said he would talk to the NAIC Communications team to discuss meeting with PIOs and updating the NAIC website to make the materials easier to find.

3. Discussed the Subgroup's Next Steps

Buono asked what projects, other than updating the FAQ, the Subgroup should be working on during the last third of the year.

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Dr. Cude recommended reviewing the consumer information posted by NAIC Communications. She noted that those posts sometimes conflict with materials developed by the Subgroup. Buono said he would reach out to Communications to discuss.

Jennette suggested developing information on the No Surprises Act (NSA) and how the Independent Dispute Resolution (IDR) process works.

Having no further business, the Consumer Information (B) Subgroup adjourned.

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Draft: 10/23/24

Health Innovations (B) Working Group
Virtual Meeting
October 15, 2024

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met Oct. 15, 2024. The following Working Group members participated: Nathan Houdek, Chair, Barbara Belling, and Jennifer Stegall (WI); Amy Hoyt, Vice Chair (MO); Sarah Bailey, Jacob Lauten, and Chelsy Maller (AK); Debra Judy and Jill Mullen (CO); Andria Seip (IA); Alex Peck (IN); Julie Holmes (KS); Joe Keith and Jeff Hayden (MI); Daniel Bradford and Laura Miller (OH); Andrew R. Stolfi (OR); Rachel Bowden and Amelia Berry (TX); Tanji J. Northrup and Heidi Clausen (UT). Also participating were: Martin Swanson and Maggie Reinert (NE); and Jill Reinking and Lauren White (WY).

1. Heard a Presentation on Hospital Price Caps in Oregon

Hoyt introduced Roslyn Miller (Brown University). Miller gave a presentation on hospital price caps in Oregon, which limit payments to hospitals in the state employee plan to 200% of the Medicare amount. Hoyt asked if Oregon implemented additional price transparency requirements to help consumers compare prices and shop for services. Miller said this was discussed but no additional transparency initiatives were implemented and noted that the materials provided for today's call include more information on the policy.

Reinert asked if hospitals are prohibited from dropping out of the networks. Miller said there is no prohibition but the program's 185% cap on payments for out-of-network payments is critical to preventing providers from leaving the network. She said that none of the 24 participating hospitals have left.

Seip asked how the state arrived at the 200% of the Medicare amount cap. She asked if actuaries were involved in setting the cap. Miller explained that she was not involved in that process, but the cap was set a little lower than the current average reimbursement levels, which are 237% of the Medicare amount.

Hoyt noted that this program applies to the state employee plans but asked who receives coverage from that plan. Miller said state employees and teachers are in the health plan, which is about 15% of the insured population in the state.

2. Heard a Presentation from CHIR and AHIP on Federal TiC Requirements for Health Insurers

Hoyt introduced Sabrina Corlette (Center on Health Insurance Reforms—CHIR) and Kelley Schultz (AHIP). Corlette and Shultz gave a presentation on the federal Transparency in Coverage (TiC) requirements for health insurers. This presentation was a follow-up of their presentations to the Health Insurance and Managed Care (B) Committee at the Summer National Meeting, which were cut short due to time constraints.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) asked if machine-readable files could be used to find pricing trends for certain procedures or types of procedures, or possible patterns of pricing for specific groups of consumers, such as preventive care for people with intellectual or developmental disabilities. Schultz noted that the information is not broken down by disability, but the data can be parsed by geography.

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3. Heard a Presentation from the PhRMA Foundation on a Veterans Affairs Program

Hoyt introduced Amy M. Miller (PhRMA Foundation), who introduced Helen Omuya (PhRMA Foundation). Omuya gave a presentation on a U.S. Department of Veterans Affairs (VA) program that helps veterans understand their prescription drugs, eliminate prescriptions that are no longer needed, and prevent conflicting drug usage. Hoyt asked if this could also be used in other programs, like Medicaid, which are less integrated. Omuya said that CancelRx, a health information technology (IT) tool, could be useful in other settings.

Having no further business, the Health Innovations (B) Working Group adjourned.

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Draft: 11/8/24
Adopted by the Executive (EX) Committee and Plenary, Dec. __, 2024
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 19, 2024

2025 Proposed Charges

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Health Insurance and Managed Care (B) Committee** will:
   A. Respond to inquiries from the U.S. Congress (Congress), the White House, and federal agencies; analyze policy implications and their effect on the states of proposed and enacted federal legislation and regulations; and communicate the NAIC's position through letters and testimony, when requested.
   B. Monitor the activities of the Health Actuarial (B) Task Force.
   ~~C. Monitor the activities of the Long-Term Care Insurance (B) Task Force.~~
   ~~D~~C. Monitor the activities of the Regulatory Framework (B) Task Force.
   ~~E~~D. Monitor the activities of the Senior Issues (B) Task Force.
   ~~F~~E. Serve as the official liaison between the NAIC and the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), the National Committee for Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC).
   ~~G~~F. Examine factors that contribute to rising health care costs and insurance premiums. Review state initiatives to address cost drivers.
   ~~H~~G. Coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues.
   ~~I~~H. Coordinate with the Market Regulation and Consumer Affairs (D) Committee, as necessary, to collect uniform data and monitor market conduct trends on plans that are not regulated under the federal Affordable Care Act (ACA), including short-term, limited-duration (STLD) insurance, association health plans (AHPs), and packaged indemnity health products.

2. The **Consumer Information (B) ~~Subgroup~~Working Group** will:
   A. Develop information or resources, as needed, that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance.
   B. Review NAIC publications that touch on health insurance to determine if they need updating. If updates are needed, suggest specific revisions to the appropriate NAIC group or NAIC division to make the changes.

3. The **Health Innovations (B) Working Group** will:
   A. Gather and share information, best practices, experience, and data to inform and support health innovation at the state and national levels, including, but not limited to, state flexibility options through the ACA and other health insurance-related policy initiatives.
   B. Discuss state innovations related to health care—i.e., access, insurance plan designs, underlying medical and prescription drug costs, stability for health care and insurance as a whole, health insurer and provider consolidation or competition, the use of data in regulatory and policy decision making, and health care delivery and financing models—to achieve better patient outcomes and lower spending trends.

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C. Explore sources and methods for state insurance regulators to obtain data to inform health reform initiatives.
D. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to use the information gathered by the Working Group.
E. Take up other matters as directed by the Health Insurance and Managed Care (B) Committee.

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

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Proposed Revisions to Model #171

Language from the permitted exclusion section 7D:

D. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except for the following permitted exclusions:

Drafting Note: States should review the provisions of this subsection carefully to determine if any of the exceptions to limiting or excluding coverage by type of illness, accident, treatment or medical condition included in the subsection should apply to short-term, limited-duration health insurance coverage.

(1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;

(2) Mental or emotional disorders, alcoholism and drug addiction;

Drafting Note: This provision is optional. States should review the desirability of permitting such exclusions, particularly those exclusions related to mental health and substance use, included in subsections D(2) and D(4) of this section, in short-term limited duration and disability policies.

Short-Term, Limited Duration Coverage Language from Section 8H.

H. Short-Term, Limited-Duration Health Insurance Coverage

(1) "Short-term, limited-duration health insurance" means health insurance coverage offered or provided to residents of the state pursuant to a contract with a health carrier, regardless of the situs of the contract, that has an expiration date specified in the contract that is less than [X] [days or months] after the original effective date and, taking into account any extensions that may be elected by the policyholder with or without the carrier's consent, has a duration no longer than [X] [days or months] after the original effective date of the contract.

(2) (a) Short-term, limited-duration health insurance must comply with the benefit and coverage requirements of this state, including, if the state requires, providing benefits and coverage of state-mandated benefits and being subject to the state's external and internal review requirements.

Drafting Note: States should consider whether mental health and substance use disorder benefits, as described in Sections 7, D(2) and D(4), should be permitted exclusions to short-term limited duration policies.

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Adopted by the Health Insurance and Managed Care (B) Committee – Nov. 19, 2024
Adopted by the Regulatory Framework (B) Task Force – Nov. 4, 2024
Adopted by the Accident and Sickness Insurance Minimum Standards (B) Subgroup – Oct. 17, 2024

Draft: 11/19/24
Model#171

The revisions to this draft reflect changes made from the existing model. Any comments on this draft should be sent by email only to Jolie Matthews at jmatthews@naic.org.

MODEL REGULATION TO IMPLEMENT THE ~~ACCIDENT AND SICKNESS~~SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

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Section 1. Purpose

The purpose of this regulation is to implement [insert reference to state law equivalent to the NAIC ~~Accident and Sickness~~ *Supplementary and Short-Term Health Insurance Minimum Standards Model Act*] (the Act) to standardize and simplify the terms and coverages, ~~of individual accident and sickness insurance policies, and group accident and sickness policies and certificates providing hospital confinement indemnity, accident only, specified disease specified accident or limited benefit health coverage (hereafter referred to as "group supplemental health insurance"). This regulation is also intended~~ to facilitate public understanding and comparison of coverage, to eliminate provisions ~~contained in individual accident and sickness insurance policies and group supplemental health insurance~~ that may be misleading or confusing in connection with the purchase and renewal of the coverages or with the settlement of claims~~;~~ and to provide for full disclosure in the marketing and sale of ~~individual accident and sickness insurance policies and group supplemental health insurance~~ supplementary and short-term health insurance, as defined in the Act. This regulation is also intended to assert the commissioner's jurisdiction over limited scope dental coverage and limited scope vision ~~plans~~coverage, and to provide for disclosure in the sale of those ~~plans~~coverages.

~~**Drafting Note**: States should determine if the phrase "individual accident and sickness insurance policies" is broad enough or particular enough to cover the array of individual health insurance issuers in the state. States that use different terminology (e.g. "subscriber contracts" of "nonprofit hospital, medical and dental associations") to cover these plans should choose terminology conforming to state statute.~~

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [insert reference to state law equivalent to NAIC ~~Accident and Sickness~~*Supplementary and Short-Term Health Insurance Minimum Standards Model Act* and any other appropriate section of law regarding authority of commissioner to issue regulations].

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Section 3. Applicability and Scope

A. This regulation applies to all individual ~~accident and sickness insurance policies~~ and group ~~supplemental health~~insurance policies and certificates providing hospital indemnity or other fixed indemnity, accident only, specified accident, specified disease, limited benefit health and disability income protection, referred to collectively in Section 1 of the Act and hereafter, as "supplementary health insurance," delivered or issued for delivery in this state on and after [insert effective date] that are not specifically exempted from this regulation. This regulation applies to short-term, limited-duration insurance coverage offered, delivered or issued for delivery to residents of this state regardless of the situs of the delivery of the contract on and after [insert effective date].

B. This ~~Act~~regulation ~~shall apply~~applies to limited scope dental ~~plans~~coverage and limited scope vision ~~plans~~coverage only as specified.

C. This regulation shall not apply to:

~~(1) Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this regulation;~~

~~(2) Policies issued to employees or members as additions to franchise plans in existence on the effective date of this regulation;~~

~~(3)~~(1) Medicare supplement policies subject to [insert reference to state law equivalent to the Model Regulation to Implement the NAIC *Medicare Supplement Insurance Minimum Standards Model Act*];

~~(4)~~(2) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act*]; ~~or~~

~~(5)~~(3) TRICARE ~~Civilian Health and Medical Program of the Uniformed Services~~ (Chapter 55, ~~t~~Title 10 of the United States Code) ~~(CHAMPUS)~~ supplement insurance policies; or

(4) Limited long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Limited Long-Term Care Insurance Model Act*].

Drafting Note: ~~CHAMPUS~~TRICARE supplement insurance is not subject to federal regulation. ~~CHAMPUS~~TRICARE supplement policies are sold only to eligible individuals as determined by the Department of Defense and are tied to ~~CHAMPUS~~TRICARE benefits. In general, states regulate ~~CHAMPUS~~TRICARE supplement insurance policies under the state group or individual insurance laws.

D. The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted.

Section 4. Effective Date

This regulation shall be effective on [insert a date not less than 120 days after the date of adoption of the regulation]. The amendments to this regulation shall apply to any policies [or certificates] issued on or after the effective date of the adoption of the amended regulation.

Section 5. Definitions

For purposes of this regulation:

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A. "Excepted benefits" means coverage listed at section 2791(c) of the Public Health Service Act (PHSA) or subsequently added by regulation where authorized.

B. "Medicare" means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

C. "Short-term, limited-duration insurance" has the meaning stated in Section 3I of the Act.

Section ~~5~~6. Policy Definitions

A. (1) Except as provided in this regulation, ~~an individual accident and sickness insurance policy or group supplemental health insurance policy~~a supplementary health insurance or a short-term limited duration insurance policy delivered or issued for delivery to any person in this state and to which this regulation applies shall contain definitions respecting the matters set forth below that comply with the requirements of this section.

(2) Except as provided in this regulation, to the extent these definitions are used in a policy [or certificate], definitions used in a policy [or certificate] may vary from the definitions in this section, but not in a manner that restricts coverage.

~~B (1) "Accident," "accidental injury," and "accidental means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.~~

~~(2) The definition shall not be more restrictive than the following: "injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause and that occurs while the insurance is in force.~~

~~(3) The definition may provide that injuries shall not include injuries for which benefits are provided under workers' compensation, employers' liability or similar law; or under a motor vehicle no-fault plan, unless prohibited by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.~~

~~C~~B. "Convalescent nursing home," "extended care facility," ~~or~~ "skilled nursing facility," "assisted living facility" or "continued care retirement community" ~~shall be defined~~means in relation to its status, facility and available services.

(1) A definition of the home or facility shall not be more restrictive than one requiring that it:

(a) Be operated pursuant to law;

(b) Be approved for payment of Medicare and/or Medicaid benefits or be qualified to receive approval for payment of Medicare and/or Medicaid benefits, if so requested;

(c) Be ~~primarily~~ engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(d) Except for an "assisted living facility" or a "continued care retirement community," ~~Provide~~provide continuous twenty-four-hour-a-day nursing service by or under the supervision of a registered nurse; and

(e) Maintain a daily medical record of each patient.

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(2) The definition of the home or facility ~~may provide that the term shall not be inclusive of~~ is permitted but is not required to exclude:

(a) A home, facility or part of a home or facility used primarily for rest;

(b) A home or facility for the aged and/or for the care of ~~drug addicts or alcoholics~~individuals with a substance use disorder; or

(c) A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care.

Drafting Note: The laws of the states relating to nursing and extended care facilities recognized in health insurance policies are not uniform. Reference to the individual state or federal Medicare or Medicaid law may be required in structuring this definition.

C. "Home health care agency":

(1) Is an agency approved under Medicare;

(2) Is licensed to provide home health care under applicable state law; or

(3) Meets all the following requirements:

(a) It is primarily engaged in providing home health care services;

(b) Its policies are established by a group of professional personnel, including at least one physician and one licensed nurse;

(c) A physician or a registered nurse provides supervision of home health care services;

(d) It maintains clinical records on all patients; and

(e) It has a full-time administrator.

Drafting Note: State licensing laws vary concerning the scope of "home health care" or "home health agency services" and should be consulted. In addition, a few states have mandated benefits for home health care, including the definition of required services.

~~C~~D. "Hospital" ~~may be defined~~means in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission ~~on Accreditation of Healthcare Organizations~~.

(1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

(a) Be an institution licensed to operate as a hospital pursuant to law;

(b) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and

(c) Provide twenty-four-hour nursing service by or under the supervision of registered nurses.

(2) The definition of the term "hospital" ~~may state that the term shall not be inclusive of~~ is permitted but is not required to exclude:

(a) Convalescent homes or, convalescent, rest or nursing facilities;

(b) Facilities affording primarily custodial, educational or ~~rehabilitory~~rehabilitative care;

(c) Facilities for the aged~~, drug addicts or alcoholics~~ or individuals with a substance use disorder; or

(d) A military or veterans' hospital, a soldiers' home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services ~~rendered on an emergency basis~~ where a legal liability for the patient exists for charges made to the individual for the services.

Drafting Note: The laws of the states relating to the type of hospital facilities recognized in health insurance policies are not uniform. References to individual state law may be required in structuring this definition.

E. (1) "Injury" means a bodily injury resulting from an accident, independent of disease, which occurs while the coverage is in force.

(2) The definition shall not use words such as "external, violent, visible wounds" or similar words of characterization or description.

(3) The definition may state that the disability shall have occurred within a specified period of time (not less than thirty (30) days) of the injury, otherwise the condition shall be considered a sickness.

(4) The definition may provide that "injury" shall not include an injury for which benefits are provided under workers' compensation, employers' liability or similar law; or under a motor vehicle no-fault plan, unless prohibited by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.

~~E. "Medicare" means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.~~

F. "Mental or nervous disorder" ~~shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind~~ means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or its successor.

G. "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as an advance practice nurse, a registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words "nurse," "advance practice nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

Drafting Note: States may want to consider whether the functions of an advance practice nurse fall under this definition or the definition of "physician" in Subsection J.

H. "One period of confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

I. "Partial disability" ~~shall be defined in relation to~~ means that, due to a disability, an individual:

(1) ~~the individual's inability~~ Is unable to perform one or more but not all ~~of~~ the "major," "important" or "essential" duties of the individual's employment or existing occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation; and

(2) Is in fact engaged in work for wage or profit.

J. (1) "Physician" ~~may be defined by~~means and ~~including~~includes words such as "qualified physician" or "licensed physician~~.~~" and may not be defined more narrowly than applicable state licensing laws. ~~The use of these terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when the services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.~~

(2) The definition or concept may exclude the insured, the owner, the assignee, any person related to the insured, owner or assignee by blood or marriage, any person who shares a significant business interest with the insured, owner or assignee, or any person who is a partner in a legally sanctioned domestic partnership or civil union with the insured, owner or assignee.

Drafting Note: The laws of the states relating to the type of providers' services recognized in health insurance policies are not uniform. References to the individual state law may be required in structuring this definition.

K. "Preexisting condition" ~~shall not be defined more restrictively than the following: "Preexisting condition~~ means ~~the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a [two] year period preceding the effective date of the coverage of the insured person or~~ a condition for which medical advice or treatment was recommended by a physician or received from a physician within a [two-] year period preceding the effective date of the coverage of the insured person."

Drafting Note: This definition does not prohibit an insurer, using an application or enrollment form, including a simplified application form, designed to elicit the health history of a prospective insured and on the basis of the answers on that application or enrollment form, from underwriting in accordance with that insurer's established standards and in accordance with state law. It is assumed that an insurer that elicits a health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition, the policy or certificate will be endorsed or amended by including the specific exclusion. This same requirement of notice to the prospective insured of the specific exclusion will also apply to insurers that elect to use simplified application or enrollment forms containing questions relating to the prospective insured's health. This definition does, however, prohibit an insurer that elects to use a simplified application or enrollment form, with or without a question as to the proposed insured's health at the time of application or enrollment, from reducing or denying a claim on the basis of the existence of a preexisting condition that is defined more restrictively than above.

~~States that have specific requirements with respect to waivers or exclusionary riders or evidence of insurability requirements for group insurance should modify the preceding paragraphs by deleting group references and adding a new paragraph addressing these requirements. In states which have adopted or are operating under the "federal fallback" provisions the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for major medical coverage issued to a HIPAA eligible individual, there can be no preexisting condition exclusion. In addition, states that have specific preexisting condition requirements for group insurance may need to modify section Subsection K according to applicable statutes.~~

L. "Residual disability" ~~shall be defined~~means in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important" or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy that provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import that in the opinion of the commissioner adequately and fairly describes the benefit.

M. "Sickness" ~~shall not be defined to be more restrictive than the following: "Sickness~~ means sickness, illness, or disease of an insured person that first manifests itself after the effective date of insurance and while the

insurance is in force. A definition of sickness may provide for a probationary period that shall not exceed thirty (30) days from the effective date of the coverage of the insured person.~~"~~ The definition may be ~~further~~ modified to exclude sickness or disease for which benefits are provided under a ~~worker's~~workers' compensation, occupational disease, employers' liability or similar law.

N. "Total disability"

(1) A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience; and is not in fact engaged in any employment or occupation for wage or profit.

(2) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to:

(a) Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation"; or

(b) Engage in a training or rehabilitation program.

(3) An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may require care by a physician other than the insured or a member of the insured's immediate family.

Section ~~6~~7. Prohibited Policy Provisions

A. (1) Except as provided in ~~Section 5K~~this subsection, a policy shall not contain provisions establishing a probationary or waiting period during which ~~no~~ coverage ~~is provided~~ under the policy is excluded or restricted.~~, subject to the further exception that~~

(2) A policy, other than an accident only policy, may exclude coverage for a loss due to a preexisting condition, as defined in Section 6J, for a period not to exceed twelve (12) months following the issuance of the policy or certificate. The twelve-month limitation is not required if the condition was disclosed during the application or enrollment process and specifically excluded by the terms of the policy or certificate, or when the insured knowingly made a material misrepresentation during the application or enrollment process.

(3) ~~a~~A policy, other than an accident only policy or a short-term, limited duration health insurance policy, may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting from disease or condition related to hernia, disorder of the ~~reproduction~~reproductive organs, varicose veins, adenoids, ~~appendix~~ and tonsils, except when~~. However, the permissible six-month exception shall not be applicable where~~ the specified diseases or conditions are treated on an emergency basis. ~~Accident policies shall not contain probationary or waiting periods.~~

~~B. (1) A policy or rider for additional coverage may not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. A dividend policy or rider for additional coverage shall not be issued for an initial term of less than six (6) months.~~

~~(2) The initial renewal subsequent to the issuance of a policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional.~~

~~C. A policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than twelve (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 conditions or prior medical care and treatment and the preexisting condition is not specifically excluded by the terms of the policy or certificate.~~

~~**Drafting Note:** Where the state has enacted the NAIC Individual Accident and *Sickness Insurance Minimum Standard Act*, Subsection C is unnecessary. States that have specific preexisting condition requirements for group supplemental insurance may need to modify the preceding subsection according to applicable statutes.~~

~~D~~B. A disability income protection policy may contain a "return of premium" or "cash value benefit" option so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy; and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to the Act and this regulation shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

Drafting Note: This provision is optional and the desirability of its use should be reviewed by the individual states.

~~E~~C. Policies providing hospital ~~confinement~~ indemnity or other fixed indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

~~F~~D. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except ~~as follows~~for the following permitted exclusions:

Drafting Note: States should review the provisions of this subsection carefully to determine if any of the exceptions to limiting or excluding coverage by type of illness, accident, treatment or medical condition included in the subsection should apply to short-term, limited-duration health insurance coverage.

(1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;

(2) Mental or emotional disorders, alcoholism and drug ~~addition~~addiction;

Drafting Note: This provision is optional. States should review the desirability of permitting such exclusions, particularly those exclusions related to mental health and substance use, in Paragraph (2) of this subsection above and Paragraph (4) of this subsection, in short-term, limited-duration insurance policies and disability income protection insurance policies.

(3) Pregnancy, except for complications of pregnancy, other than for policies defined in Section ~~7H~~8C of this regulation;

(4) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it;

(b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

(c) Non-commercial or recreational ~~A~~aviation;

(d) With respect to short-term nonrenewable policies, interscholastic sports; and

(e) With respect to disability income protection policies, incarceration.

Drafting Note: What should be an allowable exclusion in disability income protection insurance policies generates much debate. States should be aware that some argue for exclusion of certain diseases or conditions that are difficult to diagnose or are potentially subject to frequent claims (e.g., carpal tunnel and chronic fatigue syndromes). Others argue that carriers have

the ability to detect fraudulent claims and deny payment on that basis without singling out specific conditions for blanket exclusion.

(5) Cosmetic surgery, except ~~that "cosmetic surgery" shall not include~~ for reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly ~~of a covered dependent child~~ that has resulted in a functional defect;

(6) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or asymptomatic complaints of the feet;

(7) Chiropractic ~~C~~care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

Drafting Note: States should examine any existing "freedom of choice" statutes that require reimbursement of treatment provided by chiropractors~~,~~ and make adjustments if needed.

(8) ~~Treatment provided in a government hospital; b~~Benefits provided under Medicare or other governmental program (except Medicaid), a state or federal ~~workmen's~~workers' compensation, employers liability or occupational disease law, or motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance;

(9) Dental care or treatment, except where the provision of dental services is medically necessary due to the underlying covered medical condition or clinical status of the covered person, including but not limited to, reconstructive surgery;

(10) Eye-glasses, hearing aids and examination for the prescription or fitting of them;

(11) Rest cures, custodial care, transportation and routine physical examinations; ~~and~~

(12) Territorial limitations, provided that they do not exclude coverage for services rendered within the United States and its territories or possessions; and

(13) Genetic testing not ordered by a medical provider, and not used to diagnose or treat a disease.

Drafting Note: Some of the exclusions set forth in this provision may be unnecessary or in conflict with existing state legislation and should be deleted.

~~G~~E. Notwithstanding Subsection D of this section, ~~This~~this regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page.

~~**Drafting Note:** States with specific waiver requirements that differ for group insurance should add language in Subsection G to be consistent with applicable statutes.~~

~~H~~F. The enumeration in this section of specific precluded ~~Policy~~policy provisions ~~precluded in this section~~ shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with [cite Section ~~3~~4B of the ~~Accident and Sickness~~*Supplementary and Short-Term Health*

Insurance Minimum Standards Act] that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.

G. A policy providing a type of supplementary health insurance that is not defined as a "plan" under the *Coordination of Benefits Model Regulation* (#120) shall not include a coordination of benefits provision or any other provision that allows it to reduce its benefits based on the existence of other coverage its insured may have.

H. A policy shall not limit an insured's choice of health care provider if the provider is licensed or otherwise qualified under state law and the services to be provided are within the health care provider's scope of practice.

Drafting Note: Former Subsection B in this section established provisions related to the issuance of a policy or rider for additional coverage as a dividend under specified circumstances. Subsection B was deleted because insurers rarely offer consumers policy dividends as a benefit on policies covered by this regulation. Such provisions are common in life insurance policies. If policy dividends are available on policies covered by this regulation in your state, you should look to the treatment of dividends in life insurance. Generally, consumers should be allowed to take the policy dividend as a cash payment, but insurers may offer the consumer additional policy benefits in lieu of a cash payment at the option of the consumer.

Section ~~7~~8. ~~Accident and Sickness~~ Supplementary and Short-Term Health Insurance Minimum Standards for Benefits

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. ~~An individual accident and sickness insurance policy or group supplemental~~A supplementary or short-term health insurance policy or certificate shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for the specified categories or the commissioner finds that the policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the outline of coverage in Section ~~8L~~9H of this regulation.

This section shall not preclude the issuance of any policy or contract combining two or more categories of excepted benefits set forth in [cite state law equivalent to Section 5~~A and~~ B and C of the NAIC ~~Accident and *Sickness*~~*Supplementary and Short-Term Health Insurance Minimum Standards Model Act*].

A. General Rules

(1) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" individual ~~accident and sickness~~supplementary policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy shall provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured.

Drafting Note: States should review the use of the term "spouse" in paragraph (1) above and replace it or add additional terms in accordance with state law or regulations.

(2) (a) The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Section ~~8~~9A~~(1)~~.

(b) The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in an individual ~~accident and sickness~~supplementary policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

~~(c) An individual accident and sickness or individual accident-only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed.~~

~~(d)~~(c) Except as provided ~~above~~in subparagraph (d) of this paragraph, the term "guaranteed renewable" may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

(d) An individual supplementary policy or individual accident-only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may be designated as "guaranteed renewable" if it provides that the insured has the right to continue the policy, while actively and regularly employed, at least until the insured has reached full retirement and, as defined under the federal Social Security Act.

(3) In an individual ~~accident and sickness~~supplementary policy covering ~~both husband and wife~~a married couple or civil union couple, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in the policy.

Drafting Note: The references to "married couple" and "civil union couple" in paragraph (3) above are intended to apply to any legally recognized marital relationship or domestic partnership recognized in the state. States should revise the language in accordance with state law or regulations. In addition, states should review the use of the term "spouse" and replace it or add additional terms in accordance with state law or regulations.

Drafting Note: For Paragraphs (2) and (3) above, coverage ~~as defined under~~ subject to Title XXVII of the federal Public Health Service Act (PHSA), as enacted by HIPAA and amended by the federal Affordable Care Act (ACA), ~~or applicable state law~~ must be guaranteed renewable except for reasons stated in ~~Part B~~PHSA ~~Section~~§ 2742 (42 U.S.C. § 300gg-42)~~of Title XXVII (Public Health Service Act) as amended by HIPAA or applicable state law~~, unless it is an excepted benefit as described in ~~Part B Sections 2721, 2763 and 2791 of Title XXVII as amended by HIPAA~~ PHSA § 2791(c) (42 U.S.C. § 300gg-91(c))~~or~~. ~~a~~Applicable state law may impose requirements that mirror or exceed the federal requirements.

(4) When accidental death and dismemberment coverage is part of the individual ~~accident and sickness~~supplementary insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.

(5) If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.

(6) ~~In the event the insurer cancels or refuses to renew, p~~Policies providing pregnancy benefits shall provide for an extension of benefits, in the event the insurer cancels or refuses to renew for reasons other than non-payment of premium, as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

(7) Policies providing convalescent or extended care benefits following hospitalization ~~shall not~~may condition the benefits upon admission to the convalescent or extended care facility within a ~~period~~

~~of~~ specified time after discharge from the hospital, as long as the required admission date is not less than ~~fourteen (14) days~~thirty (30) days after discharge from the hospital.

(8) In individual ~~accident and sickness~~supplementary or short-term health insurance policies, coverage shall continue for a dependent child who is incapable of self-sustaining employment due to ~~mental retardation or physical handicap~~intellectual or physical disability on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days ~~of~~ after the date the ~~company~~insurer receives due proof of the ~~incapacity~~disability in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.

(9) A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.

(10) A policy may contain a provision relating to recurrent disabilities; but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six (6) months.

(11) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income protection benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.

(12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(13) An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage and the disclosure materials required under Section 9 of this regulation the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.

(14) Termination of the policy shall be without prejudice ~~of to~~to the right to receive benefits for a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.

(15) A policy providing coverage for certain illnesses and injuries may not define covered illnesses and injuries in a way that is misleading or includes unfair exclusions. For example, a policy providing coverage for fractures or dislocations may not provide benefits only for "full or complete" fractures or dislocations.

~~B. Basic Hospital Expense Coverage~~

~~"Basic hospital expense coverage" is a policy of accident and sickness insurance that provides coverage for a period of not less than thirty-one (31) days during a continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:~~

~~(1) Daily hospital room and board in an amount not less than the lesser of:~~

(a) [80%] of the charges for semiprivate room accommodations or

(b) [$100] per day;

Drafting Note: The commissioner may determine the level of daily room and board benefits that he or she considers appropriate as a minimum for a basic hospital contract in his state. It should be an underlying principle for the establishment of benefits that the amounts are to be minimums, not maximums. In order to accommodate those states that have a substantial differential in hospital room and board costs between urban and rural areas within a state, the following language may be used in addition to the language in Subsection B(1) above: "except that $[insert amount] may be reduced to $[insert amount] outside the area." Other dollar amounts and percentages applicable to the various minimum benefits that follow are also bracketed to permit a commissioner to set the level of minimum benefits for his or her particular state.

(2) Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies that are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either [80%] of the charges incurred up to at least [$3,000] or [ten] times the daily hospital room and board benefits; and

(3) Hospital outpatient services consisting of:

(a) Hospital services on the day surgery is performed,

(b) Hospital services rendered within seventy-two (72) hours after injury, in an amount not less than [$150]; and

(c) X-ray and laboratory tests to the extent that benefits for the services would have been provided in an amount of less than [$100] if rendered to an in-patient of the hospital.

(4) Benefits provided under Paragraphs (1) and (2) of this subsection may be provided subject to a combined deductible amount not in excess of [$100].

C. Basic Medical-Surgical Expense Coverage

"Basic medical-surgical expense coverage" is a policy of accident and sickness insurance that provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

(1) Surgical services:

(a) In amounts not less than those provided on a fee schedule based on the relative values contained in the [insert reference to a fee schedule based on the Current Procedure Terminology (CPT) coding or other acceptable relative value schedule].up to a maximum of at least [$1000] for a one procedure; or

(b) Not less than [80%] of the reasonable charges.

(2) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or the physician assistant) performing the surgical services:

(a) In an amount not less than [80%] of the reasonable charges; or

(b) [15%] of the surgical service benefit.

(3) In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is

~~required, in an amount not less than [80%] of the reasonable charges, or [$50] per day for not less than twenty-one (21) days during one period of confinement.~~

~~D. Basic Hospital/Medical-Surgical Expense Coverage~~

~~"Basic hospital/medical-surgical expense coverage" is a combined coverage and must meet the requirements of both Subsections B and C.~~

~~E~~B. Hospital ~~Confinement~~ Indemnity or Other Fixed Indemnity Coverage

(1) "Hospital ~~confinement~~ indemnity or other fixed indemnity coverage" ~~is a policy of accident and sickness insurance that~~ provides ~~daily~~ benefits ~~for~~as a result of hospital confinement or other health-related events and based on a fixed dollar amount, ~~on an indemnity basis in an amount not less than [$40] per day and not less than thirty-one (31) days during each period of confinement for each person insured under the policy~~ regardless of the amount of expenses incurred, without coordination with any other health coverage.

(2) "Hospital indemnity coverage" may provide a single lump sum benefit for hospital confinement of not less than $[X], and/or daily benefit for hospital confinement on an indemnity basis in an amount not less than $[X] per day and not less than [X] days during each period of confinement for each person insured under the policy.

Drafting Note: Paragraph (2) above provides a framework for the state insurance regulators to establish minimum benefit amounts they feel are appropriate for hospital indemnity coverage. When setting these minimum benefit amounts, state insurance regulators should be mindful to not set a benefit amount so low such that the product does not provide a meaningful benefit to the consumer or set a benefit amount so high that a consumer could be led to believe the product is comprehensive major medical coverage. State insurance regulators can address this issue by requiring that this coverage is not offered, marketed, or sold as a substitute for, or an alternative to, comprehensive major medical coverage, and requiring the use of disclosures that this coverage is supplementary insurance.

~~(2)~~(3) Coverage shall not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.

~~(3) Except for the NAIC uniform provision regarding other insurance with the insurer, benefits shall be paid regardless of other coverage.~~

Drafting Note: Hospital ~~confinement~~ indemnity or other fixed indemnity coverage is ~~recognized as supplemental~~supplementary coverage. Any hospital ~~confinement~~ indemnity or other fixed indemnity coverage, therefore, must be payable regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of hospital ~~confinement~~ indemnity or other fixed indemnity coverage. Section 3H(4) of the ~~Group~~ *Coordination of Benefits Model Regulation* states that the definition of a plan (for the purposes of coordination of benefits)…shall not include individual or family insurance contracts…." States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of hospital ~~confinement~~ indemnity or other fixed indemnity coverage purchased by the insured.

Drafting Note: For indemnity products that are triggered by a variety of health events and provide a variety of daily benefit dollar amounts, state insurance regulators should examine the amount payable per day and the total amount payable per year or lifetime to determine whether an indemnity product's benefits could be mistaken for comprehensive major medical coverage. Indemnity products should not be offered, marketed, or sold as an alternative to, or substitute for, or ~~a~~ replacement for major medical coverage. It is the marketing of supplementary coverage as an alternative, substitute or replacement for comprehensive major medical coverage that presents the unfair trade practice, and not the supplementary coverage itself when it is offered and marketed as supplementary excepted benefits coverage and accurately described to the consumer.

~~F. Individual Major Medical Expense Coverage~~

~~(1) "Individual major medical expense coverage" is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than [$500,000]; coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles shall not exceed ten thousand dollars ($10,000) per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed five percent (5%) of the aggregate maximum limit under the policy for each covered person for at least:~~

~~(a) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;~~

~~(b) Miscellaneous hospital services;~~

~~(c) Surgical services;~~

~~(d) Anesthesia services;~~

~~(e) In-hospital medical services;~~

~~(f) Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and~~

~~(g) Not fewer than three (3) of the following additional benefits:~~

~~(i) In-hospital private duty registered nurse services;~~

~~(ii) Convalescent nursing home care;~~

~~(iii) Diagnosis and treatment by a radiologist or physiotherapist;~~

~~(iv) Rental of special medical equipment, as defined by the insurer in the policy;~~

~~(v) Artificial limbs or eyes, casts, splints, trusses or braces;~~

~~(vi) Treatment for functional nervous disorders, and mental and emotional disorders; or~~

~~(vii) Out-of-hospital prescription drugs and medications.~~

~~(2) If the policy is written to complement underlying basic hospital expense and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.~~

~~(3) The minimum benefits required by 7F(1) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. A major medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under 7F(1)(g) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subsection through the application of special or internal limitations, a major medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual,~~

~~customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.~~

~~G. Individual Basic Medical Expense Coverage~~

~~(1) "Individual basic medical expense coverage" is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $250,000; coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles shall not exceed $25,000 per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed ten percent (10%) of the aggregate maximum limit under the policy for each covered person for at least:~~

~~(a) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides or such other rate agreed to between the insurer and provider for a period of not less than thirty-one (31) days during continuous hospital confinement;~~

~~(b) Miscellaneous hospital services;~~

~~(c) Surgical services;~~

~~(d) Anesthesia services;~~

~~(e) In-hospital medical services;~~

~~(f) Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy and hemodialysis ordered by a physician; and~~

~~(g) Not fewer than three (3) of the following additional benefits:~~

~~(i) In-hospital private duty graduate registered nurse services;~~

~~(ii) Convalescent nursing home care;~~

~~(iii) Diagnosis and treatment by a radiologist or physiotherapist;~~

~~(iv) Rental of special medical equipment, as defined by the insurer in the policy;~~

~~(v) Artificial limbs or eyes, casts, splints, trusses or braces;~~

~~(vi) Treatment for functional nervous disorders, and mental and emotional disorders; or~~

~~(vii) Out-of-hospital prescription drugs and medications.~~

~~(2) If the policy is written to complement underlying basic hospital expense and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.~~

~~(3) The minimum benefits required by 7G(1) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. An individual basic medical expense policy may also~~

~~have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under 7G(1)(g) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subsection through the application of special or internal limitations, anindividual basic medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.~~

~~H~~C. Disability Income Protection Coverage

"Disability income protection coverage" is a policy that provides for periodic payments, ~~weekly or monthly~~no less frequently than monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them that:

(1) Provides that ~~periodic payments that are payable at ages after sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to sixty-two (62)~~ a plan is prohibited from reducing periodic payments based on age, except that a plan may reduce periodic payments provided that such reductions do not take place until the individual has reached full retirement age, as defined under the federal Social Security Act, to receive Social Security benefits;

Drafting Note: Age 62 was removed so that retirement age would align with the federal Social Security Act full retirement age.

(2) Contains an elimination period no greater than:

(a) Fifty percent (50%) of the benefit period in the case of coverage providing a benefit of one hundred and eighty (180) days or less;

(b) Ninety (90) days in the case of a coverage providing a benefit of one hundred and eighty (180) days to one year ~~or less~~;

~~(b)~~(c) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or

~~(c)~~(d) Three hundred and sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury;

(3) Has a ~~maximum~~ period of time of at least three (3) months for which it is payable during disability ~~of at least six (6) months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one month~~. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period~~. Section 7F does not apply to those policies providing business buy-out coverage~~; and

(4) Where a policy provides both total disability benefits and partial disability benefits, only one elimination period may be required.

~~I~~D. Accident Only Coverage

"Accident only coverage" is a policy that provides coverage, singly or in combination, for death, dismemberment, disability, injury, or hospital and medical care caused by accident. Accidental death and

double dismemberment amounts under the policy shall be at least ~~[$1,000]~~$[X] and a single dismemberment amount shall be at least ~~[$500]~~$[X].

~~J~~E. Specified Disease Coverage

(1) "Specified disease coverage" pays benefits for the diagnosis and treatment of a specifically named disease or diseases. A specified disease policy must meet the following rules in paragraph (2) and one of the following sets of minimum standards for benefits:

(a) Insurance covering cancer only or cancer in conjunction with other conditions or diseases must meet the standards of Paragraph (4), (5) or (6) of this subsection.

(b) Insurance covering specified diseases other than cancer must meet the standards of Paragraphs (3) and (6) of this subsection.

(2) General Rules

Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following rules shall apply to specified disease coverages in addition to all other rules imposed by this regulation. In cases of conflict between the following and other rules, the following shall govern:

(a) Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this section.

(b) Any policy issued pursuant to this section that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead.

(c) Notwithstanding any other provision of this regulation, specified disease policies shall provide benefits to any covered person not only for the specified disease or diseases, but also for any other conditions or diseases~~,~~ directly caused or aggravated by ~~the~~a specified disease~~s~~ or the treatment of the specified disease.

(d) Individual ~~accident and sickness~~supplementary policies containing specified disease coverage shall be at least guaranteed renewable.

(e) No policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days. A specified disease policy may contain a waiting or probationary period following the issue or reinstatement date of the policy or certificate in respect to a particular covered person before the coverage becomes effective as to that covered person.

(f) An application or enrollment form for specified disease coverage shall contain a statement above the signature of the applicant or enrollee that a person to be covered for specified disease is not covered also by any Title XIX program (Medicaid, MediCal or any similar name). The statement may be combined with any other statement for which the insurer may require the applicant's or enrollee's signature.

Drafting Note: States may prohibit individuals who are covered by a Title XIX program from enrolling in a specified disease policy. However, this would not prohibit an individual who purchases a specified disease policy and later becomes eligible for coverage under a Title XIX program from utilizing the benefits of the specified disease policy to which the individual may be entitled to receive.

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(g) Payments may be conditioned upon an insured person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.

(h) ~~Except for the NAIC uniform provision regarding other insurance with this insurer, benefits~~ Benefits for specified disease coverage shall be paid regardless of other coverage, except as permitted by [insert reference to state law equivalent to Section 3B(3) of the *Uniform Individual Accident and Sickness Policy Provision Law* (UPPL) (#180), regarding multiple policies with the same insurer].

Drafting Note: Specified disease coverage is recognized as ~~supplemental~~supplementary coverage. Any specified disease coverage, therefore, must be payable in addition to and regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of specified disease coverage. Section 3H(4) of the ~~Group~~ *Coordination of Benefits Model Regulation* states that the definition of a "plan" (for the purpose of coordination of benefits) "shall not include individual or family insurance contracts." States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of specified disease coverage purchased by the insured.

(i) After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis.

(j) Policies providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount of expenses. Instead, the term "charge," "expense," or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase "actual charges" or "actual expenses."

(k) "Preexisting condition" shall not be defined to be more restrictive than the following and shall be consistent with the provisions of Section 7B of the Act: "Preexisting condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within the six (6) month period preceding the effective date of coverage of an insured person."

(l) Coverage for specified diseases will not be excluded due to a preexisting condition for a period greater than six (6) months following the effective date of coverage of an insured person unless ~~the~~a named preexisting condition is specifically excluded.

(m) Hospice Care.

(i) "Hospice" means a ~~facility~~provider licensed, certified or registered in accordance with state law that provides a formal program of care that is:

(I) For terminally ill patients whose life expectancy is less than six (6) months;

(II) Provided on an inpatient or outpatient basis; and

(III) Directed by a physician.

(ii) Hospice care is an optional benefit. However, if a specified disease insurance product offers coverage for hospice care, it shall meet the following minimum standards:

(I) Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less;

(II) A fixed-sum payment of at least ~~$50~~$[X] per day; and

(III) A lifetime maximum benefit limit of at least ~~$10,000~~$[X].

(iii) Hospice care does not cover non-terminally ill patients who may be confined in a:

(I) Convalescent home;

(II) Rest or nursing facility;

(III) Skilled nursing facility;

(IV) Rehabilitation unit; or

(V) Facility providing care or treatment for persons suffering from mental ~~diseases or~~ disorders ~~or care for the~~, who are aged, or ~~substance abusers~~who have a substance use-related disorder.

(3) The following minimum benefits standards apply to non-cancer coverages:

(a) Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of ~~[$250]~~$[X] and an overall aggregate benefit limit of no less than ~~[$10,000]~~$[X] and a benefit period of not less than [two (2) years] for at least the following incurred expenses:

(i) Hospital room and board and any other hospital furnished medical services or supplies;

(ii) Treatment by a ~~legally qualified~~licensed physician, ~~or~~ surgeon, or other health care professional acting within the scope of their license;

Drafting Note: States should review their laws and regulations to determine whether to use the word "acting" or "performing" in Paragraph (3)(a)(ii) above. Some states use the word "acting," while others use the word "performing."

(iii) Private duty services of a ~~registered~~licensed nurse ~~(R.N.)~~;

(iv) ~~X-ray, radium and other therapy procedures~~Tests, procedures, and other medical services and supplies used in diagnosis and treatment;

(v) Professional ambulance for ~~local~~ service to or from a ~~local~~ hospital nearest able to appropriately treat the condition;

(vi) Blood transfusions, including expense incurred for blood donors;

(vii) Drugs and medicines prescribed by a physician;

~~(viii) The rental of an iron lung or similar mechanical apparatus;~~

~~(ix)~~(viii) ~~Braces, crutches and wheel chairs as are~~ Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;

~~(x)~~(ix) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and

~~(xi)~~(x) May include coverage of any other expenses necessarily incurred in the treatment of the disease.

(b) Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than ~~[$25,000]~~$[X] payable at the rate of not less than ~~[$50]~~$[X] a day while confined in a hospital and a benefit period of not less than 500 days.

(4) A policy that provides coverage ~~for each insured person~~on an expense-incurred basis for cancer-only coverage, or for cancer in combination with one or more other specified diseases ~~on an expense incurred basis~~ shall provide coverage for each insured person for services, supplies, care and treatment of cancer, consistent with the requirements in this paragraph.

(a) Coverage ~~in~~may be limited to amounts not in excess of the usual and customary charges, with a deductible amount not in excess of ~~[$250]~~$[X], ~~and~~ an overall aggregate benefit limit of not less than ~~[$10,000]~~$[X], and a benefit period of not less than three (3) years ~~shall provide at least the following minimum provisions:~~.

(b) A policy shall include at least the minimum benefits specified in this subparagraph. Coverages under items (i) through (xiv) of this subparagraph may be subject to cost-sharing by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an outpatient basis:

~~(a)~~(i) Treatment by, or under the direction of, a ~~legally qualified~~licensed physician, ~~or~~ surgeon, or other health care professional acting within the scope of their license;

Drafting Note: States should review their laws and regulations to determine whether to use the word "acting" or "performing" in Paragraph (3)(a)(ii) above. Some states use the word "acting," while others use the word "performing."

~~(b)~~(ii) ~~X-ray, radium chemotherapy and other therapy procedures~~Tests, procedures, and other medical services and supplies used in diagnosis and treatment;

~~(c) Hospital room and board and any other hospital furnished medical services or supplies;~~

~~(d)~~(iii) Blood transfusions and their administration, including expense incurred for blood donors;

~~(e)~~(iv) Drugs and medicines prescribed by a physician, including but not limited to, chemotherapy, including both oral and IV administered, immunotherapy, targeted therapies, and chemotherapy supportive drugs;

~~(f) Professional ambulance for local service to or from a local hospital;~~

~~(g)~~(v) Private duty services of a ~~registered~~licensed nurse provided in a hospital;

~~(h) May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, Subparagraphs (a), (b), (d), (e) and (g) plus at least the following also shall be included, but may be subject to copayment by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an out-patient basis;~~

~~(i)~~(vi) ~~Braces, crutches and wheelchairs~~Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;

~~(j)~~(vii) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; ~~and~~

~~(k)~~(viii) (I) Home health care that is necessary care and treatment provided at the insured person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person's attending physician, who shall approve the program prior to its start. ~~The physician must certify that hospital confinement would be otherwise required. A "home health care agency" (1) is an agency approved under Medicare, or (2) is licensed to provide home health care under applicable state law, or (3) meets all of the following requirements:~~

~~(I) It is primarily engaged in providing home health care services;~~

~~(II) Its policies are established by a group of professional personnel (including at least one physician and one registered nurse;~~

~~(III) A physician or a registered nurse provides supervision of home health care services;~~

~~(IV) It maintains clinical records on all patients; and~~

~~(V) It has a full time administrator.~~

Drafting Note: State licensing laws vary concerning the scope of "home health care" or "home health agency services" and should be consulted. In addition, a few states have mandated benefits for home health care including the definition of required services.

~~(ii)~~(II) Home health care includes, but is not limited to:

~~(I)~~a. Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse;

~~(II)~~b. Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapists;

~~(III)~~c. Physical, occupational or speech and hearing therapy; and

~~(IV)~~d. Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital~~.~~;

~~(l)~~(ix) Physical, speech, hearing and occupational therapy;

~~(m)~~(x) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, ~~chux~~disposable absorbent pads, oxygen, surgical dressings, rubber shields, colostomy and ~~eleostomy~~ileostomy appliances;

~~(n)~~(xi) Prosthetic devices including wigs and artificial breasts;

~~(o)~~(xii) Nursing home care for noncustodial services; ~~and~~

~~(p)~~(xiii) Reconstructive surgery when deemed necessary by the attending physician;

(xiv) Hospice services, as defined in paragraph (2)(m) above~~.~~;

(xv) Hospital room and board and any other hospital furnished medical services or supplies; and

(xvi) Professional ambulance for service to or from a hospital nearest able to appropriately treat the condition.

(c) A policy may include coverage of any other expenses necessarily incurred in the treatment of the disease.

Drafting Note: Policies that offer transportation and lodging benefits for an insured person should not condition those benefits on hospitalization.

(5) (a) The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons:

(i) A fixed-sum payment of at least ~~[$100]~~$[X] for each day of hospital confinement for at least [365] days;

(ii) A fixed-sum payment ~~equal to one half~~of at least [X%] the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least 365 days of treatment; and

(iii) A fixed-sum payment of at least ~~$50~~$[X] per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.

(b) Benefits tied to ~~confinement~~receipt of care in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal or exceed the following:

(i) A fixed-sum payment equal to ~~one fourth~~[X%] the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.

(ii) A fixed-sum payment equal to ~~one fourth~~[X%] the hospital in-patient benefit for each day of home health care for at least 100 days.

(iii) Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease.

(iv) Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in (b)(i) and (b)(ii) whether by definition or otherwise, shall be no more restrictive than those under Medicare.

(6) The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease:

(a) These coverages must pay indemnity benefits ~~on behalf of insured persons of~~for a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of ~~$1,000~~$[X].

Drafting Note: Policies that offer extremely high dollar benefits may induce fraud and concealment on the part of applicants for coverage. The commissioner should ~~be sensitive to this possibility in approving policies~~avoid approving these policies in light of the fact that these policies are not intended to be comprehensive coverage and are not intended to be sold as such. Policies offering extremely low dollar amounts, however, may offer illusory coverage that may not be understood by consumers. State insurance regulators can address this issue by requiring that this coverage is not offered, marketed, or sold as a substitute for, or alternative to, comprehensive major medical coverage, and requiring the use of disclosures that this coverage is supplementary coverage.

(b) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease ~~with one exception. In the case~~ unless there are ~~of~~ clearly identifiable subtypes with significantly lower treatment~~s~~ costs, in which case lesser amounts may only be payable ~~so long as~~if the policy clearly differentiates that subtype and its reduced benefits.

Drafting Note: The purpose of requiring equal coverage for all subtypes of a specified disease is to ensure that specified disease policies actually provide what people reasonably expect them to. In approving ~~skin cancer or other~~ exceptions, commissioners should consider whether a specified disease policy might mislead if it treats a subtype of a disease differently from the rest of the specified disease.

~~K~~F. Specified Accident Coverage

"Specified accident coverage" is a policy that provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than ~~[$1,000]~~$[X] for accidental death, ~~[$1,000]~~$[X] for double dismemberment ~~[$500]~~$[X] for single dismemberment.

~~L~~G. Limited Benefit Health Coverage

(1) "Limited benefit health coverage" is a policy or contract, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under Subsections B, ~~C,~~ D, ~~E,~~ and F~~, G, I and K~~. These policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section ~~8L~~8H of this regulation is completed and delivered as required by Section 8B of this regulation and the policy or certificate is clearly labeled as a limited benefit policy or certificate as required by Section 8A(17). A policy covering a single specified disease or combination of diseases shall meet the requirements of Section ~~7J~~7E and shall not be offered for sale as ~~a~~ "limited benefit health coverage."

(2) This subsection does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance, as defined in [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act* and *Medicare Supplement Insurance Minimum Standards Model Act*].

Drafting Note: The NAIC *Long-Term Care Insurance Model Act* defines long-term care insurance as a policy that provides coverage for not less than twelve months. If a state allows issuance of policies that provide benefits similar to long-term care insurance for a period of less than twelve months, then those policies should be considered limited ~~benefit health~~long-term care insurance ~~plans~~policies, and should be subject to the ~~NAIC Accident and Sickness Insurance Minimum Standards Model Act~~

~~and implementing regulation~~ *Limited Long-Term Care Insurance Model Act* (#642) and its implementing regulation, the *Limited Long-Term Care Insurance Model Regulation* (#643).

Drafting Note: This regulation permits the combining of excepted benefit-type products described in this section with other excepted benefit plans. However, it should be noted that combining excepted benefit coverages described in this section with other coverages, whether or not described in this section, could cause the combined product to fail to meet the requirements for excepted benefits under HIPAA or for similar exemptions under state law. This would mean that major medical insurance requirements under federal and state law may apply, such as guaranteed availability, guaranteed renewability, and premium rating restrictions. State insurance regulators should also require that supplementary coverage is not offered, marketed, or sold as a substitute for, or alternative to, comprehensive major medical coverage, including enforcement of the requirements in this regulation for disclosures that this coverage is supplementary coverage.

H. Short-Term, Limited-Duration Health Insurance Coverage

(1) "Short-term, limited-duration health insurance" means health insurance coverage offered or provided to residents of the state pursuant to a contract with a health carrier, regardless of the situs of the contract, that has an expiration date specified in the contract that is less than [X] [days or months] after the original effective date and, taking into account any extensions that may be elected by the policyholder with or without the carrier's consent, has a duration no longer than [X] [days or months] after the original effective date of the contract.

(2) (a) Short-term, limited-duration health insurance must comply with the benefit and coverage requirements of this state, including, if the state requires, providing benefits and coverage of state-mandated benefits and being subject to the state's external and internal review requirements.

Drafting Note: States should consider whether mental health and substance use disorder benefits, as described in Section 7D(2) and Section 7D(4) of this regulation, should be permitted exclusions to short-term, limited-duration insurance policies.

(b) A short-term, limited-duration health insurance policy or certificate must have:

(i) An annual or lifetime limit of no less than [$1,000,000];

(ii) A coinsurance requirement of no more than fifty percent (50%) of covered charges; and

(iii) A family maximum out-of-pocket limit of not more than [X] per year.

Drafting Note: The annual and lifetime limit and the out-of-pocket limits should vary depending on the specific state interest. For states that have severely limited coverage time frames with limited renewals or extensions, smaller annual and lifetime limits and out-of-pocket maximums should apply.

(3) Short-term, limited-duration health insurance cannot be issued if it would result in an individual being covered by a short-term, limited duration health insurance policy or certificate for more than [X] months [in any 12-month period].

(4) Short-term, limited-duration health insurance, including individual policies and group certificates:

(a) May not be marketed as guaranteed renewable;

(b) Must be marketed as either nonrenewable, or renewable for a limited time without re-underwriting;

(c) Must clearly state the duration of the initial term and the total maximum duration, including any renewal options;

(d) May not be modified after the date of issuance, except by signed acceptance of the policyholder or the certificate holder, if the policy holder or the certificate holder contributes to the premium; and

(e) If the coverage is renewable, the individual policy or group certificate must:

(i) Include a statement that the insured has a right to continue the coverage in force by timely payment of premiums for the number of terms listed;

(ii) Include a statement that the carrier will not increase premium rates or make changes in provisions in the policy or certificate on renewal based on individual health status; and

(iii) Include a statement that the carrier, at the time of renewal, may not deny renewal based on individual health status.

(5) A short-term, limited-duration health insurance carrier may not include a waiting period or a probationary period.

(6) A carrier may not rescind a short-term limited duration health insurance policy or certificate during the coverage period except if the insured intentionally fails to disclose a prior diagnosis of a health condition or if the insured intentionally fails to disclose the insured was previously covered under a short-term limited duration health insurance policy or certificate. If the policy or certificate is rescinded, the carrier must refund all payments to the insured to the extent that they exceed claims paid under the rescinded policy or certificate.

Drafting Note: States should be aware that the language in paragraph (6) concerning an insured's failure to disclose prior coverage under a short-term, limited-duration health insurance policy or certificate will need to be tailored to the state's laws and regulations concerning such disclosures of prior coverage.

(7) A carrier may not cancel a short-term, limited-duration health insurance policy or certificate during the coverage period except in the following circumstances:

(a) Nonpayment of premium;

(b) Violation of the carrier's published policies approved by the commissioner;

(c) An insured's commitment of fraudulent acts as to the carrier;

(d) An insured's material breach of the insurance contract; or

(e) A change or implementation of a federal or state law or regulation that no longer permits the continuing offering of the coverage.

(8) In the event of a cancellation or rescission of a short-term, limited-duration health insurance policy or certificate, the carrier must notify the insured in writing [thirty (30) days] prior to the cancellation date or in writing a notice of rescission with an appeal period of [thirty (30) days].

Drafting Note: The timeframe for notifying the insured of a cancellation or rescission is bracketed because states may have different timeframes for such notices.

Drafting Note: States should carefully examine their health insurance markets to determine the appropriate maximum term and duration for such plans and whether additional definitions or standards may be needed. In addition, states should review

any relevant federal regulations establishing requirements for short-term, limited duration insurance coverage that could differ from the state's requirements.

Section ~~8~~9. Required Disclosure Provisions

A. General Rules

(1) (a) All applications, policies, and certificates for coverage~~s specified in Sections 7B, C, D, E, G, I, J, K and L~~ of supplementary or short-term health insurance shall ~~contain~~include a prominent disclosure statement~~, by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:~~ as required by this section, that reflects the type of coverage being provided.

(b) The disclosures required by this section may be modified only as needed to improve the accuracy and clarity of the disclosure and only with the approval of the commissioner.

Drafting Note: Because states may have different statutory requirements for short-term, limited duration insurance coverage, states should carefully review the disclosure statement requirements in this section for such coverage to ensure it accurately reflects a state's specific requirements. States also should be aware that proposed federal regulations for short-term, limited duration insurance coverage and hospital indemnity or other fixed indemnity coverage include specific disclosure statement requirements for these coverages and recognize that the disclosure statement requirements in this section may need to contain additional information as required by applicable state law, rules, or guidance. A state also may need to require disclosure language to reflect any additional requirements a state may have, such as requirements regarding minimum essential coverage or special enrollment periods for expiration or loss of eligibility for this coverage.

~~"The [policy] [certificate] provides limited benefits. Review your [policy][certificate] carefully."~~

(c) The disclosure statement shall be in a sans serif font, in a font size at least equal to the size type used for headings or captions of sections of the document.

(d) In the application, the disclosure statement shall be placed in close proximity to the applicant's signature block.

(e) In the policy and certificate, the disclosure statement shall be placed on the first page.

(f) In this section, the term "prominent" means one or more methods are used to draw attention to the language, including using a larger font size, leading, underlining, bolding, color, or italics.

Drafting Note: States should review their existing readability laws and regulations to help to ensure the statements above are readable. States should also review their existing laws and regulations to ensure the statements above are accessible to potential applicants, including those with disabilities such as blindness or macular degeneration, deafness or hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity, and combinations of these.

(2) Any disclosures, and the documents to which they refer, shall be delivered in the written medium (digital or heard copy) the applicant requests. These documents shall be provided before the applicant submits a completed application.

(3) For hospital indemnity coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "fixed dollar benefits" made prominent:

"This [policy] [certificate] pays fixed dollar benefits as a result of a covered hospitalization due to a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder]

[certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

Drafting Note: States should review the above notice and disclosure requirements for hospital indemnity coverage for consistency with their state regulations. In addition, states should review any relevant federal regulations establishing notice and disclosure requirements for hospital indemnity coverage that could differ from the state's requirements.

(4) For other fixed indemnity coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "fixed dollar benefits" made prominent:

"This [policy] [certificate] pays fixed dollar benefits as a result of covered events due to a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

Drafting Note: States should review the above notice and disclosure requirements for other fixed indemnity coverage for consistency with their state regulations. In addition, states should review any relevant federal regulations establishing notice and disclosure requirements for other fixed indemnity coverage that could differ from the state's requirements.

~~(2) All applications for dental plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:~~

~~"The [policy] [certificate] provides dental benefits only. Review your [policy] [certificate] carefully."~~

~~(3) All applications for vision plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:~~

~~"The [policy] [certificate] provides vision benefits only. Review your [policy] [certificate] carefully."~~

(5) For disability income protection coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "while you are disabled" made prominent:

"This [policy] [certificate] provides periodic payments [weekly, bi-weekly, or monthly] for a set length of specific period of time while you are disabled from a covered sickness or injury. Read the description of benefits provided along with your [enrollment form/application] carefully."

(6) For accident only coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "from a covered accident" made prominent:

"This [policy] [certificate] pays benefits for covered injuries from a covered accident. It does not provide benefits resulting from sickness. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(7) For specified disease coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "of a covered disease" made prominent:

"This [policy] [certificate] pays limited benefits as a result of the diagnosis or treatment of a covered disease specified in the [policy] [certificate]. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(8) For specified accident coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "for a specifically identified type of accident" made prominent:

"This [policy] [certificate] provides benefits for a specifically identified type of accident as named in the [policy] [certificate]. It does not provide benefits resulting from sickness. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(9) For limited benefit coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "limited benefits and only for the events specified" made prominent:

"The [policy] [certificate] pays limited benefits and only for the events specified in the [policy] [certificate]. These limited benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(10) For limited scope dental coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the sentence "It is not intended to cover all dental expenses." made prominent:

"The [policy] [certificate] provides dental benefits only. It is not intended to cover all dental expenses. Read your [policy] [certificate] carefully to understand what dental services it covers and any cost-sharing that may be your responsibility."

(11) For limited scope vision coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the sentence "It is not intended to cover all vision expense." made prominent:

"The [policy] [certificate] provides vision benefits only. It is not intended to cover all vision expenses. Read your [policy] [certificate] carefully to understand what vision services are covered and any cost-sharing that may be your responsibility."

(12) For short-term health insurance, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the word "Important" and the sentence "It is not comprehensive health insurance." made prominent:

"Important: This is short-term health insurance. This is temporary insurance. It is not comprehensive health insurance. Read your [policy] [certificate] carefully to make sure you understand what is covered and any limitations on coverage.

- This insurance might not cover or might limit coverage for:
  - Preexisting conditions; or
  - Essential health benefits (such as pediatric, hospital, emergency, maternity, mental health, substance use services, prescription drugs, or preventive care).
- You will not qualify for federal financial help to pay for premiums or out-of-pocket costs for this policy.
- You are not protected from surprise medical bills.
- When this policy ends, you might have to wait until an open enrollment period to get comprehensive health insurance.

Visit HealthCare.gov online or call 1-800-318-2596 (TTY: 1-855-889-4325) to review your options for comprehensive health insurance. If you're eligible for coverage through your employer or a family member's employer, contact the employer for more information. Contact the [State] department of insurance if you have questions or complaints about this policy."

~~(4)~~(13) Each policy of individual ~~accident and sickness insurance and group supplemental health insurance~~ supplementary or short-term health insurance subject to this regulation, as provided in Section 3A of this regulation, shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

~~(5)~~(14) ~~Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all~~All riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law. The signature requirement~~s~~ in this paragraph ~~apply~~applies to group supplemental health insurance certificates only where the certificate holder also pays the insurance premium.

~~(6)~~(15) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy or certificate and the combined total premium clearly identified as such.

~~(7)~~(16) A policy or certificate that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of the terms and a clear ~~an~~ explanation of the terms in its accompanying outline of coverage.

~~(8)~~(17) If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall ~~appear as~~be clearly explained in a separate paragraph of the policy or certificate ~~and be~~ labeled ~~as~~ "Preexisting Condition~~s~~ Limitations."

~~(9) All accident-only policies and certificates shall contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, a prominent statement as follows:~~

~~"Notice to Buyer: This is an accident-only [policy][certificate] and it does not pay benefits for loss from sickness. Review your [policy][certificate] carefully."~~

~~Accident-only [policies][certificates] that provide coverage for hospital or medical care shall contain the following statement in addition to the Notice to Buyer above: "This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."~~

~~(10)~~(18) All policies and certificates, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed in sans serif font on the first page of the policy or certificate or attached to it stating ~~in substance~~clearly that the policy~~holder~~ or certificate holder shall have the right to return the policy or certificate within thirty [30] days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason.

Drafting Note: This ~~section~~paragraph should be included only if ~~the~~ it is consistent with applicable state law~~has legislation granting authority~~.

~~(11)~~(19) If age is to be used as a determining factor ~~for reducing~~to reduce the ~~maximum aggregate~~ benefits made available in the policy or certificate as originally issued, ~~that fact~~a clear explanation of how age is used shall be prominently set forth in the outline of coverage.

~~(12)~~(20) If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be "Conversion Privilege" or words of similar import. The provision shall ~~indicate the~~clearly explain which persons are eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person ~~by whom~~who may exercise the conversion privilege ~~may be exercised~~. The provision shall clearly specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

~~(13)~~(21) (a) Outlines of coverage delivered in connection with policies defined in this regulation as hospital ~~confinement~~ indemnity or other fixed indemnity (Section ~~7E~~8B), specified disease (Section ~~7J~~8E), or limited benefit health coverages (Section ~~7L~~8G) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Subsections ~~F~~D and ~~J~~F, the following language, which shall be printed on or attached to the first page of the outline of coverage, with the sentence "This is not a Medicare Supplement policy." made prominent:

This ~~IS NOT A MEDICARE SUPPLEMENT~~is not a Medicare Supplement policy. If you are eligible for Medicare, ~~review~~ask the company for the Guide to Health Insurance for People ~~W~~with Medicare ~~available from the company~~.

Drafting Note: States may want to review the disclosure language in paragraph (21)(a) above for consistency with the consumer disclosure language in Appendix C of the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651).

(b) An insurer shall deliver to persons eligible for Medicare any notice required under [insert reference to state law equivalent of Section 17D of the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act*].

Drafting Note: States that permit individuals under the age of 65 with Medicare coverage to purchase Medicare supplement policies should review how insurers should provide the notices required under paragraph (21)(a) to these individuals.

~~(14)~~(22) Insurers~~, except direct response insurers,~~ shall give a person applying for specified disease insurance a Buyer's Guide approved by the commissioner at the time of application enrollment and shall obtain all recipients' written acknowledgement of the guide's delivery. ~~Direct response insurers shall provide the Buyer's Guide upon request but not later than the time that the policy or certificate is delivered.~~

Drafting Note: Paragraph (22) only applies if a state has such a Buyer's Guide.

~~(15) All specified disease policies and certificates shall contain on the first page or attached to it in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate], a prominent statement as follows: Notice to Buyer: This is specified disease [policy] [certificate]. This [policy] [certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your [policy] [certificate] carefully with the outline of coverage and the Buyer's Guide.~~

~~**Drafting Note:** The second sentence of this caption should only be required in those states where the commissioner exercises discretionary authority and requires the guide.~~

~~(16) All hospital confinement indemnity policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached~~

to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This is a hospital confinement indemnity [policy][certificate]. This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."

(17) All limited benefit health policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This is a limited benefit health [policy][certificate]. This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."

(18) All basic hospital expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This is a basic hospital expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."

(19) All basic medical-surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This is a basic medical-surgical expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."

(20) All basic hospital/medical-surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This is a basic hospital/medical-surgical expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."

(21) All individual basic medical expense policies shall display prominently by type, stamp or other appropriate means on the first page of the policy, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy the following:

"Notice to Buyer: This is an individual basic medical expense policy. This policy provides benefits that are not as comprehensive as individual major medical expense coverage and should not be considered a substitute for comprehensive health insurance coverage."

(22) All dental plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in

~~boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This [policy] [certificate] provides dental benefits only."~~

~~(23) All vision plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This [policy] [certificate] provides vision benefits only."~~

B. Outline of Coverage Requirements

(1) An insurer shall deliver an outline of coverage to an applicant ~~or enrollee in the sale of individual accident and sickness insurance, group supplemental health insurance, dental plans and vision plans~~ all applicable plans as required in Section 6 of the Act.

(2) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) point sans serif type, immediately above the company name, with the sentence "It is different from the outline of coverage you received when you [applied] [enrolled]." made prominent:

"NOTICE: Read this outline of coverage carefully. It is ~~not identical to~~different from the outline of coverage ~~provided upon~~you received when you [~~application~~applied][~~enrollment~~enrolled]~~,~~ ~~and the~~The coverage ~~originally~~you applied for ~~has~~was not ~~been~~ issued."

~~(3) The appropriate outline of coverage for policies or contracts providing hospital coverage that only meets the standards of Section 7B shall be that statement contained in Section 8C. The appropriate outline of coverage for policies providing coverage that meets the standards of both Sections 7B and C shall be the statement contained in Section 8E. The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 7B and E or Sections 7C and E or Sections 7B, C, and E shall be the statement contained in Section 8G.~~

~~(4)~~(3) In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the commissioner for prior approval. In such instances, no policies may be sold or renewed until approved by the commissioner.

~~(5)~~(4) Advertisements may fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage in Section 6H of the Act as well as this regulation.

~~C. Basic Hospital Expense Coverage (Outline of Coverage)~~

~~An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7B of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:~~

~~[COMPANY NAME]~~

~~BASIC HOSPITAL EXPENSE COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND~~

SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR
COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY][CERTIFICATE] CAREFULLY!

(2) Basic hospital coverage is designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.

(3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

(a) Daily hospital room and board;

(b) Miscellaneous hospital services;

(c) Hospital out-patient services; and

(d) Other benefits, if any.]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

D. Basic Medical-Surgical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND
SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR
COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the

actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) Basic medical-surgical expense coverage is designed to provide, to persons insured, coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses fees or unlimited medical-surgical expenses.

(3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

(a) Surgical services;

(b) Anesthesia services;

(c) In-hospital medical services; and

(d) Other benefits, if any]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

E. Basic Hospital/Medical-Surgical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Sections 7B and C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed.

[COMPANY NAME]

BASIC HOSPITAL/MEDICAL-SURGICAL EXPENSE COVERAGE

THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) Basic hospital/medical-surgical expense coverage is designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services,

~~hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical surgical expenses.~~

~~(3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:~~

~~(a) Daily hospital room and board;~~

~~(b) Miscellaneous hospital services;~~

~~(c) Hospital outpatient services;~~

~~(d) Surgical services;~~

~~(e) Anesthesia services;~~

~~(f) In-hospital medical services; and~~

~~(g) Other benefits, if any.]~~

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.~~

~~(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]~~
~~(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]~~

~~F~~C. Hospital ~~Confinement~~ Indemnity or Other Fixed Indemnity Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section ~~7E~~8B of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~HOSPITAL CONFINEMENT INDEMNITY COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

[Hospital Indemnity] [Other Fixed Indemnity] Coverage

The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [~~P~~policy][~~C~~certificate] ~~C~~carefully. ~~—~~ This outline of coverage ~~provides a very brief description of~~briefly describes your coverage's ~~the~~ important feature~~s of coverage~~. ~~This~~It is not the insurance contract ~~and only the actual policy provisions will control~~. The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations ~~of both you~~ and those of your insurance

company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY] [CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!

(2) [Hospital ~~confinement~~ indemnity] [Other fixed indemnity] coverage is designed to ~~provide, to persons insured, coverage in the form of~~pay a fixed ~~daily~~dollar benefit as a result of a ~~during periods of~~ covered ~~hospitalization resulting from a~~ [hospital stay] [event] due to a ~~covered accident or~~ sickness or injury~~, subject to any limitations set forth in the policy~~. The benefit may be limited in ways described in the [policy] [certificate]. ~~Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.~~ The fixed dollar benefit may be less than the [hospital stay's] [event's] cost.

(3) [A brief, but clear and specific, description of the benefits in the following order:

(a) ~~Daily benefit payable during hospital confinement~~When the benefits are payable; ~~and~~

(b) The d~~D~~uration of benefits described in (a); and

(c) The fixed dollar amount of the benefits.]

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely.~~

(4) [A clear description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit, described in Paragraph (3) above.]

(5) [A clear description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

(6) [~~Any~~A clear description of any benefits provided in addition to the ~~daily~~fixed dollar [hospital] [event] benefit.]

~~G. Individual Major Medical Expense Coverage (Outline of Coverage)~~

~~An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7F of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:~~

~~[COMPANY NAME]~~

~~INDIVIDUAL MAJOR MEDICAL EXPENSE COVERAGE~~

~~OUTLINE OF COVERAGE~~

~~(1) Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!]~~

~~(2) Individual major medical expense voverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.~~

(3) [A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

(a) Daily hospital room and board;

(b) Miscellaneous hospital services,

(c) Surgical services;

(d) Anesthesia services;

(e) In-hospital medical services,

(f) Out-of-hospital care;

(g) Maximum dollar amount for covered charges; and

(h) Other benefits, if any]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

H. Individual Basic Medical Expense Coverage

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7G of this regulation. The items included in the outline of coverage must appear in the sequence prescribed.

[COMPANY NAME]

INDIVIDUAL BASIC MEDICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Individual basic medical expense coverage is designed to provide, to persons insured, limited coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

(3) [A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

~~(a) Daily hospital room and board;~~

~~(b) Miscellaneous hospital services,~~

~~(c) Surgical services;~~

~~(d) Anesthesia services;~~

~~(e) In-hospital medical services,~~

~~(f) Out-of-hospital care;~~

~~(g) Maximum dollar amount for covered charges; and~~

~~(h) Other benefits, if any]~~

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.~~

~~(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]~~

~~(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]~~

~~I~~D. Disability Income Protection Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section ~~7H~~8C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~DISABILITY INCOME PROTECTION COVERAGE~~
Disability Income Protection Coverage

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [~~P~~policy] [certificate] ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of~~briefly describes your coverage's ~~the~~ important features ~~of your policy~~. ~~This~~It is not the insurance contract. ~~and only the actual policy provisions will control.~~ The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations ~~of both you and~~ those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR POLICY CAREFULLY~~read your [policy] [certificate] carefully!

(2) Disability income protection coverage is designed to ~~provide, to persons insured, coverage~~pay a benefit for disabilities resulting from a covered ~~accident or~~ sickness or injury~~, subject to any limitations set forth in the policy~~. The benefit may be limited in the ways described in the [policy] [certificate]. ~~Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.~~ The benefit might not fully replace your income.

(3) [~~A brief~~Brief, but clear and specific, description of the benefits contained in ~~this~~the [policy] [certificate].]

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely.~~

(4) [A clear description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A clear description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

~~J~~E. Accident-Only Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with policies or certificates meeting the standards of Section ~~7I~~8D of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~ACCIDENT-ONLY COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

Accident-Only Coverage

The benefits in this [policy] [certificate] are limited.
They are intended to supplement your other health insurance coverage.

They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [~~P~~policy][~~C~~certificate] ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features~~ of the coverage~~. ~~This~~It is not the insurance contract. ~~and only the actual policy provisions will control~~. The [policy] [certificate] ~~itself sets forth in detail~~details ~~the~~your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!

(2) Accident-only coverage ~~is designed to provide, to persons insured, coverage~~pays benefits for ~~certain losses resulting~~covered injuries from a covered accident ~~ONLY, subject to any limitations contained in the policy~~. It does not provide benefits resulting from sickness. The benefits may be limited in ways described in the [policy] [certificate]. ~~Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.~~

(3) [~~A brief~~Brief, but clear and specific, description of the benefits and a description of any deductible or copayment provisions applicable to the benefits described.]

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.~~

(4) [A clear description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above. Proper disclosure of benefits that vary according to the type of accidental cause shall be made in accordance with Section 8A(13) of this regulation.]

(5) [A clear description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

~~K~~F. Specified Disease or Specified Accident Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with policies or certificates meeting the standards of Sections ~~7J~~8E and ~~K~~F of this regulation. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~[SPECIFIED DISEASE] [SPECIFIED ACCIDENT] COVERAGE~~

~~THIS [POLICY] [CERTIFICATE] PROVIDES LIMITED BENEFITS~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

Specified Disease or Specified Accident Coverage (Outline of Coverage)

The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) ~~This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it.~~ Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

Drafting Note: States should review whether they have the Buyer's Guide to Specified Disease Insurance referenced above. If they do, the state should determine if it is up to date before requiring such a guide to be provided. If the state does not have such a guide, then the state should revise this outline of coverage accordingly.

(2) Read ~~Y~~your [policy] [certificate] ~~[Outline of Coverage]~~ ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features ~~of coverage~~. ~~This~~It is not the insurance contract ~~and only the actual policy provisions will control~~. The [policy] [certificate] ~~itself sets forth in detail the~~details your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY] [CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!

(3) [Specified disease][Specified accident] coverage is designed to ~~provide, to persons insured, restricted coverage paying benefits ONLY~~ pay limited benefits ~~when certain losses occur~~ as a result of the diagnosis or treatment [of a ~~[specified diseases~~covered disease] or [resulting from a ~~[specified accidents~~specifically identified type of accident]. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(4) [~~A brief~~Brief, but clear and specific, description of the benefits, including dollar amounts and a description of any deductible or copayment provisions applicable to the benefits described.] Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 8A(13) of this regulation.

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.~~

~~L~~G. Limited Benefit Health Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates which do not meet the minimum standards of Sections ~~7~~8B, D and G~~C, D, E, F, G, I and K~~ of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~LIMITED BENEFIT HEALTH COVERAGE~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND~~
~~ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~
Limited Benefit Health Coverage
The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [~~P~~policy][~~C~~certificate] ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features ~~of your policy~~. ~~This~~It is not the insurance contract ~~and only the actual policy provisions will control~~. The [policy] [certificate] itself ~~sets forth in detail~~details ~~the~~your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!

(2) Limited benefit health coverage ~~is designed to provide, to persons insured, limited or supplemental coverage~~ pays limited benefits. This [policy] [certificate] is not major medical insurance and does not replace it.

(3) [~~A brief~~Brief, but clear and specific, description of the benefits, including dollar amounts and a description of any deductible or copayment provisions applicable to the benefits described.]

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.~~

(4) [A clear description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

H. Short-Term, Limited Duration Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section 8H of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Short-Term, Limited Duration Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

The [policy] [certificate] may not cover preexisting conditions.

OUTLINE OF COVERAGE

(1) Read your [policy] [certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) This is a short-term, limited duration [policy] [certificate]. This is temporary insurance. It is not comprehensive health insurance. It might not cover or might limit coverage for preexisting conditions. It might not cover essential health benefits such as pediatric, hospital, emergency, maternity, mental health, substance use services, prescription drugs, or preventive care. Read your [policy] [certificate] carefully to make sure you understand what is covered and any limitations on coverage.

(3) [Brief, but clear and specific, description of the benefits in the following order:

(a) Benefits covered by the policy or certificate, including required cost-sharing;

(b) Benefits that are not covered by the policy or certificate; and

(c) Duration of benefits described above.]

(4) A clearly worded prominent notice that cost-sharing limitations do not apply to benefits not covered by the policy or certificate.

(5) [A clear description of provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in paragraph (3) above.]

(6) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

~~M~~I. Limited Scope Dental ~~Plans~~Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with dental ~~plan~~care policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Limited Scope Dental Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [p~~P~~olicy][~~C~~certificate] ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features~~ of your policy~~. ~~This~~It is not the insurance contract~~ and only the actual policy provisions will control~~. The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations~~ of both you~~ and those of your

insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE] CAREFULLY~~read your [policy] [certificate] carefully!

(2) Limited scope dental coverage pays benefits for dental benefits only. It is not intended to cover all dental expenses. Read your [policy] [certificate] carefully to understand what dental care it covers and any cost-sharing that may be your responsibility.

~~(2)~~(3) [~~A brief~~Brief, but clear and specific, description of the benefits.]

~~(3)~~(4) [A clear description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph ~~(1)~~(3) above.]

~~(4)~~(5) [A clear ~~descripton~~description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

~~N~~J. Limited Scope Vision ~~Plans~~Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with vision ~~plan~~care policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Limited Scope Vision Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [p~~P~~olicy][~~C~~certificate] ~~C~~carefully. ~~—~~ This outline of coverage ~~provides a very brief description of the~~ briefly describes your coverage's important features~~ of your policy~~. ~~This~~It is not the insurance contract~~ and only the actual policy provisions will control~~. The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations~~ of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE] CAREFULLY~~read your [policy] [certificate] carefully!

(2) Limited scope vision coverage pays benefits for vision benefits only. It is not intended to cover all vision expenses. Read your [policy] [certificate] carefully to understand what vision care it covers and any cost-sharing that may be your responsibility.

~~(2)~~(3) [~~A brief~~Brief, but clear and specific, description of the benefits.]

~~(3)~~(4) [A clear description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph ~~(1)~~(3) above.]

~~(4)~~(5) [A clear description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

Section ~~9~~10. Requirements for Replacement of Individual ~~Accident and Sickness Insurance~~Supplementary and Short-Term Health Insurance Coverage

~~**Drafting Note:** Group supplemental health insurance is not addressed here because it is addressed in the Group Coverage Discontinuance and Replacement Model Regulation, which is applicable. States may also have other statutes or regulations that apply.~~

A. An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other ~~accident and sickness~~supplementary or short-term health insurance subject to this regulation, as provided in Section 3A of this regulation, presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used.

B. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subsection C below. The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in Subsection D below. ~~In no event, h~~However, ~~will the~~this notice~~s be~~is not required in the solicitation of ~~the following types of policies:~~ accident-only policies or the replacement of ~~and~~ single-premium nonrenewable policies.

C. The notice required by Subsection B above for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

~~NOTICE TO APPLICANT REGARDING REPLACEMENT~~

~~OF ACCIDENT AND SICKNESS INSURANCE~~
Notice to Applicant About Replacement of [Supplementary] [Short-Term] Health Insurance

According to [your application] [information you have ~~furnished~~provided], you intend to lapse or otherwise ~~terminate existing~~ end the ~~accident and sickness~~supplementary or short-term health insurance you have now and replace it with a policy ~~to be issued by~~the [insert company name] Insurance Company will issue. For your own ~~information and~~ protection, you should ~~be aware of and seriously consider certain factors that~~know how replacing your policy with a new one ~~may~~might affect ~~the insurance protection available to you under the new policy~~your coverage.

(1) A new policy might not pay claims that the policy you have now would pay. A new policy might not cover ~~Health~~health conditions ~~which you may~~that you might ~~presently~~ have~~,~~ now (preexisting conditions) or ~~may~~might not ~~be immediately or fully covered under the new policy~~cover them right away. ~~This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy~~ A new policy might cover some but not all the costs related to treating preexisting conditions.

Drafting Note: This subsection may be modified if preexisting conditions are covered under the new policy.

(2) ~~You may wish to secure the advice of your present insurer or its agent~~Talk with your current insurance agent ~~regarding the proposed replacement of your present~~or company representative about replacing your policy. ~~This is not only your right, but it~~It is ~~also~~ in your best interest~~s~~ to ~~make~~be sure you understand ~~all the relevant factors involved in replacing your present~~how replacing your policy could affect your future coverage.

(3) If~~, after due consideration, you still wish to terminate your present~~ you decide to buy a new policy~~, and replace it with new coverage, be certain~~be sure to truthfully and completely answer all questions on the application ~~concern~~about your medical/health history. ~~Failure to include all material medical information on an application may provide a basis for~~If you do not, the company ~~to~~could deny any future claims and ~~to~~ refund your premium as though your policy had never been in force. ~~After the~~Check that the information on your application ~~has been completed~~is complete and correct ~~and~~ before you sign it~~, reread it carefully to be certain that all information has been properly recorded~~.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

D. The notice required by Subsection B of this section for a direct response insurer shall be as follows:

~~NOTICE TO APPLICANT REGARDING REPLACEMENT~~

~~OF ACCIDENT AND SICKNESS INSURANCE~~
Notice to Applicant About Replacement of [Supplementary] [Short-Term] Health Insurance

According to [your application] [information you have ~~furnished~~provided], you intend to lapse or otherwise ~~terminate existing~~end the ~~accident and sickness~~supplementary or short-term health insurance you have now and replace it with the attached policy ~~delivered herewith~~ issued by [insert company name] Insurance Company. ~~Your new policy provides~~You have thirty days ~~within which you may~~to decide ~~without~~at no cost ~~whether you desire to~~if you want to keep the new policy. For your own ~~information and~~ protection, you should ~~be aware of and seriously consider certain factors that~~know how replacing your policy with a new one ~~may~~might affect ~~the insurance protection available to you under the new policy~~your coverage.

(1) A new policy might not pay claims that the policy you have now would pay. A new policy might not cover ~~Health~~health conditions ~~that~~ you ~~may presently~~ have~~,~~ now (preexisting conditions) ~~may not be immediately or fully covered under the new policy~~or might not cover them right away. ~~This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.~~A new policy might cover some but not all the costs related to preexisting conditions.

(2) ~~You may wish to secure the advice of your present insurer or its~~ Talk with your insurance agent or company representative ~~regarding the proposed replacement of your present~~about replacing your policy. ~~This is not only your right, but it~~It is ~~also~~ in your best interest~~s~~ to ~~make~~be sure you understand ~~all the relevant factors involved in replacing~~how replacing your policy could affect your ~~present~~future coverage.

(3) [To be included only if the application is attached to the policy]. If~~, after due consideration,~~ you ~~still wish to terminate your present~~decide to buy a new policy, ~~and replace it with new coverage,~~ read the copy of the attached application ~~attached to your new policy~~ and be sure that all questions are answered fully and correctly. ~~Omissions or misstatements in the application could cause~~If they are not, the company could refuse to pay an otherwise valid claim ~~to be denied~~. Carefully check the application and write to [insert company name and address] within ten days if any information is not correct and complete, or if any past medical history has been left ~~out of~~off the application.

[COMPANY NAME]

Drafting Note: The sentence "You have thirty days to decide at no cost if you want to keep the new policy." should only be required if the state has adopted Section 9A(18).

Section ~~10~~11. Separability

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

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HEALTH ACTUARIAL (B) TASK FORCE

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Draft: 11/22/24

Health Actuarial (B) Task Force
Denver, Colorado
November 16, 2024

The Health Actuarial (B) Task Force met in Denver, CO, Nov. 16, 2024. The following Task Force members participated: Anita G. Fox, Chair, represented by Kevin Dyke (MI); Jon Pike, Vice Chair, represented by Ryan Jubber (UT); Mark Fowler represented by Sanjeev Chaudhuri (AL); Ricardo Lara represented by Ali Zaker-Shahrak (CA); Michael Conway represented by Sydney Sloan (CO); Andrew N. Mais represented by Paul Lombardo (CT); Dean L. Cameron represented by Weston Trexler (ID); Holly W. Lambert represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Marie Grant represented by Brad Boban (MD); Robert L. Carey represented by Marti Hooper (ME); Chlora Lindley-Meyers represented by William Leung (MO); Eric Dunning represented by Margaret Garrison (NE); D.J. Bettencourt represented by Jennifer Li (NH); Justin Zimmerman represented by Seong-min Eom (NJ); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Dave Yanick (PA); Cassie Brown represented by R. Michael Markham (TX); Scott A. White represented by Tim Connell (VA); and Mike Kreidler represented by Lichiou Lee (WA).

1. Adopted its Oct. 1 and Summer National Meeting Minutes

Dyke said the Task Force met Oct. 1. During this meeting, the Task Force took the following action: 1) adopted its 2025 proposed charges; and 2) exposed an American Academy of Actuaries (Academy) draft of knowledge statements for appointed actuary roles for the health blank for a 30-day public comment period that ended Oct. 31.

Lombardo made a motion, seconded by Sloan, to adopt the Task Force's Oct. 1 (Attachment One) and Aug. 12 (*see NAIC Proceedings – Summer 2024, Health Actuarial (B) Task Force*) minutes. The motion passed unanimously.

2. Heard an Update from the SOA Research Institute on Its Activities

Dale Hall (Society of Actuaries—SOA) gave a presentation on recent SOA Research Institute activities (Attachment Two). Hall said the SOA's Medicaid underwriting margin project has been updated to incorporate COVID-19 data from 2020 through 2022. He said it has been updated with NAIC statutory reporting information from 2020 through 2022, which supplements the existing data set in the last report from 2013 through 2019. Hall said the research presented in the report, along with an accompanying Excel workbook, helps define an empirically supported, methodologically sound, and actuarially grounded model that can be used to transparently develop an underwriting margin within the context of Medicaid managed care rate certification. He said the SOA plans to further update this to examine the impact of Medicaid unwinding changes.

Hall said the SOA typically publishes a long-term medical trend update every year and did so in September using projections from 2025 through 2035. He said it is a long-term medical cost trend protection model based on over 30 years of observation of different variables often correlated with health care trends. Hall said some actuaries use this as a starting point for some of their evaluations of retiree medical care benefits. He said some key observations from this year's projection include that long-run medical cost increases estimated around 5% per year, eventually declining to match any rate of increase that might be seen in per capita income, and the component assumptions of long-run medical cost increases are unchanged from last year.

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Hall said the SOA Research Institute is working on the next version of its Long-Term Care Experience Study. He said this will be done in partnership with some funding from the NAIC. Hall said the study will focus on contingencies such as claim incidence, claim continuance, claim utilization, and mortality for policies on claims and for active lives.

3. Heard an Update from the Federal CCIIO

Jeff Wu (Center for Consumer Information and Insurer Oversight—CCIIO) said the federal Centers for Medicare & Medicaid Services (CMS) published the Proposed Notice of Benefit and Payment Parameters (NBPP) for 2026 on Oct. 4. Dyke said the deadline for commenting on the proposed NBPP has passed. Wu said it proposes policies that will allow expanded enforcement against the lead agents of insurance agencies for unauthorized enrollments and other violations. Wu said the proposed NBPP includes a discussion of ways that CMS can work with state insurance regulators and the NAIC to reduce the risk of insurer insolvencies, particularly across state lines. He said the NBPP includes a proposal and a solicitation for comments related to cost-sharing reduction (CSR) loading for Silver plans. He said CMS has attempted to capture this in proposed and final rules, which essentially state that CMS defers to the states on how they instruct or permit carriers to assess the load for CSRs, provided that the total load is reasonable and actuarially justified.

Wu said the proposed NBPP contains a proposal to phase out a particular adjustment in the risk adjustment model for hepatitis C drugs. He said it also contains a proposal to treat pre-exposure prophylaxis (PrEP) as a condition instead of a preventive service within the risk adjustment model. Wu said there is a proposal to increase the federal exchange user fee to 2.5%.

Wu said that after more than a year of hard work and deliberations, the U.S. Departments of Health and Human Services (HHS), Labor (DOL), and the Treasury (Treasury Department) have finalized the Mental Health Parity and Addiction Equity Act (MHPAEA). He said the rule focuses on strengthening and clarifying obligations relating to non-quantitative treatment limitations. Wu said the rule points out a focus on network adequacy as being subject to non-quantitative treatment limitation analysis, and it makes it incumbent upon plans and issuers to conduct quantitative analyses to determine the impact of their non-quantitative treatment limitations. He said if the analyses show material differences in access between mental health benefits and medical/surgical benefits, plans and issuers will be required to take actions to remedy the discrepancy.

Wu said that last week, CMS released a Notice of Funding Opportunity (NOFO) on Essential Health Benefit (EHB)-Benchmark Plan Modernization for states with a federally facilitated exchange (FFE). He said that since it is funded through user fees, it is only available in federal exchange states. Wu said the grants can be as much as $250,000, with an additional $125,000 if the state chooses to establish an advisory board. He said the application deadline is Jan. 15, 2025, with an optional interim deadline of Dec. 16 to file a letter of intent. Wu said CMS expects to make awards in March 2025.

4. Heard an Update from the Academy Health Practice Council

Matthew Williams (Academy) gave an update (Attachment Three), on recent and upcoming activities, publications, and webinars for the Academy Health Practice Council.

5. Heard an Academy Professionalism Update

Darrell Knapp (Academy) said that the Academy's Committee on Qualifications (COQ) is strongly interested in assuring that U.S. actuaries are qualified to do their work. He said that the COQ is committed to providing the appropriate qualification guidance for actuaries and contributing a basic and continued education necessary for U.S. actuaries to become qualified and maintain their qualifications over time. Knapp said that regarding the

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current U.S. Qualification Standards, the COQ has received 28 questions in 2024, covering primarily continuing education (CE) and specific qualification requirements. He said 43 questions were received during 2023. Knapp said the COQ typically receives more than half of the questions in any given year toward the end of that year when actuaries complete CE requirements. He said that for each question received, the COQ considers whether the question merits addition to the frequently asked questions (FAQ) or if a direct response should be sufficient. Knapp said questions specific to the questioner's circumstances and experience may be referred to the Actuarial Board for Counseling and Discipline (ABCD) and become a request for guidance. He said one item in the U.S. Qualification Standards issued in 2021 that has impacted all actuaries is a CE requirement to have one hour of bias CE annually.

Dyke said he is the chair of the Actuarial Standards Board (ASB) for 2024 and is also the incoming chair for 2025. He said the purpose of the ASB is to set standards for appropriate actuarial practice in the U.S. through the development and promulgation of Actuarial Standards of Practice (ASOPs). Dyke said ASOP No. 28, Statements of Actuarial Opinion Regarding Health Insurance Assets and Liabilities, was exposed briefly for a scope change. The final version with those scope changes became effective Oct. 1. He said ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification, and ASOP No. 45, The Use of Health Status Based Risk Adjustment Methodologies, are in development and under review by the respective task forces and are expected to come before the ASB in 2025.

Dyke said the ASB has been working on several cross- and multi-practice area ASOPs. He said the ASB has approved the second exposure draft of ASOP No. 41, Actuarial Communications. Dyke said the exposure draft considered the hundreds of comments received and that it will be released Nov. 26. He said the deadline for comments on the draft exposure is March 1, 2025. Dyke said the ASB is close to finalizing a new enterprise risk management (ERM) ASOP that will consolidate ASOP No. 46, Risk Evaluation in Enterprise Risk Management, and ASOP No. 47, Risk Treatment in Enterprise Risk Management. He said the second exposure draft was released this fall and three comments were received. Dyke said the ASB will review those comments at its December meeting. Dyke said comments received on the first exposures of ASOP No. 12, Risk Classification, and ASOP No. 7, Analysis of Life, Health, or Property/Casualty Insurer Cash Flows, are being reviewed and proposed revisions will come before the ASB in 2025.

Dyke said ASOP No. 1, Introductory Actuarial Standard of Practice, has been proposed for revisions. He said Dave Neve (Actuarial Resources Corporation of Georgia) and Laura Hansen (Pacific Life) will be continuing to serve as ASB vice chairs in 2025, and Mary Frances Miller (Select Actuarial Services) will replace Patrick Woods (Retired), whose term has expired, as a casualty representative.

Shawna Ackerman (California Earthquake Authority—CEA) said she is a member of the ABCD. She said John Schubert (Deloitte Consulting LLP) and April Choi (Retired) are the ABCD's health practitioners. Ackerman said the ABCD's two primary functions are to respond to requests for guidance and to consider complaints of possible violations of the Academy's Code of Professional Conduct. She said the ABCD presents educational activities and will host its annual Tales from the Dark Side webinar Dec. 6.

6. Discussed Comments Received on the Exposure of the Academy's Draft Knowledge Statements

Dyke said comments were received from the SOA (Attachment Four), the Washington State Office of the Insurance Commissioner (OIC) (Attachment Five), and Regence BlueCross BlueShield (Attachment Six) in response to the Task Force's exposure of the Academy's draft of knowledge statements for an appointed actuary for the health blank. He said one purpose of the knowledge statements would be to use them as a measure of consistency between what is believed to be the expected understanding of health actuaries when issuing a statement of actual opinion on a health blank and the SOA's new fellowship education redesign. Dyke said the next steps are for the Academy to respond to any of the comments and for the Task Force to review the final version of the knowledge statements.

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7. Heard a Presentation on Nebraska Medicare Supplement Market Issues

Garrison and Michael Muldoon (Muldoon Actuarial and Biostatistical Analysis) gave a presentation on Nebraska's Medicare supplement insurance (Medigap) market new business rate setting and underwriting issues (Attachment Seven).

Having no further business, the Health Actuarial (B) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/HATF/2024_Fall/11-16-24 HATF/HATF Minutes 11-16-24.docx

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Draft: 10/4/24

Health Actuarial (B) Task Force
Virtual Meeting
October 1, 2024

The Health Actuarial (B) Task Force met Oct. 1, 2024. The following Task Force members participated: Anita G. Fox, Chair, represented by Kevin Dyke (MI); Jon Pike, Vice Chair, represented by Ryan Jubber (UT); Ricardo Lara represented by Ali Zaker-Shahrak (CA); Michael Conway represented by Sydney Sloan (CO); Michael Yaworsky represented by Kyle Collins (FL); Gordon I. Ito represented by Max Tang (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); Marie Grant represented by Brad Boban (MD); Robert L. Carey represented by Marti Hooper (ME); Chlora Lindley-Meyers represented by William Leung (MO); Eric Dunning represented by Margaret Garrison (NE); D.J. Bettencourt represented by Jennifer Li (NH); Justin Zimmerman represented by Seong-min Eom (NJ); Judith L. French represented by Craig Kalman (OH); Michael Humphreys represented by Dave Yanick (PA); Cassie Brown represented by Aaron Hodges (TX); Scott A. White represented by David Shea (VA); and Mike Kreidler represented by Lichiou Lee (WA).

1. Adopted its 2025 Proposed Charges

Lombardo made a motion, seconded by Shea, to adopt the Task Force's 2025 proposed charges (Attachment One-A). The motion passed unanimously.

2. Exposed Draft Knowledge Statements for Comment

Dyke said the Task Force will expose an American Academy of Actuaries (Academy) draft of knowledge statements for appointed actuary roles for the health blank (Attachment One-B) for a 30-day public comment period ending Oct. 31.

Having no further business, the Health Actuarial (B) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Committees/B CMTE/HATF/2024_Fall/HATF/10-1-24 HATF/HATF Minutes 10-01-24.docx

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Draft: 9/30/24
Adopted by the Executive (EX) Committee and Plenary, Dec.dd, 2024
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. dd, 2024
Adopted by the Health Actuarial (B) Task Force, Oct. 1, 2024

2025 Proposed Charges

HEALTH ACTUARIAL (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Health Actuarial (B) Task Force** will:
   A. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate long-term care insurance (LTCI) rates, rating practices, and rate changes.
   B. Provide support for issues related to implementation of, and/or changes to, the federal Affordable Care Act (ACA).
   C. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.
   D. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.
   E. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary to other NAIC groups relative to their work on health actuarial matters.
   F. Monitor and evaluate the actuarial approach used in the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document, and make modifications, as appropriate. Additionally, monitor and evaluate the progress of the MSA rate review process and the state insurance department rate review actions related to the MSA Framework.

2. The **Long-Term Care Actuarial (B) Working Group**:
   A. Assist the Health Actuarial (B) Task Force in completing the following charges:
      i. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate LTCI rates, rating practices, and rate changes.
      ii. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a PBR framework.
      iii. Develop LTCI experience reporting requirements in VM-50 and VM-51, Experience Reporting Formats, of the *Valuation Manual*.
      iv. Monitor and evaluate the actuarial approach used in the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document, and make modifications, as appropriate. Additionally, monitor and evaluate the progress of the MSA rate review process and the state insurance department rate review actions related to the MSA Framework.

Staff Support: Eric King

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August 1, 2024

Kevin Dyke, Chair
Ryan Jubber, Vice Chair
Health Actuarial (B) Task Force
National Association of Insurance Commissioners (NAIC)
1100 Walnut Street, Ste 1000
Kansas City, MO 64106

Re: Draft Knowledge Statements for Life and Health Actuaries

Dear Chair Dyke and Vice Chair Jubber,

On behalf of the American Academy of Actuaries (Academy),[1] I appreciate the opportunity to share an update regarding the Life Actuarial (A) Task Force's (LATF) request following the Fall National Meeting in Orlando.

In a November 30, 2023, letter, LATF requested that the Academy develop knowledge statements that outline the knowledge necessary for life actuaries signing certain statements of actuarial opinion, including the roles of appointed actuary, illustration actuary, and qualified actuary for principles-based reserves. After meeting with LATF leadership, along with several members of the Health (B) Actuarial Task Force (HATF) to better understand expectations, the Academy has drafted the attached materials. The draft reflects our initial effort to develop such knowledge statements for appointed actuary roles for orange blank filings (health).

The drafted knowledge statements are intended to reflect a baseline level of knowledge that the actuary should have for a designated role. Meeting this baseline level of knowledge does not imply that an actuary is qualified to issue the specified actuarial opinion. The *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States* (USQS) has many components of qualification beyond the baseline level of knowledge. In addition, there may be certain situations where the specified actuarial opinion is so limited in scope that some components of the baseline level of knowledge are not necessary.

The knowledge statements were developed by a group of Academy volunteers and have not been subject to a formal exposure process. As such, they should not be interpreted to be prescriptive or to be an interpretation of the USQS.

[1] The American Academy of Actuaries is a 20,000-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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The Academy is pleased to be able to assist both actuarial task forces in this analysis. We appreciate your ongoing collaboration and feedback on this effort. Per the original request, we do expect that the final drafts will be submitted to HATF before the end of 2024. If you have any further questions, please feel free to contact Geralyn Trujillo, senior director of public policy (trujillo@actuary.org, 202-785-7875).

Sincerely,

Lisa Slotznick, President
American Academy of Actuaries

cc: Eric King, NAIC

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Knowledge Statements for Appointed Actuary for Health Blank

These knowledge statements would apply to Appointed Actuary for Health and apply to the Health Annual Statement, also known as the Health Blank or Orange Blank.

As stated within the Health Blank instructions, the requirements for an actuary to qualify as the Appointed Actuary and be permitted to sign the Actuarial Opinion are that the actuary must be "a member in good standing of the American Academy of Actuaries, or a person recognized by the American Academy of Actuaries as qualified for such actuarial valuation." Being a member in good standing implies, among other things, that an actuary adheres to the "Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States" (USQS), effective January 1, 2022.

The USQS was revised from prior editions of the qualification standards and therefore specifically apply to actuaries issuing Statements of Actuarial Opinion (SAOs) starting on January 1, 2023. Furthermore, such actuaries need to meet the continuing education (CE) requirements before issuing any SAOs.

Section 2.1 of the USQS specifies the Basic Education and Experience Requirements, stating that an actuary should have achieved the following:

- Through education or mutual recognition, received a Fellow or Associate designation from either the Society of Actuaries (SOA) or the Casualty Actuarial Society (CAS). It is important to note that this would most likely be the SOA for an actuary issuing an opinion related to the Health/Orange Blank.
- Membership in the Academy.
- Three years of responsible actuarial experience, which is defined as work that requires knowledge and skill in solving actuarial problems.
- Be knowledgeable, through education or documented professional development, of
    1. U.S. Law, including statues, regulations, judicial decisions, and other statements having legally binding authority, applicable to the SAO, and
    2. U.S. actuarial practices and principles.
- Have either
    1. Obtained Fellowship in the CAS or SOA. In addition to obtaining this fellowship, the actuary must:
        i. Have completed education relevant to the subject of the SAO. Such education may have been obtained in attaining the fellowship designation or highest possible designation of a non-U.S. actuarial organization, or by completing additional education relevant to the subject of the SAO; or
        ii. Have a minimum of one year of responsible actuarial experience in the particular subject relevant to the SAO, under the review of an actuary who was qualified to issue the SAO at the time the review took place under the USQS in effect at the time.

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OR

2. Have a minimum of three years of responsible actuarial experience in the particular subject relevant to the SAO, under the review of an actuary who was qualified to issue the SAO at the time the review took place under the USQS in effect at that time.

Section 3. of the USQS specifies the Specific Qualification Standards beyond those required to satisfy the General or Basic Education and Experience requirements. For issuing Health SAO, this includes examinations administered by either the Academy, CAS or SOA covering

a) Principles of insurance and underwriting;
b) Principles of ratemaking;
c) Statutory insurance accounting and expense analysis;
d) Premium, loss, expense and contingency reserves; and
e) Social insurance.

Alternatively, this education may be acquired through responsible work or self-study, if another qualified actuary familiar with the work is willing to attest to the knowledge of the opining actuary. To meet the experience requirement, an actuary is required to have at least three years of responsible experience relevant to the Opinion, under the review of another actuary who was qualified to issue the Opinion at the time the review took place.

DRAFTING NOTES: The regulators may allow caveats in the stem since not all statements filed on the Health Blank will include every item listed in the Knowledge Statement.

To address the regulatory concern of "not knowing what you don't know," a comprehensive listing is a good direction. These knowledge statements should also be seen as a flexible document that keeps old products relevant while being updated to allow for new product concepts along the way

It may be beneficial to include guidance in a cover page or introduction to the knowledge statements that suggests a "best practice" for the actuary, encouraging record keeping of the key items and an explanation of how the actuary met the requirement, such as when they achieved a credential or what their 1 or 3 years of experience looked like, which is kept updated. This record is particularly valuable when there are changes within their organization, to help an Appointed Actuary think about and know about when working with a new product.

Principles of Insurance and Underwriting

1. **Insurable Risk Concepts**: Understanding the dynamic between moral hazard and insurable risks; recognizing the increased risks associated with moral hazards as insurable risks diminish.

2. **Health Insurance Products**: In-depth knowledge of various health insurance products and their unique features, including:
    - **Medical Insurance**: Differentiating between individual, small group, large group, self-funded, Medicare Advantage, Medicare Part D, Medicare Supplement, Managed Medicaid, and short-term medical plans.
    - **Dental and Vision Insurance**: Characteristics and coverage details.
    - **Group Term Life and AD&D**: Key aspects and insurance parameters.
    - **Disability Insurance**: Nuances of short-term, individual, and long-term disability insurance.
    - **Long-Term Care**: Coverage scope and policy features.
    - **Specialized Health Insurance**: Understanding cancer/critical illness and hospital indemnity insurance.
3. **Distribution Methods**: Comprehensive knowledge of distribution channels for each type of coverage.
4. **Underwriting Processes**: Mastery of underwriting procedures for each coverage type and strategies to address selection risks.
5. **Behavioral Underwriting Factors**:
    - Effects of network and coverage limitations.
    - Impact of healthy lifestyle incentives on consumer choices.
    - The correlation between individual choices and funding sources.
6. **Seasonal Claim Patterns**: Recognizing and analyzing seasonal trends in claim incidences for different products.

Principles of Ratemaking

1. **Premium Rate Components**: Understanding the constituents of premium rates, including benefit costs, expenses, and risk charges.
2. **Medical Insurance Contract Elements**: Comprehensive knowledge of risk assumption, provider network access, care management/wellness programs, and claims management/adjudication.
3. **Risk Levels of Different Products**: Expertise in evaluating risk for diverse products, including self-funded plans, dental/vision, retrospective experience rated, fully insured plans, specific and aggregate stop loss, disability, and long-term care (LTC).
4. **Renewal Rate Change Rules**: Familiarity with renewal rate change regulations for each product.
5. **Rating Restrictions**: Understanding the rating limitations for products such as those under the 2010 federal statute, the Patient Protection and Affordable Care Act (ACA).
6. **Risk Adjustment in ACA and Medicare Advantage**: Proficiency in the impact of risk adjustment on premium amounts and payment timings, including risk adjustment data validation (RADV) issues.

Statutory Insurance Accounting and Expense Analysis

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1. **Statutory Accounting Principles**: Deep understanding of statutory accounting principles and guidance sources.
2. **Statutory Accounting Blanks and SSAPs**: Familiarity with statutory accounting blanks and associated Statements of Statutory Accounting Principles (SSAPs).
3. **Conservatism in Financial Statements**: Knowledge of the treatment of conservatism in statutory financial statements.
4. **Reserves vs. Liabilities**: Distinguishing between reserves and liabilities.
5. **Covered and Uncovered Expenses/Liabilities**: Understanding the differences and implications.
6. **Reinsurance Treatment**: Mastery of reinsurance treatment in statutory accounting, including issues related to risk transfer.
7. **Expense Segmentation**: Skills in segmenting expenses between claim adjustment expenses and distinguishing between variable and overhead costs.
8. **Appointed Actuary Requirements**: Familiarity with the roles and responsibilities.
9. **Actuarial Opinion and Memorandum Components**: Understanding of the different types of opinions, prescribed language, and scope.
10. **Timing of Actuarial Opinions and Memorandums**: Knowledge of appropriate timing for these documents.
11. **Risk-Based Capital (RBC) Formula Elements**: Expertise in the components of the risk-based capital formula and its regulatory impacts.
12. **Testing of Prior Period Liabilities and Assets**: Skills in evaluating the accuracy and adequacy of prior period liabilities and actuarial assets.

Premium, Loss, Expense, and Contingency Reserves (and Actuarial Assets)

1. **Premium Reserves**: Understanding of assets and liabilities typically found in health products, calculation methods, and their documentation. Premium reserves include items such as:
    1. Due and uncollected premium
    2. Premium paid in advance
    3. Unearned premium
    4. Retrospective premium receivable or payable
    5. Risk adjustment receivable or payable
    6. Minimum loss ratio (MLR) refund liability
    7. Risk corridor assets and liabilities

2. **Loss Reserves**: Proficiency in calculating loss reserves, including segmentation and consideration for various factors. Loss reserves include items such as:
    1. Unpaid claim reserves and liabilities, including segmentation into not reported, in course of settlement, due and unpaid and present value of amounts not yet due.
    2. Contract reserves and gross premium reserves, including prescribed minimum assumptions.
    3. Provider assets and liabilities, including the types of contractual provisions that give rise to such assets/liabilities.

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3. **Claim Adjustment Expense Liability**: Expertise in determining claim adjustment expense liabilities.

4. **Premium Deficiency Reserves**: Mastery in calculating premium deficiency reserves (PDR), including considerations for grouping, projection time periods, expense reallocation, treatment of investment income, and tax implications.

5. **Asset Adequacy Analysis**: Skills in conducting asset adequacy analysis and determining additional reserve requirements.

6. **Capitations and Provider Insolvency Risks**: Knowledge of capitations and the associated risks of provider insolvency.

7. **Other Actuarial Assets**: Expertise in estimating and documenting other actuarial assets specific to health insurance products. Other actuarial assets include items such as:
    1. Provider risk sharing receivables
    2. Loans and advances to providers
    3. Capitation arrangement receivables
    4. Pharmacy rebate receivables
    5. Claim overpayment receivables

Social Insurance

1. **Medicare Program**: Comprehensive understanding of the components, coverages, and funding mechanisms of the Medicare program.
2. **Medicaid and CHIP**: In-depth knowledge of Medicaid and the Children's Health Insurance Program (CHIP), including their components, coverages, and funding.
3. **Disability Insurance and Social Security**: Understanding the components and coverages of the Disability Insurance (DI) portion of Social Security and its interactions with other disability income coverages.

Professionalism and Business Skills

The Appointed Actuary must have professional and business skills to enable the Appointed Actuary to perform the required actuarial services in an ethical manner that upholds the reputation of the actuarial profession. The Appointed Actuary must know and adhere to the Code of Professional Conduct, as well as relevant ASOPs and must meet the USQS. The Appointed Actuary must have the professional and business skills to manage the tasks, make informed decisions, communicate effectively with users of the actuary's work products, resolve disagreements, and seek guidance as necessary.

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1. **Code of Conduct**: Familiarity with the Code of Conduct and its application in professional scenarios.
2. **US Qualification Standards**: Profound understanding of the USQS.
3. **Actuarial Standards of Practice (ASOPs) and Applicability**: Mastery of applicable ASOPs and guidelines for their application. The actuary should refer to the Academy's Applicability Guidelines to determine applicable ASOPs.
4. **Documentation:** Understanding the importance of documentation of work as discussed in many ASOPs and as required by the Laws and Regulations applicable to the SAO.

In addition to these knowledge statements, Section 2.1.c of the USQS requires the actuary to be knowledgeable of the U.S. law applicable to the SAO. For a health blank actuarial opinion signed by the Appointed Actuary, this would include knowledge of:

- Health Insurance Reserves Model Regulation.
- NAIC Health Reserve Guidance Manual.
- NAIC Annual Statement Instructions, specifically as it relates to Health and the SAO.
- Applicable provisions of Health Insurance Portability and Accountability Act (HIPAA)
- Applicable SSAPs including:
    - SSAP 54
    - SSAP 55
    - SSAP 84
- Individual state laws and regulations applicable to the actuarial opinion and assets and liabilities within the scope of the opinion.
- Other applicable laws and regulations related to specific products referenced in the specific SAO.

Familiarity with the relevant Practice Notes from the Academy is also a valuable component of professionalism.

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SOCIETY OF ACTUARIES RESEARCH UPDATE TO HATF

November 16, 2024

Dale Hall, FSA, MAAA, CERA
Managing Director of Research

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SOA Health Research Updates



Medicaid Underwriting Margin - COVID Update

Update to previous studies, adding data from 2020-2022 NAIC reporting statements and current financial and risk-based capital information



Long-term Medical Trend Update: 2025-2035+



Update on Long Term Care Experience Study

SOA Research INSTITUTE

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Additional Health Research

3

Experience Studies & Practice Research

Project Name	Objective	Expected Completion Date
Actuarial Weather Extremes - Hurricane Helene September 2024	Highlight observations for extreme weather events across North America	https://www.soa.org/resources/research-reports/2019/weather-extremes/
Medicaid Underwriting Margin - COVID Update	Update the Medicaid Underwriting Margin Model with data through CY 2023 and incorporating data from the COVID PHE and the beginning of the PHE Unwinding.	https://www.soa.org/resources/research-reports/2024/medicaid-underwriting-margin-model/
Actuarial Weather Extremes - Drought Around the World in Early 2024	Highlight observations for extreme weather events across North America	https://www.soa.org/resources/research-reports/2019/weather-extremes/
Getzen Model 2025	This research examines is a model that does long term medical trend projects. In addition, there is a write-up which describes how each of the assumptions were chosen.	https://www.soa.org/resources/research-reports/2024/2025-getzen-model-update/
Medicaid Underwriting Margin - Post COVID Update	Update the Medicaid Underwriting Margin Model with data through CY 2025 and incorporating data from the PHE Unwinding.	6/1/2026
ACA@15	This report will examine the success of the ACA to different stakeholders in the Individual, Small Group and Medicaid Marketplaces	3/24/2025
Behavior Health Article Series	This project will consist of a series of BH articles addressing various aspects of behavioral health from an actuarial health perspective	5/31/2025
Long Term Care Population Research Model	Assesses the impact of reform proposals for LTC system changes on stakeholders including consumers.	10/30/2024
HCCI 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.	12/16/2024
HIV + Medicare	This research involves evaluating the impact of HIV positive individuals on Medicare Advantage.	11/15/2024
Assessing and Valuing the Impact of Technology in HealthCare	Examines the way actuaries value Technology within the Healthcare System	11/11/2024
The Impact of Social Determinants of Health on Risk Adjustment	Analyzes the potential impact of SDOH factors on Risk Adjustment	12/3/2024

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4

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Health Practice Council Update

Health Actuarial (B) Task Force (HATF) Meeting

November 16, 2024

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American Academy of Actuaries

About the Academy

American Academy of Actuaries

The American Academy of Actuaries is a 20,000-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.

For more information, please visit:
actuary.org

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Recent Engagement

3

Long-Term Care (B) Actuarial Working Group (LTCAWG)

Comments submitted on LTCI MSA Proposals

Health Risk-Based Capital (E) Working Group (HRBC)

H2—Underwriting Review project: final report still intended by year-end

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Recent Health Practice Council Activity

4

Webinars:

- Overview of CMS' Final Rules for Ensuring Access to Medicaid Services, and Managed Care Access, Finance, and Quality

Publications:

- Issue Brief (and Executive Summary) on Examining ERISA in the Context of Health Benefits

Academy Annual Meeting:

- Plenary Session with Commissioner Mais and NAIC CEO Gary Anderson; breakout health sessions on behavioral health and the costs of enhanced or new benefits, integration of care for the dually-eligible, and a session with CCIIO

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Recent and Upcoming Academy Activity

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Webinars:

- Ethical Dilemmas Facing Health Actuaries: Insights and Case Studies
- Other topics in December include capital markets (retirement focused), the annual professionalism session: Tales from the Dark Side, and surplus considerations for public pension plans

Publications

- Health: The State of Long-Term Care
- Casualty: Insurance Fraud: Impacts on Premiums, Claim Costs, and the Public
- Retirement: Collective Defined Contribution Plans, Immigration and Social Security, Public Pension Plans: Evaluating Buyout Programs
- Risk Management: Big Data Terminology

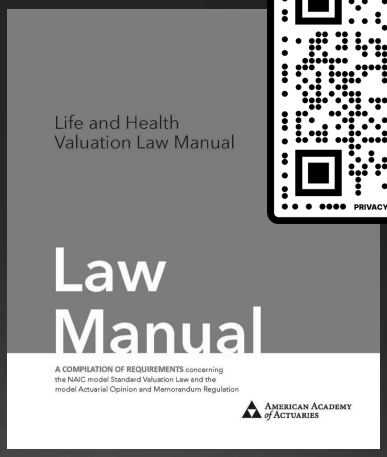
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Coming Soon
Life and Health Valuation Law Manual

What's Inside?

- Current topics section outlining key valuation developments and specific state guidance;
- Current NAIC model laws and regulations that effect reserve calculations;
- A discussion of generally distributed interpretations; and
- Current actuarial guidelines from the NAIC *Financial Examiners Handbook*.



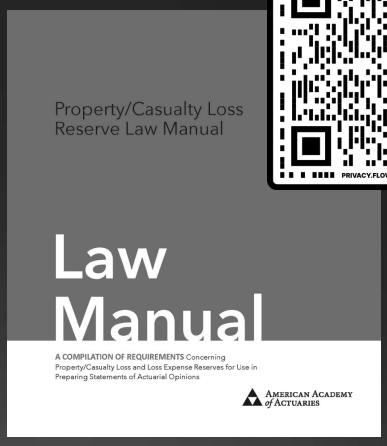
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Coming Soon
Property/Casualty Loss Reserve Law Manual

What's Inside?

- SAO requirements and the laws and regulations establishing those requirements;
- Annual statement instructions for the SAO for property/casualty, title loss, and loss expense reserves; and
- Other pertinent annual statement instructions.



American Academy of Actuaries

11/16/24

Plan ahead for these 2025 events



Investment Symposium
Spring 2025
New York, NY
Registration opening soon.



Life and Health Qualifications Seminar
Fall 2025
Arlington, Va.

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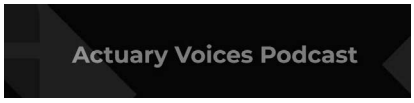
www.actuary.org/calendar

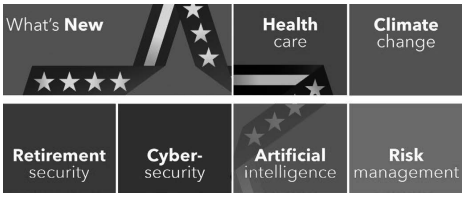
Other Resources

9

Follow the Academy on LinkedIn

Check out the Academy's Policy Issues Clearinghouse, Actuarially Sound blog, and Academy Voices podcast





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Thank you

10

Questions?

For more information, contact:

Matthew Williams, williams@actuary.org

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To: Kevin Dyke, NAIC HATF Chair
Ryan Jubber, NAIC HATF Vice-Chair
Paul Lombardo, NAIC HATF Member
Eric King, NAIC Health Actuary, Research and Actuarial
From: Stuart Klugman, SOA Senior Staff Fellow, Education
Subject: Draft Health Knowledge Statements, SOA Mapping and Comments
Date: November 4, 2024

The Society of Actuaries (SOA) is pleased to have the opportunity to review the health knowledge statements prepared by the American Academy of Actuaries.

In general, we urge the NAIC to leave knowledge of particular niche coverages and knowledge of single-state program features off the knowledge statements required for all appointed actuaries.

Below please find comments on specific sections of the draft knowledge statements.

Principles of Insurance and Underwriting

2 **Health Insurance Products**: In-depth knowledge of various health insurance products and their unique features, including:

- **Disability Insurance**: Nuances of short-term, individual, and long-term disability insurance.

  We believe disability insurance should fall outside the required knowledge for health FSAs desiring to sign health annual statements. However, we acknowledge that if this coverage is relevant to a particular health annual statement the appointed actuary should have knowledge in this area, which can appropriately be gained through experience and continuing education.

- **Long-Term Care**: Coverage scope and policy features.

  We believe long-term care coverage should fall outside the required knowledge for health FSAs desiring to sign health annual statements. However, we acknowledge that if this coverage is relevant to a particular health annual statement the appointed actuary should have knowledge in this area, which can appropriately be gained through experience and continuing education.

- **Specialized Health Insurance**: Understanding cancer/critical illness and hospital indemnity insurance.

  We believe specialized health insurances should fall outside the required knowledge for health FSAs desiring to sign health annual statements. However, we acknowledge that if this coverage is relevant to a particular health annual statement the appointed actuary should have knowledge in this area, which can appropriately be gained through experience and continuing education.

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6 **Seasonal Claim Patterns**: Recognizing and analyzing seasonal trends in claim incidences for different products.

3 **Risk Levels of Different Products**: Expertise in evaluating risk for diverse products, including self-funded plans, dental/vision, retrospective experience rated, fully insured plans, specific and aggregate stop loss, disability, and long-term care (LTC).

We believe these subjects fall outside the broad required knowledge for health FSAs desiring to sign health annual statements. However, we acknowledge If any of these subjects is relevant to a particular health annual statement the appointed actuary should have the knowledge in this area, which can appropriately be gained through experience and continuing education.

Social Insurance

3 **Disability Insurance and Social Security**: Understanding the components and coverages of the Disability Insurance (DI) portion of Social Security and its interactions with other disability income coverages.

We believe disability insurance and social security fall outside the recommended courses for health FSAs desiring to sign health annual statements. However, we acknowledge that if this coverage is relevant to a particular health annual statement the appointed actuary should have knowledge in this area, which can appropriately be gained through experience and continuing education.

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Attachment Five
Health Actuarial (B) Task Force
11/16/24

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON
OFFICE OF
INSURANCE COMMISSIONER

Phone: 360-725-7000
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October 30, 2024

Eric King, Senior Health Actuary
NAIC
eking@naic.org

RE: AAA draft Knowledge Statements for Appointed Actuary for Health Blanks

Dear Eric King,

Please consider the attached feedback about the American Academy of Actuaries' (AAA's; Academy's) August 1, 2024, draft "Knowledge Statements for Appointed Actuary for Health Blank." I am writing on behalf of the actuaries from the Office of the Insurance Commissioner (OIC) in the State of Washington. Please let me know if you have any questions or want more information. You may reach out to me directly at Amy.Peach@oic.wa.gov.

1. The statements describe different levels of knowledge required by the appointed actuary.
    a. Observed examples include, but are not limited to, the following:
        i. Understanding, recognizing, familiarity, skills, knowledge, knowledgeable, mastery, expertise, proficiency
        ii. In-depth knowledge, comprehensive knowledge, comprehensive understanding, deep understanding, profound understanding
    b. If several terms mean the same thing, we recommend only using one term throughout the knowledge statements.
    c. If terms have different meanings, we recommend clarifying how they differ.
2. Statutory Insurance Accounting and Expense Analysis:
   #4, Reserves vs. Liabilities: Please consider rewriting this item because certain reserves may be a subset of liabilities, but not all liabilities are reserves.
3. Premium, Loss, Expense, and Contingency Reserves (and Actuarial Assets):
    a. #1.4, Premium reserves, retrospective premium receivable or payable: We recommend also mentioning "contracts subject to redetermination." For example, see the full description of financial statement page 2, line 15.3.
    b. The AAA's drafting notes say the Knowledge Statements should start with a comprehensive listing. As such, we recommend covering the broader scope of items addressed by Health Statements of Actuarial Opinion (SAOs) and Actuarial Standards of Practice (ASOPs) No. 5 and No. 42.

       Below are examples that appear missing or incomplete in the draft statements.

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OFFICE OF THE INSURANCE COMMISSIONER

Eric King
NAIC
RE: AAA draft Knowledge Statements for Appointed Actuary for Health Blanks
October 30, 2024
Page 2

i. Reserve for insufficient administrative fees for self-insured contracts
ii. Reserve for future contingent benefits
iii. Reserves for rate credits or experience rating refunds
iv. Amounts receivable relating to uninsured plans and liabilities for amounts held under uninsured plans including those related to the Medicare Part D program
v. Amounts receivable under government insured plans
vi. Liabilities and/or offsets for reinsurance

4. Below the Knowledge Statements, several SSAPs are listed. It may be worthwhile to expand the list to include one or more of the following SSAPs.
   a. Other often relevant SSAPs include the following:
      i. SSAP No. 47
      ii. SSAP No. 66
      iii. SSAP No. 107
   b. If an even more extensive list of SSAPs is preferred, you may also wish to consider including other SSAPs, such as the following:
      i. SSAP No. 5R
      ii. SSAP No. 6
      iii. SSAP No. 50
      iv. SSAP No. 61R
5. The document ends by mentioning "relevant Practice Notes from the Academy." You may wish to consider listing key Practice Notes.

Sincerely,

Amy Peach

Amy Peach, FSA, MAAA,
Actuary

[cc:
Lichiou Lee, ASA, MAAA, Chief Actuary;
Ned Gaines, Deputy Commissioner, Rates, Forms, and Provider Networks Division]

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From: Brown, Megan
To: King, Eric
Cc: Walter Wright, Kristen; Ramsey, Shannon; Eng, Eugene
Subject: Health Knowledge Statements Comments
Date: Thursday, October 31, 2024 2:55:35 PM

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Eric,

Below please find our comments regarding the Health Knowledge Statements Draft document available on the HATF website. We appreciate your time and consideration.

While the Appointed Actuary is expected to possess the necessary knowledge and expertise to attest to these knowledge statements, as demonstrated by their fulfillment of continuing education requirements under the U.S. General and U.S. Specific Qualification Standards, the explicit listing of these statements may be perceived as overly prescriptive. The USQS already provides a comprehensive framework outlining the requisite knowledge areas for an Appointed Actuary signing a Statement of Actuarial Opinion. Therefore, the inclusion of these knowledge statements may be seen as an unnecessary additional requirement, potentially creating an undue burden on the Appointed Actuary.

We believe further clarification on the following items is also needed:

- The intended audience and intended issuer of the knowledge statement are not entirely clear and could benefit from further clarification.
- Will the knowledge statements be included in the Statement of Actuarial Opinion? Or would the Appointed Actuary attest to these statements separately with the Academy as part of their continuing education requirements?
- Will the Appointed Actuary have the authority to exclude attestations that are not relevant for the SAO they are signing, and will they be required to provide further documentation regarding any attestations that are excluded?
- The knowledge content as described by the draft Life knowledge statement is much more concise than the draft Health knowledge statement. The draft Health knowledge statement is much more specific and at times redundant to the current USQS. Rather than duplicating or distilling the content of the USQS and the Continuing Education requirements, it would be helpful to specifically reference the USQS ("as stated in the USQS" or "reference the USQS for more information") and other published standards/requirements for qualification.

Megan Brown, FSA, MAAA
Kristen Walter Wright, FSA, MAAA
Shannon Ramsey, FSA, MAAA
Eugene Eng, ASA, MAAA

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Nebraska
Medicare Supplement Market
New Business Rate Setting & UW Issues

November 16th, 2024

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Presenters

Margaret Garrison – Life & Health Actuary (near ASA)

- **12 years in the Health Insurance Industry, actuarial experience with several Blue Cross Blue Shield Plans.**
- **Cost of Care analysis, Provider negotiations, Rate Filings, Reserving.**
- **Two and a half years as Life and Health actuarial examiner at the NE DOI.**

Michael Muldoon, ASA, MAAA, FCA – Muldoon Actuarial & Biostatistical

- **ASA in 1994, has worked for 30 years as a designated actuary.**
- **Former Chief Actuary for the CO DOI (2016-2018) and NE DOI (2022-2024).**
- **3 years as Actuarial Director, McKesson Health Disease Management.**
- **Masters Degree in Statistics, Ball State University, Indiana (1995).**

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NE DOI Actuarial Role

Review of Medicare Supplement Rate Filings

New Business

- **Initial New Business rate filings after 5/1/2022.**
- **Detailed review of initial pricing development and assumptions.**
- **Obtain all rating model data, rate development spreadsheets.**
- **Request our Template + additional support and documentation.**

Renewal Business

- **Initial rate filings on or after 1/1/2020.**
- **Review NE and Nationwide experience, initial and current assumptions, and LT LR projection models.**
- **DOI requests trend rate increases for young blocks without credible experience, or credible experience rate adjustments.**
- **Original pricing models are not re-opened and challenged if block entered before 5/1/2022.**

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Insurers in the Market

NE Medicare Supplement Rate Filings

Medium to Large Domestic Insurers

- Have large size blocks of stable NE Med Supp experience.
- Can be used for pricing new blocks of business.

Large Non-Domestic Insurers

- Several with moderate size blocks of stable Nationwide Med Supp experience.
- May have some NE Med Supp experience.

Other Insurers

- Mostly Non-Domestic insurers with small size blocks.
- Often do not have credible Nationwide or NE Med Supp experience to use for pricing new business.

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Setting Sustainable Rates

What are Sustainable Rates?

Rates that will be sufficient to cover all future benefits and expenses, with only future annual medical trend and aging increases needed.

Nebraska's large domestic companies have sufficient experience available, and generally set rates to be sustainable.

NAIC Medicare Supplement rating guidelines do not allow actuaries to price new blocks with the intent to "Ride the Selection Curve" and underprice blocks in early years.

Such underpricing will lead to rates that are not sustainable, requiring large rate increases greater than trend and aging in later years.

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The Fundamental Problem in the Nebraska Market

Medicare Supplement 2010 Plan Business

- **Between 2017 and 2022 several dozen insurers submitted new business rates that were grossly underpriced.**
- **Plans were priced 15-45% below our Large Domestic Insurers. These were priced considerably lower than what would have been needed to create a "sustainable" block.**

After UW selection wore off:

- **Lifetime Loss Ratios rapidly deteriorated, then annual rate increases of 12% to 25% were needed every year.**
- **Unhealthy policyholders are unable to leave these blocks and move to another carrier's plan, due to medical conditions preventing them from passing UW. They are trapped in blocks with escalating rate increases.**

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Review of New Business Pricing Models

- **Smaller Non-Domestic carriers often do not have credible experience of their own to appropriately set initial rates.**
- **A few large actuarial consulting firms submitted most of these underpriced new business rate filings. They often utilized a Public Medicare Data based rating model to set initial rates.**
- **Prior to May 2022, NE DOI did not have rate review resources in place to review these new business rate filings in SERFF.**
- **Beginning in May 2022, NE DOI Actuarial was assigned to perform review of these models and found numerous issues regarding how the Medicare data was improperly and inconsistently used to set base costs, rating factors, and final rates for new Med Supp rate filings.**

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Use of Public Medicare Data

New Business Rate Filings often submitted Actuarial Memorandums with insufficient support for starting claim cost levels.

We found numerous problems with the rating models and support in filings:

- **Used very old data, did not disclose date ranges of data used.**
- **Assumed % of members to be UW were unrealistically high, such as 60-70%, versus historical 15% to 30% UW levels.**
- **Used incorrect claims and membership categories.**
- **Incorrectly summarized benefit data.**
- **Used incorrect geographic factors, population adjustments, and claim run-out completion factors.**

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Typical Rating Pattern of Underpriced Blocks

New Medicare Supplement 2010 Plan G:

Effective Date	Policyholders	Rate Increase
2020	0	NEW
2021	100	0%
2022	500	3%
2023	900	15%
2024	950	19%

Company requested to close this block to new sales for 2024.

Group will submit a new block for 2024 sales under a different entity.

New blocks today often deteriorate considerably within 4 years from issue.

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New Business Rate Review

Rate Filing actuaries are required to provide sufficient support in NE SERFF for initial and renewal rates for new blocks of Medicare Supplement business.

A New Business Template and a sample spreadsheet for Durational Lifetime Loss Ratio development are provided on the NE DOI website:

https://doi.nebraska.gov/insurers/life-and-health

Under the "Accident and Sickness Insurance" section, click "Medicare Supplement" for links to:

- **NE Medicare Supplement New Business Template.pdf**
- **Durational Loss Ratio Exhibit for Medicare Supplement, Jan 2nd, 2024.xls**

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NE DOI Rating Regulation Approach

- **Control rates on New Business rate filings to prevent large underpricing from occurring on initial rates.**
- **Require rating trends be applied in early renewal years for blocks that do not yet have credible experience to use to revise rates.**
- **For blocks with sufficient experience at renewal, review the LT LR projections and utilize experience rated adjustments.**
- **Keep the LT LR on target each year to prevent large rate increases from being needed in later renewal years.**
- **Only cap future rate increases when carriers have directly refused to take trend or rate increases in early years as directed by the NE DOI. In these cases, caps will allow no more than rating trend (plus aging) in later renewal years.**

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Capping Large Rate Increases

Nebraska DOI has opted in general not to place caps on large rate increases, other than for the specific cases noted on the prior slide.

Potential issues with applying Rate Caps:

- **Large rate increases at renewal may be justified and needed based on an insurer's poor experience, and high Lifetime Loss Ratios.**
- **Applying artificial Rate Caps may trade a rating problem for a potential solvency problem with an Insurer.**
- **The DOI approved the rates filed in the early years of the Block, even if they did not have the resources to perform rigorous rate review. The DOI has some responsibility to correct rates for blocks that are losing money in later years.**

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Birthday or Anniversary Rule Issues I

Nebraska DOI and Industry have opted not to pursue a Birthday or Anniversary rule. Here were observations provided on these methods:

- **Undermines the integrity of UW in the Market.**
- **Overall Medicare Supplement Market average rates could increase.**
- **Market anti-selection could occur if new rules would apply to any new applicant, as healthy seniors may delay enrollment.**
- **Carriers with blocks of business currently in large loss positions could take very large increases to expedite the migration of high-cost members to other carriers.**
- **Carriers that priced responsibly could then be hit with high-cost members migrating from companies that did not price responsibly.**

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Birthday or Anniversary Rule Issues II

- **Incentive for increased churn of policies for agent commissions. Increase in consumers being "pestered" by agents on a more regular basis - something the NAIC says they are trying to alleviate.**
- **Medicare Supplement is different from MA and ACA.**
  MA and ACA have no UW, but they also have risk funding and ACA RA transfers, so insurers receiving a large share of sick members can be protected. This protection does not exist in Medicare Supplement with the elimination of UW.
- **In the first year, sick members trapped in high rates on spiraling blocks would use the Birthday Rule as a chance to move down to the lowest priced insurer's plan in the market. Those plans would not have priced for that enrollment and would immediately need large rate hikes. The rate increase cycle accelerates.**

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Contact Information

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Maggie Reinert – L&H Rates & Forms Administrator
Maggie.Reinert@nebraska.gov

Michael Muldoon, ASA, MAAA, FCA – Muldoon Actuarial & Biostatistical
Michael@muldoonact.com

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Resource Links

- **Department of Insurance General** - https://doi.nebraska.gov/
- **Department of Insurance Medicare Supplement NB Rate Template** - https://doi.nebraska.gov/insurers/life-and-health
- **NAIC link** - https://content.naic.org/index_committees.htm
- **Public SERFF Filing Access** - https://www.serff.com/serff_filing_access.htm
- **Medicare -** https://www.medicare.gov/
- **CMS (Centers for Medicare & Medicaid Services)** - https://www.cms.gov/

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LONG-TERM CARE INSURANCE (B) TASK FORCE

Long-Term Care Insurance (B) Task Force Nov. 17, 2024, Minutes 6-117
Long-Term Care Insurance (B) Task Force Oct. 2, 2024, Minutes (Attachment One) 6-120
Comment Letter Regarding the Proposed 2025 Charges (Attachment One-A)....6-121
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Long-Term Care Actuarial (B) Working Group Nov. 16, 2024, Minutes (Attachment Two)....6-124
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Draft: 11/21/24

Long-Term Care Insurance (B) Task Force
Denver, Colorado
November 17, 2024

The Long-Term Care Insurance (B) Task Force met in Denver, CO, Nov. 17, 2024. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Grace Arnold, Vice Chair, represented by Fred Andersen (MN); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Sanjeev Chaudhuri (AL); Ricardo Lara represented by Ahmad Kamil (CA); Michael Conway represented by Sydney Sloan (CO); Trinidad Navarro represented by Jessica Luff (DE); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Holly W. Lambert represented by Scott Shover (IN); Sharon P. Clark represented by Angi Raley (KY); Timothy J. Temple represented by Vicki Dufrene (LA); Michael T. Caljouw represented by Kevin Beagan (MA); Marie Grant represented by Mary Kwei (MD); Robert L. Carey represented by Marti Hooper and Robert Wake (ME); Chlora Lindley-Myers represented by Jo LeDuc and William Leung (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Margaret Garrison and Maggie Reinert (NE); D.J. Bettencourt represented by Michelle Heaton (NH); Scott Kipper represented by Todd Rich (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by Numi Griffith (OR); Michael Humphreys represented by Dave Yanick and Lindsi Swartz (PA); Elizabeth Kelleher Dwyer represented by Patrick Smock (RI); Michael Wise represented by Karl Bitzky (SC); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Scott McAnally (TN); Cassie Brown represented by Daniel McAdams (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Fairbanks (VA); Kevin Gaffney represented by Anna Van Fleet (VT); Mike Kreidler represented by John Haworth (WA); Nathan Houdek represented by Rebecca Rebholz (WI); Allan L. McVey represented by Joylynn Fix (WV); and Jeff Rude represented by Tana Howard (WY).

1. Adopted its Oct. 2 and Summer National Meeting Minutes

The Task Force conducted an e-vote that concluded Oct. 2 to adopt a recommendation to the Health Insurance and Managed Care (B) Committee for 2025 proposed charges, which include disbanding the Long-Term Care Insurance (B) Task Force on Dec. 31, 2024, and recommending charges for the Senior Issues (B) Task Force and the Health Actuarial (B) Task Force.

Smock made a motion, seconded by Kamil, to adopt the Task Force's Oct. 2 (Attachment One) and Aug. 13 minutes (*see NAIC Proceedings – Summer 2024, Long-Term Care Insurance (B) Task Force*). The motion passed unanimously.

2. Adopted the Report of the Long-Term Care Actuarial (B) Working Group

Andersen said many regulators have been concerned about escalating long-term care insurance (LTCI) rates for policyholders who are over the age of 85. In the 25-years-and-over duration range, these policyholders have faced cumulative rate increases in excess of 400% and are facing future rate increases. This has been labeled the "85/25/400" policyholder issue. He said that during discussions, a suggestion to resolve the 85/25/400 issue is to adjust the cost-sharing factors in the Minnesota rate review methodology. The 400% cumulative rate increase issue would be addressed by flattening the slope of future rate increases after 400%. It was determined that it would be difficult to address the age 85 and duration 25 issues. However, after the study, it was determined that fixing the 400% cumulative rate increase issue indirectly addresses the age 85 and duration 25 issues.

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Andersen said these discussions impact filings that insurers voluntarily submit to the multistate actuarial (MSA) team. The MSA process in the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) is intended to increase uniformity between states, but it does not impose any requirements on state insurance departments regarding rate approvals.

Andersen said the Long-Term Care Actuarial (B) Working Group met Nov. 16 and Oct. 9. During its Nov. 16 meeting, the Working Group discussed comments received on proposed LTCI cost-sharing approaches. The Working Group adopted the proposed cost-sharing factors that would be applied to the Minnesota approach.

Fix made a motion, seconded by Chaudhuri, to adopt the report of the Long-Term Care Actuarial (B) Working Group (Attachment Two). It was noted the motion does not include adoption of revisions to the LTCI MSA Framework, as those revisions will be exposed and adopted by the Task Force separately. The motion passed unanimously.

3. Exposed Proposed Revisions to the LTCI Multistate Rate Review Framework

Lombardo said the Minnesota approach and cost-sharing are already included in the current LTCI MSA Framework. He said the Task Force was given two tasks by commissioners early in the year. The first is to develop a single methodology that was more explainable and understandable for commissioners, regulators, and consumers as to how the MSA team's recommendation was determined. There was significant support from the Long-Term Care Actuarial (B) Working Group for the Minnesota method to become the single rate review methodology, which the Working Group adopted at its Oct. 9 meeting.

Lombardo said the second task that commissioners asked the Task Force to address was to find a solution for the 85/25/400 policyholder issue. The Long-Term Care Actuarial (B) Working Group discussed ways to do this. Several individuals indicated there was a risk of discrimination in addressing this issue by increasing rates for younger policyholders in the block. The Working Group aimed to reduce the impact on the 85/25/400 policyholders without creating discrimination and without having each state pass different legislation limiting increases in the rate filings. He said if the Task Force keeps the existing cost-sharing approach in the LTCI MSA Framework, the Task Force will not have addressed the task given by the commissioners. The 85/25/400 issue will remain and will need to continue to be discussed.

Lombardo said Andersen proposed an approach where the curve is greater at the beginning years, winds down at 400%, and reduces rate increases after reaching a 400% cumulative rate increase level. He said Leung offered a different methodology. Lombardo said Andersen's proposal was adopted by the Working Group at its Nov. 16 meeting. He said he understands regulators continue to have questions. Lombardo said that he and Andersen will meet individually with any state insurance department that needs help understanding the approaches, but he will not tell states how to vote. He said each state insurance department should make its own educated decision on the cost-sharing approach.

Lombardo recommended exposing the draft revisions to the LTCI MSA Framework, including the proposed single LTCI MSA rate review approach and modifications to the cost-sharing formula as adopted by the Working Group, for a 25-day comment period ending Dec. 13, 2024. There was no objection to the exposure or comment deadline.

Lombardo said other issues that were discussed at the Working Group meeting on Nov. 16 will continue to be discussed by the Working Group in the future, including adding clarifying language and reader notes.

Chaudhuri said he does not understand the impact of the new cost-sharing formula compared to the existing cost-sharing formula and asked if an example of the impact could be provided. Fix suggested a regulator-only educational session before the Dec. 13 comment period deadline to walk regulators through an insurer's actual

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rate increase filing using the revised cost-sharing formula. Lombardo and Andersen agreed to schedule an educational session.

Lombardo said the Long-Term Care Insurance (B) Task Force will schedule an open meeting during the week of Dec. 16 to receive and discuss comments on the exposure draft and consider adopting revisions to the LTCI MSA Framework. If adoption cannot be achieved at that meeting, the Health Actuarial (B) Task Force will conduct further discussion and re-exposure in 2025.

4. Heard a Presentation on the Results of the RBOs and Consumer Notices Research Project

Brenda Rourke (NAIC) provided an overview of the research project being conducted by the Center for Insurance Policy and Research (CIPR) on reduced benefit options (RBOs), consumer notices, and consumer choices (Attachment Three). Rourke said that, in conclusion, the study results indicated:

1. The clarity of the letters matters. Staff recommend revisiting the guidelines used to review rate increase letters to ensure communication is accessible to the general population and uses "plain language."
2. Greater perceived behavioral control and financial knowledge impact choice. Therefore, it is important to provide education and resources to help consumers make this choice.
3. Individuals who received a prior rate increase and had a greater perception of the risk of needing long-term care were more likely to keep their policy and pay the higher premium, regardless of age, income, or education.

Rourke said a complete report on the findings is expected to be published by the CIPR by Dec. 31, 2024. In 2025, the CIPR will focus on further research related to: 1) the impact of modifying the language and adding a table of values to the consumer letter and 2) continuing to look at consumer understanding and perceptions of RBOs.

Lombardo said the CIPR may be asked to present the results of future work on this project during a future Senior Issues (B) Task Force meeting.

Having no further business, the Long-Term Care Insurance (B) Task Force adjourned.

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Draft: 10/4/24

Long-Term Care Insurance (B) Task Force
E-Vote
October 2, 2024

The Long-Term Care Insurance (B) Task Force conducted an e-vote that concluded Oct. 2, 2024. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Grace Arnold, Vice Chair, represented by Fred Andersen (MN); Lori K. Wing-Heier represented by Sarah Bailey (AK); Barbara D. Richardson (AZ); Karima M. Woods represented by Philip Barlow (DC); Trinidad Navarro represented by Sally Frechette (DE); Amy L. Beard represented by Scott Shover (IN); Sharon P. Clark (KY); Timothy J. Temple (LA); Kevin P. Beagan (MA); Joy Y. Hatchette represented by Brad Boban (MD); Robert L. Carey represented by Marti Hooper (ME); Chlora Lindley-Myers represented by William Leung (MO); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning (NE); D.J. Bettencourt represented by Jennifer Li (NH); Scott Kipper (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Elizabeth Kelleher Dwyer represented by Beth Vollucci (RI); Cassie Brown represented by R. Michael Markham (TX); Jon Pike (UT); Scott A. White represented by Julie Fairbanks (VA); Kevin Gaffney (VT); Mike Kreidler (WA); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted a Recommendation for Its 2025 Proposed Charges

The Task Force exposed a recommendation to the Health Insurance and Managed Care (B) Committee for the Long-Term Care Insurance (B) Task Force regarding its 2025 proposed charges for a 15-day public comment period that ended Sept. 27. The recommendation included: 1) disbanding the Task Force as of Dec. 31; 2) moving the Long-Term Care Actuarial (B) Working Group to report to the Health Actuarial (B) Task Force; and 3) moving remaining charges to the Senior Issues (B) Task Force and Health Actuarial (B) Task Force.

A joint comment letter was received from the American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP) requesting two edits (Attachment One-A). Lombardo and Andersen agreed to include the edits in the final recommendation for adoption.

A majority of the Task Force members voted in favor of adopting its 2025 recommendation with the edits from the ACLI and AHIP (Attachment One-B). The motion passed.

Having no further business, the Long-Term Care Insurance (B) Task Force adjourned.

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Hi Jane and Eric,
On behalf of the ACLI and AHIP, below are our comments regarding the proposed 2025 charges of the LTCAWG and HATF:

ACLI and AHIP believe that the LTC Actuarial Working Group is best suited to monitor and evaluate the rate review process and the state insurance department rate review actions related to the MSA Framework because they have the technical knowledge about long-term care insurance rates. If they can't track the progress of the MSA process, they can't make informed adjustments. Similarly, evaluating options for helping consumers with rate increases involves technical aspects that the Senior Issues Task Force may not be equipped to handle alone. Collaborating with the LTC Actuarial Working Group ensures a more thorough and informed approach to these important issues.

ACLI/AHIP suggest the following revisions to the proposed charges to better align the responsibilities with the relevant expertise of each group.

1. LTC Actuarial Working Group:
    1. Monitor and evaluate the actuarial approach used in the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document and make modifications as appropriate. Additionally, monitor and evaluate the progress of the MSA rate review process and the state insurance department rate review actions related to the MSA Framework.
2. Health Actuarial Task Force:
    1. No changes needed for this charge. (Keep the original language).
    Note that the proposed 2025 charges for the LTCAWG stated that the following charge was moved from the LTC Actuarial Working Group to the Health Actuarial Task Force: however it does not appear that this was included in the proposed 2025 charges of HATF - Monitor and evaluate the progress of the multistate actuarial (MSA) rate review process as outlined in the Long-Term Care Insurance Multistate Rate Review Framework (MSA Framework), and make modifications as appropriate. Monitor state insurance department rate review actions subsequent to the implementation of the MSA Framework and MSA rate review recommendations.
3. Senior Issues Task Force:
    1. Monitor and evaluate options to help consumers manage the impact of rate increases, including ongoing research. This should be conducted in conjunction with the LTC Actuarial Working Group to assess the use and impact of guidance for states regarding reduced benefit options (RBOs) and make modifications as appropriate.

Thank you for the opportunity to comment. We are happy to answer any questions you may have.
Best,
Jan Graeber, ASA, MAAA
Senior Actuary, ACLI

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Attachment One-B
Long-Term Care Insurance (B) Task Force
11/17/24

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

To: Director Anita G. Fox (MI), Chair of Health Insurance and Managed Care (B) Committee

From: Paul Lombardo (CT), Chair of Long-Term Care Insurance (B) Task Force

Date: October 2, 2024

Re: Recommendation for 2025 Charges

In 2024, the Long-Term Care Insurance (B) Task Force and its Working Group have made important progress on the work of improving the multistate actuarial (MSA) rate review process and conducting research through the NAIC Center for Insurance Policy and Research (CIPR) on reduced benefit options (RBOs) and consumer notices. Based on this progress, it is recommended continued work on these topics will be better served by and align with the work of the Senior Issues (B) Task Force and the Health Actuarial (B) Task Force in 2025.

The following is recommended.

- The Long-Term Care Insurance (B) Task Force should disband as of December 31, 2024.
- Charges related to ongoing work on the MSA rate review process as outlined in the *Long-Term Care Insurance Multistate Rate Review Framework* (MSA Framework) should be moved to the Health Actuarial (B) Task Force in 2025.
- Charges related to research and maintenance of guidance for RBO's should be moved to the Senior Issues (B) Task Force in 2025
- The Long-Term Care Actuarial (B) Working Group should report to the Health Actuarial (B) Task Force in 2025.

The following are suggested amendments to those charges.

Recommendation for 2025 Charges:

Move the following charge to Health Actuarial (B) Task Force.

1. Monitor and evaluate the progress of the multistate actuarial (MSA) rate review process as outlined in the Long-Term Care Insurance Multistate Rate Review Framework (MSA Framework), and make modifications as appropriate. Monitor state insurance department rate review actions subsequent to the implementation of the MSA Framework and MSA rate review recommendations.

Move the following charge to Senior Issues (B) Task Force.

1. Monitor and evaluate options to help consumers manage the impact of rate increases, including monitoring ongoing research, ~~an~~ evaluating ~~on of~~the use and impact of ~~previously adopted~~ guidance for states regarding reduced benefit options (RBOs) and making modifications, as appropriate. This should be conducted in conjunction with the LTC Actuarial Working Group to assess the use and impact of guidance for states regarding reduced benefit options (RBOs) and make modifications as appropriate.

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Amend charges and have the Working Group report to the Health Actuarial (B) Task Force.

The Long-Term Care Actuarial (B) Working Group will:

1. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate long-term care insurance (LTCI) rates, rating practices, and rate changes.
2. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.
3. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM51, Experience Reporting Formats.
4. ~~Develop a uniform actuarial approach to multistate long-term care insurance (LTCI) rate increase reviews for use in the LTCI Long-Term Care Insurance Multistate Rate Review Framework (MSA Framework) in support of completing Long-Term Care Insurance (B) Task Force Charge~~ Monitor and evaluate ~~the progress of~~ the actuarial approach used in the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document, and make modifications, as appropriate. ~~Monitor state insurance department rate review actions subsequent to the implementation of the MSA Framework and MSA rate review.~~ Additionally, monitor and evaluate the progress of the MSA rate review process and the state insurance department rate review actions related to the MSA Framework.

If you have any questions, please contact myself, or NAIC Staff, Jane Koenigsman (jkoenigsman@naic.org).

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Draft: 11/19/24

Long-Term Care Actuarial (B) Working Group
Denver, Colorado
November 16, 2024

The Long-Term Care Actuarial (B) Working Group of the Long-Term Care Insurance (B) Task Force met in Denver, CO, Nov. 16, 2024. The following Working Group members participated: Paul Lombardo, Co-Chair (CT); Fred Andersen, Co-Chair (MN); Sarah Bailey (AK); Sanjeev Chaudhuri (AL); Ahmad Kamil (CA); Stephen Flick (DC); Kyle Collins (FL): Wes Trexler (ID); Scott Shover (IN); Nicole Boyd (KS); Marti Hooper (ME); Kevin Dyke (MI); William Leung (MO); Margaret Garrison (NE); Jennifer Li (NH); Laura Miller (OH); Lily Sobolik, Numi Griffith, and Tashia Sizemore (OR); Dave Yanick, Jim Laverty and Shannen Logue (PA); R. Michael Markham (TX); Tomasz Serbinowski (UT); Rebecca Rebholz (WI); and Joylynn Fix (WV).

1. Adopted its Oct. 9, and Summer National Meeting Minutes

Lombardo said the Working Group met Oct. 9, and Aug. 12. During its Oct. 9 meeting, the Working Group took the following action: 1) discussed comments received on the exposure of the Minnesota Approach with adjustments to haircut percentages and cumulative rate increase ranges of the cost-sharing formula as a candidate for a single long-term care insurance (LTCI) multistate rate review approach methodology for use in multistate actuarial (MSA) filing reviews; 2) adopted the Minnesota Approach with the current cost-sharing formula as the single multistate rate review approach methodology for use in MSA filing reviews; and 3) exposed the Minnesota Approach, with particular focus on the cost-sharing factors and blending factors associated with the if-knew/makeup approach, for a 19-day public comment period that ended Oct. 28. During its Aug. 12 meeting, the Working Group took the following action: 1) heard a presentation from Minnesota on proposed adjustments to the cost-sharing formula in the Minnesota approach to address large rate increases for policyholders at roughly age 85 with a policy duration of 25 years (85/25 issue); 2) discussed comments received on the Minnesota approach with any suggested adjustments to the cost-sharing formula to address the 85/25 issue as a candidate for a single LTCI multistate rate review approach; and 3) exposed the Minnesota approach with specified adjustments to the cost-sharing formula to address the 85/25 issue, as well as cumulative rate increases greater than 400%, as a candidate for a single LTCI multistate rate review approach for a 45-day public comment period ending Sept. 27.

Dyke made a motion, seconded by Schallhorn to adopt the Working Group's Oct. 9 (Attachment Two-A), and Aug. 12 (*see NAIC Proceedings – Summer 2024, Long-Term Care Insurance (B) Task Force*) minutes. The motion passed unanimously.

2. Discussed Proposed Modifications to the Minnesota Approach for Use as the Single LTCI MSA Rate Review Approach

Lombardo presented comments received from the Colorado Division of Insurance (Attachment Two-B), America's Health Insurance Plans (AHIP) and the American Council of Life Insurers (ACLI) (Attachment Two-C), and Genworth Life Insurance Company (Attachment Two-D) in response to the Working Group's request for comments on modifications to the Minnesota Approach as the single multistate rate review approach methodology for use in MSA filing reviews, with particular focus on the cost-sharing factors and blending factors associated with the if-knew/makeup approach.

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In response to the AHIP/ACLI comments, Lombardo said the cost-sharing element of the Minnesota Approach has been a part of the *Long-Term Care Insurance Multistate Rate Review Framework* (Framework) since its inception, and the Working Group is not adding explicit cost-sharing to the Framework. He said on Oct. 9, the Working Group adopted the Minnesota Approach as the single rate review methodology in the Framework and removed the Texas Approach from the Framework. Lombardo said the Working Group is now focusing on updating the existing cost-sharing parameters to address the concerns of most, if not all, commissioners regarding the 85/25/400 issue. He said he does not have an issue with the suggested addition to Future Non-Actuarial Considerations under Subsection F (Non-Actuarial Considerations) of Section V (Actuarial Review) of the Framework, other than he does not agree with the addition of "Further non-actuarial adjustments are inappropriate". He said he thinks the Working Group should have the capability to review the adjustments being considered now at a future date. Lombardo said the comment letter later contradicts this when it is suggested that "Monitoring and Periodic Review: Establish a process for the periodic review of costsharing measures to assess their impact on insurers and policyholders and to determine if future adjustments to the framework are necessary based on evolving market conditions and block performance." be added to the Framework. Ray Nelson (AHIP) said the comment was not intended to say there should not be periodic reviews of Framework elements, but AHIP/ACLI wants to avoid the unintentional addition of greater cost-sharing.

Lombardo said the Minnesota Approach does not penalize a company for disapproval of past rate increases, and asked what the ACLI/AHIP suggestion for an adjustment for delayed or reduced state approvals is intended to accomplish. Nelson said he agrees this is not an issue when an MSA review is based on a nationwide cumulative rate increase value. He said if an individual state that had previously disapproved rate increases were to apply the Minnesota Method, it would create additional cost-sharing for the company based on past cumulative rate increases that are less than the national value. He said ACLI/AHIP thinks inserting language concerning an adjustment will not impact the MSA Team's review of a rate increase filing, but thinks the addition will be helpful for state-specific reviews. Lombardo said he does not disagree, but that it will be difficult to add this to the Framework that is intended to be applied at a national level. Lombardo and Nelson agreed that the intent of the comment can be accomplished with the addition of a reviewer's note.

Lombardo said the Minnesota Approach as detailed in the Framework is formulaic and without ambiguity, and does not understand the ACLI/AHIP request for the addition of a guardrail related to cost-sharing transparency and flexibility. He asked if the request for flexibility is for within the Framework or at the state level. Jan Graeber (ACLI) said she thinks it can be for both, and that depending on whether only active policyholder experience or active policyholder and policyholder on claim experience is used, the level of cost-sharing can differ. Lombardo said it is possible to clarify the policyholder basis within the Framework.

Lombardo asked for clarification on the ACLI/AHIP comment requesting considerations for newer block profitability. Graeber said newer blocks may not develop loss ratios in excess of 100%, but should not have their rate increase requests unreasonably reduced by cost-sharing. Andersen said both cost-sharing adjustment proposals being considered lower a company's cost-sharing for rate increases less than 100%, and does not think anything in the proposals will discourage a company from entering the market. Graeber said the comment was intended to address predictability and transparency that will ensure companies know how their blocks of business will be reviewed, and the greater likelihood of entering the market when there is predictability and transparency. Lombardo said an MSA review and the Minnesota Approach that is used as a single methodology within the Framework does not preclude companies from requesting and receiving rate increases less than 100%.

Miller asked how often ACLI/AHIP thinks its members will need to request block-specific flexibility as suggested in the comments, and if this flexibility is intended to be applied through the MSA process or at the state level after

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the MSA review. Graeber said it is intended to be at both the MSA and state levels, and that ACLI/AHIP wants it to be stated that there are considerations other than the application of the formula that actuaries need to take into account. She said she can not estimate how many companies will need to request block-specific flexibility, as it depends on the unique characteristics of each block of business. Miller asked Andersen and Lombardo if they think there is room in the Framework for the flexibility requested by ACLI/AHIP. Andersen said he has used the Minnesota Approach for eight or nine years, and industry has not provided any instances where its application would be inappropriate. He said, in general, he does not think flexibility needs to be added to the approach. Lombardo said if ACLI/AHIP thinks the changes in cost-sharing that have been proposed will impact individual companies differently, the Working Group can continue discussing this issue. He said the Framework will always be open for review, modifications, and additions of reviewer notes.

Andersen said that implementing many of the suggestions made in the Genworth Life Insurance Company (Genworth) comments will conflict with commissioner efforts to address the 85/25/400 issue. Lombardo asked if Genworth will provide numerical examples of the resulting Minnesota Approach rate increases with cumulative rate increases backed out before the blending of makeup and if-knew premiums. Matthew DeRose (Genworth) said he believes this has been provided and will research if it has. Lombardo said he can not envision a scenario where the Minnesota Approach will generate a negative if-knew premium, and asked Genworth to provide an example of this occurring. Miller asked DeRose if he thinks cost-sharing should be removed from the MSA review and instead be handled between the company and each state individually. DeRose said given that the cost-sharing could vary by block and by company that it is something that lends itself better to discussions between individual insurers and state regulators.

Lombardo said the main difference between cost-sharing modification Proposal A and Proposal B presented in the request for comments is Proposal B has rate increase caps and Proposal B does not. He asked the Working Group members to discuss their thoughts on the different proposals. Andersen said one of the initiatives of the Long-Term Care Insurance (B) Task Force is to discourage the application of rate increase caps. He said he thinks application of rate caps will disturb the balance between consumer protection and preventing further company financial distress. Andersen said he thinks a cap will be too disruptive for inforce blocks at this point in their lifespans. He said applying the 100% of original premium cap could also go counter to the goal of having similar rate levels between states due to varying levels of rate increase approvals among the states.

3. Adopted Modifications to the Cost-Sharing Formula Used in the Single LTCI MSA Rate Review Approach

Fix made a motion, seconded by Boyd, to modify the cost-sharing used in the Framework's single LTCI MSA rate review approach to be a 5% haircut for the first 100% of a rate increase, a 20% haircut for the portion of cumulative rate increase between 100% and 400%, and an 80% haircut for the portion of the cumulative rate increase in excess of 400% (Proposal A). The motion passed, with AK, DC, KS, ME, NE, WV, and WI voting for, MO, OR, and TX voting against, and AL, CA, FL, IN, MI, NH, NY, OH, OK, PA, and UT abstaining.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.

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Draft: 10/24/24

Long-Term Care Actuarial (B) Working Group
Virtual Meeting
October 9, 2024

The Long-Term Care Actuarial (B) Working Group of the Long-Term Care Insurance (B) Task Force met Oct. 9, 2024. The following Working Group members participated: Paul Lombardo, Co-Chair (CT); Fred Andersen, Co-Chair (MN); Sarah Bailey (AK); Sanjeev Chaudhuri (AL); Stephen Flick (DC); Lilyan Zhang (FL): Heir Cooper (IN); Nicole Boyd (KS); Marti Hooper (ME); Kevin Dyke (MI); William Leung (MO); David Yetter (NC); Margaret Garrison (NE); Jennifer Li (NH); Craig Kalman and Laura Miller (OH); Jim Laverty (PA); Aaron Hodges and R. Michael Markham (TX); Tomasz Serbinowski (UT); Rebecca Rebholz (WI); and Joylynn Fix (WV).

1. Discussed Comments on a Single LTCI Multistate Rate Review Approach

Lombardo presented comments received from the American Academy of Actuaries (Academy) (Attachment Two-A1), America's Health Insurance Plans (AHIP) and the American Council of Life Insurers (ACLI) (Attachment Two-A2), Genworth Life Insurance Company (Attachment Two-A3), the Missouri Department of Commerce and Insurance (Attachment Two-A4), the Texas Department of Insurance (TDI) (Attachment Two-A5), and the Utah Insurance Department (Attachment Two-A6) on the exposure of the Minnesota Approach with adjustments to haircut percentages and cumulative rate increase ranges of the cost-sharing formula as candidates for a single long-term care insurance (LTCI) multistate rate review approach methodology for use in multistate actuarial (MSA) filing reviews.

Lombardo asked Jan Graeber (ACLI) if ACLI or AHIP member companies have used the Minnesota Approach spreadsheet that was provided to analyze the effects of the Minnesota Approach on any of their blocks of business and if they have any feedback on results. Graeber said some member companies have done so, but due to variances in characteristics between members' blocks, the Minnesota Approach's cost sharing feature works well for some blocks but not as well for others. She said the use of any formulaic approach needs to be clearly documented within the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) so that its application can be understood by others that examine rate increase review decisions in the future. She said this will give companies the predictability and transparency they need to be comfortable with the MSA process.

Serbinowski said regulators tend to favor an approach that results in a lower rate increase, and insurers tend to favor one that results in a higher increase. He said there should be a set of criteria that guides how a decision on cost sharing modifications is made. Lombardo said the Working Group needs to consider, as commented on by Genworth Life Insurance Company and the Utah Insurance Department, how waiver of premium is treated in whatever single approach is adopted. He said there are additional actuarial issues that were received in the comments that the Working Group will continue to address as it develops a single approach. Lombardo said the Working Group will continue to work on creating and documenting increased transparency and consistency for any single approach that is adopted. Serbinowski said the Working Group needs to address how to restate past elements that are used in a rate increase review in a uniform way. Andersen and Lombardo said that as the Working Group considers developing various elements of a single approach, it will analyze how changes to the approach will have an impact on resulting rate increase determinations.

Lombardo said he wants the Working Group to consider adoption of the Minnesota Approach as the single multistate rate review approach methodology for use in MSA filing reviews. He said he also wants the Working

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Group to then continue to develop modifications to address cumulative rate increases greater than 400% for policyholders at roughly age 85 with a policy duration of 25 years (85/25/400 issue), as well as issues presented in the comment letters for consideration of adoption in 2025. Miller said she is not familiar enough with the Minnesota Approach to fully understand the impact of any adjustments to it. The Working Group agreed to hold an educational session to explain the application of the Minnesota Approach to LTCI rate increase reviews.

2. Adopted a Single LTCI Multistate Rate Review Approach

Serbinowski made a motion, seconded by Fix, to adopt the Minnesota Approach with the current cost-sharing formula as the single multistate rate review approach methodology for use in MSA filing reviews and then continue to develop modifications to address the 85/25/400 issue and other issues. Lombardo said the Texas Approach will be removed from the MSA Framework, and the Minnesota Approach with the current cost-sharing formula will be the single approach that will be termed the MSA Approach. The motion passed, with Texas voting against adoption. Lombardo said the adoption by the Working Group will be forwarded to the Long-Term Care Insurance (B) Task Force for its consideration.

3. Exposed a Single LTCI Multistate Rate Review Approach for Comment

Lombardo said the Working Group will expose the Minnesota Approach, with particular focus on the cost-sharing factors and blending factors associated with the if-knew/makeup approach, for a 19-day public comment period ending Oct. 28. He said comments received will be used to discuss modifications to the Minnesota Approach with the current cost-sharing formula as the single multistate rate review approach methodology for use in MSA filing reviews.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.

Meetings/Member Meetings/B CMTE/HATF/2024_Fall/10-9-24 LTCAWG/LTCAWG Minutes 10-9-24.docx

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September 27, 2024

Fred Andersen, Co-Chair
Paul Lombardo, Co-Chair
Long-Term Care Actuarial (B) Working Group (LTCAWG)
Long-Term Care Insurance (B) Task Force
National Association of Insurance Commissioners (NAIC)

Via email: eking@naic.org

Re: Proposals A & B for a Single Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework)

Dear Co-Chairs Andersen and Lombardo,

On behalf of the American Academy of Actuaries (Academy)[1] Long-Term Care (LTC) Committee (Committee), I appreciate the opportunity to provide comments in response to the NAIC LTCAWG's August 12, 2024, request for comments on Proposals A and B as candidates for a Single LTCI Multistate Rate Review Approach.

As discussed in our July 23, 2024, comment letter, the Committee considers all of the adjustments in either proposal to fall into the category of "Non-Actuarial Considerations" as defined in Section V.F of the *NAIC LTCI MSA Framework*. We offer the following comments, noting that the proposed changes may have longer-term effects on future rate increase filings and/or company solvency.

Proposal B's explicit caps on cumulative and annual rate increases may introduce unanticipated solvency risks in future years. The proposed cap of 100% of the original premium may cause allowable rate increase percentages to shrink over time, regardless of the level of emerging experience on the relevant block of LTC policies. Phasing in a justified rate increase itself may result in larger necessary rate increases in future years to maintain stability of the block. The proposed 600% cumulative cap would be in place over the lifetime of the block, which could extend for 50 or more years. Given that LTC policies are typically guaranteed renewable rather than non-cancelable policies, a fixed cap on all future rate increases is not part of the regulatory scheme under which these policies were designed, approved, and issued.

Proposal A would change the cost-sharing factors used in the Minnesota Approach (see item 6.a. of the Appendix to the NAIC LTCI Multistate Rate Review Framework) by changing the slope of the cost-sharing curve and potentially allowing larger rate increases during the earlier durations of a LTC policy form. Because a rate increase request that is denied or delayed today would need to be at a greater amount later in order to achieve the same effectiveness, allowing higher approvals at earlier durations may reduce the need for larger increases in future years.

[1] The American Academy of Actuaries is a 20,000-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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Additional consideration may be necessary for blocks with prior rate increases that had been already limited in early durations and would now be even further limited at later durations when determining their allowable rate increase under the revised Minnesota Approach. As previously discussed in our July 23, 2024, comment letter, we support an appropriate catch-up provision to adjust for such situations.

*****

The Committee welcomes the opportunity to speak with you in more detail and answer any questions you have regarding these comments on finding a single MSA approach. If you have any questions or to discuss further, please contact Matthew Williams, the Academy's senior health policy analyst, at williams@actuary.org.

Sincerely,

Andrew Dalton
Chairperson, LTC Committee
American Academy of Actuaries

CC:
Eric King, NAIC

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September 27, 2024

Paul Lombardo, Co-Chair, NAIC Long-Term Care Actuarial Working Group
Fred Andersen, Co-Chair, NAIC Long-Term Care Actuarial Working Group

Dear Paul and Fred,

The American Council of Life Insurers (ACLI)[1] and the America's Health Insurance Plans[2] (AHIP) appreciate the opportunity to comment on the NAIC Long-Term Care Actuarial Working Group (LTCAWG) request for comments on two proposals to adjust the Minnesota Approach "haircut percentages and cumulative rate increase ranges of the cost-sharing formula" as candidates for a Single LTCI Multistate Rate Review (MSRR) Approach. The adjustments are intended to address the "85/25/400" issue as discussed at the Working Group's August 12th meeting in Chicago.

We know that rate increases for policyholders present complex technical and public policy issues for both regulators and the industry. This remains a difficult issue to address, despite our collective efforts to find balanced solutions. We understand the public policy concerns regulators face when responding to company rate increase requests. Given the diverse nature of long-term care blocks of business—ranging from different coverage structures and rate stabilization requirements to varied rate approval histories—a one-size-fits-all approach is not feasible. While the MSRR framework may be suitable for some blocks of business, it may be unworkable for others. Just as states adapt model laws to fit their legal frameworks, the MSRR framework should allow flexibility to account for these differences across blocks and companies.

In response to the August 12th exposure, industry has the following four key requests of the LTCAWG:

1. Encourage the LTCAWG to Reject Proposal B: To support the financial sustainability of long-term care coverage, ACLI/AHIP encourage the LTCAWG to ensure that long-term care rate increases are based on actuarial science, rather than arbitrary caps like Proposal B.
2. Clarify the Intention and Transparency of Cost-Sharing in the MSRR Framework: To the extent that cost-sharing is incorporated into the Multi-State Actuarial (MSA) recommendation, clarify within the LTCI MSRR framework that cost-sharing is meant to address specific public policy challenges. In addition, the total amount of cost sharing, both implicitly and explicitly, should be transparent.
3. Allow for Tailored Solutions: Incorporate appropriate guardrails into the NAIC's MSRR framework to reflect the diversity and complexity of blocks of business, ensuring a balanced and fair approach to cost-sharing.

[1] The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

[2] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and to help create a space where coverage is more affordable and accessible for everyone.

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4. Address and Document Ambiguities in the Methodology: As noted in prior comment letters, there are ambiguities in the current methodology that should be addressed for all stakeholders to understand.

Encourage the LTCAWG to Reject Proposal B

The NAIC has taken a careful approach to addressing long-term care rate increases, focusing on balancing consumer protection with insurer financial harm. Through the adoption of the MSRR Framework, the NAIC highlighted the need for a more consistent state-based approach when evaluating long-term care insurance rate increase requests by insurers. Key objectives of the Framework are to educate and advise states on the appropriateness of actuarially based rates for policyholders' benefits, narrowing rate review practices and reducing inequities among policyholders[3].

Rate adjustments grounded in actuarial science align with the 2014 NAIC Long-Term Care Insurance Model Regulation (Model #641), which emphasizes the importance of actuarial justification for premium rate increases to ensure both fairness for policyholders and the financial stability of insurance companies. Sections 10 (Initial Filing Requirements), 20 (Premium Rate Schedule Increases), and 21 (Filing Requirement) of Model #641 support the principle that rates should be grounded in actuarial science, not arbitrary limits.

ACLI/AHIP encourage the LTCAWG to reject "Proposal B," which would add additional non-actuarial factors and complexity to the process. Specifically,

- "Adjustment a," which would require the cumulative rate increase to be no more than 600% after all adjustments, creates an arbitrary cap that is contrary to supporting the financial sustainability of long-term care coverage. In addition, this adjustment continues to reward states that have disapproved prior rate requests as these disapprovals result in higher future rate requests.
- "Adjustment b," which would require that each rate increase filing not increase the cumulative rate increase by more than 100% from that of the current rate, adds complexity of the calculation, especially if calculated on a seriatim basis.

Clarify the Intention and Transparency of Cost-Sharing

To maintain fairness and avoid perpetual adjustments, ACLI/AHIP propose clearly defining the role of cost-sharing within the regulatory framework. It is important to emphasize that cost-sharing should be recognized as a compromise to address public policy concerns, not a precedent for further limitations on rate increases. Any additional capping or restrictions by states beyond this agreed-upon mechanism would undermine the concessions that have already been made and could lead to further financial strain on insurers. This, in turn, could limit insurers' ability to provide adequate coverage to consumers in the long term. Clarification should be incorporated into the LTCI MSRR Framework as follows:

The paragraph titled "Future Non-Actuarial Considerations" under Subsection F (Non-Actuarial Considerations) of Section V (Actuarial Review), should be amended to read:

[3] https://content.naic.org/article/naic-membership-adopts-framework-address-long-term-care-insurance-rate-approvals

Future Non-Actuarial Considerations

The MSA Review will continue to develop and evolve as it is implemented. To achieve more consistency and minimize the number of differences across states in their application of other non-actuarial considerations in rate review criteria for LTCI rate filings, the LTCI MSA Framework was amended in 2024 to adjust the cost-sharing components within the Minnesota method to address specific public policy challenges, particularly around large increases for older-age policyholders, with longer durations. Further non-actuarial adjustments are inappropriate, however, the Task Force may ~~will~~ encourage its appointed Subgroup, or an appropriate NAIC actuarial committee or group, to collectively consider new future non-actuarial considerations, if ~~as~~ they arise. This process will provide for input and technical advice from actuaries to states as they exercise their authority in considering nonactuarial factors. States are therefore encouraged to discuss new and developing practices and/or recommendations in this area.

In addition, the following reviewer note should be added before Step 7 of the Minnesota Approach outlined in Appendix C of the LTCI MSRR Framework:

Reviewers note: The blending of the if-knew and makeup premiums (Step 5) and the cost-sharing formula (Step 6) were reviewed and updated in 2024 to address specific public policy challenges, particularly around large increases for older-age policyholders, with longer durations. Additional cost-sharing or other non-actuarial adjustments to address these challenges are inappropriate.

Allow for Tailored Solutions

While there is mutual agreement between regulators and the insurance industry that a one-size-fits-all approach is not appropriate for addressing long-term care premium increases, the regulatory view that the current process will work for "most" companies does not go far enough. The diverse nature of long-term care blocks—each with varying assumptions, benefit structures, and policyholder demographics—means that even if the process works for some blocks, significant gaps remain for other companies.

A process that works for some but not all can inadvertently lead to unfair outcomes for certain blocks of business, especially those with unique challenges such as prior delayed, limited, or denied rate approvals, longer-duration policies, or varying benefit designs. To ensure a truly fair and equitable system, it is crucial to implement appropriate guardrails that address these differences, preventing the imposition of excessive cost sharing where it is inappropriate and allowing for tailored solutions that reflect the specific characteristics of each block.

Incorporating appropriate guardrails into the NAIC's long-term care premium increase process is essential to ensuring a balanced and fair approach to cost-sharing. While cost-sharing adjustments within the formula are intended to address public policy concerns, these adjustments must be applied in a way that accounts for the diversity and complexities of long-term care blocks of business.

Without potential limitations and tailored flexibility, insurers may face undue financial strain, and the long-term viability of long-term care coverage could be compromised. Guardrails would not only

protect insurers from disproportionate burdens but also ensure a transparent, predictable process that regulators and companies can rely on, fostering a stable insurance market that benefits both policyholders and the industry.

ACLI/AHIP encourage regulators to consider adding guardrails for cost-sharing in the MSRR framework to reflect the diversity and complexity of blocks of business. Potential guardrails include:

1. Block-Specific Flexibility: Introduce flexibility that allows for customized cost-sharing adjustments based on the unique characteristics of a block (e.g., block age, benefit richness, timing of past rate approvals) to reflect the diversity of long-term care insurance portfolios.
2. Adjustment for Delayed or Reduced State Approvals: Establish a mechanism to reduce or eliminate cost-sharing for older blocks where previously delayed, limited, or denied rate approvals by states have contributed to financial strain, acknowledging that timely approvals could have prevented the need for large, accumulated increases.
3. Cost Sharing Transparency: Allow companies to clearly outline the degree of cost-sharing being applied, helping regulators understand how much of the needed premium increase has already been absorbed by the insurer versus passed to the policyholders.
4. Recognition of Block Profitability: Include considerations for newer, leaner blocks, where excessive cost-sharing could result in unreasonably low profitability, potentially discouraging insurers from entering in the long-term care market or leading them to exit.
5. Monitoring and Periodic Review: Establish a process for the periodic review of cost-sharing measures to assess their impact on insurers and policyholders and to determine if future adjustments to the framework are necessary based on evolving market conditions and block performance.

Address and Document Ambiguities in the Methodology

As stated in our August 2nd comment letter, ACLI and AHIP strongly encourage the LTCAWG to address the ambiguity in current methodology, including the complex layers of cost-sharing embedded within the Minnesota Method. This will promote clarity, transparency, and alignment with actuarial integrity, ensuring fairness to both policyholders and insurers.

Specifically, we recommend that the working group review and respond to the questions, proposals, and alternatives presented by the ACLI/AHIP and other stakeholders. This will ensure all perspectives are considered and foster a transparent decision-making process.

We urge the LTCAWG to clarify its stance on key recommendations, particularly in the context of how the MSA team will consider these outstanding issues in their review of long-term care filings. Specific feedback should clarify areas of agreement or disagreement by the MSA team. If not in agreement, the reasons should be documented to guide further refinement.

Conclusion

As previously stated, the inclusion of non-actuarial factors in the rate review process opens the door for allowing political or social considerations to override actuarial principles and sets a dangerous precedent that could lead to unintended consequences. Insurers have a fundamental responsibility to ensure the financial sustainability of their products, and actuarially sound rates are critical to this goal. While addressing affordability concerns for older policyholders is important, premiums must be set fairly and reflect actuarial justification to protect both consumers and insurers. Consumer protection efforts should focus on empowering individuals to make informed

decisions based on their financial situation and risk tolerance, while timely approval of actuarially justified rate increases is essential to maintaining market stability and protecting consumers from sudden premium hikes or lapses in coverage.

By addressing these issues, we can create a more predictable and consistent process for all parties involved, which will help encourage insurers to remain or enter the market.

Thank you for considering these critical issues.

Sincerely,





Jan Graeber
Senior Actuary, ACLI

Ray Nelson
Consultant for AHIP

Genworth Life Insurance Company & Genworth Life Insurance Company of New York
Response to MSA Single Method Exposure Draft
September 27, 2024

Genworth Life Insurance Company and Genworth Life Insurance Company of New York (collectively, "Genworth" or the "Company") appreciate the opportunity for continued engagement in the MSA Single Review Method development process. Before commenting on specific adjustments to various additional cost-sharing proposals (as distributed August 14, 2024, and included in Appendix B), we must first clarify the considerations for the other modeling steps within the MSA Framework guidance on the Minnesota Method to ensure an appropriate foundation on which to base conclusions.

In attempting to use the MSA Framework guidance to determine the justification of requested rate increases, the presentation of results lacks the necessary transparency to support consistent results across states, and therefore is not, in its current form, an optimal tool for reviewing rate increase requests. **Any method used to support rate increase decision-making should be clear in its inputs and methodology**, and should be expected to produce the same results across all jurisdictions using the same inputs. While there may be some subjectivity in final adjustments based on company or block-specific considerations, the modeled result should be clear and consistently produced. The current guidance in the MSA Framework does not provide sufficient detail to achieve this objective. While an instructional presentation based on one interpretation of the guidance may be helpful for those regulators able to attend, it should not take the place of **clearly written, enduring guidance** that can be applied consistently by regulatory and industry participants over a long period of time.

Genworth would also like to make clear that while it understands that some state regulators may choose to use some form of a Blended If-Knew method (such as that invoked by the Minnesota Method) to inform rate increase decisions, **the inclusion of If-Knew in these decisions renders them non-actuarial**. A regulator's use of a policy adjustment, including the use of the Minnesota Method with its If-Knew component, does not make that adjustment actuarial in nature.

While the majority of the discussion on the Minnesota Method at Actuarial Working Group ("AWG") sessions has been to voice concerns over the non-actuarial components, Genworth believes **the AWG should discuss the truly actuarial components of the methodology** to ensure agreement in approach (See Appendix A for conversation guide). Genworth has significant first-hand experience, through its interactions with regulators as part of the rate increase filing process, with the various approaches to calculating and blending rate increase methods, and has noted some divergence in their application. A universal decision on each of the below components would better support stability within the industry, and enable reliable modeling and risk management. Consistent with its experience in applying these methodologies over numerous filings and across several jurisdictions, Genworth believes the following approaches are most appropriate when attempting to blend an actuarially justified rate increase with an "If-Knew" rate increase, as is attempted in the Minnesota Method. (Please note that the following statements do not constitute a position that the use of "If-Knew" in any form could be deemed appropriate in certain applications)

- **Aggregate Approach.** The most appropriate, and most easily understood, approach to assessing the need for rate increases in a Blended If-Knew methodology is to use what the MSA Framework describes as the "Aggregate Application." The example in the MSA Framework documentation is based on this approach, providing clarity and leading to more consistent application. Genworth's

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experience has shown that this approach is used almost exclusively as it provides the most transparency without the subjectivity inherent in the assumed profit of the "Sample Policy-Level Verification."

- **Implementation Date.** As detailed in the AWG White Paper on this topic (issued October 2018), "delays in implementing actuarially justified rate increases due to either a carrier failing to file a needed rate increase, or delays in the regulatory approval of a needed rate increase, can pose a potential solvency risk." Insurers should be permitted to use a likely implementation date in the projections, and update the implementation date as necessary for prolonged rate review timelines to avoid additional financial strain and more closely mimic the impact of the rate increases.
- **Consistency with Existing Laws.** As the current Framework is not tethered to existing regulations, such as the use of the 58/85 test described in Rate Stabilization regulations, the use of Blended If-Knew, or any other rate increase methodology, will comply with, and not supersede, existing law. Furthermore, the use of MAE should also be included for applicable products/policies, so as not to conflict with issued guidance and the ability for actuaries to certify to the rate increase requests. Removal of MAE from the final rate increase offered/granted is an additional form of cost-sharing above what the standard Blended If-Knew would recommend. To specifically avoid conflict, the Framework should be updated to clarify that the final result must comply with existing laws and regulations.

There are other topics which are less consistent nationwide, and while Genworth has strong positions on these matters, it understands there are additional conversations that may lend themselves better to individual interactions with state regulators as they arise on specific filings.

- **Waiver of Premium.** The inclusion or exclusion of Waiver of Premium (WOP) benefits should be consistent with original pricing methodology. If a company included WOP as a claim benefit and grossed up premiums when setting original rates which were approved for use by a regulator, such an approach should be permissible in subsequent rate increase calculations.
- **Phasing of Rate Increases.** For larger increases, Genworth believes it is sometimes reasonable, though not always preferable, to phase increases in over a number of years (usually two to three years) if the regulator chooses to approve on that basis. This approach works best when there is agreement between the company and regulator that future filings are not planned, meaning a sufficient approval is being granted to prevent an immediate refiling. Otherwise, phasing causes unnecessary delays in future filings, driving up the ultimate level of increase needed to achieve a similar financial impact if implemented immediately.
- **Additional Cost-Sharing.** There are many downsides to a one-size-fits-all approach to the additional cost-sharing provision, as assumptions, benefit structures, and policyholder demographics can vary significantly from block-to-block. Furthermore, as this provision may be waived for unspecified "solvency concerns," the determination of whether additional cost-sharing is needed, and to what extent, may vary significantly from company-to-company. Given the dynamic nature of any additional cost-sharing that regulators may wish to impose, it seems most prudent to explicitly leave the determination to discussions between insurers and regulators so that regulators may preserve the ability to specifically address public policy concerns, as permitted by applicable law, for the consideration of policyholders within each state.

Finally, to support transparency, Genworth believes that **cumulative past increases should be backed out before blending**. Once this has been completed, it provides a very clear and transparent view to decision-makers in the exact contributions of the two components of the increase. For the If-Knew portion, the result should be floored at zero so as not to imply that a rate *decrease* would be appropriate given that

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the initiation of the pricing exercise was the result of a deterioration in experience. A negative contribution from If-Knew would be logically unsound and inherently negate the validity of the result.

Additional Cost-Sharing Proposals Detailed In Exposure

Regarding the additional cost-sharing formula proposals in the most recent exposure: while Proposal A may be a compromise to the original Minnesota method, Genworth cannot support arbitrary limitations and levels not based in sound analytical or actuarial methods. The arbitrary caps detailed in Proposal B would further hinder a company's ability to manage its in-force business, and reward states which have been slow to review and approve justified increases, thereby increasing the rate increase needs to support claims-paying ability. Any cost-sharing on top of a review methodology should be discussed and decided between an individual insurer and regulator based on applicable law and unique circumstances, as stated above.

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Appendix A

Recommended questions to be answered by actuarial discussion:

1. **Aggregate Approach.** Do we agree that the Aggregate approach is the preferred approach in most cases (unless circumstances specifically require an exception to use the Sample Policy approach)?
2. **Transparent Blending.** Do we agree that the method should provide transparency between what is actuarially justified for the current request compared to the If-Knew component, before blending and explicit additional cost-sharing is applied?
3. **Dynamic Additional Cost-Sharing.** Do we agree that the additional cost-sharing is not a one size fits all approach, and should be left to separate discussions between insurers and individual regulators?

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Appendix B

To: Long-Term Care Actuarial (B) Working Group Members, Interested Regulators, and Interested Parties:

The Working Group requests comments on the Minnesota Approach with adjustments to haircut percentages and cumulative rate increase ranges of the cost-sharing formula as shown in **Proposal A** and **Proposal B** below as candidates for a Single LTCI Multistate Rate Review Approach. The adjustments are intended to address the "85/25/400" issue as discussed at the Working Group's Aug. 12 meeting.

Proposal A:

Current:

- No haircut for the first 15%.
- 10% for the portion of cumulative rate increase between 15% and 50%
- 25% for the portion of cumulative rate increase between 50% and 100%
- 35% for the portion of cumulative rate increase between 100% and 150%
- 50% for the portion of cumulative rate increase in excess of 150%.

Proposal A:

- 5% haircut for the first 100%
- 20% haircut for the portion of cumulative rate increase between 100% and 400%
- 80% haircut for the portion of the cumulative rate increase in excess of 400%

Proposal B:

Missouri is supportive of the development of a single MSA actuarial approach exposed and believe the following adjustments will be appropriate:

a) The cumulative rate increase should be no more than 600% after all the adjustments and cost sharing.

b) Each rate increase filing should not increase the cumulative rate increase by more than 100% from that of the current rate. In other words, the increase should not be more than 100% of the original rate.

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Comments on Single MSA Actuarial Approach Exposure 9/27/2024

Missouri is supportive of the development of a single MSA actuarial approach exposed and believe the following adjustments will be appropriate:

Currently the single MSA actuarial approach utilizes a blended cumulative rate increase, where

a. The weighting towards the makeup premium is the percentage of original policyholders remaining.

b. The weighting towards the if-knew premium is the percentage of original policyholders no longer having active policies, or 1 minus the percentage in a.

With an understanding that the earlier rate increases are critical for a LTC plan's sustainability and would help reduce the need and magnitude of later duration increases, it would make sense for the rate increase to be considered without reference to the If-Knew premium during the first 100% cumulative rate increase. This can be achieved by setting the percentage in a to 100% and the percentage in b to 0%. For the same reason, it may be better for both the company and the policyholders if the cost sharing is 0% instead of the 5% in proposal A. The idea is that if the rate increase is reviewed and considered appropriate under the minimum standard loss ratio and 58/85 rule, the rate increase should be allowed when the cumulative rate increase is not more than 100%.

It appears that the industry has been avoiding the MSA process, but filed with each individual state directly for rate increases within the first 100% and most states would approve or non-disapprove the request without explicit or implicit margin for such direct filings. The above proposed adjustment to the single MSA approach would encourage companies to apply to the MSA Team in early durations and be consistent with current practices.

Proposal Ba) in the exposure is trying to set a guardrail on the resultant cumulative rate increase. Its determination will help shape the cost sharing percentages in Proposal A. While 600% may be a reasonable target maximum for pre-stabilization plans, a much smaller target maximum may be more appropriate for post-stabilization plans for which the pricing assumptions are considered more recent and better experience supported.

William Leung

Life and Health Actuary

Missouri DCI

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Texas Response to Proposed Cost Sharing Techniques

Current and Proposed Cost Sharing Techniques

Texas' primary concern with the current MN Method is that it may justify excessive rate increases. There are three reasons for this:

- Use of the statutory discount interest rate
- Use of a 60% pricing loss ratio
- When applicable, not considering the 58/85 test rate stabilization requirement (Model Regulation 641) that was adopted by most states. While uncommon, Texas has seen a few filings where the proposed increase fails the 58/85 dual loss ratio test, but is justified under alternative approaches, including the TX PPV method.

Regarding the Current and Proposed Cost Sharing Techniques:

- Missouri Proposal
  Texas seldom approves a rate increase that exceeds 100% and would welcome a cumulative cap of 600%. The Missouri proposal could easily be applied in conjunction with the Current Method or Proposal A Method.

  Texas supports the Missouri Proposal of a 100% cap for any increase and a cumulative 600% cap.

- Proposal A
  This method justifies larger rate increases with restrictions once the cumulative rate increase exceeds 400%.

- Current Method
  Texas supports the Current Method and given the MN Method as applied, we believe the current cost sharing may be optimal. However, if assumptions are "tightened", the Current Method may become too restrictive.

Under current review conditions, Texas prefers the Current Method with the Missouri proposed single increase and cumulative increase restrictions.

Balance between Company Solvency and Fairness to Policyholders

Texas strives to strike a balance between rates that support company solvency and that is fair to consumers.

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While mindful of the importance of a premium rate that supports claims obligations, we are required by Texas law (Texas Insurance Code Section 560.002 (c)(3)(B)) to ensure that rates represent a "reasonable relationship to the expected loss." This statute is consistent with Actuarial Standards of Practice (ASOP) 8 - Section 3.11.3.

These are the types of questions we consider with respect to Section 560.002 and ASOP 8:

- Large rate increases to older, declining blocks commonly have insignificant impact on the lifetime loss ratio. We increasingly see a company strategy to implement extremely large increases, hopeful that policyholders will either significantly reduce benefits or lapse coverage and qualify for nonforfeiture. We question whether such a strategy is fair to the average consumer in these blocks – typically aged in the eighties or even nineties – who often have limited to no alternative market options.

- With rate increase that may exceed 500%, consumers (and regulators) are justified to ask: "Where is the transfer of risk?"

- Since LTC premiums are issue-age based, the rate charged to a person who purchased a policy at age 55, and who is now 85, should bear a reasonable relationship to rates charged to someone who is 55.

In short, Texas must be able to actuarially support any rate increase that we approve. As such, Texas is transparent with our independent analysis and conclusions subject to proprietary and confidentiality concerns.

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From: Tomasz Serbinowski
To: King, Eric; Lombardo, Paul; Andersen, Fred
Cc: Pike, Jon; Wiseman, Shelley; Northrup, Tanji J.
Subject: Comments on the LTCAWG Proposals A & B
Date: Friday, September 20, 2024 4:40:10 PM

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Dear Mr. King,

On behalf of the state of Utah, I'd like to offer the following comments regarding the two proposals for a cost sharing approach to be used in MSA rate reviews.

Both proposals can be viewed as alternative cost sharing proposals. MO proposal does not advocate for a specific cost sharing formula. Instead it proposes that any cost sharing formula adopted for the MSA reviews result in a cumulative rate increase cap of 600%. This can be achieved by increasing cost sharing to 100% above certain threshold.

Therefore, MO proposal could be applied to modify either of the MN cost sharing approaches (current and proposed).

MO proposal, in addition, includes a phase in feature that would require certain rate increases to be implemented in steps, by limiting any single rate increase to 100% of the original premium rate.

My comments are limited to the cost sharing aspect of the two proposals.

1. Impact of the proposals is difficult to gauge

For cumulative blended rate increases under 712%, Proposal A results in higher approvable rate increases than the current cost sharing. Here is a comparison of the approvable rate increases under the current and proposed cost sharing for rate increases ranging from 50% to 1000%.

Blended	*Current*	*Proposal A*
50%	47%	48%
100%	84%	95%
150%	117%	135%
200%	142%	175%
250%	167%	215%
300%	192%	255%
350%	217%	295%
400%	242%	335%
450%	267%	345%
500%	292%	355%
550%	317%	365%
600%	342%	375%
650%	367%	385%
700%	392%	395%
750%	417%	405%
800%	442%	415%
850%	467%	425%

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900%	492%	435%
950%	517%	445%
1000%	542%	455%

It is worth noting that for cumulative blended rate increases under 1000%, the issue of 600% cap does not come to play under either cost sharing method.

The impact of the Proposal A is difficult to gauge without having some idea of what the distribution of future increases might be. For newer blocks of business with very low lapse rates, low mortality, and low assumed investment returns, vast majority (if not all) of future rate increases may be such that Proposal A would result in a higher approvable rate increase than the current cost sharing formula.

2. There is no set of criteria or any metric under which to evaluate the proposals
When MN method was proposed as one of the methods to be used for MSA reviews, there was no regulatory discussion on what is an appropriate cost sharing formula. This was an existing method used by a state and regulators felt that it was reasonable. But it was arbitrary, and many other (equally arbitrary) cost sharing formulas would have been reasonable.

Now regulators are asked to indicate a preference for one cost sharing formula over another. Both formulas are arbitrary. No specific criteria were stated to evaluate the proposals. In effect, any preference expressed would be a subjective opinion with no substantive backing.

3. It isn't clear if the proposals achieve the desired objective
The original impetus behind the proposals was regulators' desire to protect vulnerable population, those with very high attained ages. As the attained age is not an allowable ratting variable for the LTCI (and neither is duration), the change is attempting to address this issue in an indirect fashion. To the extent that higher cumulative rate increases tend to occur at later durations, one may expect that cumulative rate increases over 400% would likely apply in late durations (25+) and thus affect those with high attained ages.

However, no support was provided to show how the size of the rate increase correlates with the duration or attained age of the affected policyholders. If an average issue age for a block is 60, 25 years down the road, average age may be less than 85. While voluntary lapse rates may be lower for older policyholders, mortality and incidence rates are significantly higher. Cost sharing formula being based on the size of the increase (and not the actual distribution of attained ages of the block), may provide relief for blocks with an average attained age much below 85.

4. This appears to be a public policy matter, not a technical actuarial matter
The original impetus being the desire to protect policyholders with attained ages 85 and above suggests that the ultimate goal is a public policy of protecting what is perceived to be a vulnerable population. As such, this is not a technical actuarial matter and would be better suited for one of the parent committees.

Idea of cost sharing could be simplified so that individuals with no technical actuarial training (like commissioners) be able to provide input on it. For example, commissioners could be asked what portion of the justifiable rate increase should be borne by the policyholders. This could take the following form:

Justifiable Increase	*Hair Cut*	*Policyholders' Responsibility*
100%		
300%		
500%		
700%		
900%		
1100%		

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Input from the commissioners (policymakers) could be then used to craft a cost sharing formula. If the commissioners required additional information on the impact of a particular cost sharing scheme, LTCAWG would be a proper venue to provide such technical information.

5. There are multiple unresolved technical issues surrounding application of the MN method
To the extent that MN method relies on the projections to calculate blended rate increase, there is a host of issues that may impact the calculations that have not been discussed by the LTCAWG.

Here are some of the items:
- Treatment of waived premiums and WOP benefits in calculation of If-Knew and Make-Up increases
- Whether If-Knew and Make-Up increases should be calculated using best estimate assumptions or assumptions with margins. If margins are allowed, should they be prescribed by the regulator (for example 5%), same as in the original pricing (may not be well documented), or whatever the actuary deems appropriate?
- Treatment of limited pay policies
- Treatment of paid-up policies (including policies on NF)
- Whether there should be some lower bound on the future loss ratio? In particular, can the rate increase result in a future loss ratio that is lower than the past loss ratio?
- Whether increases should be calculated assuming everyone pays the increase or reflecting shock lapse, reductions of benefits, and adverse selection.

Each of these issues impacts the allowable rate increase. And each is an actual technical matter that can be argued for and against by actuaries.

In conclusion, should the proposal be put to vote, Utah might feel forced to abstain or vote for the current cost sharing formula not because it is preferable, but to maintain status quo and continuity and consistency of the regulation.

Sincerely,

--
The Utah Insurance Department is committed to providing excellent service to all customers. We invite you to provide us feedback on your experience at https://utdoi.qualtrics.com/jfe/form/SV_3F6papl8sRhMjsi.

Tomasz Serbinowski, Actuary
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From: Brady - DORA, Sean <sean.brady@state.co.us>
Sent: Thursday, October 24, 2024 3:54 PM
To: King, Eric
Cc: Batista, Deborah; Nugent, Peter; Sloan, Sydney
Subject: Re: Long-Term Care Actuarial (B) Working Group Exposure - Comments Due October 28

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Working Group Exposure - Comments Due October 28

- Proposal A:
  - Colorado stance: We support this change to reduce haircuts on early increases; while also increasing haircuts on later increases.
  - Colorado would also support creating another level of cost-sharing between 100% and 400%.
- Proposal B:
  - Colorado stance:
  - a) We are not in support of any cap on cumulative rate increase.
  - b) We are also not in support of capping each rate increase. Limiting each rate increase filing might delay desperately needed increases due to filings taking a non-zero number of days to achieve approval. By delaying the needed rate increase(s), the cumulative increase may need to be higher.

On Wed, Oct 9, 2024 at 12:53 PM King, Eric <EKing@naic.org> wrote:

> ***To: Long-Term Care Actuarial (B) Working Group Members, Interested Regulators, and Interested Parties:***
>
> The Working Group requests comments on the Minnesota Approach, with particular focus on the cost-sharing factors (including Proposals A & B from the previous exposure, reproduced below) and blending factors associated with the if-knew / makeup approach.
>
> The Minnesota Approach, including the current cost-sharing formula and blending factors, is described here: https://content.naic.org/sites/default/files/documents/ltci-msa-framework.pdf
>
> Please provide comments to Eric King at eking@naic.org by Monday, October 28, 2024.

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Current:

- No haircut for the first 15%.
- 10% for the portion of cumulative rate increase between 15% and 50%
- 25% for the portion of cumulative rate increase between 50% and 100%
- 35% for the portion of cumulative rate increase between 100% and 150%
- 50% for the portion of cumulative rate increase in excess of 150%.

Proposal A:

- 5% haircut for the first 100%
- 20% haircut for the portion of cumulative rate increase between 100% and 400%
- 80% haircut for the portion of the cumulative rate increase in excess of 400%

Proposal B:

Missouri is supportive of the development of a single MSA actuarial approach exposed and believe the following adjustments will be appropriate:

a) The cumulative rate increase should be no more than 600% after all the adjustments and cost sharing.

b) Each rate increase filing should not increase the cumulative rate increase by more than 100% from that of the current rate. In other words, the increase should not be more than 100% of the original rate.

Adjustment a) can be achieved by increasing the current cost sharing when cumulative rate is more than 500%. For example, increase the cost sharing from 50% to 90% when Cumulative Rate exceeds 500% and further increase to 95% when Cumulative Rate Increase exceeds 1000%. The cost sharing is increased to 100% when Cumulative Rate Increase exceeds 5000% (If this is perceived as a hard cap, it can be replaced by something like 99%).

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Below is an example comparing proposal a) against the current cost sharing percentages (note resultant cumulative rate increase of 453% is less than the 600% target threshold):

Potential Cost-Sharing Formula for Typical Circumstance Cumulative Rate Increase (CRI) since issue date is haircut by:								
		Current					Propose	
Blended Increase		3238%			Blended Increase		3238%	
CRI	Hair cut	Applicable CRI	with Hair cut		CRI	Hair cut	Applicable CRI	with Hair cut
15%	0	15%	15%		15%	0	15%	15%
50%	10%	35%	32%		50%	10%	35%	32%
100%	25%	50%	38%		100%	25%	50%	38%
150%	35%	50%	33%		150%	35%	50%	33%
300%	50%	150%	75%		300%	50%	150%	75%
400%	50%	100%	50%		400%	50%	100%	50%
500%	50%	100%	50%		500%	50%	100%	50%
1000%	50%	500%	250%		1000%	90%	500%	50%
5000%	50%	2238%	1119%		5000%	95%	2238%	112%
100000%	50%	0%	0%		100000%	100%	0%	0%
CRI allowed		3238%	1661%		CRI allowed		3238%	453%

Adjustment b) is a secondary control over the resultant cumulative rate increase with haircut.

Here is an example of the application of Adjustment b):

Minnesota (Blended if-Knew/Make-up) Approach	current	Propose
Loss ratio at the original premium level	62.0%	62.0%
Minimum loss ratio applicable to the form	60%	60%
If Knew Increase (IKI)	200%	200%
Make-up increase (MUI)	10000%	10000%
Remaining policyholders percentage (RPP)	31%	31%
Blended increase (RPPxMUI+(1-RPP)xIKI)	3238%	3238%
Cost sharing increase Sum((1-CSi%)xlayeri)	1661%	453%
Past rate increase (PRI)	215%	215%
Cumulative Rate Increase when increase is limited to 100% Original Rate (Cumulative Rate Increase Allowed, CRIA)	1661%	315%
Rate Increase under MN approach in % of Current Rate =(1+CRIA)/(1+PRI)-1	459%	32%
Maximum Justified Rate Increase based on Make Up Increase = (1+MUI)/(1+PRI)-1	3106%	3106%
Maximum allowable rate increase	459%	32%

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Adjustment b) can be with or without re-visitation depending on fellow regulators' input and industry discussion.

Alternative 1 is that there should be no more subsequent rate increase filing if there is no further experience deterioration.

Alternative 2 can see the 100% original rate increase as a phase in mechanism where the filer may come back for more after every three years.

This proposal is limited to addressing the old age/long duration issue in LTCi rate increase filing. Comments on reducing cost sharing in early durations will be provided separately.

Thanks,

Eric J. King, FSA, MAAA
Senior Health Actuary
Research & Actuarial Services

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--
Sean Brady FSA FLMI
Actuary

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October 28, 2024

Paul Lombardo, Co-Chair, NAIC Long-Term Care Actuarial Working Group
Fred Andersen, Co-Chair, NAIC Long-Term Care Actuarial Working Group

Dear Chairs Lombardo and Andersen,

The American Council of Life Insurers (ACLI)[1] and the America's Health Insurance Plans[2] (AHIP) appreciate the opportunity to comment on the Minnesota Approach, with particular attention to the cost-sharing factors outlined in Proposals A & B and the blending of "if-knew" and "make-up" premium approaches. We understand that the Working Group's priorities for 2024 include establishing a single actuarial method and addressing the 85/25/400 issue, and we are committed to supporting progress in this area.

Proposals A and B aim to address the 85/25/400 challenge. As stated in our September 27th letter, we encourage the LTCAWG to ensure that long-term care rate increases are based on actuarial science, rather than arbitrary caps, and reject Proposal B. If changes are made to the cost-sharing table contained in the current MSA Framework, we believe that Proposal A better aligns with the attempt to address the core issue of sharing the financial burden between insurers and policyholders.

Cost-sharing is not a new concept—it has been occurring for many years. More recently, it has occurred both implicitly and explicitly within the Minnesota Method through the blending of "make-up" and "if-knew" premiums, as well as through the explicit cost-sharing table. Additionally, there have been instances where actuarially justified rate increases were limited, denied, or delayed by states, which effectively impose cost-sharing on the insurer. These examples demonstrate the continuous balancing of state regulator, insurer, and policyholder responsibilities, reinforcing the need for a transparent and predictable approach.

Timely approval of actuarially justified rate increases significantly reduces the likelihood of large increases later. For states that are behind in implementing necessary rate increases, applying the same cost-sharing adjustment is not appropriate. These states should consider their own rate increase history and avoid applying a one-size-fits-all solution, which may exacerbate financial challenges and perpetuate inconsistency of rates between states.

It is important to emphasize that cost-sharing is a compromise to address regulatory challenges that go beyond purely actuarial considerations and require a broader, consumer-centric approach, not a precedent for further limitations on rate increases. We encourage the LTCAWG to incorporate the role of cost-sharing into the LTCI MSRR Framework as follows:

[1] The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

[2] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and to help create a space where coverage is more affordable and accessible for everyone.

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Amend the paragraph titled "Future Non-Actuarial Considerations" under Subsection F (Non-Actuarial Considerations) of Section V (Actuarial Review), to read:

> Future Non-Actuarial Considerations
> *The MSA Review will continue to develop and evolve as it is implemented. To achieve more consistency and minimize the number of differences across states in their application of other non-actuarial considerations in rate review criteria for LTCI rate filings, the LTCI MSA Framework was amended in 2024 to adjust the cost-sharing components within the Minnesota method to address specific public policy challenges, particularly around large increases for older-age policyholders, with longer durations. Further non-actuarial adjustments are inappropriate, however, the Task Force may ~~will~~ encourage its appointed Subgroup, or an appropriate NAIC actuarial committee or group, to collectively consider new future non-actuarial considerations, if ~~as~~ they arise. This process will provide for input and technical advice from actuaries to states as they exercise their authority in considering nonactuarial factors. States are therefore encouraged to discuss new and developing practices and/or recommendations in this area.*

Add the following reviewer note before Step 7 of the Minnesota Approach outlined in Appendix C:

> *Reviewers note: The blending of the if-knew and makeup premiums (Step 5) and the cost-sharing formula (Step 6) were reviewed and updated in 2024 to address specific public policy challenges, particularly around large increases for older-age policyholders, with longer durations. Additional cost-sharing or other non-actuarial adjustments to address these challenges are inappropriate.*

Finally, incorporating guardrails into the MSRR process is key to ensuring a fair and balanced approach to cost-sharing. Cost sharing adjustments intended to address regulatory challenges, which go beyond purely actuarial considerations and require a broader approach, must also account for the diversity and complexity of long-term care blocks. Without tailored flexibility and limits, insurers could face undue financial strain, potentially compromising the sustainability of long-term care coverage. Guardrails would provide a transparent, predictable process that benefits both policyholders and the industry. We urge the LTCAWG to add the following to Section V, Actuarial Review, of the MSRR framework in 2024:

> To ensure a truly fair and equitable system, the MSA team will consider the following guardrails to account for the diversity and complexity of long-term care blocks. These guardrails will prevent the imposition of excessive cost sharing where it is inappropriate and allow for tailored solutions that reflect the specific characteristics of each block.
>
> 1. Block-Specific Flexibility: Introduce flexibility that allows for customized cost-sharing adjustments based on the unique characteristics of a block (e.g., block age, benefit richness, timing of past rate approvals) to reflect the diversity of long-term care insurance portfolios.
> 2. Adjustment for Delayed or Reduced State Approvals: Establish a mechanism to reduce or eliminate cost-sharing for older blocks where previously delayed, limited, or denied rate approvals by states have contributed to financial strain, acknowledging that timely approvals could have prevented the need for large, accumulated increases.

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3. Cost Sharing Transparency: Allow companies to clearly outline the degree of cost-sharing being applied, helping regulators understand how much of the needed premium increase has already been absorbed by the insurer versus passed to the policyholders.
4. Recognition of Block Profitability: Include considerations for newer, leaner blocks, where excessive cost-sharing could result in unreasonably low profitability, potentially discouraging insurers from entering the long-term care market or leading them to exit.
5. Monitoring and Periodic Review: Establish a process for the periodic review of cost-sharing measures to assess their impact on insurers and policyholders and to determine if future adjustments to the framework are necessary based on evolving market conditions and block performance.

We appreciate your continued efforts and look forward to collaborating as we work towards a balanced and sustainable solution for long-term care insurance rate reviews. By addressing these issues, we can create a more predictable and consistent process for all parties involved, which will help encourage insurers to remain in or enter the market.

Thank you for your consideration.

Sincerely,





Jan Graeber
Senior Actuary, ACLI

Ray Nelson
Consultant for AHIP

Genworth Life Insurance Company & Genworth Life Insurance Company of New York
Response to Single LTCI Multistate Rate Review Exposure Draft
October 28, 2024

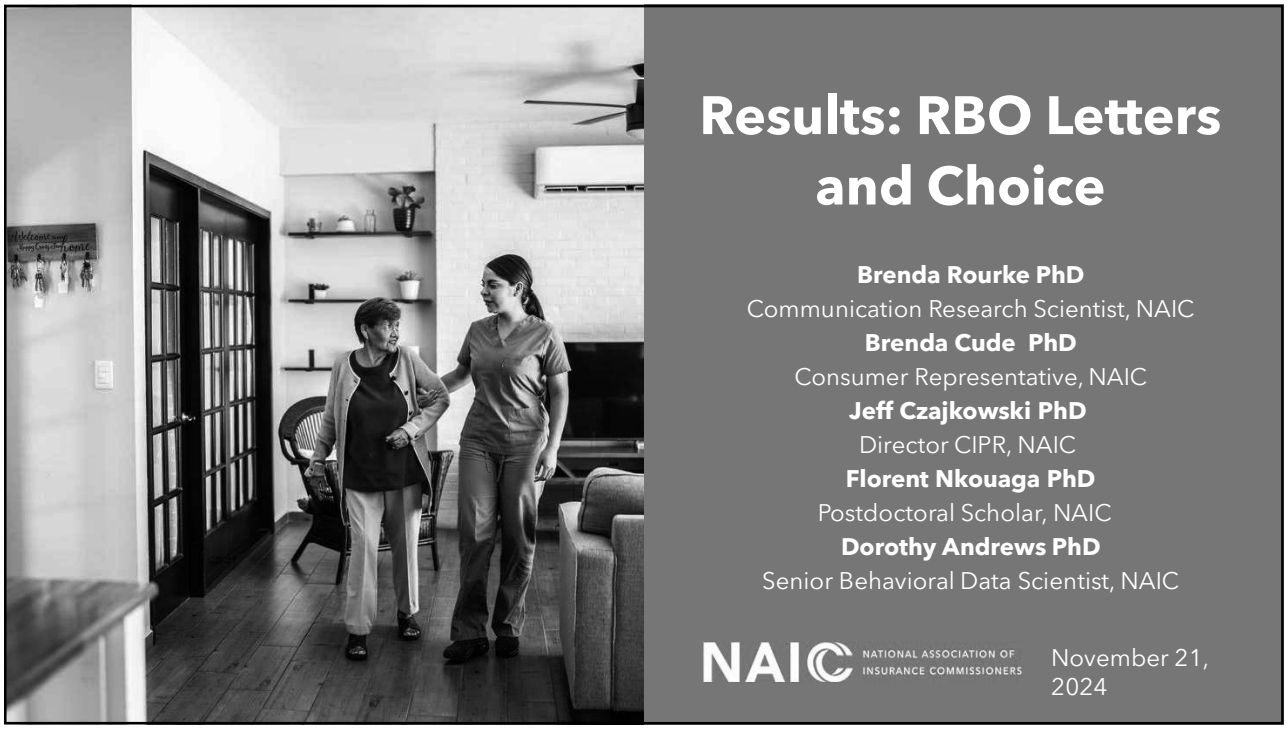
Genworth Life Insurance Company and Genworth Life Insurance Company of New York (collectively, "Genworth" or the "Company") appreciate the opportunity for continued engagement in the Single LTCI Multistate Rate Review development process.

Before commenting on the merits or drawbacks of a potential update to the additional cost-sharing provision, it is necessary to achieve clarity on the base method that produces the results to which the cost-sharing is applied. To begin, Genworth believes that **cumulative past increases should be backed out before blending**. Once this has been completed, it provides a very clear and transparent view to decision-makers of the exact contributions of the two components of the increase, and the amount of cost-sharing absorbed by the insurer. For the If-Knew portion, the result should be floored at zero so as not to imply that a rate *decrease* would be appropriate given that the initiation of the pricing exercise was the result of a deterioration in experience; a negative contribution from If-Knew would be logically unsound. Additional clarity would also be necessary regarding Aggregate vs. Sample Policy approach, treatment of future implementation dates, consistency with existing laws, handling of Waiver of Premium benefits, and phasing of rate increases, all of which can have profound impacts on the ultimate rate increase before considering how the additional cost-sharing may alter the result.

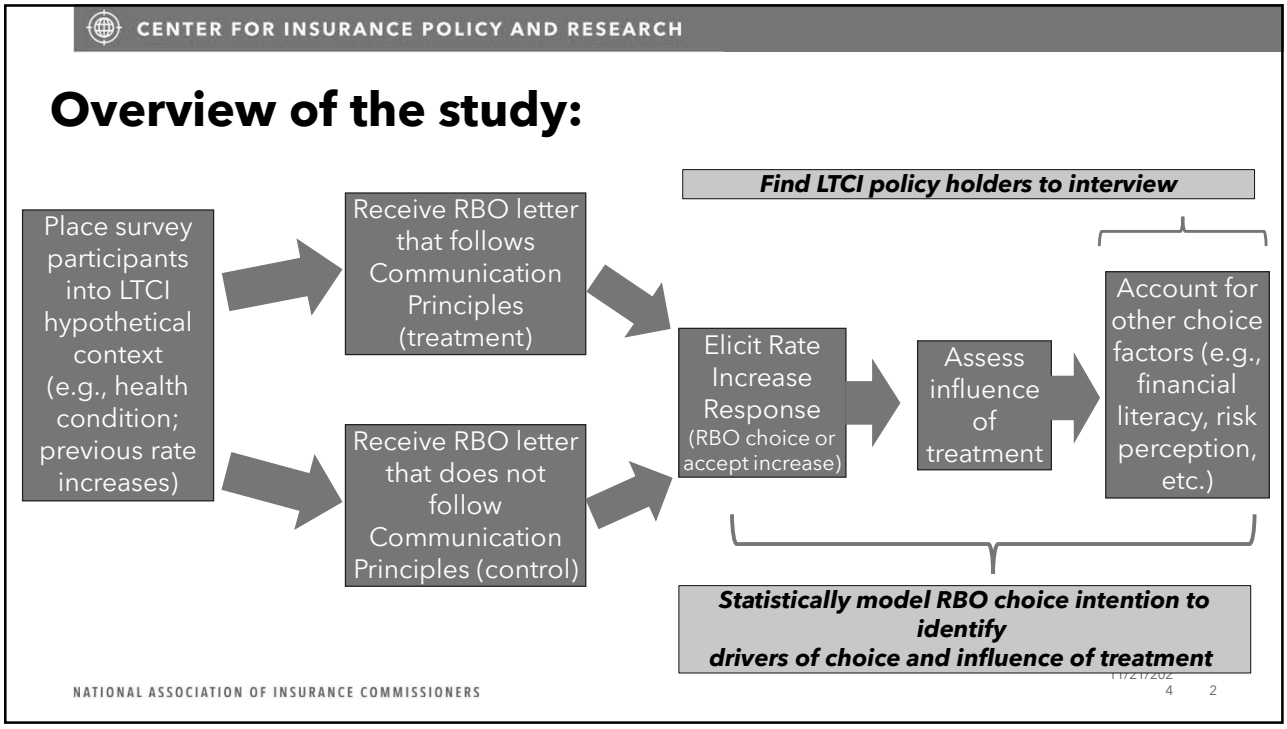
Additional Cost-Sharing Proposals Detailed In Exposure

Regarding the additional cost-sharing formula proposals in the most recent exposure: while Proposal A may be a compromise to the original Minnesota method, Genworth cannot support arbitrary limitations and levels not based in sound analytical or actuarial methods. The arbitrary caps detailed in Proposal B would further hinder a company's ability to manage its in-force business, and reward states which have been slow to review and approve justified increases, thereby increasing the rate increase needs to support claims-paying ability. Any cost-sharing on top of a review methodology should be discussed and decided between an individual insurer and regulator based on applicable law and unique circumstances.

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Results: RBO Letters and Choice
Brenda Rourke PhD
Communication Research Scientist, NAIC
Brenda Cude PhD
Consumer Representative, NAIC
Jeff Czajkowski PhD
Director CIPR, NAIC
Florent Nkouaga PhD
Postdoctoral Scholar, NAIC
Dorothy Andrews PhD
Senior Behavioral Data Scientist, NAIC
NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
November 21, 2024

1


CENTER FOR INSURANCE POLICY AND RESEARCH
Overview of the study:
Find LTCI policy holders to interview
Place survey participants into LTCI hypothetical context (e.g., health condition; previous rate increases)
Receive RBO letter that follows Communication Principles (treatment)
Receive RBO letter that does not follow Communication Principles (control)
Elicit Rate Increase Response (RBO choice or accept increase)
Assess influence of treatment
Account for other choice factors (e.g., financial literacy, risk perception, etc.)
Statistically model RBO choice intention to identify drivers of choice and influence of treatment
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4 2

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CENTER FOR INSURANCE POLICY AND RESEARCH

The Participants

N= 1118
Female = 581
Male= 537

Zone	n	Percent
Northeast	380	34%
Southeast	201	18%
Midwest	396	35%
Western	141	13%
Total	**1118**	

Age	n	Percent
55 - 64	385	34%
65 - 74	492	44%
75 - 84	220	20%
85 or older	21	2%
Total	**1118**	

66% of the sample is 65 or older.

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(see the reference slides for more demographics)

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CENTER FOR INSURANCE POLICY AND RESEARCH

Choice: Premium Increase, Contingent Nonforfeiture or Reduced Benefit Option (RBO)

Choices used in the models:

Participant Choice	Count	Percent
1. Pay the increase	314	28%
2. Contingent non-forfeiture	183	16%
3. Other RBO Choice	621	55%
Total	**1118**	

All Other RBO Choices	Count	Percent
Reduce daily/monthly benefit	282	25%
Reduce inflation protection	148	13%
Shorten benefit period	123	11%
Increase elimination period	68	6%
Total	621	55%

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4

CENTER FOR INSURANCE POLICY AND RESEARCH

Modeling Choice

Every model includes the following:

1. The Conditions
2. Personal Characteristics
3. Demographics

Model 1: Perceptions of The Letter and The Context

Do perceptions of the letter, or having a prior rate increase explain the acceptance of the premium increase or a reduced benefit option?

Model 2: The Theory of Planned Behavior

Do attitudes, perceived behavioral control, and subjective norms explain the acceptance of the premium increase or a reduced benefit option?

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Model 1:

	Variables	Accept Premium Increase	Contingent Nonforfeiture	All Other Reduced Benefit Options
Conditions	Prior Rate Increase	✓*		-✓*
	Type of Letter			
Perceptions of the Letter	Tone		-✓*	
	Clarity	✓*		-✓*
Personal Characteristics	Financial Knowledge	✓*	✓*	-✓**
	Risk Perceptions	✓*		
	Risk Tolerance			
Demographics	Age			
	Gender	-✓**	✓**	
	Education			
	Income			
	Total # of Savings Accounts			-✓*

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- Indicates a negative relationship ***p*<.05 ****p*<.01

6

6

CENTER FOR INSURANCE POLICY AND RESEARCH

Model 1 Summary

1. Participants who thought the letter was clear were more likely to accept the premium increase or an RBO other than the CNF option.
2. Participants who were asked to assume a prior rate increase were more likely to accept the premium increase and less likely to accept the other RBOs.
3. Women were less likely to accept the premium increase and more likely to take the CNF option.
4. Financial knowledge was a significant predictor – Such that those that scored higher in financial knowledge were more likely to accept the premium increase or the contingent nonforfeiture option and they were less likely to accept any of the reduced benefit options.
5. Participants who were more likely to think they may need long-term care were also more likely to accept the premium increase.

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CENTER FOR INSURANCE POLICY AND RESEARCH

Model 2:

Variables		Accept Premium Increase	Contingent Nonforfeiture	All Other Reduced Benefit Options
Conditions	Prior Rate Increase			- ✓ *
	Type of Letter			
Theory of Planned Behavior	Attitudes			✓ *
	Behavioral Control	✓ *		- ✓ **
	Normative Beliefs	✓ *		
Personal Characteristics	Financial Knowledge	✓ *	✓ *	- ✓ ***
	Risk Perceptions	✓ *		
	Risk Tolerance			
Demographics	Age			
	Gender	- ✓ **	✓ **	
	Education			
	Income			
	Total # of Savings Accounts			- ✓ *

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- Indicates a negative relationship ***p*<.05 **p*<.01 *p*<.001*** 8

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Model 2 Summary

1. Participants with more positive attitudes were more likely to accept an RBO.
2. Participants who thought they had more behavioral control were more likely to accept the premium increase and less likely to choose an RBO.
3. Financial knowledge was a significant predictor in each model, but negatively related to choosing an RBO.
4. Participants who thought they were more likely to need long-term care were more likely to pay the higher premium.
5. Women are less likely to accept the premium increase and more likely to choose the CNF option.
6. Participants who were asked to assume a prior rate increase were less likely to select an RBO.

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Results Summary

1. The clarity of the letters matters.

– We recommend revisiting the guidelines used to review rate increase letters to ensure the communication is accessible to the general population and uses "plain language" (Blaise, 2023).

1. Plain language emphasizes brevity: short sentences, short paragraphs, and short sections.
2. Plain language prefers using present tense verbs and active voice.
3. Writing with simple words and phrases, minimizing jargon, abbreviations, and definitions exemplify plain language.

2. Greater perceived behavioral control and financial knowledge.

- Policyholders make different choices when they believe they have the skills and ability to make this choice.
  - Providing education and resources to help consumers make this choice is important.

3. Those who received a prior rate increase, and a greater perception of the risk of needing long-term care were more likely to keep their policy and pay the higher premium, regardless of age, income, or education.

**** A complete report of the findings from this work will be published by the end of the year.***

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Looking Forward to 2025:

What we don't know:

1. How would modifying the language used in the letter ("plain language", reading level, etc.) impact clarity and choice?

   How to test this:

   Test letters that use a lower reading level and remove complicated "insurance language" and jargon where applicable.

2. Should all rate increase letters include values for each of the options?

   How to test this:

   Provide letters with a table that shows the impact of each choice on their premium.

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3. What additional criteria from the Principles and Guidelines could be tested and how will this impact clarity and choice?

   How to test this: *Continue looking at consumer understanding and perceptions of RBO options by examining:*

   1. The perceived value of the options

   2. The impact of the decision

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Reference Slide

From the Guidelines and Checklist:

From the Guidelines:

Understanding Policy Options

Insurers should consider communicating the impact of options by:

- Displaying the options in a way that enables policyholders to compare options, including details such as:
  - o Daily/monthly benefit.
  - o Benefit period.
  - o Inflation option.
  - o Maximum lifetime amount.
  - o Premium increase percentage and/or new premium.
  - o Nonforfeiture (NFO) or contingent nonforfeiture (CNF) amount.
  - o If the policy is Partnership qualified, changes to benefits may impact Partnership status.
  - o Current premium

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From the Checklist

Readability and accessibility:

1. 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.
2. Are all technical insurance terms clearly explained in the communication?
3. Are all technical terms used consistently throughout the communication?
4. Is the communication in an easily readable font? For example: Is the type at least 11-pointtype?
5. Does the communication use headings to help the reader find information easily?
6. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?
7. Are tables, charts, and other graphics, easy to read and understand? (See question 18 for reference).
8. Are the grade level and reading ease scores appropriate according to state readability standards?
9. Are reduced benefit options clear and not misleading? For example: Are there side-by-side illustrations of options compared with current benefits?

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REGULATORY FRAMEWORK (B) TASK FORCE

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Draft: 11/19/24

Regulatory Framework (B) Task Force
Denver, Colorado
November 17, 2024

The Regulatory Framework (B) Task Force met in Denver, CO, Nov. 17, 2024. The following Task Force members participated: Glen Mulready, Chair (OK); Ann Gillespie, Vice Chair, represented by Chris Heisler (IL); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Sanjeev Chaudhuri (AL); Michael Conway represented by Kate Harris and Debra Judy (CO); 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 Shannon Hohl (ID); Holly W. Lambert represented by Scott Shover (IN); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark represented by Shaun Orme (KY); Michael T. Caljouw represented by Kevin P. Beagan (MA); Robert L. Carey represented by Marti Hooper (ME); Chlora Lyndley-Myers represented by Amy Hoyt (MO); Mike Causey represented by Charles Whitehead (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Maggie Reinert and Margaret Garrison (NE); D.J. Bettencourt represented by Michelle Heaton (NH); Scott Kipper (NV); Judith L. French represented by Kyla Dembowski (OH); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Debra Diaz-Lara and Daniel McAdams (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Mike Kreidler represented by Ned Gaines (WA); Nathan Houdek represented by Rebecca Rebholz (WI); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted its Nov. 4 and Summer National Meeting Minutes

The Task Force met Nov. 4. During this meeting, the Task Force adopted its 2025 proposed charges and proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).

Bartuska made a motion, seconded by Kosky, to adopt the Task Force's Nov. 4 (Attachment One) and Aug. 13 (*see NAIC Proceedings – Summer 2024, Regulatory Framework (B) Task Force*) minutes. The motion passed unanimously.

2. Adopted its Subgroup and Working Group Reports

Keen made a motion, seconded by Fix, to adopt the following reports: 1) the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Oct. 17 (Attachment Two) and Sept. 9 (Attachment Three) minutes; 2) the Employee Retirement Income Security Act (ERISA) (B) Working Group; 3) the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its Aug. 14 (Attachment Four) minutes; and 4) the Pharmaceutical Benefit Management Regulatory Issues (B) Working Group. The motion passed unanimously.

3. Heard a Presentation from AffirmedRX on PBM Transparency

Rob Nolan (AffirmedRX) discussed pharmacy benefit management (PBM) transparency initiatives. He offered a brief overview of PBMs, emphasizing the importance of transparency in PBM operations and addressing related challenges and barriers. He described public benefit corporations (PBCs) and PBC PBMs, highlighting how PBC PBMs focus on providing transparent and ethical drug pricing while ensuring access to medications for underserved populations. Nolan said this approach: 1) enhances trust among stakeholders, partners, and the public; 2) attracts socially conscious investors; and 3) improves public image and reputation. He discussed future directions, including PBM transparency emerging trends, the potential impact of new technologies, and ongoing

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legislative and regulatory efforts. He noted that AffirmedRX is an example of a PBM that uses a fully transparent, fee-based model that passes through rebates directly to consumers, avoiding hidden fees and ensuring that savings are shared.

Nolan emphasized the importance of PBM transparency for fair pricing and improved patient outcomes. He also stressed the importance of continuing efforts to promote transparency and accountability. Nolan encouraged stakeholders to support transparency initiatives and advocate for policies that ensure fair and equitable access to medications.

Fix asked about AffirmedRX's relationship with pharmacies and whether its transparency model is the same for pharmacies. Nolan said AffirmedRX operates with the same transparency in its contracts with pharmacies.

Commissioner Mulready asked Nolan to clarify what he meant about PBC PBMs' ability to attract socially conscious investors. Nolan explained that being socially conscious means investors are aligned with a PBC PBM's mission to provide transparent and ethical drug pricing while ensuring access to medications for underserved populations. Commissioner Mulready asked why AffirmedRX uses a separate company, JustifyRX, a full-service rebate collective PBC, for its rebating operations. Nolan said AffirmedRX decided to contract with JustifyRX as part of its transparency initiatives and, as such, wanted an arm's length arrangement between the two companies.

4. Discussed Issues Related to the Implementation of ACA Section 1557 and its Final Regulation

Amy Killelea (Killelea Consulting) and Jalisa Clark (Center on Health Insurance Reforms—CHIR) provided an overview of the federal Affordable Care Act's (ACA's) Section 1557 nondiscrimination provisions, including the application of its nondiscrimination provisions to Medicare supplemental insurance (Medigap) and other excepted benefit products. They also highlighted that Section 1557's nondiscrimination provisions apply to any health program or activity, including any part of which is receiving federal financial assistance.

Killelea noted that given the recent presidential election, it is anticipated that there could be a change in direction on how the final regulations could be interpreted and implemented. She said that because of this, state insurance regulators can play an important role in ensuring that Section 1557's nondiscrimination protections are applied and enforced.

Meghan Stringer (AHIP) said AHIP supports the final regulation's protections against discrimination. She discussed the importance of excepted benefit products to consumers and the value they provide to millions of Americans. She highlighted the four categories of excepted benefit products most utilized: 1) Medigap; 2) supplemental health (hospital or other fixed indemnity, specified disease, accident-only); 3) disability income; and 4) long-term care (LTC).

Stringer noted the outstanding questions that remain, including: 1) what the rules are for using gender as a rating factor; and 2) how the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) will evaluate "unaffordability" and "fundamental alteration" as applied to plan benefit design and underwriting. She said federal guidance is needed to clarify and answer these questions, particularly with respect to Medigap plans, because neither covered entities nor state insurance regulators have the information to answer these outstanding questions.

Stringer said trying to implement the final regulations amid this level of uncertainty would cause severe and potentially unnecessary disruptions in the market and create confusion among consumers. Stringer urged state insurance regulators to wait until the OCR provides guidance to answer the questions.

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Harris asked Killelea and Clark what recommendations or best practices they would suggest for state insurance regulators to use to ensure enforcement of Section 1557's nondiscrimination provisions. Killelea said the complaint process is one tool, but on a more proactive basis, state insurance regulators should use their review authority to review plan benefit designs for potential discriminatory benefit designs.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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Draft: 11/7/24

Regulatory Framework (B) Task Force
Virtual Meeting
November 4, 2024

The Regulatory Framework (B) Task Force met Nov. 4, 2024. The following Task Force members participated: Glen Mulready, Chair (OK); Ann Gillespie, Vice Chair (IL); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Anthony Williams and Yada Horace (AL); Ricardo Lara represented by Tyler McKinney (CA); Michael Conway represented by Debra Judy (CO); 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); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Angi Raley (KY); Michael T. Caljouw represented by Kevin Beagan (MA); Robert L. Carey represented by Robert Wake (ME); Chlora Lyndley-Myers (MO); Mike Causey represented by Ted Hamby and Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); D.J. Bettencourt represented by Michelle Heaton (NH); Justin Zimmerman represented by David Wolf (NJ); Scott Kipper represented by Jeremy Christensen (NV); Judith L. French represented by Laura Miller (OH); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Rachel Bowden and Debra Diaz-Lara (TX); Jon Pike represented by Shelley Wiseman and Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Mike Kreidler represented by Ned Gaines (WA); Nathan Houdek (WI); and Allan L. McVey (WV). Also participating was: Andy Schallhorn (OK).

1. Adopted the Revisions to Model #171

Commissioner Mulready said the Task Force's first item of business is to consider adoption of the proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). He explained that in 2013, the former Affordable Care Act Model (ACA) Review (B) Working Group identified Model #171 and its companion model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*), as needing to be revised because of the federal Affordable Care Act (ACA). After completing revisions to other NAIC models with a higher priority, in 2016, the Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup to revise Model #170 and Model #171. The Subgroup completed its work on Model #170 in late 2018. The full NAIC membership adopted those revisions in February 2019.

Commissioner Mulready said the Model #170 revisions removed provisions for certain types of health insurance products that would not be permitted because of the requirements of the ACA leaving only those products considered to be excepted benefits and, therefore, not subject to the ACA's requirements. He said the Subgroup also added short-term, limited-duration (STLD) plans to the model because there was no other vehicle available in which to incorporate such plans, and the Subgroup did not want to create a new model for them. Commissioner Mulready said the proposed revisions to Model #171 revise the model for consistency with Model #170. The revisions also add standards for STLD plans and clarify provisions on consumer disclosure and outline of coverage requirements. He said the Subgroup adopted the revisions on Oct. 17.

Commissioner Humphreys said the NAIC consumer representatives submitted a comment letter to the Task Force just prior to the start of the meeting suggesting that they could not support the proposed revisions due to a provision in Model #171 that allows carriers to exclude coverage for "mental or emotional disorders, alcoholism, and drug addiction" and "suicide (sane or insane), attempted suicide, or intentionally self-inflected injury." He expressed concern about the provision and given this concern, he said he could not support the proposed revisions. Commissioner Humphreys suggested that the Task Force and the Health Insurance and Managed Care

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(B) Committee should discuss the issue, particularly as to mental health coverage, more broadly. He said a lot has changed with respect to mental health coverage since the ACA was enacted and since the time the Subgroup began discussing the Model #171 revisions. Commissioner McVey expressed support for having a broader conversation of the issue. He also said he would vote to adopt the proposed revisions to move the model forward to the Health Insurance and Managed Care (B) Committee to hold those discussions.

Commissioner Humphreys asked if the Subgroup discussed the NAIC consumer representatives' concerns. Commissioner Mulready said the Subgroup had an extensive discussion on this provision. He also reiterated that Model #171 sets minimum standards, which means states can go further. Schallhorn, as co-chair of the Subgroup, agreed with Commissioner Mulready's comments.

Chris Petersen (Arbor Strategies LLC) noted that when the Subgroup discussed the provision, it was pointed out that the federal Mental Health Parity and Addiction Equity Act (MHPAEA) does not apply to excepted benefits coverage. He said there was also a concern expressed that mandating such coverage would require reopening Model #170. Petersen expressed support for moving the model forward for the Health Insurance and Managed Care (B) Committee's consideration and, if the Task Force decides it is appropriate, discussing the issue the NAIC consumer representatives' issue independently.

Jackson Williams (Dialysis Patient Citizens—DPC) said the proposed revisions to Model #171 represent a missed opportunity to bring greater value to consumers on products notorious for being of low value. He expressed disappointment that the Subgroup did not consider his proposals to address the issue.

J.P. Wieske (Horizon Government Affairs) said it is important to keep in mind that the products regulated under Model #170 and Model #171 are medically underwritten. As such, mandating mental health coverage could have the unintended consequence of limiting product availability. He also said Model #170 would have to be reopened.

Lucy Culp (The Leukemia & Lymphoma Society—LLS) restated the NAIC consumer representatives' comments included in its letter, including that the provision in Model #171 allowing a permitted exclusion for mental health coverage is not only out-of-step with advances in the mental health field, but also it is at odds with the NAIC's commitment to mental health parity and meaningful response to the opioid crisis. She also said that the landscape regarding mental health coverage has changed even since last year given the recently issued federal final rules implementing the ACA's Section 1557 nondiscrimination provisions. Culp said the NAIC consumer representatives believe the issue is not settled and that there needs to be further discussion. She asked about the process for reopening Model #170. Jolie H. Matthews (NAIC) said the Health Insurance and Managed Care (B) Committee would have to approve a Request for NAIC Model Law Development to reopen Model #170. She highlighted a few of the requirements necessary for such approval. Culp said the NAIC consumer representatives disagree with the comments suggesting that Model #170 would need to be reopened.

Deborah Steinberg (Legal Action Center—LAC) said that at the time the Subgroup discussed this issue, as other NAIC consumer representatives have stated, there were no mental health and substance use disorder experts included in the discussion. She said that as a mental health and substance use disorder expert, she would appreciate the opportunity to speak on the issue and include others with similar expertise as part of the discussion given the importance of recognizing these as health conditions. Amy Killelea (Killelea Consulting LLC) expressed support for Culp's and Steinberg's comments. She also said that as stated in the NAIC consumer representatives' comment letter, because the ACA's Section 1557 nondiscrimination protections apply to any excepted benefit products that receive federal assistance, directly or through a parent company, the permitted exclusion provision for mental health coverage in Model #171 is also likely illegal under federal law for a subset of these products. She urged the Task Force to take a closer look at the potential impact of the ACA's Section 1557 nondiscrimination provisions on the proposed revisions.

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William Schiffbauer (Schiffbauer Law Office) said that adding mental health benefits to excepted benefit products could make them look more like comprehensive major medical coverage, which is what the Subgroup has been trying to avoid throughout the drafting process. He also acknowledged that the ACA's Section 1557 discrimination provisions apply to products that receive federal funds, but he said the excepted benefit products regulated under Model #170 and Model #171 do not receive federal funds. Wieske noted that if the permitted exclusion for mental or emotional disorders, alcoholism, and drug addiction was removed from Model #171, that would not result in coverage for those conditions. He said Model #170 would have to be revised to require coverage.

Commissioner McVey made a motion, seconded by Heaton, to adopt the revisions to Model #171 (Attachment One-A). The motion passed with the following states present and voting in favor of the motion: Alaska, Connecticut, Idaho, Iowa, Kansas, Kentucky, Maine, Massachusetts, Missouri, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, South Dakota, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin. The following states voted against the motion: Colorado and Pennsylvania. The following states abstained: Indiana and Ohio.

2. Adopted its 2025 Proposed Charges

Commissioner Mulready said that prior to this meeting, NAIC staff distributed the Task Force's 2025 proposed charges for comment with a public comment period ending Oct. 24. The Task Force received one comment from Virginia suggesting that the Task Force add "excepted benefit products" to charge #1F. He said that in addition to this change, the other substantive change from the 2024 charges is the deletion of the charge for the Accident and Sickness Insurance Minimum Standards (B) Subgroup because it has completed its charge.

Gaines made a motion, seconded by Commissioner McVey, to adopt the Task Force's 2025 proposed charges (Attachment One-B). The motion passed unanimously.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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Adopted by the Health Insurance and Managed Care (B) Committee - TBD
Adopted by the Regulatory Framework (B) Task Force – Nov. 4, 2024
Adopted by the Accident and Sickness Insurance Minimum Standards (B) Subgroup – Oct. 17, 2024

Draft: 10/17/24
Model#171

The revisions to this draft reflect changes made from the existing model. Any comments on this draft should be sent by email only to Jolie Matthews at jmatthews@naic.org.

MODEL REGULATION TO IMPLEMENT THE ~~ACCIDENT AND SICKNESS~~SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

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Section 1. Purpose

The purpose of this regulation is to implement [insert reference to state law equivalent to the NAIC ~~Accident and Sickness~~ *Supplementary and Short-Term Health Insurance Minimum Standards Model Act*] (the Act) to standardize and simplify the terms and coverages, ~~of individual accident and sickness insurance policies, and group accident and sickness policies and certificates providing hospital confinement indemnity, accident only, specified disease specified accident or limited benefit health coverage (hereafter referred to as "group supplemental health insurance"). This regulation is also intended~~ to facilitate public understanding and comparison of coverage, to eliminate provisions ~~contained in individual accident and sickness insurance policies and group supplemental health insurance~~ that may be misleading or confusing in connection with the purchase and renewal of the coverages or with the settlement of claims~~;~~ and to provide for full disclosure in the marketing and sale of ~~individual accident and sickness insurance policies and group supplemental health insurance~~ supplementary and short-term health insurance, as defined in the Act. This regulation is also intended to assert the commissioner's jurisdiction over limited scope dental coverage and limited scope vision ~~plans~~coverage, and to provide for disclosure in the sale of those ~~plans~~coverages.

~~**Drafting Note**: States should determine if the phrase "individual accident and sickness insurance policies" is broad enough or particular enough to cover the array of individual health insurance issuers in the state. States that use different terminology (e.g. "subscriber contracts" of "nonprofit hospital, medical and dental associations") to cover these plans should choose terminology conforming to state statute.~~

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [insert reference to state law equivalent to NAIC ~~Accident and Sickness~~*Supplementary and Short-Term Health Insurance Minimum Standards Model Act* and any other appropriate section of law regarding authority of commissioner to issue regulations].

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Section 3. Applicability and Scope

A. This regulation applies to all individual ~~accident and sickness insurance policies~~ and group ~~supplemental health~~insurance policies and certificates providing hospital indemnity or other fixed indemnity, accident only, specified accident, specified disease, limited benefit health and disability income protection, referred to collectively in Section 1 of the Act and hereafter, as "supplementary health insurance," delivered or issued for delivery in this state on and after [insert effective date] that are not specifically exempted from this regulation. This regulation applies to short-term, limited-duration insurance coverage offered, delivered or issued for delivery to residents of this state regardless of the situs of the delivery of the contract on and after [insert effective date].

B. This ~~Act~~regulation ~~shall apply~~applies to limited scope dental ~~plans~~coverage and limited scope vision ~~plans~~coverage only as specified.

C. This regulation shall not apply to:

~~(1) Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this regulation;~~

~~(2) Policies issued to employees or members as additions to franchise plans in existence on the effective date of this regulation;~~

~~(3)~~(1) Medicare supplement policies subject to [insert reference to state law equivalent to the Model Regulation to Implement the NAIC *Medicare Supplement Insurance Minimum Standards Model Act*];

~~(4)~~(2) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act*]; ~~or~~

~~(5)~~(3) TRICARE ~~Civilian Health and Medical Program of the Uniformed Services~~ (Chapter 55, ~~t~~Title 10 of the United States Code) ~~(CHAMPUS)~~ supplement insurance policies; or

(4) Limited long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Limited Long-Term Care Insurance Model Act*].

Drafting Note: ~~CHAMPUS~~TRICARE supplement insurance is not subject to federal regulation. ~~CHAMPUS~~TRICARE supplement policies are sold only to eligible individuals as determined by the Department of Defense and are tied to ~~CHAMPUS~~TRICARE benefits. In general, states regulate ~~CHAMPUS~~TRICARE supplement insurance policies under the state group or individual insurance laws.

D. The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted.

Section 4. Effective Date

This regulation shall be effective on [insert a date not less than 120 days after the date of adoption of the regulation]. The amendments to this regulation shall apply to any policies [or certificates] issued on or after the effective date of the adoption of the amended regulation.

Section 5. Definitions

For purposes of this regulation:

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A. "Excepted benefits" means coverage listed at section 2791(c) of the Public Health Service Act (PHSA) or subsequently added by regulation where authorized.

B. "Medicare" means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

C. "Short-term, limited-duration insurance" has the meaning stated in Section 3I of the Act.

Section ~~5~~6. Policy Definitions

A. (1) Except as provided in this regulation, ~~an individual accident and sickness insurance policy or group supplemental health insurance policy~~a supplementary health insurance or a short-term limited duration insurance policy delivered or issued for delivery to any person in this state and to which this regulation applies shall contain definitions respecting the matters set forth below that comply with the requirements of this section.

(2) Except as provided in this regulation, to the extent these definitions are used in a policy [or certificate], definitions used in a policy [or certificate] may vary from the definitions in this section, but not in a manner that restricts coverage.

~~B (1) "Accident," "accidental injury," and "accidental means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.~~

~~(2) The definition shall not be more restrictive than the following: "injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause and that occurs while the insurance is in force.~~

~~(3) The definition may provide that injuries shall not include injuries for which benefits are provided under workers' compensation, employers' liability or similar law; or under a motor vehicle no-fault plan, unless prohibited by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.~~

~~C~~B. "Convalescent nursing home," "extended care facility," ~~or~~ "skilled nursing facility," "assisted living facility" or "continued care retirement community" ~~shall be defined~~means in relation to its status, facility and available services.

(1) A definition of the home or facility shall not be more restrictive than one requiring that it:

(a) Be operated pursuant to law;

(b) Be approved for payment of Medicare and/or Medicaid benefits or be qualified to receive approval for payment of Medicare and/or Medicaid benefits, if so requested;

(c) Be ~~primarily~~ engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(d) Except for an "assisted living facility" or a "continued care retirement community," ~~Provide~~provide continuous twenty-four-hour-a-day nursing service by or under the supervision of a registered nurse; and

(e) Maintain a daily medical record of each patient.

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(2) The definition of the home or facility ~~may provide that the term shall not be inclusive of~~ is permitted but is not required to exclude:

(a) A home, facility or part of a home or facility used primarily for rest;

(b) A home or facility for the aged and/or for the care of ~~drug addicts or alcoholics~~individuals with a substance use disorder; or

(c) A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care.

Drafting Note: The laws of the states relating to nursing and extended care facilities recognized in health insurance policies are not uniform. Reference to the individual state or federal Medicare or Medicaid law may be required in structuring this definition.

C. "Home health care agency":

(1) Is an agency approved under Medicare;

(2) Is licensed to provide home health care under applicable state law; or

(3) Meets all the following requirements:

(a) It is primarily engaged in providing home health care services;

(b) Its policies are established by a group of professional personnel, including at least one physician and one licensed nurse;

(c) A physician or a registered nurse provides supervision of home health care services;

(d) It maintains clinical records on all patients; and

(e) It has a full-time administrator.

Drafting Note: State licensing laws vary concerning the scope of "home health care" or "home health agency services" and should be consulted. In addition, a few states have mandated benefits for home health care, including the definition of required services.

~~C~~D. "Hospital" ~~may be defined~~means in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission ~~on Accreditation of Healthcare Organizations~~.

(1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

(a) Be an institution licensed to operate as a hospital pursuant to law;

(b) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and

(c) Provide twenty-four-hour nursing service by or under the supervision of registered nurses.

(2) The definition of the term "hospital" ~~may state that the term shall not be inclusive of~~ is permitted but is not required to exclude:

(a) Convalescent homes or, convalescent, rest or nursing facilities;

(b) Facilities affording primarily custodial, educational or ~~rehabilitory~~rehabilitative care;

(c) Facilities for the aged~~, drug addicts or alcoholics~~ or individuals with a substance use disorder; or

(d) A military or veterans' hospital, a soldiers' home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services ~~rendered on an emergency basis~~ where a legal liability for the patient exists for charges made to the individual for the services.

Drafting Note: The laws of the states relating to the type of hospital facilities recognized in health insurance policies are not uniform. References to individual state law may be required in structuring this definition.

E. (1) "Injury" means a bodily injury resulting from an accident, independent of disease, which occurs while the coverage is in force.

(2) The definition shall not use words such as "external, violent, visible wounds" or similar words of characterization or description.

(3) The definition may state that the disability shall have occurred within a specified period of time (not less than thirty (30) days) of the injury, otherwise the condition shall be considered a sickness.

(4) The definition may provide that "injury" shall not include an injury for which benefits are provided under workers' compensation, employers' liability or similar law; or under a motor vehicle no-fault plan, unless prohibited by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.

~~E. "Medicare" means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.~~

F. "Mental or nervous disorder" ~~shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind~~ means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or its successor.

G. "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as an advance practice nurse, a registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words "nurse," "advance practice nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

Drafting Note: States may want to consider whether the functions of an advance practice nurse fall under this definition or the definition of "physician" in Subsection J.

H. "One period of confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

I. "Partial disability" ~~shall be defined in relation to~~ means that, due to a disability, an individual:

(1) ~~the individual's inability~~ Is unable to perform one or more but not all ~~of~~ the "major," "important" or "essential" duties of the individual's employment or existing occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation; and

(2) Is in fact engaged in work for wage or profit.

J. (1) "Physician" ~~may be defined by~~means and ~~including~~includes words such as "qualified physician" or "licensed physician~~.~~" and may not be defined more narrowly than applicable state licensing laws. ~~The use of these terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when the services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.~~

(2) The definition or concept may exclude the insured, the owner, the assignee, any person related to the insured, owner or assignee by blood or marriage, any person who shares a significant business interest with the insured, owner or assignee, or any person who is a partner in a legally sanctioned domestic partnership or civil union with the insured, owner or assignee.

Drafting Note: The laws of the states relating to the type of providers' services recognized in health insurance policies are not uniform. References to the individual state law may be required in structuring this definition.

K. "Preexisting condition" ~~shall not be defined more restrictively than the following: "Preexisting condition~~ means ~~the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a [two] year period preceding the effective date of the coverage of the insured person or~~ a condition for which medical advice or treatment was recommended by a physician or received from a physician within a [two-] year period preceding the effective date of the coverage of the insured person."

Drafting Note: This definition does not prohibit an insurer, using an application or enrollment form, including a simplified application form, designed to elicit the health history of a prospective insured and on the basis of the answers on that application or enrollment form, from underwriting in accordance with that insurer's established standards and in accordance with state law. It is assumed that an insurer that elicits a health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition, the policy or certificate will be endorsed or amended by including the specific exclusion. This same requirement of notice to the prospective insured of the specific exclusion will also apply to insurers that elect to use simplified application or enrollment forms containing questions relating to the prospective insured's health. This definition does, however, prohibit an insurer that elects to use a simplified application or enrollment form, with or without a question as to the proposed insured's health at the time of application or enrollment, from reducing or denying a claim on the basis of the existence of a preexisting condition that is defined more restrictively than above.

~~States that have specific requirements with respect to waivers or exclusionary riders or evidence of insurability requirements for group insurance should modify the preceding paragraphs by deleting group references and adding a new paragraph addressing these requirements. In states which have adopted or are operating under the "federal fallback" provisions the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for major medical coverage issued to a HIPAA eligible individual, there can be no preexisting condition exclusion. In addition, states that have specific preexisting condition requirements for group insurance may need to modify section Subsection K according to applicable statutes.~~

L. "Residual disability" ~~shall be defined~~means in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important" or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy that provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import that in the opinion of the commissioner adequately and fairly describes the benefit.

M. "Sickness" ~~shall not be defined to be more restrictive than the following: "Sickness~~ means sickness, illness, or disease of an insured person that first manifests itself after the effective date of insurance and while the

insurance is in force. A definition of sickness may provide for a probationary period that shall not exceed thirty (30) days from the effective date of the coverage of the insured person.~~"~~ The definition may be ~~further~~ modified to exclude sickness or disease for which benefits are provided under a ~~worker's~~workers' compensation, occupational disease, employers' liability or similar law.

N. "Total disability"

(1) A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience; and is not in fact engaged in any employment or occupation for wage or profit.

(2) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to:

(a) Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation"; or

(b) Engage in a training or rehabilitation program.

(3) An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may require care by a physician other than the insured or a member of the insured's immediate family.

Section ~~6~~7. Prohibited Policy Provisions

A. (1) Except as provided in ~~Section 5K~~this subsection, a policy shall not contain provisions establishing a probationary or waiting period during which ~~no~~ coverage ~~is provided~~ under the policy is excluded or restricted.~~, subject to the further exception that~~

(2) A policy, other than an accident only policy, may exclude coverage for a loss due to a preexisting condition, as defined in Section 6J, for a period not to exceed twelve (12) months following the issuance of the policy or certificate. The twelve-month limitation is not required if the condition was disclosed during the application or enrollment process and specifically excluded by the terms of the policy or certificate, or when the insured knowingly made a material misrepresentation during the application or enrollment process.

(3) ~~a~~A policy, other than an accident only policy or a short-term, limited duration health insurance policy, may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting from disease or condition related to hernia, disorder of the ~~reproduction~~reproductive organs, varicose veins, adenoids, ~~appendix~~ and tonsils, except when~~. However, the permissible six-month exception shall not be applicable where~~ the specified diseases or conditions are treated on an emergency basis. ~~Accident policies shall not contain probationary or waiting periods.~~

~~B. (1) A policy or rider for additional coverage may not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. A dividend policy or rider for additional coverage shall not be issued for an initial term of less than six (6) months.~~

~~(2) The initial renewal subsequent to the issuance of a policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional.~~

~~C. A policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than twelve (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 conditions or prior medical care and treatment and the preexisting condition is not specifically excluded by the terms of the policy or certificate.~~

~~**Drafting Note:** Where the state has enacted the NAIC Individual Accident and *Sickness Insurance Minimum Standard Act*, Subsection C is unnecessary. States that have specific preexisting condition requirements for group supplemental insurance may need to modify the preceding subsection according to applicable statutes.~~

~~D~~B. A disability income protection policy may contain a "return of premium" or "cash value benefit" option so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy; and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to the Act and this regulation shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

Drafting Note: This provision is optional and the desirability of its use should be reviewed by the individual states.

~~E~~C. Policies providing hospital ~~confinement~~ indemnity or other fixed indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

~~F~~D. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except ~~as follows~~for the following permitted exclusions:

Drafting Note: States should review the provisions of this subsection carefully to determine if any of the exceptions to limiting or excluding coverage by type of illness, accident, treatment or medical condition included in the subsection should apply to short-term, limited-duration health insurance coverage.

(1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;

(2) Mental or emotional disorders, alcoholism and drug ~~addition~~addiction;

Drafting Note: This provision is optional. States should review the desirability of permitting such exclusions.

(3) Pregnancy, except for complications of pregnancy, other than for policies defined in Section ~~7H~~8C of this regulation;

(4) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it;

(b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

(c) Non-commercial or recreational ~~A~~aviation;

(d) With respect to short-term nonrenewable policies, interscholastic sports; and

(e) With respect to disability income protection policies, incarceration.

Drafting Note: What should be an allowable exclusion in disability income protection insurance policies generates much debate. States should be aware that some argue for exclusion of certain diseases or conditions that are difficult to diagnose or are potentially subject to frequent claims (e.g., carpal tunnel and chronic fatigue syndromes). Others argue that carriers have the ability to detect fraudulent claims and deny payment on that basis without singling out specific conditions for blanket exclusion.

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(5) Cosmetic surgery, except ~~that "cosmetic surgery" shall not include~~ for reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly ~~of a covered dependent child~~ that has resulted in a functional defect;

(6) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or asymptomatic complaints of the feet;

(7) Chiropractic ~~C~~care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

Drafting Note: States should examine any existing "freedom of choice" statutes that require reimbursement of treatment provided by chiropractors~~,~~ and make adjustments if needed.

(8) ~~Treatment provided in a government hospital; b~~Benefits provided under Medicare or other governmental program (except Medicaid), a state or federal ~~workmen's~~workers' compensation, employers liability or occupational disease law, or motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance;

(9) Dental care or treatment, except where the provision of dental services is medically necessary due to the underlying covered medical condition or clinical status of the covered person, including but not limited to, reconstructive surgery;

(10) Eye-glasses, hearing aids and examination for the prescription or fitting of them;

(11) Rest cures, custodial care, transportation and routine physical examinations; ~~and~~

(12) Territorial limitations, provided that they do not exclude coverage for services rendered within the United States and its territories or possessions; and

(13) Genetic testing not ordered by a medical provider, and not used to diagnose or treat a disease.

Drafting Note: Some of the exclusions set forth in this provision may be unnecessary or in conflict with existing state legislation and should be deleted.

~~G~~E. Notwithstanding Subsection D of this section, ~~This~~this regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page.

~~**Drafting Note:** States with specific waiver requirements that differ for group insurance should add language in Subsection G to be consistent with applicable statutes.~~

~~H~~F. The enumeration in this section of specific precluded ~~Policy~~policy provisions ~~precluded in this section~~ shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with [cite Section ~~3~~4B of the ~~Accident and Sickness~~*Supplementary and Short-Term Health Insurance Minimum Standards Act*] that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.

G. A policy providing a type of supplementary health insurance that is not defined as a "plan" under the *Coordination of Benefits Model Regulation* (#120) shall not include a coordination of benefits provision or any other provision that allows it to reduce its benefits based on the existence of other coverage its insured may have.

H. A policy shall not limit an insured's choice of health care provider if the provider is licensed or otherwise qualified under state law and the services to be provided are within the health care provider's scope of practice.

Drafting Note: Former Subsection B in this section established provisions related to the issuance of a policy or rider for additional coverage as a dividend under specified circumstances. Subsection B was deleted because insurers rarely offer consumers policy dividends as a benefit on policies covered by this regulation. Such provisions are common in life insurance policies. If policy dividends are available on policies covered by this regulation in your state, you should look to the treatment of dividends in life insurance. Generally, consumers should be allowed to take the policy dividend as a cash payment, but insurers may offer the consumer additional policy benefits in lieu of a cash payment at the option of the consumer.

Section ~~7~~8. ~~Accident and Sickness~~ Supplementary and Short-Term Health Insurance Minimum Standards for Benefits

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. ~~An individual accident and sickness insurance policy or group supplemental~~A supplementary or short-term health insurance policy or certificate shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for the specified categories or the commissioner finds that the policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the outline of coverage in Section ~~8L~~9H of this regulation.

This section shall not preclude the issuance of any policy or contract combining two or more categories of excepted benefits set forth in [cite state law equivalent to Section 5~~A and~~ B and C of the NAIC ~~Accident and *Sickness*~~*Supplementary and Short-Term Health Insurance Minimum Standards Model Act*].

A. General Rules

(1) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" individual ~~accident and sickness~~supplementary policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy shall provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured.

Drafting Note: States should review the use of the term "spouse" in paragraph (1) above and replace it or add additional terms in accordance with state law or regulations.

(2) (a) The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Section ~~8~~9A~~(1)~~.

(b) The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in an individual ~~accident and sickness~~supplementary policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

~~(c) An individual accident and sickness or individual accident only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to~~

~~continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty five (65) while actively and regularly employed.~~

~~(d)~~(c) Except as provided ~~above~~in subparagraph (d) of this paragraph, the term "guaranteed renewable" may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

(d) An individual supplementary policy or individual accident-only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may be designated as "guaranteed renewable" if it provides that the insured has the right to continue the policy, while actively and regularly employed, at least until the insured has reached full retirement and, as defined under the federal Social Security Act.

(3) In an individual ~~accident and sickness~~supplementary policy covering ~~both husband and wife~~a married couple or civil union couple, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in the policy.

Drafting Note: The references to "married couple" and "civil union couple" in paragraph (3) above are intended to apply to any legally recognized marital relationship or domestic partnership recognized in the state. States should revise the language in accordance with state law or regulations. In addition, states should review the use of the term "spouse" and replace it or add additional terms in accordance with state law or regulations.

Drafting Note: For Paragraphs (2) and (3) above, coverage ~~as defined under~~ subject to Title XXVII of the federal Public Health Service Act (PHSA), as enacted by HIPAA and amended by the federal Affordable Care Act (ACA), ~~or applicable state law~~ must be guaranteed renewable except for reasons stated in ~~Part B~~PHSA ~~Section~~§ 2742 (42 U.S.C. § 300gg-42)~~of Title XXVII (Public Health Service Act) as amended by HIPAA or applicable state law~~, unless it is an excepted benefit as described in ~~Part B Sections 2721, 2763 and 2791 of Title XXVII as amended by HIPAA~~ PHSA § 2791(c) (42 U.S.C. § 300gg-91(c))~~or~~. ~~a~~Applicable state law may impose requirements that mirror or exceed the federal requirements.

(4) When accidental death and dismemberment coverage is part of the individual ~~accident and sickness~~supplementary insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.

(5) If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.

(6) ~~In the event the insurer cancels or refuses to renew, p~~Policies providing pregnancy benefits shall provide for an extension of benefits, in the event the insurer cancels or refuses to renew for reasons other than non-payment of premium, as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

(7) Policies providing convalescent or extended care benefits following hospitalization ~~shall not~~may condition the benefits upon admission to the convalescent or extended care facility within a ~~period of~~ specified time after discharge from the hospital, as long as the required admission date is not less than ~~fourteen (14) days~~thirty (30) days after discharge from the hospital.

(8) In individual ~~accident and sickness~~supplementary or short-term health insurance policies, coverage shall continue for a dependent child who is incapable of self-sustaining employment due to ~~mental retardation or physical handicap~~intellectual or physical disability on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days ~~of~~ after the date the ~~company~~insurer receives due proof of the ~~incapacity~~disability in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.

(9) A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.

(10) A policy may contain a provision relating to recurrent disabilities; but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six (6) months.

(11) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income protection benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.

(12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(13) An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage and the disclosure materials required under Section 9 of this regulation the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.

(14) Termination of the policy shall be without prejudice ~~of to~~to the right to receive benefits for a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.

(15) A policy providing coverage for certain illnesses and injuries may not define covered illnesses and injuries in a way that is misleading or includes unfair exclusions. For example, a policy providing coverage for fractures or dislocations may not provide benefits only for "full or complete" fractures or dislocations.

~~B. Basic Hospital Expense Coverage~~

~~"Basic hospital expense coverage" is a policy of accident and sickness insurance that provides coverage for a period of not less than thirty-one (31) days during a continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:~~

~~(1) Daily hospital room and board in an amount not less than the lesser of:~~

~~(a) [80%] of the charges for semiprivate room accommodations or~~

~~(b) [$100] per day;~~

~~**Drafting Note**: The commissioner may determine the level of daily room and board benefits that he or she considers appropriate as a minimum for a basic hospital contract in his state. It should be an underlying principle for the establishment of benefits that the amounts are to be minimums, not maximums. In order to accommodate those states that have a substantial differential in hospital room and board costs between urban and rural areas within a state, the following language may be used in addition to the language in Subsection B(1) above: "except that $[insert amount] may be reduced to $[insert amount] outside the area." Other dollar amounts and percentages applicable to the various minimum benefits that follow are also bracketed to permit a commissioner to set the level of minimum benefits for his or her particular state.~~

~~(2) Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies that are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either [80%] of the charges incurred up to at least [$3,000] or [ten] times the daily hospital room and board benefits; and~~

~~(3) Hospital outpatient services consisting of:~~

~~(a) Hospital services on the day surgery is performed,~~

~~(b) Hospital services rendered within seventy two (72) hours after injury, in an amount not less than [$150]; and~~

~~(c) X-ray and laboratory tests to the extent that benefits for the services would have been provided in an amount of less than [$100] if rendered to an in-patient of the hospital.~~

~~(4) Benefits provided under Paragraphs (1) and (2) of this subsection may be provided subject to a combined deductible amount not in excess of [$100].~~

~~C. Basic Medical-Surgical Expense Coverage~~

~~"Basic medical-surgical expense coverage" is a policy of accident and sickness insurance that provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:~~

~~(1) Surgical services:~~

~~(a) In amounts not less than those provided on a fee schedule based on the relative values contained in the [insert reference to a fee schedule based on the Current Procedure Terminology (CPT) coding or other acceptable relative value schedule].up to a maximum of at least [$1000] for a one procedure; or~~

~~(b) Not less than [80%] of the reasonable charges.~~

~~(2) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or the physician assistant) performing the surgical services:~~

~~(a) In an amount not less than [80%] of the reasonable charges; or~~

~~(b) [15%] of the surgical service benefit.~~

~~(3) In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than [80%] of the reasonable charges, or [$50] per day for not less than twenty-one (21) days during one period of confinement.~~

~~D. Basic Hospital/Medical-Surgical Expense Coverage~~

~~"Basic hospital/medical-surgical expense coverage" is a combined coverage and must meet the requirements of both Subsections B and C.~~

~~E~~B. Hospital ~~Confinement~~ Indemnity or Other Fixed Indemnity Coverage

(1) "Hospital ~~confinement~~ indemnity or other fixed indemnity coverage" ~~is a policy of accident and sickness insurance that~~ provides ~~daily~~ benefits ~~for~~as a result of hospital confinement or other health-related events and based on a fixed dollar amount, ~~on an indemnity basis in an amount not less than [$40] per day and not less than thirty-one (31) days during each period of confinement for each person insured under the policy~~ regardless of the amount of expenses incurred, without coordination with any other health coverage.

(2) "Hospital indemnity coverage" may provide a single lump sum benefit for hospital confinement of not less than $[X], and/or daily benefit for hospital confinement on an indemnity basis in an amount not less than $[X] per day and not less than [X] days during each period of confinement for each person insured under the policy.

Drafting Note: Paragraph (2) above provides a framework for the state insurance regulators to establish minimum benefit amounts they feel are appropriate for hospital indemnity coverage. When setting these minimum benefit amounts, state insurance regulators should be mindful to not set a benefit amount so low such that the product does not provide a meaningful benefit to the consumer or set a benefit amount so high that a consumer could be led to believe the product is comprehensive major medical coverage. State insurance regulators can address this issue by requiring that this coverage is not offered, marketed, or sold as a substitute for, or an alternative to, comprehensive major medical coverage, and requiring the use of disclosures that this coverage is supplementary insurance.

~~(2)~~(3) Coverage shall not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.

~~(3) Except for the NAIC uniform provision regarding other insurance with the insurer, benefits shall be paid regardless of other coverage.~~

Drafting Note: Hospital ~~confinement~~ indemnity or other fixed indemnity coverage is ~~recognized as supplemental~~supplementary coverage. Any hospital ~~confinement~~ indemnity or other fixed indemnity coverage, therefore, must be payable regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of hospital ~~confinement~~ indemnity or other fixed indemnity coverage. Section 3H(4) of the ~~Group~~ *Coordination of Benefits Model Regulation* states that the definition of a plan (for the purposes of coordination of benefits)…shall not include individual or family insurance contracts…." States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of hospital ~~confinement~~ indemnity or other fixed indemnity coverage purchased by the insured.

Drafting Note: For indemnity products that are triggered by a variety of health events and provide a variety of daily benefit dollar amounts, state insurance regulators should examine the amount payable per day and the total amount payable per year or lifetime to determine whether an indemnity product's benefits could be mistaken for comprehensive major medical coverage. Indemnity products should not be offered, marketed, or sold as an alternative to, or substitute for, or ~~a~~ replacement for major medical coverage. It is the marketing of supplementary coverage as an alternative, substitute or replacement for comprehensive major medical coverage that presents the unfair trade practice, and not the supplementary coverage itself when it is offered and marketed as supplementary excepted benefits coverage and accurately described to the consumer.

~~F. Individual Major Medical Expense Coverage~~

~~(1) "Individual major medical expense coverage" is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than~~

~~[$500,000]; coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles shall not exceed ten thousand dollars ($10,000) per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed five percent (5%) of the aggregate maximum limit under the policy for each covered person for at least:~~

~~(a) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;~~

~~(b) Miscellaneous hospital services;~~

~~(c) Surgical services;~~

~~(d) Anesthesia services;~~

~~(e) In-hospital medical services;~~

~~(f) Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and~~

~~(g) Not fewer than three (3) of the following additional benefits:~~

~~(i) In-hospital private duty registered nurse services;~~

~~(ii) Convalescent nursing home care;~~

~~(iii) Diagnosis and treatment by a radiologist or physiotherapist;~~

~~(iv) Rental of special medical equipment, as defined by the insurer in the policy;~~

~~(v) Artificial limbs or eyes, casts, splints, trusses or braces;~~

~~(vi) Treatment for functional nervous disorders, and mental and emotional disorders; or~~

~~(vii) Out-of-hospital prescription drugs and medications.~~

~~(2) If the policy is written to complement underlying basic hospital expense and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.~~

~~(3) The minimum benefits required by 7F(1) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. A major medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under 7F(1)(g) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subsection through the application of special or internal limitations, a major medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.~~

~~G. Individual Basic Medical Expense Coverage~~

~~(1) "Individual basic medical expense coverage" is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $250,000; coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles shall not exceed $25,000 per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed ten percent (10%) of the aggregate maximum limit under the policy for each covered person for at least:~~

~~(a) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides or such other rate agreed to between the insurer and provider for a period of not less than thirty-one (31) days during continuous hospital confinement;~~

~~(b) Miscellaneous hospital services;~~

~~(c) Surgical services;~~

~~(d) Anesthesia services;~~

~~(e) In-hospital medical services;~~

~~(f) Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy and hemodialysis ordered by a physician; and~~

~~(g) Not fewer than three (3) of the following additional benefits:~~

~~(i) In-hospital private duty graduate registered nurse services;~~

~~(ii) Convalescent nursing home care;~~

~~(iii) Diagnosis and treatment by a radiologist or physiotherapist;~~

~~(iv) Rental of special medical equipment, as defined by the insurer in the policy;~~

~~(v) Artificial limbs or eyes, casts, splints, trusses or braces;~~

~~(vi) Treatment for functional nervous disorders, and mental and emotional disorders; or~~

~~(vii) Out-of-hospital prescription drugs and medications.~~

~~(2) If the policy is written to complement underlying basic hospital expense and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.~~

~~(3) The minimum benefits required by 7G(1) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. An individual basic medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under 7G(1)(g) and other such special~~

~~or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subsection through the application of special or internal limitations, anindividual basic medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.~~

~~H~~C. Disability Income Protection Coverage

"Disability income protection coverage" is a policy that provides for periodic payments, ~~weekly or monthly~~no less frequently than monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them that:

(1) Provides that ~~periodic payments that are payable at ages after sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to sixty-two (62)~~ a plan is prohibited from reducing periodic payments based on age, except that a plan may reduce periodic payments provided that such reductions do not take place until the individual has reached full retirement age, as defined under the federal Social Security Act, to receive Social Security benefits;

Drafting Note: Age 62 was removed so that retirement age would align with the federal Social Security Act full retirement age.

(2) Contains an elimination period no greater than:

(a) Fifty percent (50%) of the benefit period in the case of coverage providing a benefit of one hundred and eighty (180) days or less;

(b) Ninety (90) days in the case of a coverage providing a benefit of one hundred and eighty (180) days to one year ~~or less~~;

~~(b)~~(c) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or

~~(c)~~(d) Three hundred and sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury;

(3) Has a ~~maximum~~ period of time of at least three (3) months for which it is payable during disability ~~of at least six (6) months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one month~~. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period~~. Section 7F does not apply to those policies providing business buy-out coverage~~; and

(4) Where a policy provides both total disability benefits and partial disability benefits, only one elimination period may be required.

~~I~~D. Accident Only Coverage

"Accident only coverage" is a policy that provides coverage, singly or in combination, for death, dismemberment, disability, injury, or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least ~~[$1,000]~~$[X] and a single dismemberment amount shall be at least ~~[$500]~~$[X].

~~J~~E. Specified Disease Coverage

(1) "Specified disease coverage" pays benefits for the diagnosis and treatment of a specifically named disease or diseases. A specified disease policy must meet the following rules in paragraph (2) and one of the following sets of minimum standards for benefits:

(a) Insurance covering cancer only or cancer in conjunction with other conditions or diseases must meet the standards of Paragraph (4), (5) or (6) of this subsection.

(b) Insurance covering specified diseases other than cancer must meet the standards of Paragraphs (3) and (6) of this subsection.

(2) General Rules

Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following rules shall apply to specified disease coverages in addition to all other rules imposed by this regulation. In cases of conflict between the following and other rules, the following shall govern:

(a) Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this section.

(b) Any policy issued pursuant to this section that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead.

(c) Notwithstanding any other provision of this regulation, specified disease policies shall provide benefits to any covered person not only for the specified disease or diseases, but also for any other conditions or diseases~~,~~ directly caused or aggravated by ~~the~~a specified disease~~s~~ or the treatment of the specified disease.

(d) Individual ~~accident and sickness~~supplementary policies containing specified disease coverage shall be at least guaranteed renewable.

(e) No policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days. A specified disease policy may contain a waiting or probationary period following the issue or reinstatement date of the policy or certificate in respect to a particular covered person before the coverage becomes effective as to that covered person.

(f) An application or enrollment form for specified disease coverage shall contain a statement above the signature of the applicant or enrollee that a person to be covered for specified disease is not covered also by any Title XIX program (Medicaid, MediCal or any similar name). The statement may be combined with any other statement for which the insurer may require the applicant's or enrollee's signature.

Drafting Note: States may prohibit individuals who are covered by a Title XIX program from enrolling in a specified disease policy. However, this would not prohibit an individual who purchases a specified disease policy and later becomes eligible for coverage under a Title XIX program from utilizing the benefits of the specified disease policy to which the individual may be entitled to receive.

(g) Payments may be conditioned upon an insured person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.

(h) ~~Except for the NAIC uniform provision regarding other insurance with this insurer, benefits~~ Benefits for specified disease coverage shall be paid regardless of other coverage, except as permitted by [insert reference to state law equivalent to Section 3B(3) of the *Uniform Individual Accident and Sickness Policy Provision Law* (UPPL) (#180), regarding multiple policies with the same insurer].

Drafting Note: Specified disease coverage is recognized as ~~supplemental~~supplementary coverage. Any specified disease coverage, therefore, must be payable in addition to and regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of specified disease coverage. Section 3H(4) of the ~~Group~~ *Coordination of Benefits Model Regulation* states that the definition of a "plan" (for the purpose of coordination of benefits) "shall not include individual or family insurance contracts." States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of specified disease coverage purchased by the insured.

(i) After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis.

(j) Policies providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount of expenses. Instead, the term "charge," "expense," or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase "actual charges." or "actual expenses."

(k) "Preexisting condition" shall not be defined to be more restrictive than the following and shall be consistent with the provisions of Section 7B of the Act: "Preexisting condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within the six (6) month period preceding the effective date of coverage of an insured person."

(l) Coverage for specified diseases will not be excluded due to a preexisting condition for a period greater than six (6) months following the effective date of coverage of an insured person unless ~~the~~a named preexisting condition is specifically excluded.

(m) Hospice Care.

(i) "Hospice" means a ~~facility~~provider licensed, certified or registered in accordance with state law that provides a formal program of care that is:

(I) For terminally ill patients whose life expectancy is less than six (6) months;

(II) Provided on an inpatient or outpatient basis; and

(III) Directed by a physician.

(ii) Hospice care is an optional benefit. However, if a specified disease insurance product offers coverage for hospice care, it shall meet the following minimum standards:

(I) Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less;

(II) A fixed-sum payment of at least ~~$50~~$[X] per day; and

(III) A lifetime maximum benefit limit of at least ~~$10,000~~$[X].

(iii) Hospice care does not cover non-terminally ill patients who may be confined in a:

(I) Convalescent home;

(II) Rest or nursing facility;

(III) Skilled nursing facility;

(IV) Rehabilitation unit; or

(V) Facility providing care or treatment for persons suffering from mental ~~diseases or~~ disorders ~~or care for the~~, who are aged, or ~~substance abusers~~who have a substance use-related disorder.

(3) The following minimum benefits standards apply to non-cancer coverages:

(a) Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of ~~[$250]~~$[X] and an overall aggregate benefit limit of no less than ~~[$10,000]~~$[X] and a benefit period of not less than [two (2) years] for at least the following incurred expenses:

(i) Hospital room and board and any other hospital furnished medical services or supplies;

(ii) Treatment by a ~~legally qualified~~licensed physician, ~~or~~ surgeon, or other health care professional acting within the scope of their license;

Drafting Note: States should review their laws and regulations to determine whether to use the word "acting" or "performing" in Paragraph (3)(a)(ii) above. Some states use the word "acting," while others use the word "performing."

(iii) Private duty services of a ~~registered~~licensed nurse ~~(R.N.)~~;

(iv) ~~X-ray, radium and other therapy procedures~~Tests, procedures, and other medical services and supplies used in diagnosis and treatment;

(v) Professional ambulance for ~~local~~ service to or from a ~~local~~ hospital nearest able to appropriately treat the condition;

(vi) Blood transfusions, including expense incurred for blood donors;

(vii) Drugs and medicines prescribed by a physician;

~~(viii) The rental of an iron lung or similar mechanical apparatus;~~

~~(ix)~~(viii) ~~Braces, crutches and wheel chairs as are~~ Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;

~~(x)~~(ix) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and

~~(xi)~~(x) May include coverage of any other expenses necessarily incurred in the treatment of the disease.

(b) Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than ~~[$25,000]~~$[X] payable at the rate of not less than ~~[$50]~~$[X] a day while confined in a hospital and a benefit period of not less than 500 days.

(4) A policy that provides coverage ~~for each insured person~~on an expense-incurred basis for cancer-only coverage, or for cancer in combination with one or more other specified diseases ~~on an expense incurred basis~~ shall provide coverage for each insured person for services, supplies, care and treatment of cancer, consistent with the requirements in this paragraph.

(a) Coverage ~~in~~may be limited to amounts not in excess of the usual and customary charges, with a deductible amount not in excess of ~~[$250]~~$[X], ~~and~~ an overall aggregate benefit limit of not less than ~~[$10,000]~~$[X], and a benefit period of not less than three (3) years ~~shall provide at least the following minimum provisions:~~.

(b) A policy shall include at least the minimum benefits specified in this subparagraph. Coverages under items (i) through (xiv) of this subparagraph may be subject to cost-sharing by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an outpatient basis:

~~(a)~~(i) Treatment by, or under the direction of, a ~~legally qualified~~licensed physician, ~~or~~ surgeon, or other health care professional acting within the scope of their license;

Drafting Note: States should review their laws and regulations to determine whether to use the word "acting" or "performing" in Paragraph (3)(a)(ii) above. Some states use the word "acting," while others use the word "performing."

~~(b)~~(ii) ~~X-ray, radium chemotherapy and other therapy procedures~~Tests, procedures, and other medical services and supplies used in diagnosis and treatment;

~~(c) Hospital room and board and any other hospital furnished medical services or supplies;~~

~~(d)~~(iii) Blood transfusions and their administration, including expense incurred for blood donors;

~~(e)~~(iv) Drugs and medicines prescribed by a physician, including but not limited to, chemotherapy, including both oral and IV administered, immunotherapy, targeted therapies, and chemotherapy supportive drugs;

~~(f) Professional ambulance for local service to or from a local hospital;~~

~~(g)~~(v) Private duty services of a ~~registered~~licensed nurse provided in a hospital;

~~(h) May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, Subparagraphs (a), (b), (d), (e) and (g) plus at least the following also shall be included, but may be subject to copayment by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an out-patient basis;~~

~~(i)~~(vi) ~~Braces, crutches and wheelchairs~~Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;

~~(j)~~(vii) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; ~~and~~

~~(k)~~(viii) (I) Home health care that is necessary care and treatment provided at the insured person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person's attending physician, who shall approve the program prior to its start. ~~The physician must certify that hospital confinement would be otherwise required. A "home health care agency" (1) is an agency approved under Medicare, or (2) is licensed to provide home health care under applicable state law, or (3) meets all of the following requirements:~~

~~(I) It is primarily engaged in providing home health care services;~~

~~(II) Its policies are established by a group of professional personnel (including at least one physician and one registered nurse;~~

~~(III) A physician or a registered nurse provides supervision of home health care services;~~

~~(IV) It maintains clinical records on all patients; and~~

~~(V) It has a full time administrator.~~

Drafting Note: State licensing laws vary concerning the scope of "home health care" or "home health agency services" and should be consulted. In addition, a few states have mandated benefits for home health care including the definition of required services.

~~(ii)~~(II) Home health care includes, but is not limited to:

~~(I)~~a. Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse;

~~(II)~~b. Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapists;

~~(III)~~c. Physical, occupational or speech and hearing therapy; and

~~(IV)~~d. Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital.~~;~~;

~~(l)~~(ix) Physical, speech, hearing and occupational therapy;

~~(m)~~(x) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, ~~chux~~disposable absorbent pads, oxygen, surgical dressings, rubber shields, colostomy and ~~eleostomy~~ileostomy appliances;

~~(n)~~(xi) Prosthetic devices including wigs and artificial breasts;

~~(o)~~(xii) Nursing home care for noncustodial services; ~~and~~

~~(p)~~(xiii) Reconstructive surgery when deemed necessary by the attending physician;

(xiv) Hospice services, as defined in paragraph (2)(m) above~~.~~;

(xv) Hospital room and board and any other hospital furnished medical services or supplies; and

(xvi) Professional ambulance for service to or from a hospital nearest able to appropriately treat the condition.

(c) A policy may include coverage of any other expenses necessarily incurred in the treatment of the disease.

Drafting Note: Policies that offer transportation and lodging benefits for an insured person should not condition those benefits on hospitalization.

(5) (a) The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons:

(i) A fixed-sum payment of at least ~~[$100]~~$[X] for each day of hospital confinement for at least [365] days;

(ii) A fixed-sum payment ~~equal to one half~~of at least [X%] the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least 365 days of treatment; and

(iii) A fixed-sum payment of at least ~~$50~~$[X] per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.

(b) Benefits tied to ~~confinement~~receipt of care in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal or exceed the following:

(i) A fixed-sum payment equal to ~~one fourth~~[X%] the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.

(ii) A fixed-sum payment equal to ~~one fourth~~[X%] the hospital in-patient benefit for each day of home health care for at least 100 days.

(iii) Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease.

(iv) Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in (b)(i) and (b)(ii) whether by definition or otherwise, shall be no more restrictive than those under Medicare.

(6) The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease:

(a) These coverages must pay indemnity benefits ~~on behalf of insured persons of~~for a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of

the specified disease. Dollar benefits shall be offered for sale only in even increments of ~~$1,000~~$[X].

Drafting Note: Policies that offer extremely high dollar benefits may induce fraud and concealment on the part of applicants for coverage. The commissioner should ~~be sensitive to this possibility in approving policies~~avoid approving these policies in light of the fact that these policies are not intended to be comprehensive coverage and are not intended to be sold as such. Policies offering extremely low dollar amounts, however, may offer illusory coverage that may not be understood by consumers. State insurance regulators can address this issue by requiring that this coverage is not offered, marketed, or sold as a substitute for, or alternative to, comprehensive major medical coverage, and requiring the use of disclosures that this coverage is supplementary coverage.

(b) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease ~~with one exception. In the case~~ unless there are ~~of~~ clearly identifiable subtypes with significantly lower treatment~~s~~ costs, in which case lesser amounts may only be payable ~~so long as~~if the policy clearly differentiates that subtype and its reduced benefits.

Drafting Note: The purpose of requiring equal coverage for all subtypes of a specified disease is to ensure that specified disease policies actually provide what people reasonably expect them to. In approving ~~skin cancer or other~~ exceptions, commissioners should consider whether a specified disease policy might mislead if it treats a subtype of a disease differently from the rest of the specified disease.

~~K~~F. Specified Accident Coverage

"Specified accident coverage" is a policy that provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than ~~[$1,000]~~$[X] for accidental death, ~~[$1,000]~~$[X] for double dismemberment ~~[$500]~~$[X] for single dismemberment.

~~L~~G. Limited Benefit Health Coverage

(1) "Limited benefit health coverage" is a policy or contract, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under Subsections B, ~~C,~~ D, ~~E,~~ and F~~, G, I and K~~. These policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section ~~8L~~8H of this regulation is completed and delivered as required by Section 8B of this regulation and the policy or certificate is clearly labeled as a limited benefit policy or certificate as required by Section 8A(17). A policy covering a single specified disease or combination of diseases shall meet the requirements of Section ~~7J~~7E and shall not be offered for sale as ~~a~~ "limited benefit health coverage."

(2) This subsection does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance, as defined in [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act* and *Medicare Supplement Insurance Minimum Standards Model Act*].

Drafting Note: The NAIC *Long-Term Care Insurance Model Act* defines long-term care insurance as a policy that provides coverage for not less than twelve months. If a state allows issuance of policies that provide benefits similar to long-term care insurance for a period of less than twelve months, then those policies should be considered limited ~~benefit health~~long-term care insurance ~~plans~~policies, and should be subject to the ~~NAIC Accident and Sickness Insurance Minimum Standards Model Act and implementing regulation~~ *Limited Long-Term Care Insurance Model Act* (#642) and its implementing regulation, the *Limited Long-Term Care Insurance Model Regulation* (#643).

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Drafting Note: This regulation permits the combining of excepted benefit-type products described in this section with other excepted benefit plans. However, it should be noted that combining excepted benefit coverages described in this section with other coverages, whether or not described in this section, could cause the combined product to fail to meet the requirements for excepted benefits under HIPAA or for similar exemptions under state law. This would mean that major medical insurance requirements under federal and state law may apply, such as guaranteed availability, guaranteed renewability, and premium rating restrictions. State insurance regulators should also require that supplementary coverage is not offered, marketed, or sold as a substitute for, or alternative to, comprehensive major medical coverage, including enforcement of the requirements in this regulation for disclosures that this coverage is supplementary coverage.

H. Short-Term, Limited-Duration Health Insurance Coverage

(1) "Short-term, limited-duration health insurance" means health insurance coverage offered or provided to residents of the state pursuant to a contract with a health carrier, regardless of the situs of the contract, that has an expiration date specified in the contract that is less than [X] [days or months] after the original effective date and, taking into account any extensions that may be elected by the policyholder with or without the carrier's consent, has a duration no longer than [X] [days or months] after the original effective date of the contract.

(2) (a) Short-term, limited-duration health insurance must comply with the benefit and coverage requirements of this state, including, if the state requires, providing benefits and coverage of state-mandated benefits and being subject to the state's external and internal review requirements.

(b) A short-term, limited-duration health insurance policy or certificate must have:

(i) An annual or lifetime limit of no less than [$1,000,000];

(ii) A coinsurance requirement of no more than fifty percent (50%) of covered charges; and

(iii) A family maximum out-of-pocket limit of not more than [X] per year.

Drafting Note: The annual and lifetime limit and the out-of-pocket limits should vary depending on the specific state interest. For states that have severely limited coverage time frames with limited renewals or extensions, smaller annual and lifetime limits and out-of-pocket maximums should apply.

(3) Short-term, limited-duration health insurance cannot be issued if it would result in an individual being covered by a short-term, limited duration health insurance policy or certificate for more than [X] months [in any 12-month period].

(4) Short-term, limited-duration health insurance, including individual policies and group certificates:

(a) May not be marketed as guaranteed renewable;

(b) Must be marketed as either nonrenewable, or renewable for a limited time without re-underwriting;

(c) Must clearly state the duration of the initial term and the total maximum duration, including any renewal options;

(d) May not be modified after the date of issuance, except by signed acceptance of the policyholder or the certificate holder, if the policy holder or the certificate holder contributes to the premium; and

(e) If the coverage is renewable, the individual policy or group certificate must:

(i) Include a statement that the insured has a right to continue the coverage in force by timely payment of premiums for the number of terms listed;

(ii) Include a statement that the carrier will not increase premium rates or make changes in provisions in the policy or certificate on renewal based on individual health status; and

(iii) Include a statement that the carrier, at the time of renewal, may not deny renewal based on individual health status.

(5) A short-term, limited-duration health insurance carrier may not include a waiting period or a probationary period.

(6) A carrier may not rescind a short-term limited duration health insurance policy or certificate during the coverage period except if the insured intentionally fails to disclose a prior diagnosis of a health condition or if the insured intentionally fails to disclose the insured was previously covered under a short-term limited duration health insurance policy or certificate. If the policy or certificate is rescinded, the carrier must refund all payments to the insured to the extent that they exceed claims paid under the rescinded policy or certificate.

Drafting Note: States should be aware that the language in paragraph (6) concerning an insured's failure to disclose prior coverage under a short-term, limited-duration health insurance policy or certificate will need to be tailored to the state's laws and regulations concerning such disclosures of prior coverage.

(7) A carrier may not cancel a short-term, limited-duration health insurance policy or certificate during the coverage period except in the following circumstances:

(a) Nonpayment of premium;

(b) Violation of the carrier's published policies approved by the commissioner;

(c) An insured's commitment of fraudulent acts as to the carrier;

(d) An insured's material breach of the insurance contract; or

(e) A change or implementation of a federal or state law or regulation that no longer permits the continuing offering of the coverage.

(8) In the event of a cancellation or rescission of a short-term, limited-duration health insurance policy or certificate, the carrier must notify the insured in writing [thirty (30) days] prior to the cancellation date or in writing a notice of rescission with an appeal period of [thirty (30) days].

Drafting Note: The timeframe for notifying the insured of a cancellation or rescission is bracketed because states may have different timeframes for such notices.

Drafting Note: States should carefully examine their health insurance markets to determine the appropriate maximum term and duration for such plans and whether additional definitions or standards may be needed. In addition, states should review any relevant federal regulations establishing requirements for short-term, limited duration insurance coverage that could differ from the state's requirements.

Section ~~8~~9. Required Disclosure Provisions

A. General Rules

(1) (a) All applications, policies, and certificates for coverage~~s specified in Sections 7B, C, D, E, G, I, J, K and L~~ of supplementary or short-term health insurance shall ~~contain~~include a prominent disclosure statement~~, by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:~~ as required by this section, that reflects the type of coverage being provided.

(b) The disclosures required by this section may be modified only as needed to improve the accuracy and clarity of the disclosure and only with the approval of the commissioner.

Drafting Note: Because states may have different statutory requirements for short-term, limited duration insurance coverage, states should carefully review the disclosure statement requirements in this section for such coverage to ensure it accurately reflects a state's specific requirements. States also should be aware that proposed federal regulations for short-term, limited duration insurance coverage and hospital indemnity or other fixed indemnity coverage include specific disclosure statement requirements for these coverages and recognize that the disclosure statement requirements in this section may need to contain additional information as required by applicable state law, rules, or guidance. A state also may need to require disclosure language to reflect any additional requirements a state may have, such as requirements regarding minimum essential coverage or special enrollment periods for expiration or loss of eligibility for this coverage.

~~"The [policy] [certificate] provides limited benefits. Review your [policy][certificate] carefully."~~

(c) The disclosure statement shall be in a sans serif font, in a font size at least equal to the size type used for headings or captions of sections of the document.

(d) In the application, the disclosure statement shall be placed in close proximity to the applicant's signature block.

(e) In the policy and certificate, the disclosure statement shall be placed on the first page.

(f) In this section, the term "prominent" means one or more methods are used to draw attention to the language, including using a larger font size, leading, underlining, bolding, color, or italics.

Drafting Note: States should review their existing readability laws and regulations to help to ensure the statements above are readable. States should also review their existing laws and regulations to ensure the statements above are accessible to potential applicants, including those with disabilities such as blindness or macular degeneration, deafness or hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity, and combinations of these.

(2) Any disclosures, and the documents to which they refer, shall be delivered in the written medium (digital or heard copy) the applicant requests. These documents shall be provided before the applicant submits a completed application.

(3) For hospital indemnity coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "fixed dollar benefits" made prominent:

"This [policy] [certificate] pays fixed dollar benefits as a result of a covered hospitalization due to a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

Drafting Note: States should review the above notice and disclosure requirements for hospital indemnity coverage for consistency with their state regulations. In addition, states should review any relevant federal regulations establishing notice and disclosure requirements for hospital indemnity coverage that could differ from the state's requirements.

(4) For other fixed indemnity coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "fixed dollar benefits" made prominent:

"This [policy] [certificate] pays fixed dollar benefits as a result of covered events due to a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

Drafting Note: States should review the above notice and disclosure requirements for other fixed indemnity coverage for consistency with their state regulations. In addition, states should review any relevant federal regulations establishing notice and disclosure requirements for other fixed indemnity coverage that could differ from the state's requirements.

~~(2) All applications for dental plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:~~

~~"The [policy] [certificate] provides dental benefits only. Review your [policy] [certificate] carefully."~~

~~(3) All applications for vision plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:~~

~~"The [policy] [certificate] provides vision benefits only. Review your [policy] [certificate] carefully."~~

(5) For disability income protection coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "while you are disabled" made prominent:

"This [policy] [certificate] provides periodic payments [weekly, bi-weekly, or monthly] for a set length of specific period of time while you are disabled from a covered sickness or injury. Read the description of benefits provided along with your [enrollment form/application] carefully."

(6) For accident only coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "from a covered accident" made prominent:

"This [policy] [certificate] pays benefits for covered injuries from a covered accident. It does not provide benefits resulting from sickness. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(7) For specified disease coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "of a covered disease" made prominent:

"This [policy] [certificate] pays limited benefits as a result of the diagnosis or treatment of a covered disease specified in the [policy] [certificate]. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(8) For specified accident coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "for a specifically identified type of accident" made prominent:

"This [policy] [certificate] provides benefits for a specifically identified type of accident as named in the [policy] [certificate]. It does not provide benefits resulting from sickness. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(9) For limited benefit coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "limited benefits and only for the events specified" made prominent:

"The [policy] [certificate] pays limited benefits and only for the events specified in the [policy] [certificate]. These limited benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(10) For limited scope dental coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the sentence "It is not intended to cover all dental expenses." made prominent:

"The [policy] [certificate] provides dental benefits only. It is not intended to cover all dental expenses. Read your [policy] [certificate] carefully to understand what dental services it covers and any cost-sharing that may be your responsibility."

(11) For limited scope vision coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the sentence "It is not intended to cover all vision expense." made prominent:

"The [policy] [certificate] provides vision benefits only. It is not intended to cover all vision expenses. Read your [policy] [certificate] carefully to understand what vision services are covered and any cost-sharing that may be your responsibility."

(12) For short-term health insurance, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the word "Important" and the sentence "It is not comprehensive health insurance." made prominent:

"Important: This is short-term health insurance. This is temporary insurance. It is not comprehensive health insurance. Read your [policy] [certificate] carefully to make sure you understand what is covered and any limitations on coverage.

- This insurance might not cover or might limit coverage for:
  - Preexisting conditions; or
  - Essential health benefits (such as pediatric, hospital, emergency, maternity, mental health, substance use services, prescription drugs, or preventive care).
- You will not qualify for federal financial help to pay for premiums or out-of-pocket costs for this policy.
- You are not protected from surprise medical bills.
- When this policy ends, you might have to wait until an open enrollment period to get comprehensive health insurance.

Visit HealthCare.gov online or call 1-800-318-2596 (TTY: 1-855-889-4325) to review your options for comprehensive health insurance. If you're eligible for coverage through your employer or a family member's employer, contact the employer for more information. Contact the [State] department of insurance if you have questions or complaints about this policy."

~~(4)~~(13) Each policy of individual ~~accident and sickness insurance and group supplemental health insurance~~ supplementary or short-term health insurance subject to this regulation, as provided in Section 3A of this regulation, shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision

shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

~~(5)~~(14) ~~Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all~~All riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law. The signature requirements in this paragraph ~~apply~~applies to group supplemental health insurance certificates only where the certificate holder also pays the insurance premium.

~~(6)~~(15) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy or certificate and the combined total premium clearly identified as such.

~~(7)~~(16) A policy or certificate that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of the terms and a clear ~~an~~ explanation of the terms in its accompanying outline of coverage.

~~(8)~~(17) If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall ~~appear as~~be clearly explained in a separate paragraph of the policy or certificate ~~and be~~ labeled ~~as~~ "Preexisting Condition~~s~~ Limitations."

~~(9) All accident only policies and certificates shall contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, a prominent statement as follows:~~

~~"Notice to Buyer: This is an accident only [policy][certificate] and it does not pay benefits for loss from sickness. Review your [policy][certificate] carefully."~~

~~Accident only [policies][certificates] that provide coverage for hospital or medical care shall contain the following statement in addition to the Notice to Buyer above: "This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."~~

~~(10)~~(18) All policies and certificates, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed in sans serif font on the first page of the policy or certificate or attached to it stating ~~in substance~~clearly that the policy~~holder~~ or certificate holder shall have the right to return the policy or certificate within thirty [30] days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason.

Drafting Note: This ~~section~~paragraph should be included only if ~~the~~ it is consistent with applicable state law~~has legislation granting authority~~.

~~(11)~~(19) If age is to be used as a determining factor ~~for reducing~~to reduce the ~~maximum aggregate~~ benefits made available in the policy or certificate as originally issued, ~~that fact~~a clear explanation of how age is used shall be prominently set forth in the outline of coverage.

~~(12)~~(20) If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be "Conversion Privilege" or words of similar import. The provision shall ~~indicate the~~clearly explain which persons are eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person ~~by whom~~who may exercise the conversion privilege ~~may be exercised~~. The provision shall clearly specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

~~(13)~~(21) (a) Outlines of coverage delivered in connection with policies defined in this regulation as hospital ~~confinement~~ indemnity or other fixed indemnity (Section ~~7E~~8B), specified disease (Section ~~7J~~8E), or limited benefit health coverages (Section ~~7L~~8G) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Subsections ~~F~~D and ~~J~~F, the following language, which shall be printed on or attached to the first page of the outline of coverage, with the sentence "This is not a Medicare Supplement policy." made prominent:

This ~~IS NOT A MEDICARE SUPPLEMENT~~is not a Medicare Supplement policy. If you are eligible for Medicare, ~~review~~ask the company for the Guide to Health Insurance for People ~~W~~with Medicare ~~available from the company~~.

Drafting Note: States may want to review the disclosure language in paragraph (21)(a) above for consistency with the consumer disclosure language in Appendix C of the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651).

(b) An insurer shall deliver to persons eligible for Medicare any notice required under [insert reference to state law equivalent of Section 17D of the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act*].

Drafting Note: States that permit individuals under the age of 65 with Medicare coverage to purchase Medicare supplement policies should review how insurers should provide the notices required under paragraph (21)(a) to these individuals.

~~(14)~~(22) Insurers~~, except direct response insurers,~~ shall give a person applying for specified disease insurance a Buyer's Guide approved by the commissioner at the time of application enrollment and shall obtain all recipients' written acknowledgement of the guide's delivery. ~~Direct response insurers shall provide the Buyer's Guide upon request but not later than the time that the policy or certificate is delivered.~~

Drafting Note: Paragraph (22) only applies if a state has such a Buyer's Guide.

~~(15) All specified disease policies and certificates shall contain on the first page or attached to it in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate], a prominent statement as follows: Notice to Buyer: This is specified disease [policy] [certificate].This [policy] [certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your [policy] [certificate] carefully with the outline of coverage and the Buyer's Guide.~~

~~**Drafting Note:** The second sentence of this caption should only be required in those states where the commissioner exercises discretionary authority and requires the guide.~~

~~(16) All hospital confinement indemnity policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This is a hospital confinement indemnity [policy][certificate]. This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."~~

~~(17) All limited benefit health policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This is a limited benefit health [policy][certificate]. This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."~~

~~(18) All basic hospital expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This is a basic hospital expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."~~

~~(19) All basic medical-surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This is a basic medical surgical expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."~~

~~(20) All basic hospital/medical surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This is a basic hospital/medical surgical expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."~~

~~(21) All individual basic medical expense policies shall display prominently by type, stamp or other appropriate means on the first page of the policy, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy the following:~~

~~"Notice to Buyer: This is an individual basic medical expense policy. This policy provides benefits that are not as comprehensive as individual major medical expense coverage and should not be considered a substitute for comprehensive health insurance coverage."~~

~~(22) All dental plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This [policy] [certificate] provides dental benefits only."~~

~~(23) All vision plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This [policy] [certificate] provides vision benefits only."~~

B. Outline of Coverage Requirements

(1) An insurer shall deliver an outline of coverage to an applicant ~~or enrollee in the sale of individual accident and sickness insurance, group supplemental health insurance, dental plans and vision plans~~ all applicable plans as required in Section 6 of the Act.

(2) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) point sans serif type, immediately above the company name, with the sentence "It is different from the outline of coverage you received when you [applied] [enrolled]." made prominent:

"NOTICE: Read this outline of coverage carefully. It is ~~not identical to~~different from the outline of coverage ~~provided upon~~you received when you [~~application~~applied][~~enrollment~~enrolled]~~,~~. ~~and the~~The coverage ~~originally~~you applied for ~~has~~was not ~~been~~ issued."

~~(3) The appropriate outline of coverage for policies or contracts providing hospital coverage that only meets the standards of Section 7B shall be that statement contained in Section 8C. The appropriate outline of coverage for policies providing coverage that meets the standards of both Sections 7B and C shall be the statement contained in Section 8E. The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 7B and E or Sections 7C and E or Sections 7B, C, and E shall be the statement contained in Section 8G.~~

~~(4)~~(3) In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the commissioner for prior approval. In such instances, no policies may be sold or renewed until approved by the commissioner.

~~(5)~~(4) Advertisements may fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage in Section 6H of the Act as well as this regulation.

~~C. Basic Hospital Expense Coverage (Outline of Coverage)~~

~~An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7B of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:~~

~~[COMPANY NAME]~~

~~BASIC HOSPITAL EXPENSE COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE~~

~~OUTLINE OF COVERAGE~~

Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY][CERTIFICATE] CAREFULLY!

(2) Basic hospital coverage is designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.

(3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

(a) Daily hospital room and board;

(b) Miscellaneous hospital services;

(c) Hospital out-patient services; and

(d) Other benefits, if any.]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

D. Basic Medical-Surgical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) Basic medical-surgical expense coverage is designed to provide, to persons insured, coverage for medical surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses fees or unlimited medical-surgical expenses.

(3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

(a) Surgical services;

(b) Anesthesia services;

(c) In-hospital medical services; and

(d) Other benefits, if any]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

E. Basic Hospital/Medical-Surgical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Sections 7B and C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed.

[COMPANY NAME]

BASIC HOSPITAL/MEDICAL-SURGICAL EXPENSE COVERAGE

THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your [Policy][Certificate] Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) Basic hospital/medical-surgical expense coverage is designed to provide, to persons insured, coverage for hospital and medical surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical surgical expenses.

~~(3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:~~

~~(a) Daily hospital room and board;~~

~~(b) Miscellaneous hospital services;~~

~~(c) Hospital outpatient services;~~

~~(d) Surgical services;~~

~~(e) Anesthesia services;~~

~~(f) In-hospital medical services; and~~

~~(g) Other benefits, if any.]~~

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.~~

~~(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]~~
~~(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]~~

~~F~~C. Hospital ~~Confinement~~ Indemnity or Other Fixed Indemnity Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section ~~7E~~8B of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~HOSPITAL CONFINEMENT INDEMNITY COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

[Hospital Indemnity] [Other Fixed Indemnity] Coverage

The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [~~P~~policy][~~C~~certificate] ~~C~~carefully~~.~~ This outline of coverage ~~provides a very brief description of~~briefly describes your coverage's ~~the~~ important feature~~s of coverage~~. ~~This~~It is not the insurance contract ~~and only the actual policy provisions will control~~. The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY] [CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!

(2) [Hospital ~~confinement~~ indemnity] [Other fixed indemnity] coverage is designed to ~~provide, to persons insured, coverage in the form of~~pay a fixed ~~daily~~dollar benefit as a result of a ~~during periods of~~ covered ~~hospitalization resulting from a~~ [hospital stay] [event] due to a ~~covered accident or~~ sickness or injury~~, subject to any limitations set forth in the policy~~. The benefit may be limited in ways described in the [policy] [certificate]. ~~Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.~~ The fixed dollar benefit may be less than the [hospital stay's] [event's] cost.

(3) [A brief, but clear and specific, description of the benefits in the following order:

(a) ~~Daily benefit payable during hospital confinement~~When the benefits are payable; ~~and~~

(b) The d~~D~~uration of benefits described in (a); and

(c) The fixed dollar amount of the benefits.]

~~Drafting~~ Note: ~~The above description of benefits shall be stated clearly and concisely.~~

(4) [A clear description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit, described in Paragraph (3) above.]

(5) [A clear description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

(6) [~~Any~~A clear description of any benefits provided in addition to the ~~daily~~fixed dollar [hospital] [event] benefit.]

~~G. Individual Major Medical Expense Coverage (Outline of Coverage)~~

~~An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7F of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:~~

~~[COMPANY NAME]~~

~~INDIVIDUAL MAJOR MEDICAL EXPENSE COVERAGE~~

~~OUTLINE OF COVERAGE~~

~~(1) Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!]~~

~~(2) Individual major medical expense voverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.~~

~~(3) [A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:~~

(a) Daily hospital room and board;

(b) Miscellaneous hospital services,

(c) Surgical services;

(d) Anesthesia services;

(e) In-hospital medical services,

(f) Out-of-hospital care;

(g) Maximum dollar amount for covered charges; and

(h) Other benefits, if any]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

H. Individual Basic Medical Expense Coverage

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7G of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

INDIVIDUAL BASIC MEDICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Individual basic medical expense coverage is designed to provide, to persons insured, limited coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in hospital medical services, and out of hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

(3) [A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

(a) Daily hospital room and board;

~~(b) Miscellaneous hospital services,~~

~~(c) Surgical services;~~

~~(d) Anesthesia services;~~

~~(e) In-hospital medical services,~~

~~(f) Out-of-hospital care;~~

~~(g) Maximum dollar amount for covered charges; and~~

~~(h) Other benefits, if any]~~

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.~~

~~(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]~~

~~(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]~~

~~I~~D. Disability Income Protection Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section ~~7H~~8C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~DISABILITY INCOME PROTECTION COVERAGE~~
Disability Income Protection Coverage

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [~~P~~policy] [certificate] ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of~~briefly describes your coverage's ~~the~~ important features ~~of your policy~~. ~~This~~It is not the insurance contract. ~~and only the actual policy provisions will control.~~ The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR POLICY CAREFULLY~~read your [policy] [certificate] carefully!

(2) Disability income protection coverage is designed to ~~provide, to persons insured, coverage~~pay a benefit for disabilities resulting from a covered ~~accident or~~ sickness or injury~~, subject to any limitations set forth in the policy~~. The benefit may be limited in the ways described in the [policy] [certificate].~~Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.~~ The benefit might not fully replace your income.

(3) [~~A brief~~Brief, but clear and specific, description of the benefits contained in ~~this~~the [policy] [certificate].]

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely.~~

(4) [A clear description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A clear description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

~~J~~E. Accident-Only Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with policies or certificates meeting the standards of Section ~~7I~~8D of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~ACCIDENT ONLY COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

Accident-Only Coverage

The benefits in this [policy] [certificate] are limited.
They are intended to supplement your other health insurance coverage.

They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [~~P~~policy][~~C~~certificate] ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features ~~of the coverage~~. ~~This~~It is not the insurance contract. ~~and only the actual policy provisions will control~~. The [policy] [certificate] ~~itself sets forth in detail~~details ~~the~~your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!

(2) Accident-only coverage ~~is designed to provide, to persons insured, coverage~~pays benefits for ~~certain losses resulting~~covered injuries from a covered accident ~~ONLY, subject to any limitations contained in the policy~~. It does not provide benefits resulting from sickness. The benefits may be limited in ways described in the [policy] [certificate]. ~~Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.~~

(3) [~~A brief~~Brief, but clear and specific, description of the benefits and a description of any deductible or copayment provisions applicable to the benefits described.]

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.~~

(4) [A clear description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above. Proper disclosure of benefits that vary according to the type of accidental cause shall be made in accordance with Section 8A(13) of this regulation.]

(5) [A clear description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

~~K~~F. Specified Disease or Specified Accident Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with policies or certificates meeting the standards of Sections ~~7J~~8E and ~~K~~F of this regulation. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~[SPECIFIED DISEASE] [SPECIFIED ACCIDENT] COVERAGE~~

~~THIS [POLICY] [CERTIFICATE] PROVIDES LIMITED BENEFITS~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

Specified Disease or Specified Accident Coverage (Outline of Coverage)

The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) ~~This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it.~~ Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

Drafting Note: States should review whether they have the Buyer's Guide to Specified Disease Insurance referenced above. If they do, the state should determine if it is up to date before requiring such a guide to be provided. If the state does not have such a guide, then the state should revise this outline of coverage accordingly.

(2) Read ~~Y~~your [policy] [certificate] ~~[Outline of Coverage]~~ ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features ~~of coverage~~. ~~This~~It is not the insurance contract ~~and only the actual policy provisions will control~~. The [policy] [certificate] ~~itself sets forth in detail the~~details your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY] [CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!

(3) [Specified disease][Specified accident] coverage is designed to ~~provide, to persons insured, restricted coverage paying benefits ONLY~~ pay limited benefits ~~when certain losses occur~~ as a result of the diagnosis or treatment [of a ~~[specified diseases~~covered disease] or [resulting from a ~~[specified accidents~~specifically identified type of accident]. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(4) [~~A brief~~Brief, but clear and specific, description of the benefits, including dollar amounts and a description of any deductible or copayment provisions applicable to the benefits described.] Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 8A(13) of this regulation.

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.~~

~~L~~G. Limited Benefit Health Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates which do not meet the minimum standards of Sections ~~7~~8B, D and G~~C, D, E, F, G, I and K~~ of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~LIMITED BENEFIT HEALTH COVERAGE~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND~~
~~ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~
Limited Benefit Health Coverage
The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [~~P~~policy][~~C~~certificate] ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features ~~of your policy~~. ~~This~~It is not the insurance contract ~~and only the actual policy provisions will control~~. The [policy] [certificate] itself ~~sets forth in detail~~details ~~they~~your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!

(2) Limited benefit health coverage ~~is designed to provide, to persons insured, limited or supplemental coverage~~ pays limited benefits. This [policy] [certificate] is not major medical insurance and does not replace it.

(3) [~~A brief~~Brief, but clear and specific, description of the benefits, including dollar amounts and a description of any deductible or copayment provisions applicable to the benefits described.]

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.~~

(4) [A clear description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

H. Short-Term, Limited Duration Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section 8H of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Short-Term, Limited Duration Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

The [policy] [certificate] may not cover preexisting conditions.

OUTLINE OF COVERAGE

(1) Read your [policy] [certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) This is a short-term, limited duration [policy] [certificate]. This is temporary insurance. It is not comprehensive health insurance. It might not cover or might limit coverage for preexisting conditions. It might not cover essential health benefits such as pediatric, hospital, emergency, maternity, mental health, substance use services, prescription drugs, or preventive care. Read your [policy] [certificate] carefully to make sure you understand what is covered and any limitations on coverage.

(3) [Brief, but clear and specific, description of the benefits in the following order:

(a) Benefits covered by the policy or certificate, including required cost-sharing;

(b) Benefits that are not covered by the policy or certificate; and

(c) Duration of benefits described above.]

(4) A clearly worded prominent notice that cost-sharing limitations do not apply to benefits not covered by the policy or certificate.

(5) [A clear description of provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in paragraph (3) above.]

(6) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

~~M~~I. Limited Scope Dental ~~Plans~~Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with dental ~~plan~~care policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Limited Scope Dental Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [p~~P~~olicy][~~C~~certificate] ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features~~ of your policy~~. ~~This~~It is not the insurance contract~~ and only the actual policy provisions will control~~. The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations~~ of both you~~ and those of your

insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE] CAREFULLY~~read your [policy] [certificate] carefully!

(2) Limited scope dental coverage pays benefits for dental benefits only. It is not intended to cover all dental expenses. Read your [policy] [certificate] carefully to understand what dental care it covers and any cost-sharing that may be your responsibility.

~~(2)~~(3) [~~A brief~~Brief, but clear and specific, description of the benefits.]

~~(3)~~(4) [A clear description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph ~~(1)~~(3) above.]

~~(4)~~(5) [A clear ~~descripton~~description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

~~N~~J. Limited Scope Vision ~~Plans~~Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with vision ~~plan~~care policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Limited Scope Vision Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [p~~P~~olicy][~~C~~certificate] ~~C~~carefully. ~~—~~ This outline of coverage ~~provides a very brief description of the~~ briefly describes your coverage's important features~~ of your policy~~. ~~This~~It is not the insurance contract~~ and only the actual policy provisions will control~~. The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations~~ of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE] CAREFULLY~~read your [policy] [certificate] carefully!

(2) Limited scope vision coverage pays benefits for vision benefits only. It is not intended to cover all vision expenses. Read your [policy] [certificate] carefully to understand what vision care it covers and any cost-sharing that may be your responsibility.

~~(2)~~(3) [~~A brief~~Brief, but clear and specific, description of the benefits.]

~~(3)~~(4) [A clear description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph ~~(1)~~(3) above.]

~~(4)~~(5) [A clear description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

Section ~~9~~10. Requirements for Replacement of Individual ~~Accident and Sickness Insurance~~Supplementary and Short-Term Health Insurance Coverage

~~**Drafting Note:** Group supplemental health insurance is not addressed here because it is addressed in the Group Coverage Discontinuance and Replacement Model Regulation, which is applicable. States may also have other statutes or regulations that apply.~~

A. An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other ~~accident and sickness~~supplementary or short-term health insurance subject to this regulation, as provided in Section 3A of this regulation, presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used.

B. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subsection C below. The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in Subsection D below. ~~In no event, h~~However, ~~will the~~this notice~~s be~~is not required in the solicitation of ~~the following types of policies:~~ accident-only policies or the replacement of ~~and~~ single-premium nonrenewable policies.

C. The notice required by Subsection B above for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

~~NOTICE TO APPLICANT REGARDING REPLACEMENT~~

~~OF ACCIDENT AND SICKNESS INSURANCE~~
Notice to Applicant About Replacement of [Supplementary] [Short-Term] Health Insurance

According to [your application] [information you have ~~furnished~~provided], you intend to lapse or otherwise ~~terminate existing~~ end the ~~accident and sickness~~supplementary or short-term health insurance you have now and replace it with a policy ~~to be issued by~~the [insert company name] Insurance Company will issue. For your own ~~information and~~ protection, you should ~~be aware of and seriously consider certain factors that~~know how replacing your policy with a new one ~~may~~might affect ~~the insurance protection available to you under the new policy~~your coverage.

(1) A new policy might not pay claims that the policy you have now would pay. A new policy might not cover ~~Health~~health conditions ~~which you may~~that you might ~~presently~~ have~~,~~ now (preexisting conditions) or ~~may~~might not ~~be immediately or fully covered under the new policy~~cover them right away. ~~This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy~~ A new policy might cover some but not all the costs related to treating preexisting conditions.

Drafting Note: This subsection may be modified if preexisting conditions are covered under the new policy.

(2) ~~You may wish to secure the advice of your present insurer or its agent~~Talk with your current insurance agent ~~regarding the proposed replacement of your present~~or company representative about replacing your policy. ~~This is not only your right, but it~~It is ~~also~~ in your best interest~~s~~ to ~~make~~be sure you understand ~~all the relevant factors involved in replacing your present~~how replacing your policy could affect your future coverage.

(3) If~~, after due consideration, you still wish to terminate your present~~ you decide to buy a new policy~~, and replace it with new coverage, be certain~~be sure to truthfully and completely answer all questions on the application ~~concern~~about your medical/health history. ~~Failure to include all material medical information on an application may provide a basis for~~If you do not, the company ~~to~~could deny any future claims and ~~to~~ refund your premium as though your policy had never been in force. ~~After the~~Check that the information on your application ~~has been completed~~is complete and correct ~~and~~ before you sign it~~, reread it carefully to be certain that all information has been properly recorded~~.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

D. The notice required by Subsection B of this section for a direct response insurer shall be as follows:

~~NOTICE TO APPLICANT REGARDING REPLACEMENT~~

~~OF ACCIDENT AND SICKNESS INSURANCE~~
Notice to Applicant About Replacement of [Supplementary] [Short-Term] Health Insurance

According to [your application] [information you have ~~furnished~~provided], you intend to lapse or otherwise ~~terminate existing~~end the ~~accident and sickness~~supplementary or short-term health insurance you have now and replace it with the attached policy ~~delivered herewith~~ issued by [insert company name] Insurance Company. ~~Your new policy provides~~You have thirty days ~~within which you may~~to decide ~~without~~at no cost ~~whether you desire to~~if you want to keep the new policy. For your own ~~information and~~ protection, you should ~~be aware of and seriously consider certain factors that~~know how replacing your policy with a new one ~~may~~might affect ~~the insurance protection available to you under the new policy~~your coverage.

(1) A new policy might not pay claims that the policy you have now would pay. A new policy might not cover ~~Health~~health conditions ~~that~~ you ~~may presently~~ have~~,~~ now (preexisting conditions) ~~may not be immediately or fully covered under the new policy~~or might not cover them right away. ~~This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.~~A new policy might cover some but not all the costs related to preexisting conditions.

(2) ~~You may wish to secure the advice of your present insurer or its~~ Talk with your insurance agent or company representative ~~regarding the proposed replacement of your present~~about replacing your policy. ~~This is not only your right, but it~~It is ~~also~~ in your best interest~~s~~ to ~~make~~be sure you understand ~~all the relevant factors involved in replacing~~how replacing your policy could affect your ~~present~~future coverage.

(3) [To be included only if the application is attached to the policy]. If~~, after due consideration,~~ you ~~still wish to terminate your present~~decide to buy a new policy, ~~and replace it with new coverage,~~ read the copy of the attached application ~~attached to your new policy~~ and be sure that all questions are answered fully and correctly. ~~Omissions or misstatements in the application could cause~~If they are not, the company could refuse to pay an otherwise valid claim ~~to be denied~~. Carefully check the application and write to [insert company name and address] within ten days if any information is not correct and complete, or if any past medical history has been left ~~out of~~off the application.

[COMPANY NAME]

Drafting Note: The sentence "You have thirty days to decide at no cost if you want to keep the new policy." should only be required if the state has adopted Section 9A(18).

Section ~~10~~11. Separability

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

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Draft: 11/5/24
Adopted by the Executive (EX) Committee and Plenary, Dec. __, 2024
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. __, 2024
Adopted by the Regulatory Framework (B) Task Force, Nov. 4, 2024

2025 Proposed Charges

REGULATORY FRAMEWORK (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Regulatory Framework (B) Task Force** will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace, and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority, and structures.
   C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group, and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in ~~2024~~2025.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze, and report developments related to association health plans (AHPs).
   F. Monitor, analyze, and report, as necessary, developments related to excepted benefits coverage and short-term, limited-duration (STLD) coverage.

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

~~3~~2. The **ERISA (B) Working Group** will:
   A. Monitor, report, and analyze developments related to ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate with the states and the U.S. Department of Labor (DOL) efforts related to sham health plans.
   C. Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to ERISA.
   D. Review the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook), and modify it, as necessary, to reflect developments related to ERISA. Report annually.

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

~~4~~3. The **Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group** will:

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

~~5~~4. The **Pharmaceutical Benefit Management Regulatory Issues (B) Working Group** will:

A. Serve as a forum to educate state insurance regulators on issues related to pharmacy benefit manager (PBM) regulation and other stakeholders in the prescription drug ecosystem.
B. Gather and share information, best practices, experience, and data to inform and support dialogue and information-sharing among state insurance regulators on issues related to PBM regulation, such as examinations and contracting, and pharmaceutical drug pricing and transparency.
C. As the subject matter experts (SMEs) and to promote uniformity across the states, while remaining sensitive to variation in state approaches, develop a chapter for inclusion in the *Market Regulation Handbook* establishing examination standards for PBMs and related regulated entities for referral and consideration by the Market Conduct Examination Guidelines (D) Working Group.
D. Maintain a current listing of PBM laws and regulations and case law for reference by state insurance regulators.
E. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to use the information gathered by the Working Group.
F. Monitor, facilitate, and coordinate with the states and federal agencies to ensure compliance and enforcement efforts regarding PBMs.

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

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Attachment Two
Regulatory Framework (B) Task Force
11/17/24

Draft: 10/28/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
Oct. 17, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Oct. 17, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Christina Jackson (FL); Amy Hoyt and Camille Anderson-Weddle (MO); Martin Swanson (NE); Heidi Clausen (UT); Christine Menard-O'Neil and Jamie Gile (VT); and Ned Gaines (WA).

1. Adopted Revisions to Model #171

The Subgroup continued its discussion of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). Jolie H. Matthews (NAIC) said Brenda J. Cude (NAIC consumer representative) submitted additional comments suggesting more revisions to Section 9—Required Disclosure Provisions. She said most were clarifying, non-substantive suggested revisions; however, one suggested revision is more substantive. Cude suggested that for consistency with other provisions in Section 9, language should be added to Section 9I and Section 9J to outline coverage provisions for limited scope dental coverage and limited scope vision coverage, respectively. The Subgroup reviewed NAIC staff's suggested language to address Cude's comments (Attachment Two-A). After discussion, the Subgroup accepted the suggested language. The Subgroup also accepted Cude's clarifying, non-substantive suggested revisions.

Swanson made a motion, seconded by Gaines, to adopt the proposed revisions to Model #171 (*see NAIC Proceedings – Fall 2024, Regulatory Framework (B) Task Force, Attachment One-A*). The motion passed unanimously.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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NAIC STAFF SUGGESTED REVISIONS TO ADDRESS CUDE COMMENTS

I. Limited Scope Dental Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with dental care policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Limited Scope Dental Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read your [policy][certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) Limited scope dental coverage pays benefits for dental benefits only. It is not intended to cover all dental expenses. Read your [policy] [certificate] carefully to understand what dental care it covers and any cost-sharing that may be your responsibility.

(3) [Brief, but clear and specific, descriptions of the benefits.]

(4) [A clear description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

J. Limited Scope Vision Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with vision care policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Limited Scope Vision Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read your [policy][certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) Limited scope vision coverage pays benefits for vision benefits only. It is not intended to cover all vision expenses. Read your [policy] [certificate] carefully to understand what vision care it covers and any cost-sharing that may be your responsibility.

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(3) [Brief, but clear and specific, descriptions of the benefits.]

(4) [A clear description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

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Draft: 9/27/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
Sept. 9, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Sept. 9, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Howard Liebers (DC); Amy Hoyt and Camille Anderson-Weddle (MO); Eric Dunning (NE); Heidi Clausen (UT); and Anna Van Fleet and Jamie Gile (VT).

1. Discussed Additional Comments Received on Draft Revisions to Model #171

The Subgroup continued its discussion of the comments submitted by Robert Wake (ME) and Brend Cude (NAIC Consumer Representative) on the May 3 draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) (*see NAIC Proceedings – Summer 2024, Regulatory Framework (B) Task Force, Attachment Four-A*), beginning with Section 9A(4)—Required Disclosure Provisions for other fixed indemnity coverage. Cude suggests for Section 9A(4) through Section 9A(12) deleting drafting notes requiring specific phrases and sentences be made prominent in the disclosures and adding that language to the substantive provisions. The Subgroup accepted those suggested revisions.

The Subgroup discussed and accepted Wake's non-substantive, clarifying suggested revisions to Section 9A(16) and Section 9A(17). The Subgroup discussed and accepted Wake's suggestion to delete the last sentence in both Section 9A(18) and Section 9A(19) because it duplicates requirements outlined in Section 9A(2). The Subgroup discussed and accepted Wake's suggested non-substantive, clarifying suggested revisions to Section 9A(20). Consistent with its decisions for Section 9A(4) through Section 9A(12), the Subgroup also accepted Cude's suggested revisions to Section 9A(21) to delete the drafting note and move the language in the drafting note to the substantive provision.

The Subgroup next discussed Section 9A(22), which requires insurers to provide a Buyer's Guide approved by the commissioner to individuals applying for specified disease insurance. In her comments, Cude questions whether such a guide exists. After discussion, the Subgroup asked NAIC staff to add a drafting note to Section 9A(22) stating that the Section 9A(22) only applies if the state has such a guide.

The Subgroup next discussed Section 9B(1)—Outline of Coverage Requirements. In her comments, Cude questioned whether the language in Section 9B(1) requiring an insurer to deliver an outline of coverage to an applicant prior to sale was accurate given the requirements of Section 6B and Section 6C of the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170). After discussion, the Subgroup agreed to delete the words "prior to sale" in Section 9B(1) to resolve the issue.

The Subgroup next discussed Wake's and Cude's non-substantive, clarifying suggested revisions on Section 9C through Section 9J. These provisions outline the requirements for the outline of coverage for the types of coverages regulated under the revised Model #171. The Subgroup accepted all the suggested revisions. The Subgroup also agreed to add a drafting note to Section 9F—Specified Disease or Specified Accident Coverage (Outline of Coverage) suggesting that states review their regulations to determine if they have the Buyer's Guide to Specified Disease Insurance referenced in Section 9F(1) before requiring insurers to provide the guide to consumers for them to read.

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The Subgroup next discussed Wake's non-substantive, clarifying suggested revisions to Section 10—Requirements for Replacement of Individual Supplementary and Short-Term Health Insurance Coverage. After discussion, the Subgroup accepted the suggested revisions.

Jolie H. Matthews (NAIC) said the Subgroup has discussed all the Wake and Cude comments on the proposed revisions to Model #171 and no additional comments have been received. She said she will distribute a final draft of the proposed revisions to Model #171 reflecting the Subgroup's discussions to date for the Subgroup to consider adoption during a meeting sometime in October.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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Draft: 8/19/24

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Chicago, Illinois
August 14, 2024

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met in Chicago, IL, Aug. 14, 2024. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Jane Beyer, Vice Chair (WA); Crystal Phelps (AR); Debra Judy (CO); Kurt Swan (CT); Elizabeth Nunes (GA); Andria Seip (IA); Julie Holmes (KS); Mary Kwei (MD); T.J. Patton (MN); Jo LeDuc (MO); Robert Croom and Tracy Biehn (NC); Chrystal Bartuska (ND); Michelle Heaton (NH); Alejandro Amparan (NM); Kyla Dembowski (OH); Ashley Scott (OK); Shannen Logue (PA); Jill Kruger (SD); Matthew Tarpley (TX); Ryan Jubber and Shelley Wiseman (UT); Julie Fairbanks (VA); Rebecca Rebholz (WI); Joylynn Fix (WV), and Jill Reinking (WY).

1. Heard Presentations on Clinical Guidelines for Behavioral Health Care

A. MCG Health

Ravi Sitwala (MCG Health) provided background on the history of MCG Health and its parent company, Hearst Health. He said MCG Health has more than 6,000 clients, including the majority of health plans, more than 3,000 hospitals, and many state and federal agencies. For behavioral health specifically, he cited hundreds of provider organizations, health plans, and hospitals as users. He said MCG Health guidelines are continually updated to keep current with the standard of medical care, with thousands of new articles reviewed and new citations added to the latest edition. He described a three-step process for developing guidelines, including searching medical literature, reviewing sources for quality and relevance, and grading the available evidence. He said behavioral health guidelines are written by a board-certified psychiatrist and reviewed by external, active professionals. He said MCG Health is the only nationally recognized, independently published source for clinical criteria since it is not owned by a health insurer or providers.

Donna Baker-Miller (MCG Health) added that MCG Health guidelines are subscription-based, so MCG Health is not paid based on whether claims are approved or denied. Sitwala said MCG Health care guidelines align with those from specialty societies like the American Society of Addiction Medicine (ASAM). He noted that MCG Health guidelines are specifically crafted to support substance use disorder (SUD) management. He said MCG Health supports a single workflow that allows clinicians to integrate references to other guidelines in one location. He pledged to share MCG Health guidelines with state insurance regulators.

B. Optum

Chrissy Finn (Optum) and Sarah Johnson (Optum) described the InterQual clinical guidelines. Finn said the guidelines are intended to ensure patients get the right care at the right time in the right setting, efficiently. She said inappropriate care, slow adoption of evidence, increasing complexity, and unexplained variance in care contribute to inefficiency. She described InterQual criteria as an innovative technology used by thousands of hospitals and hundreds of health plans and government payers. She said InterQual develops evidence-based criteria in the same way for physical health and behavioral health. She said content development follows a rigorous cycle, including research, critical appraisal, clinical review, peer review and validation, and quality assurance and release. Johnson said InterQual criteria support mental health parity and proactively direct to the next level of care. She said the criteria incorporate content like the ASAM Criteria.

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C. LOCUS

Dr. Michael Flaum (American Association for Community Psychiatry—AACP) presented on the Level of Care Utilization System (LOCUS) family of tools. He asked Working Group members about their current level of familiarity with LOCUS, and members responded that they had minimal familiarity. He said LOCUS has been under development since the 1990s and now includes tools that cover treatment for children, adolescents, and early childhood. He said LOCUS has two major components: evaluation parameters with six dimensions and a level of care continuum with seven ordered categories of service intensity. He said a LOCUS report can be completed in less than 10 minutes in a process that can be interactive, collaborative, and iterative. He said ratings can change over a short period of time, for example, when a patient has changes in their level of stress or support. He described the major goal of LOCUS as promoting a common language among people served, providers, payers, and policymakers. Flaum said LOCUS strives for transparency and clarity. He said LOCUS should be seen as complementary with other sources of clinical guidelines, like MCG Health or InterQual.

D. ASAM

Maureen Boyle (ASAM) presented on the ASAM Criteria, Fourth Edition. She said the ASAM Criteria is the most widely used set of standards for determining the appropriate level of care for SUDs. She said dozens of health plans license the Criteria for medical necessity, and 15 states require commercial payers to use the Criteria for medical necessity. She said the overdose crisis drives its growing adoption, expanded coverage under the Affordable Care Act (ACA), mental health parity regulations, and other factors.

Boyle identified the core components of the ASAM Criteria as the level of care assessment, decision rules, and the patient's placement in the continuum of care. She said the fourth edition added a new dimension of person-centered considerations to the existing dimensions, which include intoxication and withdrawal, biomedical conditions, psychiatric conditions, substance use risks, and the recovery environment. She said the continuum of care includes levels from outpatient to medically managed inpatient. The decision rules recommend the least intensive level of care where the patient can be safely and effectively treated. She said the Criteria are intended to be integrated, patient-centered, holistic, and oriented to chronic care. Boyle said the ASAM Criteria are supported by a number of implementation tools that aid in the education of users, assessment, and decision support. She mentioned training resources, ASAM software developed in partnership with InterQual, and service request forms that allow providers to structure information and summarize treatment plans and progress.

Beyer asked how MCG Health and InterQual guidelines deal with situations when the most appropriate level of care is unavailable due to a provider shortage. Sitwala said the guidelines would take a patient to the next level of care. He said one of the considerations in the guidelines is what facilities are available. He said an additional benefit of the guidelines is that they provide an outline of evidence-based care that may be helpful for providers when more specialized providers are unavailable. Johnson said a lack of provider availability is a real problem. She said InterQual guidelines are screening guidelines that do not indicate a final decision. She said a health plan would make a final decision that takes provider availability into account. Finn said users of InterQual implement the guidelines very differently from each other. Flaum said using a common standard allows benchmarking across systems. He said under LOCUS, a health plan would be expected to fund a higher level of care when the most appropriate level is unavailable. Boyle said ASAM allows for stepping up a request to a higher level when a certain level is unavailable.

Fix asked whether clients of MCG Health are contractually permitted to adjust the guidelines. Sitwala said MCG Health guidelines are not algorithms that decide whether a user should or should not do something. He said the guidelines collect evidence and allow payers to make their own judgments. He said payers may customize the

guidelines, but when they do, the payer cannot say they are applying MCG Health guidelines to make a decision. Finn said InterQual content is no longer considered InterQual content once a payer updates it; it is then considered custom content.

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, to continue work on its goals.

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SENIOR ISSUES (B) TASK FORCE

Senior Issues (B) Task Force Nov 17, 2024, Minutes 6-227
Senior Issues (B) Task Force Oct. 21, 2024, Minutes (Attachment One) 6-232
Senior Issues (B) Task Force Sept. 20, 2024, Minutes (Attachment Two) 6-233

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Draft: 11/24/24

Senior Issues (B) Task Force
Denver, Colorado
November 17, 2024

The Senior Issues (B) Task Force met in Denver, CO, Nov. 17, 2024. The following Task Force members participated: Scott Kipper, Chair (NV); Peni 'Ben' Itula Sapini Teo, Vice Chair (AS); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Sanjeev Chaudhuri (AL); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Michael Ross (DC); Trinidad Navarro represented by Sally Frechette (DE); Michael Yaworsky represented by Alexis Bakofsky (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Randy Pipal (ID); Amy L. Beard represented by Alex Peck (IN); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark represented by Angi Raley (KY); Timothy J. Temple represented by Vicki Dufrene (LA); Michael T. Caljouw represented by Kevin Beagan (MA); Marie Grant represented by Jamie Sexton (MD); Robert L. Carey represented by Marti Hooper (ME); Anita G. Fox represented by Renee Campbell (MI); Chlora Lindley-Myers represented by Jo LeDuc (MO); Mike Chaney represented by Bob Williams (MS); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning and Martin Swanson (NE); D.J. Bettencourt represented by Michelle Heaton (NH); Justin Zimmerman (NJ); Alice T. Kane represented by Blanca Ramirez (NM); Judith L. French represented by Laura Miller (OH); Andrew R. Stolfi represented by Numi Griffith (OR); Michael Humphreys represented by Dave Yanick (PA); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Scott McAnally (TN); Cassie Brown represented Debra Diaz-Lara (TX); Jon Pike represented by Tanji Northrup (UT); Scott A. White represented by Jackie Myers (VA); Kevin Gaffney represented by Emily Brown (VT); Mike Kreidler represented by Todd Dixon (WA); Nathan Houdek represented by Darcy Paskey (WI); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted its Oct. 21, Sept. 20, and Summer National Meeting Minutes

The Task Force met Oct. 21 and Sept. 20. During these meetings, the Task Force took the following action: 1) adopted its 2025 proposed charges and forwarded them to the Health Insurance and Managed Care (B) Committee for consideration; and 2) adopted a letter to the federal Centers for Medicare & Medicaid Services (CMS) regarding provider withdrawals from Medicare Advantage (MA) plans and the Medicare supplement insurance (Medigap) guaranteed issue (GI).

Kruger made a motion, seconded by Lombardo, to adopt the Task Force's Oct. 21 (Attachment One), Sept. 20 (Attachment Two), and Summer National Meeting minutes (*see NAIC Proceedings – Summer 2024, Senior Issues (B) Task Force*.) The motion passed unanimously.

2. Discussed the Medicare Advantage/Medigap/SEP issue with the CMS

Molly Turco (CMS) said CMS appreciates and hears the recent feedback from state insurance regulators. She said CMS is working on improving communication and information sharing with regulators and stakeholders. CMS is creating a frequently asked questions (FAQ) document and updating its website to provide centralized information, and it will create a single point of contact mailbox for NAIC and state regulators to send issues and questions. It also plans to share important information with NAIC and state regulators, including enrollment changes and significant provider network changes, and it will work hard on improving communication and responsiveness based on feedback from participants throughout the year and especially at important inflection points, such as open enrollment.

Commissioner Kipper said the Task Force appreciates the willingness of CMS to work closer with state regulators

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and be a better partner on the information flow. He said there is a great deal of anticipation for the FAQ, which will hopefully be released tomorrow.

Director Dunning said state insurance regulators ask for more state regulation over MA plans on Capitol Hill, and there is more reason to advocate for state regulation of MA plans. He said that his state was fortunate to finally receive a response to its inquiries from the past six months, which came in the form of a four-paragraph letter.

Director Dunning said there are many communications from CMS in his state but many inaccurate answers. He said he has seen one communication go to one carrier but not to another, and conflicting answers go to different parties. This causes a great deal of confusion, and the State Health Insurance Assistance Program (SHIP) volunteers are thoroughly confused. They are trying to communicate answers to seniors in an open enrollment setting, but they are being tripped up by a lack of guidance from the federal government.

Kruger said she shares the sentiments of Director Dunning that he finally received a response but her state has not heard anything from CMS. She said she understands that these are difficult topics, and the CMS does not necessarily know the answers, but she said her state cannot abide by being ignored when information and guidance are sent and then requested in return, but no response is received. Turco appreciated the feedback, and CMS wants to ensure information is received on a timely basis. She said she is here to receive all feedback, negative and positive, and appreciates the Task Force's candidness. Her goal is to turn the feedback into action, and CMS is working on having an official process so states have the information and support they need.

Commissioner Kipper said there is no shortage of Task Force members and other state regulators ready to help CMS communicate better. He said most, if not every state, has a SHIP office or program that is very good at disseminating to affected consumers, and state regulators want to help CMS.

Fix asked if CMS has considered extending the open enrollment period because of all the confusion. Turco said CMS cannot respond to that at the moment; however, the end of open enrollment is rapidly approaching, and when there has been confusion in the marketplace, CMS extends the period, but currently, there is no discussion of an extension. There is less flexibility with Medicare due to federal law, but she will report any information back.

Bartuska explained that during the last open enrollment, a carrier in her state had to exit a county's market due to exceeding the Medicare Cost Plan population limit, a rule set by CMS. She believes this rule needs to be changed and also noted that the guidance CMS provided to North Dakota regarding the loss of an MA plan differs from the guidance given about losing a cost plan in a specific county.

Bartuska said the biggest issue is the difference between the Medicap C and F plans versus the Medigap D and G plans. Individuals who turned 65 before Jan. 1, 2020, are restricted to Plans C and F, and D and G are not available to them. She noted that Plan F is facing challenges due to the lack of new enrollees. Bartuska said that while recent discussions have focused on MA plans, it is important not to overlook the issue with cost plans, as they are similar concerns. She emphasized that CMS rules limit the number of carriers allowed in a single county. Seip said she echoed Bartuska's comments given the number of Medicare Cost Plans in Iowa.

Turco thanked North Dakota and Iowa for their feedback on the Medicare Cost Plans. Although she does not believe these issues are addressed in the FAQ, she will pass along the information to CMS and, hopefully, add information on these issues to the FAQ.

Turco moved on to address a few of the questions that were raised during the Task Force's Nov. 7 meeting. All of the questions will be answered in the upcoming FAQ, which will be about 10 pages long. One question that is asked frequently is what criteria CMS uses to determine whether a network change is significant. CMS recognizes

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that each provider termination is unique and carefully evaluates the circumstances to determine its significance. The goal is to make timely decisions, ensuring beneficiaries are informed of their rights and options for changing plans or Medigap coverage promptly. CMS remains committed to this approach and will continue to communicate as needed.

Another question asked is how this criteria impacts people in employer-sponsored plans and how network change is determined, as people are being told by their providers about the network change. Turco said provider terminations that occur within an employer-sponsored MA plan are subject to the same CMS requirements and processes for determining whether a Special Enrollment Period (SEP) is applicable. MA plans, including employer-sponsored MA plans, are required to report to CMS any time they have experienced a significant network change. CMS then determines if the provider termination is significant and if it is, this would be communicated to the plan. Existing CMS guidance requires the plan to notify impacted enrollees if they are eligible for a SEP and Medigap GI rights. She said CMS is working on standardizing these communications to enrollees.

Turco explained that plans must notify enrollees of this change, regardless of SEP eligibility. CMS provides resources for plans to contact them with any process-related questions. She also noted that providers may not know if an enrollee's coverage is through an employer-sponsored plan. Enrollees in such plans should check with their employer to understand additional coverage options and how decisions might affect their employer-sponsored coverage.

Another question that was asked during the Nov. 8 meeting was that although determination is communicated quickly, how long does it take to make the determination? CMS thoroughly reviews each case and works quickly so that affected enrollees are notified as fast as possible. When CMS determines the network's change is significant, the plan must notify its affected enrollees of their eligibility for a SEP, including their GI rights and how to use a SEP. CMS provides model language for this notification, but this is another area where CMS is open to feedback about timeliness and other related issues.

Turco said that another question asked was who at CMS prompts the plans to send notifications to beneficiaries when a provider network decides to no longer accept MA plans. MA plans are required to report to CMS anytime they are experiencing a network change. CMS then works to determine if the provider termination is significant. If CMS determines it is significant, MA plans are then required to communicate this to their beneficiaries. These rules are in 42 CFR 422.11 and 4222.622B.

Turco said another question is if CMS can provide a link to the model notices that carriers must follow and if CMS checks the notices to ensure compliance. CMS provides a link that can be found in the marketing model standards documents and education materials. These are updated, and CMS encourages their use. CMS is in the process of updating the model notices, and they will be shared with the NAIC upon completion.

Another question asked was if CMS could provide a crosswalk and termination list that can be sorted by state and county. CMS is working to see if this is possible. Another feedback question was asked about zero-dollar ($0) commissions. Turco said $0 commissions happen every year, but CMS is seeing more this year both in the standalone prescription drug plan (PDP) market as well as in the Medicare Advantage Prescription Drug (MAPD) and Medigap markets. The feedback that was given when this question was asked during the meeting was that some carriers are providing $0 commissions for GI Medigap plans. This is an obvious attempt to discourage the sale of plans to consumers, and this should be kept in mind as more consumers are given GI rights. Turco said this issue is not addressed in federal regulation, and Medigap commissions are subject to state laws. The primary oversight and enforcement of Medigap sales are under the purview of the state.

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A related question regarding MA plans is that some carriers are providing $0 commission for new MA sales, and does this violate the new federal rules on MA producer compensation? This question implicates aspects of the new agent and broker compensation regulation that CMS finalized in its April 2024 final rule. Certain provisions of this regulation are the subject of pending litigation. On July 3, 2024, the U.S. District Court for the Northern District of Texas issued preliminary injunctions in multiple cases nationwide. Therefore, the regulation language that was effective prior to the issuance of this final rule will be in effect, and essentially, the new regulations are not in effect due to the injunction and resorted back to the previous rules regarding MA compensation.

Turco said the language in CMS' regulation that is currently in effect provides that MA organizations and sponsors "may determine through their contracts the amount of compensation to be paid, provided it does not exceed limitations outlined in this section." This means CMS only determines what the maximum fair market value is for the initial and renewal amounts, not below that, so CMS is not mandating and does not have the authority to do so. It is within the plan's ability to have $0 commissions, and MA organizations determine the payment schedules through their contracts. A plan may set a range for that fair market value maximum, which could be zero, and they may adjust their compensation within that range.

Bartuska asked if the regulations or processes require a 90-day notice when a carrier plans to exit a market. She noted that most states require a 60- to 90-day notice from insurers and emphasized that states were not notified in this case. She added that while the federal government regulates MA, states have requested authority to do so, and if the federal government is in charge, clear timeframes should be established. Turco said she would follow up on the timeframe issue.

Swanson inquired about a situation where a significant event in a county allows people to get a SEP into Medicare and a GI into Medigap, but marketing of MA plans is still permitted in the same county. He asked if this is allowed, as it is currently happening. Turco clarified if Swanson was referring to marketing by the same plan, and Swanson confirmed. Turco explained that the confusion may stem from contracts that include multiple plans, with a SEP applying to only one plan within the contract. She noted that typically, only one plan is affected. Moving forward, she said CMS will clarify which enrollees are impacted in future communications, as it will not be all enrollees in the contract.

Swanson said that is not what the letters sent to Nebraska say. He said the letters told the two carriers that had MA in the county that they get a SEP back to original Medicare and GI back into Medigap. He said Turco's answer was confusing as well. Although there are multiple plans, one carrier was told to send this information out in a broad format, and the other one was not even communicated as having a GI.

Turco said she would be happy to discuss this specific Nebraska-Great Plains matter further, as she does not have the details in front of her now; however, it would not be accurate to say a plan would not be notified because they would be the ones communicating to the enrollees. Director Dunning said Nebraska would take the advice of the letter, and no additional conversations are necessary.

Fix acknowledged understanding CMS's point, but it is still not fully clear. She said CMS must understand that when a hospital system pulls out of a network, they have zero idea of what plans people are on. She said they pull out of the carrier, not a plan, so while the Task Force hears what CMS is saying, that is not what is happening on the ground.

Kathryn Coleman (CMS) said part of the confusion is that there are people enrolled in a plan for 2024, but it is also open enrollment for next year's plans and that plan still exists for 2025, so CMS is able to market to individuals. At the same time, there are people enrolled who are eligible for a SEP. It is challenging because there are overlapping election periods at the same time that people receive a SEP for their current plan.

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Kruger explained that the confusion lies in how a SEP triggered by a significant network change in 2024 would allow someone to enroll in the same plan for 2025 if the network is still not viable. Coleman said there could be a significant network change, but it may not impact their ability to meet CMS's network standards. The 2025 plan may still meet the MA network standards and still be a plan in 2025 without that particular provider in their network. The standards are a floor, and many times, MA plans exceed that standard.

Kruger acknowledged that the question was answered, but pointed out that for rural states, the situation is challenging. Unlike urban areas with multiple hospital systems, rural areas often have only one hospital, so when that hospital leaves a network, it becomes nearly impossible to meet the required standards. This approach does not make sense for rural states. Coleman said they have different standards based on county type, and CMS looks at access based on that type of county. CMS has four different categories of counties: urban, suburban, rural, and counties with extreme access concerns. She said CMS would be happy to talk with South Dakota about this matter. Commissioner Kipper asked if that discussion could be shared with the other rural states.

Commissioner Kipper said the Task Force and the NAIC look forward to continuing this discussion with CMS. He said CMS clearly understands the frustration of regulators and recognizes the significant communication opportunities. He encouraged CMS to leverage the expertise around the table and reiterated that state regulators and the NAIC, as always, are ready to assist CMS in addressing these issues.

Bonnie Burns (California Health Advocates—CHA) said she supports the SHIPs in California with training materials and information. This has been a particularly difficult annual enrollment period for many different reasons, and due to the Presidential Election and Thanksgiving, many people have not even begun to think about the changes to their MA plan or enroll in an MA plan.

She explained that she has been addressing situations where individuals are entitled to a Medigap policy due to changes in their MA plan, such as being moved to another MA plan, their plan exiting the market, or significant network changes. She distributed a handout, with the first page showing a notice people would receive if there was a significant change to their MA network. The notice, dated August and sent anonymously, led her to question what might have prompted CMS to send this notice to MA plans.

Burns said that if CMS is expanding access to Medigap plans due to significant changes in the MA plan, the process for determining these changes is complex and time-consuming. With less than a month left in the annual enrollment period (AEP), many elderly individuals are confused about their Medicare benefits, and there is limited information from CMS to help guide them.

Burns said providers are dropping coverage and leaving MA plans in large numbers all over the country. She said there is a lot of flux in the market right now, and she is dealing with 80-year-old people who are trying to figure out what to do about their MA plans or their Medicare benefits.

Having no further business, the Senior Issues (B) Task Force adjourned.

https://naiconline.sharepoint.com/:b:/r/sites/NAICSupportStaffHub/Member%20Meetings/B%20CMTE/SITF/FINAL%20Denver%20SITF%20Minutes.pdf

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Attachment One
Senior Issues (B) Task Force
11/17/24

Draft: 10/21/24

Senior Issues (B) Task Force
E-Vote
October 21, 2024

The Senior Issues (B) Task Force conducted an e-vote that concluded Oct. 21, 2024. The following Committee members participated: Scott Kipper, Chair (NV); Peni Itula Sapini Teo, Vice Chair (AS); Lori K. Wing-Heier (AK); Mark Fowler (AL); Ricardo Lara (CA); Andrew N. Mais (CT); Karima M. Woods (DC); Trinidad Navarro (DE); Doug Ommen (IA); Dean L. Cameron (ID); Amy L. Beard (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Timothy J. Temple (LA); Kevin P. Beagan (MA); Marie Grant (MD); Robert L. Carey (ME); Anita G. Fox (MI); Grace Arnold (MN); Mike Causey (NC); Jon Godfread (ND); Eric Dunning (NE); Judith L. French (OH); Michael Humphreys (PA); Jon Pike (UT); Scott A. White (VA); Mike Kreidler (WA); and Allan L. McVey (WV).

1. Adopted its 2025 Proposed Charges

The Task Force conducted an e-vote to consider adoption of its 2025 proposed charges and forward them to the Health Insurance and Managed Care (B) Committee. The motion passed unanimously.

Having no further business, the Senior Issues (B) Task Force adjourned.

https://naiconline.sharepoint.com/:b:/r/sites/NAICSupportStaffHub/Member%20Meetings/B%20CMTE/SITF/E-Vote%20Minutes%2010-21-24%20TPRd.pdf?csf=1&web=1&e=A4KoNg

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Draft: 9/20/24

Senior Issues (B) Task Force
E-Vote
September 20, 2024

The Senior Issues (B) Task Force conducted an e-vote that concluded Sept. 20, 2024. The following Committee members participated: Scott Kipper, Chair (NV); Peni Itula Sapini Teo, Vice Chair (AS); Lori Wing-Heier (AK); Ricardo Lara (CA); Andrew N. Mais (CT); Karima Woods (DC); Trinidad Navarro (DE); Doug Ommen (IA); Dean L. Cameron (ID); Amy L. Beard (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Timothy J. Temple (LA); Kevin Beagan (MA); Joy Hatchette (MD); Robert L. Carey (ME); Anita G. Fox (MI); Chlora Lindley-Myers (MO); Grace Arnold (MN); Mike Causey (NC); Jon Godfread (ND); Eric Dunning (NE); D.J. Bettencourt (NH); Glen Mulready (OK); Michael Humphreys (PA); Carter Lawrence (TN); Jon Pike (UT); Scott A. White (VA); Kevin Gaffney (VT); Mike Kreidler (WA); Nathan Houdek (WI); and Allan L. McVey (WV).

2. Adopted a Letter Regarding Provider Withdrawals from Medicare Advantage

The Task Force conducted an e-vote to consider the adoption of a letter to the Centers for Medicare & Medicaid Services (CMS) regarding provider withdrawals from Medicare Advantage (MA) plans and the subsequent process for beneficiaries to request a return to traditional Medicare and Medicare supplement insurance (Medigap) coverage.

The Task Force adopted the letter unanimously.

Having no further business, the Senior Issues (B) Task Force adjourned.

https://naiconline.sharepoint.com/:b:/r/sites/NAICSupportStaffHub/Member%20Meetings/B%20CMTE/SITF/E-Vote%20Minutes%2009-20-24%20TPRd.pdf?csf=1&web=1&e=Jg35Ci

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PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

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Draft: 12/2/24

Property and Casualty Insurance (C) Committee
Denver, Colorado
November 19, 2024

The Property and Casualty Insurance (C) Committee met in Denver, CO, Nov. 19, 2024. The following Task Force members participated: Alan McClain, Chair (AR); Michael Conway, Co-Vice Chair (CO); Michael Yaworsky, Co-Vice Chair (FL); Mark Fowler (AL); Andrew N. Mais and George Bradner (CT); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt (KS); Mike Chaney (MS); D.J. Bettencourt and Christian Citarella (NH); Alice T. Kane represented by Melissa Robertson (NM); Scott Kipper (NV); Andrew R. Stolfi (OR); Larry D. Deiter (SD); Tregenza A. Roach (VI); and Kevin Gaffney and Rosemary Raszka (VT). Also participating were: Ken Allen (CA); Travis Grassel (IA); Phil Vigliaturo (MN); Cynthia Amann (MO); Gennady Stolyarov (NV); Tom Botsko (OH); TK Keen (OK); and Allen L. McVey (WV).

1. Adopted its Summer National Meeting Minutes

Commissioner Mais made a motion, seconded by Commissioner Conway, to adopt the Committee's Aug. 15 minutes (*see NAIC Proceedings – Summer 2024, Property and Casualty Insurance (C) Committee*). The motion passed unanimously.

2. Adopted the Reports of its Task Forces and Working Groups

Commissioner Conway made a motion, seconded by Commissioner Bettencourt, to adopt the following task force and working group reports: Casualty Actuarial and Statistical (C) Task Force; Surplus Lines (C) Task Force; Title Insurance (C) Task Force; Workers' Compensation (C) Task Force; Cannabis Insurance (C) Working Group (Attachment One); Catastrophe Insurance (C) Working Group (Attachment Two); and Transparency and Readability of Consumer Information (C) Working Group (Attachment Three). The motion passed unanimously.

3. Adopted the *Premium Increase Transparency Guidance*

Commissioner McClain noted that the *Premium Increase Transparency Guidance* is a voluntary document that, if adopted by the Committee, would remain one that states could choose to use or modify as they wish.

Bradner stated that the Transparency and Readability of Consumer Information (C) Working Group adopted the *Premium Rate Transparency Guidance* document during its Nov. 12 meeting. The guidance document is intended to be used by states wishing to implement a disclosure notice process for insurers to explain to policyholders the causes of significant premium increases at renewal for personal auto, homeowners, and dwelling policies. Bradner explained that the document is only guidance, so if or how a disclosure notice is implemented is determined by each state.

Bradner said the project was introduced by a now-retired actuary, Charles Angell, as he felt policyholders should understand what key risk variables are driving increases in their premium given the increased complexity of rating models. Policyholders can then consider improving their risk profile and/or correcting any incomplete data the insurer uses in rating the policy. Bradner said the adoption of the guidance document comes after two years of drafting. The Working Group made substantial revisions to the document based on the comments received over two exposure periods. It also took great care in communicating why revisions were or were not made.

Bradner said the guidance uses a bifurcated approach to allow insurers time to implement needed processes. In Phase 1, insurers need to notify policyholders of their right to request an explanation for their rate increase.

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Instructions on how this should be done are included in the guidance. If and when Phase 2 begins is up to each state based on its review of Phase 1 and implementation of Phase 2 considerations. Phase 2 only applies to insurance policies with annual premium increases of $100 or more. In Phase 2, a notice is triggered when the renewal premium increases by 10% or more or upon the policyholder's written request for any increase. Insurers must send disclosure notices at least 30 days before the renewal date. Notices must have reasonable explanations and include primary factors of the premium increase. Primary factors are defined in the guidance. A suggested template for auto and homeowners disclosure notices is also included in the guidance. For both phases, insurers must respond to a policyholder's written request for explanation no later than 30 days for the first request and 20 days for subsequent requests.

Dave Snyder (American Property Casualty Insurance Association—APCIA) said he appreciated that the guidance is a voluntary document that could be modified or not adopted by a state. He said the document is labeled as guidance, and that should be emphasized. He said he appreciates the footnote that clarifies that Phase 2 may or may not occur and that the individual state would set the timetable.

Tony Cotto (National Association of Mutual Insurance Companies—NAMIC) said the process has been exemplary over the past several years in terms of responsiveness and dialogue. He said NAMIC still does not support the adoption of the guidance and recommends that Phase 2 should be deleted as it would increase compliance costs and could expose proprietary trade secrets.

Commissioner Chaney made a motion, seconded by Commissioner Yaworsky, to adopt the *Premium Increase Transparency Guidance* (*see NAIC Proceedings – Fall 2024, Property and Casualty Insurance (C) Committee, Attachment Three-A*). The motion passed, with Indiana abstaining.

4. Adopted its 2025 Proposed Charges

Commissioner Conway made a motion, seconded by Commissioner Bettencourt, to adopt the Committee's 2025 proposed charges (Attachment Four). The motion passed unanimously.

5. Heard Presentation on the Intersection of Advanced Vehicle Technology and Auto Claim Adjudication

John Petitt (QuantivRisk) said he wants to raise state insurance regulators' awareness of vehicle performance data (VPD) and how it can enhance transparency, accuracy, and fairness in the claims adjudication process. He said VPD can partially solve the current auto insurance affordability issues.

Mike Nelson (QuantivRisk) said QuantivRisk was founded with a mission to bring clarity and transparency to accident evaluation through precise data analysis. The process of looking at liability from a claims department perspective has been largely unchanged since the 1980s in terms of driver A and driver B providing their stories to their respective insurance companies. The current process is inefficient, unfair, and subjective.

Nelson said vehicle data includes: 1) the Event Data Recorder (EDR) or black box, which was designed to capture five seconds of data and is accessed by plugging into the car; 2) telematics data, which assesses driver behavior; and 3) VPD, which is the data captured or generated by the vehicle at thousandths of a second and captured for days, weeks, or months prior to a crash. Car manufacturers transmit VPD from the car to the Original Equipment Manufacturer (OEM) cloud, which is generally unavailable to insurance companies. Consumers rarely know about vehicle performance data. In the future, a data logger would augment EDRs and address some of what the car was doing at the time of the accident, but these loggers are years away.

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Petitt said QuantivRisk works with insurance companies in this space. Claims adjusters are often unaware this data exists, so they do not ask for it. He said auto OEMs fund their research and development (R&D) through insurer claim payments. OEMs are not paying for damage when they are responsible.

Nelson said the law should develop so that a neutral platform would leverage VPD to serve as an objective clearing house between insurers, consumers, auto OEMs, law enforcement, lawyers, and state insurance regulators. He said consumers should have the right to decide who uses the data. VPD can improve claim settlement accuracy and efficiency, reduce frictional costs in claim settlement, potentially lower automobile insurance rates, and enhance consumer experience with claim adjusters who understand advanced vehicle systems.

Petitt said that by working with insurers, policyholders consent to get the data in the context of an accident. He said they are seeing a 40% reduction in claim cycle times, clearer identification of subrogation with other parties, and improved fraud determination. They are still challenged with claim adjuster education and the current claim adjudication operating model.

Nelson said state insurance regulators should educate themselves on VPD and consider the removal of outdated legislation in terms of defining such data. He also noted that liability assessment will evolve with advanced vehicles.

6. Heard a Presentation on Using Fire Science and Data to Deliver Home Resilience

Jeff Klein (American Bankers Association—ABA) said he has worked with FortressFire recently and believes it has a science-based approach to mitigation that states can use to manage wildfire risk exposure and improve affordability and availability with respect to property insurance.

Duane Gibson (FortressFire) said FortressFire has created a model that, through fire physics, can predict how a wildfire will transfer to houses and neighborhoods and how to solve for that. He said the system would stop homes from burning, which would be helpful to insurers.

John Wall (FortressFire) noted that 45 million homes are located in wildfire-exposed areas of the western U.S. Insurance coverage has become more expensive, difficult to secure, and insufficient to cover potential losses. He said wildfire outcomes are binary, and current wildfire models predict more severe wildfires, therefore predicting increased losses. FortressFire's wildfire vulnerability score uses energy models that evaluate five ignition vectors of structure loss.

Wall said science-based property-level assessments can cost-effectively guide mitigations and stop wildfires from destroying homes. FortressFire produces an aerial risk report identifying an initial score and the structure's wildfire ignition risk vectors. The report leverages weather, topography, and parcel characteristics as inputs affecting fire vectors to the home. FortressFire gives property owners understand how their homes can ignite in a wildfire. Property owners can then change the home's vegetation, vents, or other materials to make them more fire-resilient. Onsite inspections are also available to refine the precision of the report and customize mitigation for the property. FortressFire offers a comprehensive annual subscription plan that includes homeowner alerts, service visits, event inspections, property preparation, and fire-retardant staging. Wall said FortressFire can identify vulnerabilities of a specific structure and mitigate those vulnerabilities to the point where the home has a near-zero risk of ignition in a wildfire.

7. Heard a Federal Update

Alex Swindle (NAIC) said a second Trump administration, alongside a new Republican majority in both chambers, will likely see: 1) a dramatic shift away from President Biden's policies; 2) reshaping of the Senate Committee on

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Banking, Housing, and Urban Affairs; 3) less activity on risk retention groups (RRGs); 4) less interest in climate-related data; 5) Republicans pursue budget reconciliation and renew the Tax Cuts and Jobs Act (TCJA); 6) rolling back federal encroachment into insurance; 7) less regulation; and 8) lower taxes. He said the NAIC will closely monitor President-elect Trump's proposed 20% tariff on imports, which could increase inflation and impact insurance reserves. He noted that the lighter regulatory approach could ease compliance costs for insurers.

Swindle said the National Flood Insurance Program's (NFIP's) future remains uncertain, and reforms could come next year as bi-partisan support for long-term flood insurance reform continues. He said there will likely be a big push next year to make the program more sustainable, and hearings and markups will likely occur.

Congress members continue to show interest in state resilience and mitigation efforts. An agriculture farm bill will include crop insurance reforms and proposals to reduce subsidies and eliminate duplicative programs. The Terrorism Risk Insurance Program (TRIP) expires in 2027 and is expected to be renewed.

Swindle said President-Elect Trump's policies may include tax incentives for first-time homebuyers and easing of regulations on home construction. It is anticipated there will be further action on the Federal Housing Finance Agency (FHFA) title pilot program as talks about privatizing Fannie Mae and Freddie Mac are becoming the focus.

8. Heard an Update on the PCMI Data Call

Commissioner McClain said the property/casualty (P/C) market intelligence (PCMI) data call was issued March 8 with data due June 6, and filings have been received from most of the insurance companies. Commissioner McClain noted a state insurance regulator data group has been meeting weekly to look at the quality of the data and assist in requesting re-filings from companies, as well as in looking at the data and creating tools to analyze the data. He said the data group continues to reach out to companies with questions about the data to better understand and improve the data. He said the data group has more recently been working on analyzing the data. Commissioner McClain said that if additional state insurance regulators need access to the data or wish to be part of the conversations on analysis, they should reach out to the NAIC.

Having no further business, the Property and Casualty Insurance (C) Committee adjourned.

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Draft: 11/22/2024

Cannabis Insurance (C) Working Group
Denver, Colorado
November 18, 2024

The Cannabis Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met in Denver, CO, Nov. 18, 2024. The following Working Group members participated: Katey Piciucco, Chair (CA); TK Keen, Vice Chair, Raven Collins, and Jason Horton (OR); Nathan Hall and Sian Ng-Ashcraft (AK); Lori Plant and Jimmy Harris (AR); Christina Miller and Catherine Reaves (DE); Angela King (DC); C.J. Metcalf (IL); Ryan Blakeney (MS); Gennady Stolyarov (NV); Randall Currier (NJ); Ursula Almada (NM); Andrew Schallhorn and Brian Downs (OK); Sebastian Conforto and Michael McKenney (PA); Damaris Rosado (PR); Beth Vollucci (RI); Karla Nuissl and Rosemary Raszka (VT); and Michael Walker (WA). Also participating was: Megan VanAusdall (NE).

1. Adopted its May 8 Minutes

The Working Group met May 8 and took the following action: 1) adopted its Dec. 19, 2023, minutes; 2) heard an update on cannabis-related legislative activities; 3) heard a presentation from BDSA on trends and emerging issues in the cannabis space; 4) heard a presentation from Jencap Specialty Insurance Services (Jencap) on insurance availability, coverage trends, and new risks in the cannabis space; and 5) heard a presentation on the work of the Insurance Institute for Highway Safety (IIHS) and the Highway Loss Data Institute (HLDI) on the legalization of marijuana for recreational use.

Vollucci made a motion, seconded by Keen, to adopt the Working Group's May 8 minutes (*see NAIC Proceedings – Summer 2024, Property and Casualty Insurance (C) Committee, Attachment One*). The motion passed unanimously.

2. Heard a Presentation on Cannabis Regulation in Colorado and CANNRA Activities

Dominique Mendiola (Colorado Department of Revenue [DOR] and Cannabis Regulators Association [CANNRA]) said the Colorado DOR licenses and regulates the commercial cultivation, manufacture, laboratory testing, and sale of medical and adult-use marijuana in the state of Colorado. The Colorado DOR brings issues it has navigated in its regulatory work in Colorado into its national engagement with cannabis regulators who are members of CANNRA. This includes the evolution of products in the market, receiverships/probate matters, premises security and surveillance, managing production to avoid oversupply risks and ensure inventory meets demand, and data-driven approaches to risk-based investigations.

CANNRA is a nonpartisan nonprofit association of government agencies involved in cannabis and/or cannabinoid hemp regulation. Its members are current government members from more than 45 states, as well as Canada and the Netherlands. CANNRA is not an advocacy group and takes no formal position for or against cannabis legalization. It is focused on education and peer-to-peer support. CANNRA has more than a dozen committees spanning the breadth of cannabis and cannabinoid policy topics (traffic safety, public health, banking, equity, packaging and labeling, etc.). Colorado is a statewide member (so all agencies with a tie to administering the state's cannabis laws are engaged, including the Department of Regulatory Agencies (DORA) and the insurance regulators.

CANNRA is focused on consumables, not industrial uses. The cannabis plant has over 100 different molecules that interact with the body (endocannabinoid system). The two most well-known cannabinoids are tetrahydrocannabinol (THC) and cannabidiol (CBD). Unlike CBD, THC has psychotropic effects and includes several

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"isomers" (delta-8, delta-9, delta-10). Delta-8 and delta-10 are present in smaller quantities than delta-9. The World Health Organization (WHO) estimates delta-8 is about 50%–75% as potent as delta-9 (but not widely studied or understood). Hemp is federally legal and regulated by the U.S. Department of Agriculture (USDA) as an agricultural plant. The legalization of hemp was done with a focus on hemp as a commodity crop (i.e., textile). Post legalization, CBD could be chemically converted into delta-8, delta-9, and delta-10 THC, using solvents (e.g., ethanol) and acids (e.g., sulfuric acid, nitric acid, etc.). Marijuana is federally illegal and regulated by states that have legal cannabis policies in place.

The 2018 Farm Bill legalized "the plant species Cannabis Sativa L. and any part of that plant, including the seeds thereof and all derivatives, extracts, cannabinoids, isomers, acids, salts, and salts of isomers, whether growing or not, with a delta-9 THC concentration of not more than 0.3% on a dry weight basis." The delta-9 THC concentration needs to be not more than 0.3% on a dry weight basis. Its definition focuses on a dry weight measurement of the plant material. When dried, however, a large amount of THC can be extracted in concentrated form, even if it initially met that 0.3% limit. As a result of the Farm Bill's language, the argument and legal interpretation many are taking is that it is legal to have more delta-9 THC in a hemp-derived product than what is allowed in a regulated marijuana product. This created a gray area of regulation and resulted in an influx of CBD products that could be converted into other cannabinoids. The Drug Enforcement Agency (DEA) made clarification efforts in 2020 but did not directly address "synthetic." The DEA has issued other positions that have not yet created significant clarity. The U.S. Court of Appeals for the Ninth Circuit's decision on May 2022 (which was a trademark copyright case over delta-8 vape products) ruled that products that contain delta-8 are completely legal under the 2018 Farm Bill. Other court cases have further assessed whether delta-8 products are legal. The court stated that the text of the Farm Bill was plain and unambiguous and that delta-8 products are lawful. The Farm Bill did not name a regulator for finished cannabinoid products, as the USDA focuses more on farming and cultivation.

Delta-8 products are being advertised in mainstream outlets nationwide (online, convenience stores, etc.). The market is also seeing an increase in delta-10 and products that do not exist in nature (e.g., hexahyrocannabinol [HHC], THC-O-acetate). Products reflect the multiple methods of consumption (edibles, vapes, etc.). Products are marketed with medicinal claims despite there being no consistent required testing or regulatory oversight. The FDA has not taken on regulatory authority but has issued health alerts and warnings to companies making health claims.

Regulatory challenges include limited authority, blurred lines, and a parallel industry that does not have consumer safety in focus but has interstate and online sales. Consumer confusion is a safety concern. Public education is tied to cannabis products. There are not the same educational efforts around hemp-derived cannabinoid products. Hemp-derived cannabinoid molecules are new and unknown, and there is a lack of product testing and oversight (unlike the testing and oversight within the regulated cannabis market). There is no oversight of additives and by-products, and there are risks of heavy metals and other contaminants.

This is evidenced by the crisis in e-cigarette or vaping use-associated lung injuries (EVALI). In the regulated cannabis market, regulators were able to intervene and prevent broad harm from unsafe byproducts (such as vitamin E acetate). The proliferation of intoxicating hemp products is reintroducing the public health/safety risks that cannabis regulators worked hard to mitigate and prevent in the cannabis space. There is no federal regulation for safety over finished products. There is also no recall authority similar to established cannabis frameworks. Medical claims are not approved by the FDA and/or supported by research. Potency, serving sizes, and package limits far exceed the regulated marijuana market. The availability of these hemp-derived intoxicating cannabinoids in retail and online stores makes them widely available to youth. All of these negative factors are undermining the regulated cannabis market, and Colorado is feeling the impact in part due to this parallel market with far lower barriers and oversight.

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Cannabis and hemp-derived cannabinoid products are highly technical subjects. This makes it difficult to educate others, including legislatures. Additionally, legislators are focused on a range of issues, resulting in an education gap. There is disagreement regarding how to define “impairing” and how to treat non-natural products (synthetics). There is no or limited regulatory authority over cannabinoid hemp products. The lack of research hinders regulators’ ability to make decisions on many of these molecules. There is limited federal engagement, increased challenges in understanding data on safety and adverse events, and increased consumer confusion about what is legal, safe, tested, and intoxicating.

The approaches states are taking include banning, regulating like marijuana, regulating like hemp, or using a hybrid approach. Some states, like California, have banned intoxicating hemp cannabinoid products. Other states, including Maryland, Nevada, and Oregon, regulate all or some cannabinoid hemp products through a state cannabis regulator. Oregon’s House Bill 3000 defined “adult-use cannabinoid” and largely moved it under the cannabis regulator with regulatory authority for THC concentration limits. Michigan in 2021 defined THC more broadly (beyond delta-9) and included whether it was artificially or naturally derived and moved it under the cannabis regulatory agency.

Some states regulate cannabinoid hemp products through another state agency (not a cannabis or hemp regulator). For example, Kentucky and Tennessee regulate all or some cannabinoid hemp products through their departments of agriculture. Some states regulate the manufacture of cannabinoid hemp products through their public health department, coupled with restrictions on sales. For example, Colorado has a safe harbor designation for “intoxicating” products, like delta-8, where such products can be manufactured in the state but only sold in other states that do not prohibit them.

Connecticut, Minnesota, and New Jersey provide allowances for THC beverages or other products meeting a specific serving size limit to be sold in certain general retail environments. Minnesota allowed THC derived from hemp to be made available to adults. The state sets a serving size that aligns with some states in their own adult-use policies for the cannabis industry. Colorado allows the manufacture of “intoxicating” cannabinoid hemp products, with restrictions on sales in the state (safe harbor designation). For other categories of products not deemed "intoxicating," there is an imposed age-gating based on the THC/CBD ratio. State actions have occurred through state legislatures (e.g., Arkansas and North Dakota), rules from regulatory agencies (e.g., Alaska), and executive orders (e.g., Missouri).

More state government agencies are engaging in this area. The Colorado Attorney General (AG) consumer protection unit directly engages in supporting efforts toward addressing risks to public health and safety and evidence of misrepresentations to consumers on labels and marketing. It filed suit against a Greeley hemp company and its owner for allegedly selling cannabis products with THC content up to 35 times higher than the legal limit. The suit, filed June 11 in Weld County District Court, alleged the business not only sold high-THC edibles, flower, and concentrates marketed as hemp and CBD products but also forged lab analysis documents. A separate lawsuit initiated against a CBD company by the Colorado AG recently led to an announcement released this week that the involved company agreed to pay a large fine ($225,0000) to resolve the matter. This case involved allegations of misrepresentations about the source of their products, their “organic” status, and misleading information about their support of particular conservation groups. There was also a lack of age-gating (i.e., age verification).

State departments of agriculture face challenges regarding authority, resources, and capacity to regulate the cannabinoid products dominating the market. There have been declines in licensees (especially licensees engaged in industrial hemp production), resulting in decreased funding for departments of agriculture to do this work.

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Other challenges include an increase in cannabinoid production over industrial production, the rise of tetrahydrocannabinolic acid (THCA) smokeable flower, and the rise of synthetic cannabinoids. There are also challenges in terms of authority, resources, and capacity to regulate the cannabinoid products dominating the market and litigation against states.

State regulators would benefit from federal regulation and oversight of cannabinoid products coming from hemp. It would also be beneficial to clarify existing state authority to regulate this space as they see fit. Additionally, reliable and sustained funding for state work in this space is needed. Investment and funding are also needed to support true industrial hemp production for food, fiber, and building materials. Additionally, state regulators would benefit from increased research on both the cannabinoid hemp and industrial hemp side.

CANNRA resources include:

- CANNRA Letter on Hemp-Derived Cannabinoids (April 2023)
- CANNRA Testimony to Congress (July 2023)
- CANNRA Response to Congressional Request for Information (RFI) (Aug 2024)
- CANNRA Best Practices for Regulating Cannabinoids
- CANNRA Letter on State Authority (May 2024) (Letter to Congress asking for further clarification to existing state authority to regulate cannabinoid hemp sales within their state.)

VanAusdall asked if CANNRA has educational information. Mendiola stated that CANNRA's website has a host of information on key regulatory topics through factsheets and topic summaries. She also recommended attending the annual stakeholder meeting in Denver in June 2025.

Piciucco asked what external influences CANNRA experiences and how it navigates them. She also asked if CANNRA reaches out to currently inactive states. Mendiola stated the annual stakeholder meeting is held to bring in outside perspectives. Attendees must be engaged in cannabis and/or cannabinoid activities and not involved in the manufacture or distribution of alcohol or tobacco. CANNRA does reach out to those not currently in its organization, particularly those in newly legalized states.

3. Heard a Presentation on Impediments for Otherwise Admitted Carriers to Write Coverage for Cannabis

Christy Thiems (American Property Casualty Insurance Association—APCIA) said cannabis remains an active issue, and many of the same challenges remain. Twenty-four states and the District of Columbia (DC) have legalized cannabis for adult use. Medical use is legal in 29 states and DC. Nebraska is the 30th state to legalize cannabis for medical use, but legal challenges are expected. In the state of Florida, 56% of voters supported legalization for adult use, but 60% were required to update the state's constitution, so the measure failed.

The legalization of cannabis failed in North Dakota and South Dakota. The psychedelics measure failed in Massachusetts. The Arkansas Supreme Court ruled the votes could not be counted. Since the Farm Bill descheduled hemp, intoxicating hemp markets have taken off and, in many states, are essentially legal. Thirteen states expressly permit intoxicating hemp products, but it is prevalent countrywide, and many states do not have an agency tasked with monitoring it.

The legal cannabis industry has the same needs as any other industry. It requires commercial insurance coverages, including general liability, property, workers' compensation, product liability, and directors and officers (D&O). Some concerns relate to complex regulations and increased risks within coverages that may seem like a fit. This

includes liability arising from: 1) third parties (e.g., an already impaired customer); 2) collateral exposures, such as the potential increased crime risk for a landlord renting to a cannabis business; 3) products used outside of the intended purpose, such as prepackaged brownie mixed used for edibles; and 4) exposure of reimbursing for legal growing, such as a homeowners policy in the event of a fire. Without an objective impairment standard and a reliable method to measure impairment, insurers continue to have concerns about roadway and workplace safety. Carriers are also concerned about coverage mandates and previously approved exclusions being rejected. While no state has mandated that admitted insurers provide coverage, going as far back as 2018 in California, admitted insurers were publicly encouraged to write for the legal cannabis industry. Some states have attempted to pass legislation "allowing" admitted carriers to write in their state without fear of prosecution, but these measures cannot provide protection from federal prosecution. The largest barrier is still the continued federal illegality of cannabis and the fear of federal prosecution.

The Secure and Fair Enforcement Regulation (SAFER) Banking Act would provide a safe harbor for the financial industry, including insurance, to do business with the legal cannabis industry. It would provide the insurance industry the certainty it needs to provide services to the legal cannabis industry. It would also address the collateral risks for companies not directly involved with the cannabis industry but still doing business (e.g., grow light and irrigation manufacturers, etc.). While the SAFER Banking Act is not expected to pass this year, there will likely be movement in the next Congress.

Rescheduling cannabis to Schedule III does not solve the federal illegality problem. Many of the same laws and uncertainty will still apply. It will open the door to more research, which is necessary to develop an objective impairment standard and reliable test for impairment. This is key to keeping roadways and workplaces safe as legalization continues.

Having no other business, the Cannabis Insurance (C) Working Group adjourned.

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Catastrophe Insurance (C) Working Group
and the NAIC/Federal Emergency Management Agency (FEMA) (C) Advisory Group
Denver, Colorado
November 17, 2024

The Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met in Denver, CO, Nov. 17, 2024, in joint session with the NAIC/Federal Emergency Management Agency (FEMA) (C) Advisory Group of the Catastrophe Insurance (C) Working Group. The following Working Group members participated: Chlora Lindley-Myers, Chair, represented by Cynthia Amann (MO); Mike Causey, Vice Chair, represented by Jackie Obusek (NC); Jimmy Gunn (AL); Crystal Phelps (AR); Ken Allen, Lucy Jabourian, and Mitra Sanandajifar (CA); George Bradner and Wanchin Chou (CT); Virginia Christy, Nicole Crockett, and Richie Frederick (FL); Jerry Bump (HI); Travis Grassel (IA); Julie Holmes (KS); Chuck Myers (LA); Jackie Horigan and Matthew Mancini (MA); Aaron Cooper (MS); Tom Botsko (OH); Glen Mulready (OK); Raven Collins (OR); David Buono (PA); Beth Vollucci (RI); Bill Huddleston (TN); Mark Worman (TX); and Allan L. McVey (WV). The following Advisory Group members participated: Glen Mulready, Chair (OK); Carter Lawrence, Vice Chair, represented by Bill Huddleston (TN); Sian Ng-Ashcraft (AK); Jimmy Gunn (AL); Ken Allen, Lucy Jabourian, and Mitra Sanandajifar (CA); George Bradner and Wanchin Chou (CT); Virginia Christy, Nicole Crockett, and Richie Frederick (FL); Travis Grassel (IA); Julie Holmes (KS); Chuck Myers (LA); Aaron Cooper (MS); Cynthia Amann (MO); Beth Vollucci (RI); and Tony Dorschner (SD). Also participating were: Phil Vigliaturo (MN); and Christian Citarella (NH).

1. Heard an Update on the Recently Released *The Flood Insurance Crisis: A Comprehensive Breakdown on Rising Flood Insurance Premiums* Paper

Alexander Swindle (NAIC) said Sen. Bill Cassidy (R-LA) is urging U.S. Congress (Congress) to reform the financially troubled National Flood Insurance Program (NFIP), aiming to make it more affordable, sustainable, and accountable. The goal is to implement reforms before the end of the next Congress.

Swindle said Sen. Cassidy's proposal includes premium relief for lower-income policyholders to ensure flood insurance does not become a financial burden. The recent *The Flood Insurance Crisis: A Comprehensive Breakdown on Rising Flood Insurance Premiums* paper outlines several critical reforms to the NFIP. These reforms include: 1) capping premium increases and placing limits on premium hikes to protect policyholders; 2) implementing means-tested discounts based on income to make insurance more affordable; 3) strengthening mitigation efforts by prioritizing flood prevention and resilience; 4) simplifying the claims process, making it easier for policyholders to navigate claims; 5) re-evaluating pricing by having FEMA reassess its pricing methodology and focus on affordability; 6) rolling back Risk Rating 2.0 by suspending it and similar changes without Congress's approval; and 7) incorporating stakeholder feedback by ensuring state and local feedback is considered to improve the affordability and effectiveness of the NFIP.

Swindle said Sen. Cassidy's report criticizes FEMA's handling of the program in the following areas: 1) mapping issues, specifically addressing FEMA's mapping methods, especially those under Risk Rating 2.0, which need improvement to align with real-world risks; 2) private partnerships and contracting addressing concerns over FEMA's reliance on private partnerships and contracting without clear accountability; and 3) disaster debt from past events and FEMA's focus on covering the past debt.

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Swindle said the potential consequences of inaction include: 1) policyholder drop-off with the possibility of a million people dropping their coverage due to rising rates; 2) concentration of risk in places like Greater New Orleans, where 52,000 policyholders have already dropped their coverage; and 3) an actuarial death spiral due to fewer policyholders, leading to higher rates for policyholders.

Swindle said Sen. Cassidy is working toward bipartisan support and engaging with stakeholders across the political spectrum by meeting with the Congressional Budget Office (CBO) to assess how reforms, especially mitigation efforts, can be funded. Sen. Cassidy plans to follow up with the CBO and other stakeholders by the end of the year for candid feedback.

Swindle said Cassidy stresses that the NFIP must balance two critical goals: 1) making the program financially available to all; and 2) ensuring it remains financially sustainable for all without relying too heavily on taxpayer bailouts.

Swindle said NAIC staff will continue to engage as we approach the introduction of Sen. Cassidy's reforms in Spring 2025.

2. Adopted its Oct. 23 Minutes

Amann said the Working Group met Oct. 23. During this meeting, the Working Group exposed the *Catastrophe Modeling Primer* for a 30-day public comment period ending Nov. 22.

Botsko made a motion, seconded by Bradner, to adopt the Working Group's Oct. 23 minutes (Attachment Two-A). The motion passed unanimously.

3. Heard a Presentation from Connecticut on its New Extreme Weather Mitigation & Resiliency Advisory Council

Bradner said the Connecticut Insurance Department (CID) has been following various initiatives states are working on to help create more resilient communities. The CID began working with the Connecticut governor's office in late 2022 to implement legislation in 2023. Part of the governor's legislative program was implementing an insurance council to examine resiliency and mitigation for both homeowners and small business owners in Connecticut. Bradner said the legislative session last year was short, and due to the full agenda, the bill ultimately did not make it to committees.

Bradner said Commissioner Andrew N. Mais (CT) wanted to move forward with a resiliency council so the CID could move forward in helping residents and communities. The core focus is shifting from a reactive response to proactive risk mitigation. Connecticut's goal is to reduce economic losses, insured losses, and the strain on public resources by making properties more resilient to extreme weather.

Bradner said the primary task of the Resiliency Advisory Council (Council) is to explore and develop a program to incentivize homeowners and businesses to invest in resiliency measures. The program will also consider various facets of the program, like grant standards, emerging insurance products, financial thresholds, and potential public/private partnerships.

Bradner said the CID is continuing to examine various perils and deciding whether to consider wind, flood, wildfire, etc. He said that since Aug. 18, western Connecticut has had record flooding. Over 25 fires have been reported in

the state, and the fires are continuing throughout the northeast in Connecticut, Maine, New Hampshire, New York, and Vermont.

Bradner said he has visited communities around the state to inform them of the importance of resiliency. He said most of the resiliency discussions to date have centered around wind. Bradner said he would talk to the Council later this week about flooding, as it is a rapidly rising issue in many states. He said the challenge is figuring out how to change the discussion on flood insurance. One of the challenges is convincing legislators, mortgage companies, realtors, and insurance agents that just because a home is not located in a flood zone does not mean there will not be any flooding.

Bradner said the Council is a multidisciplinary council with expertise in diverse fields, including academia, climate science, construction, the Connecticut Green Bank, and insurance. The Council emphasizes collaboration and public engagement and looks to public/private relationships in this endeavor. He said the Council's first public meeting will include experts from the Federal Alliance for Safe Homes (FLASH), the Insurance Institute for Business & Home Safety (IBHS), and the NAIC. The meetings will be open to the public so the Council can start informing the public about Connecticut-specific issues.

Amann said it is important to remember that implementing any risk mitigation plan requires multiple steps. The Department of Insurance (DOI), legislatures, private citizens, and public companies all have a stake in risk mitigation planning. The Working Group looks forward to hearing about programs from other states as they are implemented.

4. Heard a Presentation from Pennsylvania on its "Flood Insurance Premium Assistance Task Force Final Report"

Amann said Pennsylvania recently released the *Flood Insurance Premium Assistance Task Force Final Report*. The Flood Insurance Premium Assistance Task Force consisted of two state representatives, two state senators, and representatives from the Pennsylvania Department of Banking and Securities (DoBS), Pennsylvania Emergency Management Agency (PEMA), and Pennsylvania Insurance Commissioner Michael Humphreys, who served as chairperson.

Buono said the Task Force was established through Act 22 in November 2023 and given six months to develop recommendations for the governor and the legislature. The Task Force was charged with delivering a report containing recommendations to the governor and the general assembly to increase flood insurance awareness, accessibility, and affordability.

Buono said that prior to convening the Task Force's first meeting, it issued a bulletin notice soliciting public comments to assist in understanding the recommendations and increasing awareness and affordability. Buono said the Task Force held five public meetings between February and June 2024 through facilitated discussions and presentations from experts in the field. The experts included academics, bankers, producers, and realtors. Additionally, the Task Force received assistance from FEMA members, who attended every Task Force meeting.

Buono said one of the recommendations was to establish an office for Community Rating System (CRS) assistance. The Task Force learned that becoming a CRS community is not easy. Several presenters expressed frustration with the complexity, length of time, and extensive resources necessary to do so. The Task Force recommended creating a CRS assistance office to serve as a resource for both existing CRS communities and communities interested in becoming CRS-designated. The Task Force recommended this office be a part of PEMA because it is the entity that watches over the NFIP and works closely with FEMA.

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Buono said the CRS assistance office would: 1) assist communities and implement credible activities; 2) establish a cohesive approach to flood mitigation; 3) coordinate county or other local initiatives regarding International Organization for Standardization (ISO) building code effectiveness; 4) assist local communities in completing CRS-related applications and materials; and 5) create, maintain, and distribute educational templates that non-CRS communities can use to increase awareness of flood risk and mitigation programs. The CRS program is important because CRS communities get flood insurance discounts.

Buono said the Task Force also worked to improve disclosures during the home-buying process. He said Pennsylvania currently does not have a law or regulation requiring a property to have flood insurance coverage to obtain a mortgage. He said a seller and homeowner may not know if the property has ever experienced a flood event and, consequently, may not be aware of the need to buy flood insurance until they are at the table buying the house. Buono said some states, such as New Jersey and New York, have improved these disclosures, so the Task Force studied them. The Task Force also studied the District of Columbia's work and tried to ensure the recommendations mirrored the same goal.

Buono said another recommendation was to incorporate continuing education (CE) across professional roles. The Task Force recommended the Pennsylvania General Assembly enact legislation requiring CE on flood risk and insurance for insurance producers, real estate agents, and mortgage lenders to be incorporated into existing CE requirements. The DOI has already taken steps for insurance producers. Two hours of CE for insurance producers writing property/casualty (P/C) insurance must be on flood insurance. There was no increase in the number of hours of CE requirements; there was just the caveat that two of the required CE requirements include flood insurance. Producers need to ensure they do not tell consumers they do not need flood insurance or are not in a special flood hazard area (SFHA).

Buono said the recommendations included enhanced education and outreach because one misconception homeowners have is that a standard homeowners insurance policy covers flood damage. The Task Force recommended that the Pennsylvania Insurance Department employ an individual to act as a flood insurance ombudsman. This individual would help educate consumers and work with PEMA, FEMA, the Pennsylvania Department of Environmental Protection (DEP), and other agencies as needed to discuss flood insurance and its importance with consumers.

Buono said the Task Force recommended that the Pennsylvania General Assembly enact legislation to provide tax credits or deductions for costs incurred by homeowners making home repairs to be more flood resistant. The participating legislators are already working to incorporate this recommendation into action.

Buono said the Task Force recommended enhanced coverage for water damage. While standard homeowners and rental insurance policies exclude flooding, many insurers offer endorsements for coverage expansion provisions to cover water-related damages. The Task Force recommended that the Pennsylvania Insurance Department encourage all companies and agents offering homeowners and renters policies to educate consumers on the availability of such products. Some insurers have products that could help cover consumers up to $25,000, and consumers need to be educated about the existence of this type of coverage expansion.

Buono said there was a recommendation to incorporate flood resiliency into the building code, as it is important for building codes to stay current to protect consumers. This has been enacted in Pennsylvania.

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Buono said there is a recommendation proposing the Pennsylvania Flood Insurance Relief Act. The Task Force recommended the General Assembly introduce legislation that would allow Pennsylvania consumers to deduct flood insurance premiums from their state income tax.

Buono said the final recommendation was to further study innovative solutions. He said Puerto Rico has some helpful ideas relating to parametric insurance.

Amann said she envisions using this report to cross-reference some of the Working Group's charges in 2025. She said the report does a good job of pointing out problems from various perspectives.

Amy Bach (United Policyholders—UP) said many states are grappling with connecting mitigation with insurance discounts and whether that is mandatory or optional. She asked Buono if he believes that being in a community that is participating in the program is a model that communities can use as they seek to prepare for various perils based on the work done. Buono said that when the Task Force looked at the CRS, it did not completely comprehend how difficult the process seemed for communities to complete. Becoming a CRS community was set aside. This is a problem because potential discounts would have been available. Buono said he believes some communities have done the work but have not gone through the labor of getting credit for their work.

5. Heard from the CIPR on the Legislative Obstacles in Forming State Mitigation Program

Brian Powell (Center for Insurance Policy and Research—CIPR) said a legislative process typically establishes mitigation programs at the state level. He said he helps states work through the legislative process to form state mitigation programs and has worked with states to create legislative strategies to ensure adequate support and outcomes that benefit the insurance markets in the states interested in establishing programs. Powell said there are four areas he would discuss the following areas: 1) educating stakeholders about programs; 2) the timing of legislation and management of expectations; 3) competing legislation; and 4) situational awareness.

Powell said stakeholders should understand the purpose of mitigation programs and their relationship to insurance. Some of these relationships to insurance include reducing the risk of loss, encouraging entry or increased writing of insurance by insurers, creating competition within the insurance market, and helping control pricing. Mitigation programs benefit insurers in the reinsurance market by reducing the cost of insurance.

Powell said there has been a need to provide better education with the understanding that these programs are typically a launch platform for reducing the risk of loss in specific geographic areas within a state. The most vulnerable geographic areas in the state are not always intuitive. The CIPR provides resources for states to help them determine their most affected areas and help states decide where to invest their funds to get the biggest return on their investment.

Powell said some states may need mitigation programs for multiple perils. He said it is possible to combine two perils, and legislative authority can cover those multiple perils, but some issues need to be discussed with legislators when they reach that point.

Powell said that the risk reduction benefits of concentration and mitigation efforts should be understood geographically. He said that when the number of homes or different properties being mitigated is condensed, you start to see the most effect in the insurance market instead of spreading those mitigation projects out across a wide geographic area, which can sometimes be politically motivated.

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Powell said it is important to understand mitigation program specifics, standards, expectations, and how they operate. He also mentioned the needs and avenues for funding to support some of these programs. He said it is important to understand incentives, such as premium discounts, endorsements, and financial incentives through partnerships.

Powell said the timing of legislation requires understanding how long it takes to design and implement a state mitigation program and ensure its proper performance. This requires managing expectations, which can be an obstacle. Additionally, competing legislation can occur when other entities in the state are trying to do the same thing. There are times when other entities do not tie mitigation to insurance. Powell provided an example in which a mitigation program was already up and running and issuing grants for mitigation programs, but another state agency was doing the same thing. This example illustrates the need to combine efforts with other entities.

Powell said situational awareness can be an issue when working with legislators, especially understanding and focusing on the outcome. Other items will be affected when creating a mitigation program. For example, a state that has not enforced a building code will need to have conversations about making one, which can be a contentious conversation depending on the stakeholders involved. The political will of the state also can become a part of the conversation. Ancillary things can come from creating a mitigation program, including stricter laws against insurance fraud.

Powell said state insurance commissioners have a resource within the NAIC that will help walk their state through the process of creating a mitigation program. He said CIPR staff will help walk states through the process of creating a mitigation program and providing support for the state through an engagement team to help walk through the components a state wants to include. Powell said the CIPR is currently working with several states.

Horrigan asked what issues Powell had encountered with dedicated funding sources and whether he thinks there is a lot of support for mitigation programs. She said while there is general support for these types of programs, there is not always an understanding of how the program will be funded and how the money will flow into the program. Powell said a state creating a mitigation program needs to look at funding streams to create some level of sustainability for the program, as states cannot always count on internal funding. Powell said some states are better positioned to provide funding through internal sources within a DOI or work through a legislative authority to find additional funding. He said the legislation needs to include some authority to obtain additional funding. Powell said one thing he has seen across the country is cross-industry support. He said there have been some instances where large companies are providing grants and funding pieces of a mitigation program for some of their key employees, as well as making it a part of their continuity plan. Powell said when a large company has to shut down its operations due to a weather-related event, it can be a two-week process. He said the CIPR has seen a number of public/private partnerships included in the resources the CIPR provides.

Grassel asked Powell how important he thinks updating building codes is. He said some states are further behind than others, and building codes may be less important. Grassel said some states may also feel like they cannot pass stricter building codes at the legislative level. Powell said having stricter building codes is certainly important; however, there are differing thoughts. He said one thing the IBHS is finding out through the mitigation programs is that these programs and the science behind them work. Powell said a paper will be released soon showing how well the IBHS fortified standards worked in Alabama following Hurricane Sally. He said this was the first time there was a real opportunity for a concentration of mitigated homes to be affected by a storm. Powell said the resilience of this area was measured once the storm passed. He said these programs are a platform to start a conversation about building codes if a state does not have strong or enforced building codes.

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Powell said the IBHS and its work typically go beyond code, but he believes once the type of mitigation program is standard, it is relatively easy to convince others how it is to develop building codes to a certain standard.

Amann encouraged Working Group members to make others at their DOIs and state legislatures aware of the work the CIPR is doing. She asked the Working Group to bring any suggestions or deficiencies to the attention of the Working Group and the CIPR.

6. Heard Comments on the *Catastrophe Modeling Primer*

Amann said the *Catastrophe Modeling Primer* will introduce state insurance regulators to the catastrophe modeling process. She said more advanced information is available through the Center of Excellence (COE). The primer will provide guidance to examiners and rates and forms personnel. Amann said the document includes links to charts and more detailed information for those interested in further reading. She said state insurance regulators participating in the project included: Kristen Barrow (NC); Bob Lee (FL); Buono; Chou; Grassel; Lizabeth Landsman (CA); Mitra Sanandajifar; and Amy Waldhauer (CT). Amann said Crockett chaired the drafting group.

Crockett said it was a long process due to the intricate nature of catastrophe modeling. She thanked Sara Robben (NAIC) for her integral part in the process.

There were no oral comments from the Working Group, interested regulators, or other interested Parties. Amann said the document is exposed for a 30-day comment period ending Nov. 22.

7. Discussed Collaboration with Other Working Groups

Amann said that over the past few years, many issues have crossed over into the various working groups. She said the Working Group wants to be mindful of its charges while paying attention to any overlap.

Amann said she would like the Working Group to examine the data collected, make suggestions, and suggest additional information the Working Group members would like to see available. She would also like to hear how states are using and analyzing the data being collected.

Amann said she would like the Working Group to know what other groups are doing to see if there is room for collaboration and to eliminate duplication of efforts. She said she would like to have various members of the Working Group be responsible for reporting on what some of the other groups they participate in are doing to achieve this.

8. Heard an Update on FEMA Workshops

Commissioner Mulready said the NAIC and FEMA are planning a workshop for FEMA Region 5, which includes Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. The workshop will be held Feb. 11–12, 2025. Commissioner Mulready said these workshops have been held in many FEMA Regions. He said Oklahoma hosted the workshop held for FEMA Region 6 and believed it was a great experience for FEMA and the participating DOIs.

Commissioner Mulready said FEMA has recently sent out communications about the recent hurricanes and told Working Group members that if they would like to receive FEMA communications, they should contact Robben, who will forward the information.

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9. Heard an Update on a Recent Catastrophic Event in Tennessee

Huddleston said Hurricane Helene moved through East Tennessee Sept. 27. He said that while the hurricane was downgraded to a tropical storm, East Tennessee still experienced a lot of flooding and destruction. The flooding was exacerbated by heavy rainfall two days prior to the storm. Huddleston said Tennessee Gov. Bill Lee signed an executive order declaring a state of emergency. The declaration gave Commissioner Carter Lawrence (TN) the discretion to direct the insurers licensed in Tennessee to make reasonable efforts to assist policyholders who had experienced losses because of the severe weather. Huddleston said the DOI issued a bulletin clarifying what was expected of the insurers. The second bulletin was about a data call the DOI initiated with the assistance of the NAIC. The data call will continue for six months.

Huddleston said the DOI has created the Helene Emergency Assistance Loans (HEAL) program, which makes interest-free loans available to the affected counties in Tennessee. These loans can help with wastewater and water service damage, rebuilding local communities, and removing debris.

10. Heard an Update on a Recent Catastrophic Event in North Carolina

Obusek said North Carolina experienced a flood event Sept. 27 as a result of Hurricane Helene. She said not many people in the western part of North Carolina had flood insurance. Their data call reflects a total of 27,000 flood insurance policies, with only 277 claims filed against those policies.

Obusek said that, as of the end of October, 98,000 claims had been filed in North Carolina, and approximately $1.2 billion in losses had been incurred by North Carolina insurers. They have been conducting insurance camps in both Boone and Ashville. Obusek said there has been participation from insurers, FEMA, and the NFIP. She said they did not have many consumers participate because most affected consumers do not have insurance coverage, so they did not think they needed to go to the insurance camp. Obusek said it would have benefited consumers to attend the insurance camps, as they could have interacted with FEMA. She said they have been conducting victim assistance centers one or two days a week since they were able to get into the affected areas.

Obusek said North Carolina has released five bulletins related to the catastrophe, including one for insurers on how to handle policyholders. They hope these bulletins will be beneficial.

Having no further business, the joint meeting of the Catastrophe Insurance (C) Working Group and the NAIC/FEMA (C) Advisory Group adjourned.

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Catastrophe Insurance (C) Working Group
Virtual Meeting
October 23, 2024

The Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met Oct. 23, 2024. The following Working Group members participated: Chlora Lindley-Myers, Chair, Cynthia Amann, and Jeana Thomas (MO); Shauna Nickel (AK); Ken Allen, Giovanni Muzzarelli, and Mitra Sanadajifar (CA); Hawi Chibessa (DC); Nicole Crocket, Richie Frederick, and Whitney Herrington (FL); Gordon I. Ito and Kathleen Nakasone (HI); Travis Grassel (IA); Kevin Gregg, Chris Hollenbeck, and Craig VanAalst (KS); Chris Cerniauskas, Jessica Excano, Crystal Stutes, and Timothy J. Temple (LA); Caleb Huntington and Matthew Mancini (MA); Joy Y. Hatchette (MD); Tim Vigil (NM); Gennady Stolyarov (NV); Tom Botsko (OH); Raven Collins, David Dahl, and Ying Liu (OR); David Buono (PA); Elizabeth Kelleher-Dwyer and Beth Vollucci (RI); Zachary Crandall, Mary Freeman, Will Garrett, and Vickie Trice (TN); Marianne Baker, J'ne Byckovski, and Mark Worman (TX); and Allen L. McVey (WV). Also participating were Linda Grant (IN) and Chris Arth (MI).

1. Adopted its Summer National Meeting Minutes

Crockett made a motion, seconded by VanAalst to adopt its Summer National Meeting minutes (*see NAIC Proceedings – Summer 2024, Property and Casualty Insurance (C) Committee, Attachment Two*). The motion passed unanimously.

2. Exposed the *Catastrophe Modeling Primer*

Amann asked Crockett to update the Working Group on the drafting group's progress on the *Catastrophe Modeling Primer*. Crockett said the drafting group includes California, Connecticut, Florida, Iowa, Missouri, North Carolina, and Pennsylvania, and she thanked Shaveta Gupta (Center for Insurance Policy and Research—CIPR) and Sara Robben (NAIC) for their integral participation in the drafting of the document.

Crockett said the document provides the fundamental concepts surrounding catastrophe modes and serves as a bridge to the Center of Excellence's (COE's) available training about catastrophe models. The primer provides information about the usefulness of catastrophe models for state insurance regulators and introduces new state insurance regulators to catastrophe modeling. Other topics discussed include the evolution of catastrophe models, how they work, catastrophe model's components, key metrics, regulatory interaction, and some additional introductory concepts. The primer is advisory only and is not intended to provide mandatory guidelines.

Crocket reminded the Working Group that the COE provides state insurance regulators with more advanced technical training and expertise regarding catastrophe models and how they are used within the insurance industry.

Robben walked through the *Catastrophe Modeling Primer* section by section. The sections include: 1) the purpose and background; 2) the evolution of catastrophe modeling; 3) observed trends of hazards and losses; 4) demographic changes; 5) what a catastrophe model is and how a catastrophe model should be used; 6) model components; 7) key metrics and outputs; 8) modeled hazards; 9) state insurance regulators' perspectives; 10) regulatory concerns; 11) state-specific information; 12) consumers' perspectives; 13) summary; and 14) appendices with additional information regarding a few states' regulations and questions for regulators following a preliminary assessment of catastrophe models.

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Amann said the Working Group undertook the revising of this primer, recognizing that it is meant for the entry-level department of insurance (DOI) employee or someone new to catastrophe modeling. She said the goal of the primer is to spark interest and provide guidance to a new person. Amann said going forward the primer would serve as an introductory level to the COE.

Amann said that while state insurance regulators recognize the consumer component of catastrophe model use, consumer concerns would be better addressed in a document meant for the consumer divisions of a DOI. She asked for a motion to expose the *Catastrophe Modeling Primer* for a 30-day exposure period.

Grassel made a motion, seconded by Crockett, to expose the *Catastrophe Modeling Primer* for a 30-day public comment period ending Nov. 22. The motion passed unanimously.

Amann said the Working Group will address the comments it receives and plans to conduct an e-vote on Dec. 18. Amann said anyone wanting to make comments at the Fall National Meeting could make them orally for the Working Group to address.

Shaw asked for California's deadline to review its regulations for correctness. Amann said on or before Nov. 22 if possible.

Having no further business, the Catastrophe Insurance (C) Working Group adjourned.

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Transparency and Readability of Consumer Information (C) Working Group
Virtual Meeting
November 12, 2024

The Transparency and Readability of Consumer Information (C) Working Group of the Property and Casualty Insurance (C) Committee met Nov. 12, 2024. The following Working Group members participated: George Bradner, Chair (CT); Dusty Smith (AL); Ken Allen (CA); David Martinez (CO); Angela King (DC); Sara Zuniga (KS); Ron Henderson (LA); Daniel Bryden (MN); Jeana Thomas (MO); Angela Hatchell (NC); Tricia Goldsmith (OR); David Buono (PA); Vickie Trice (TN); and Marianne Baker (TX). Also participating was: David Forte (WA).

1. Discussed Proposed Revisions to the Premium Increase Transparency Guidance Based on Comment Letters

Bradner said the Premium Increase Transparency Guidance was previously exposed for a comment period that ended Aug. 30. Comment letters were received from Brenda J. Cude (University of Georgia), United Policyholders (UP), American Property Casualty Insurance Association (APCIA), National Association of Mutual Insurance Companies (NAMIC), and the Independent Insurance Agents & Brokers of America (IIABA). The following details revisions made to the guidance document. Sections in blue are the relevant guidance document language with redlined revisions.

NAMIC's comment letter emphasized that it believes the guidance does not consider the complexity of composite rating models, and it is disappointed with the inclusion of Phase Two without an analysis of the effectiveness of Phase One. Similarly, APCIA's comment letter stated it believes insurers will have difficulties properly "pricing" factors in the example notices and reiterated that the notices pose significant compliance challenges and burdens. Subsequent to its comment letter, APCIA requested the Working Group consider revising the guidance to reflect that Washington is considering delaying the start of Phase Two in its rule from June 2027 to June 2029. This change would move the start date of Phase Two from three years to five years after the start date of Phase One.

Forte said insurers have expressed concerns about the cost of going into Phase Two. For insurers to meet the June 2027 Phase Two deadline, they would need to begin information technology work next quarter. In response, Commissioner Kreidler has provided a Notice of Proposed Rule Making (NPRM) that he is considering delaying the start of Phase Two. However, it will be Commissioner-elect Patty Kuderer (WA), who takes office Jan. 15, 2025, who will make the ultimate decision.

Lisa Brown (APCIA) asked if the data call planned by Washington to collect information about insurer experience with Phase One is dependent on the new commissioner. Forte said that if there is a data call, it will be later in the rule-making process and collect information on insurers' experiences with Phase One began in June. Insurers are reporting they are not receiving many inquiries from consumers.

Bradner said the Working Group believes the growing complexity of rates necessitates transparency to enable consumers to understand the factors behind the increase in insurance premiums. However, it is recommended that the timing of Phase Two in the exposed guidance mirrors Washington's original premium change transparency rule timing of three years. In light of Washington's contemplation of a Phase Two date change, the Working Group has revised its wording in the Notification Thresholds section of the guidance to remove the suggested three-year Phase Two start date. It also added a footnote that specifies states should determine the Phase Two implementation time based on their review of Phase One and implementation of Phase Two considerations.

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Revised to:

Notification Thresholds

'(1) Phase One: Beginning [enter date], and effective until [enter date phase one ends*~~– such as 3 years~~], insurers must reasonably explain changes in premium for policies described in the Scope of Availability, upon written request by the policyholder, for any premium increase at renewal.

'(2) Phase Two: Beginning [enter date phase two begins], insurers must automatically provide premium change notices, with reasonable explanations and primary factors, disclosing the causes of premium increases for insurance policies for any premium increase of 10 percent or more, or upon written request by the policyholder for any premium increase at renewal. Automatic premium change notice applies to insurance policies with annual premium increases of $100 or more.

* The second phase implementation date should be decided by states based on a review of Phase One and implementation of Phase Two considerations.

NAMIC also expressed disappointment that the Working Group decided not to include Section 4(b)(2)(A) of the National Council of Insurance Legislators (NCOIL) Insurance Underwriting Transparency Model Act, which would exclude "an increase in the insurer's filed rate plan and automatic inflationary increases." The Working Group continues to believe policyholders would benefit from knowing these factors, particularly given the impact of recent inflation on rate increases. As such, this exemption would be contrary to the intent of the disclosure.

Additionally, NAMIC expressed concern that the Scope and Communication Standards sections of the guidance are inconsistent with regard to their treatment of the Fair Credit Reporting Act (FCRA). However, the Working Group did not see a conflict with the guidance document if, for example, an entity is required to provide notice regarding driving records under FCRA. The exemption of FCRA-required notices would not mean the requirements cannot mention items covered by the FCRA.

Furthermore, NAMIC felt the undefined term "major" used in the notice examples is challenging because many rating models are multiplicative, not additive. It recommended replacing "major" with "examples of" and deleting "along with the dollar impact of each of those reasons." The Working Group believes specificity provides important information to the policyholder on the factors driving the increase in their premium. However, as this is just guidance, a footnote was added to the examples to denote states may choose to exclude the requirement that specific premium amounts be attributed to the increase in premium.

Revised to include:

[* States may choose to exclude the requirement for insurers to specify each factor's dollar impact for the increase in premium. In these instances, insurers should include a statement informing policyholders they can contact a designated representative for details about the specific dollar impacts, along with the necessary contact information.]

Lastly, NAMIC suggested that, with the consolidation of the proposed notices, it would be helpful for the document to clarify that the "Factors for your policy premium increase" should be clearly tied to the uncapped premium. The

Working Group agreed. However, no revision was made, as the example already includes the following statement indicating factors are tied to uncapped premium: "*[If the policy premium is capped, a statement such as the following must be included:].*"

UP suggested that the Scope of Applicability, Exemptions, 4e, specify the telematics exemption is for those who "routinely" disclose information. They also suggested changing "may want to" to "should consider having these programs included in this disclosure." The Working Group agreed and implemented these suggestions.

Revision Accepted:

Scope of Applicability

'(4) Exemptions

'e. Where a usage based or telematics program is being used, if a company has a process for routinely disclosing information to drivers on how their performance is impacting their rate, an additional disclosure is not required. Otherwise, a state should ~~may want to~~ consider having these programs included in this disclosure, while keeping within state confidentiality laws.

UP also suggested revising the Notifications and Administrative and Notification Requirements sections to specify insurers must automatically provide at least a 60-day (rather than a 30-day) notice of renewal and disclose causes of premium increase within 15 days. The Working Group did not implement these suggestions as this is a guidance document, and, as such, the actual timelines will be determined by states in accordance with their statutory language. The guidance document intends for insurers to make every effort to respond to policyholders' inquiries before renewal. However, if the complexity of the request prevents insurers from doing so, consumers are expected to continue paying their premium payment while seeking explanations from the insurer.

The Working Group also did not implement UP's suggestion to specify that primary factors and composite rating variables are specific to the policy in the Communications section for No. 2 and No. 3. The notice already states this.

UP suggested clarifying changes in personal and/or driving characteristics come from members of the household in the Auto Notice Example. For both notice examples, it also suggested adding a requirement that the insurer disclose actions the consumer can take to reduce their premium. The Working Group did not implement these suggestions as they go beyond the scope of the guidance document. Additionally, the carrier may not always reduce premiums for the reasons stated.

APCIA suggested the Working Group amend its draft to provide a minimum premium charged to a consumer in order for the notice to be required under Phase Two of the proposal to avoid requiring notice for minor amounts. The Working Group implemented this suggestion by adding an exemption to exclude policies with an increase of less than $100 annually.

Revised to:

Scope of Applicability

'(4) Exemptions

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'f. For Phase 2, this chapter does not apply to insurance policies with a premium increase of less than $100 annually.

Notification Thresholds

'2) Phase Two: Beginning [enter date phase two begins], insurers must automatically provide premium change notices, with reasonable explanations and primary factors, disclosing the causes of premium increases for insurance policies for any premium increase of 10 percent or more, or upon written request by the policyholder for any premium increase at renewal. Automatic premium change notice applies to insurance policies with annual premium increases of $100 or more.

The Working Group did not implement APCIA's suggestion to allow insurers to interpret for themselves what "prominent disclaimer" means. As guidance, prominent disclosure requirements will be decided by each state. APCIA also noted continued concerns about disclosing proprietary information. However, the Working Group has stated there is no intent to disclose proprietary information (such as rating algorithms). The consumer just needs to understand the factors impacting their rate change.

The Working Group agreed with IIABA that the Communications Standards section needed clarity to indicate the list of primary factors is not exhaustive. It suggested revising 1e to state: "In addition to primary factors, insurers may disclose additional factors that are applicable to the premium increase."

Accepted Revision:

Communication Standards

(1) Insurers should provide sufficient information, including primary factors, in terms understandable to an average policyholder. Primary factors include:

'e. In addition to primary factors, insurers may disclose additional factors that are applicable to the premium increase. ~~Factors not listed above as primary are optional. Insurers may include additional optional factors not listed in this section, if applicable to the premium increase.~~

Dr. Cude suggested that the example notices should have a "headline" that indicates it includes important and relevant information. The Working Group implemented this concept by adding a bold, 16 pt. font, centered heading that reads, "Notice of Auto (or Homeowners) Premium Increase."

Revised to:

Notice of Auto/Homeowners Premium Increase

In response to Dr. Cude's concern that the use of the word "anticipated" in the example notices would imply uncertainty, the Working Group replaced it with "estimated."

Revised to:

According to the rating plan we filed with your state, your estimated ~~anticipated~~ renewal policy premium is [$2,121].

The Working Group also agreed that the word "only" in "only $88" implies a judgment about the dollar amount and removed it.

Revised to:

- **However, the next time you renew your policy your premium increase will be limited to ~~only~~ $88, resulting in a renewal premium of $1,257.**

Tony Cotto (NAMIC) said that while NAMIC does not agree with all the Working Group's decisions, it appreciates the Working Group's revision process and its inclusion of explanations of why revision recommendations were or were not made. Detailing this in a document is helpful to NAMIC's efforts to inform its members. NAMIC appreciates the additional footnotes but continues to have grave concerns with Phase Two. It is out of order to move to Phase Two before studying Phase One. Brown said she echoed Cotto's comments.

2. Adopted the Revised Premium Increase Transparency Guidance

Baker made a motion, seconded by Zuniga, to adopt the revised Premium Increase Transparency Guidance (Attachment Three-A). The motion passed, with Smith voting against.

Having no further business, the Transparency and Readability of Consumer Information (C) Working Group adjourned.

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PREMIUM INCREASE TRANSPARENCY DISCLOSURE NOTICE GUIDANCE FOR STATES

For renewal premium that results or does not result from a capping procedure used by the insurer

Scope of Applicability

(1) Disclosure applies to policies renewed on or after [Enter Date].
(2) Disclosure applies to authorized insurers with these types of personal insurance policies:
    a. Private passenger automobile coverage;
    b. Homeowners coverage, including mobile homeowners, manufactured homeowners, condominium owners, and renter's coverage; and
    c. Dwelling property coverage for owner occupied dwellings only
(3) Disclosure applies to renewals of policies and will not apply to the purchase of new policies or new insurance applications.
(4) Exemptions
    a. Disclosure does not apply to personal insurance policies for coverage of boats, motorcycles, off-road vehicles, recreational vehicles, antique or collector vehicles, classic vehicles, and specialty vehicles.
    b. This chapter does not apply to policyholder-initiated changes to insurance coverages, policies, or premiums such as policyholder-initiated changes to deductible, frequency of payments, or increase/decrease in what is covered.
    c. This chapter does not apply to personal umbrella policies.
    d. This chapter does not apply to notices required by the Federal Fair Credit Reporting Act (15 U.S.C. 1681 et. seq.).
    e. Where a usage based or telematics program is being used, if a company has a process for routinely disclosing information to drivers on how their performance is impacting their rate, an additional disclosure is not required. Otherwise, a state should consider having these programs included in this disclosure, while keeping within state confidentiality laws.
    f. For Phase Two, this chapter does not apply to insurance policies with a premium increase of less than $100 annually.

Notification Thresholds

(1) Phase One: Beginning [enter date], and effective until [enter date Phase One ends*], insurers must reasonably explain changes in premium for policies described in the Scope of Availability, upon written request by the policyholder, for any premium increase at renewal.

(2) Phase Two: Beginning [enter date Phase Two begins], insurers must automatically provide premium change notices, with reasonable explanations and primary factors, disclosing the causes of premium increases for insurance policies for any premium increase of 10 percent or more, or upon written request by the policyholder for any premium increase at renewal.

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Automatic premium change notice applies to insurance policies with annual premium increases of $100 or more.

[* The second phase implementation date should be decided by states based on a review of Phase One and implementation of Phase Two considerations.]

Administrative and Notification Requirements

(1) For the first phase, insurers should notify policyholders of their right to request an explanation for their rate increase in accordance with their jurisdiction's requirements. For example, a state may want to provide guidance that a prominent disclaimer be at the beginning of the first page (for printed notices), or first screen (for electronic notices) and at or near the top of renewal billing statements indicating policyholders receiving an increase to their premiums at renewal can request an explanation by contacting the insurer in writing.

(2) For the second phase, insurers must automatically send the disclosure notice at least 30 days prior to the renewal date if the policyholder receives at least a 10 percent premium increase at renewal. Disclosure notification may be included with the renewal notice or may be sent in a separate mailing, or by email (if the policyholder has elected to receive email notifications). Guidance for prominent disclosure remains the same as in Phase One.

(3) For both phases:
   a. Insurers should include a statement in notifications and/or explanations that the policyholder may contact their insurer to request additional information about premium increases.
   b. Insurers should respond to a policyholder's written request for explanation of premium change no later than 30 calendar days from receipt of the written request.
   c. Subsequent requests from a policyholder for additional information should be responded to no later than 20 calendar days. Insurers should make every effort to respond prior to the renewal date. However, there is no expectation that the premium due date will be altered.

(4) Receipt and response dates may be indicated by either postmark or electronic timestamp, in accordance with each jurisdiction's requirements.

(5) Insurers should include their contact information in all premium change notifications and explanations to policyholders and may include the producer's (if any) contact information.

(6) Insurers should provide premium change notifications and explanations to policyholders in writing. Explanations or notices may be sent by mail or electronically.

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Communication Standards

(1) Insurers should provide sufficient information, including primary factors, in terms understandable to an average policyholder. Primary factors include:
   a. Auto-related factors: change in car garaging location, driving record, miles driven, number of drivers, and number of vehicles,
   b. Property related factors: change in age, location, and value,
   c. Demographic factors: change in age, credit history, education, gender, marital status, and occupation,
   d. Other factors: change in claims history, discounts, fees and surcharges, premium capping, automatic inflationary increases, and updates to an insurer's rate plan.
   e. In addition to primary factors, insurers may disclose additional factors that are applicable to the premium increase.

(2) For the second phase, insurers must include the primary factors in the premium change notice processed for renewals, if applicable to the premium increase.

(3) If insurers include composite rating variables in their premium change explanation, the premium increase attributed to the composite rating variables should be explained.

(4) If insurers use estimated dollars, a reasonable explanation should be provided about the degree of accuracy the estimated dollars achieve.

(5) Insurers may include premium change explanations for all premium increases beyond those required.

(6) If an insurer already has a premium increase notification process acceptable to the State's regulator, the regulator may allow the insurer to continue to use the process that is in place.

Phase Two: Auto Insurance Policy Premium Increase Notice Example

Notice of Auto Premium Increase

Your current auto insurance policy premium is [$1,175].

Each insurer files a rating plan with the state insurance department. According to the rating plan we filed with your state, your estimated renewal policy premium is [$2,121] .

[If the policy premium is capped, a statement such as the following must be included:]

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However, **the next time you renew your policy your premium <u>increase</u> will be limited to $88, resulting in a renewal premium of $1,257.**

Your policy premium **will continue to increase with each of the next [how many] renewals** until it reaches $2,121.

Remember there also are other rate factors that could cause your auto insurance premium to change in the future. For example, if you change your coverage, or if your personal and/or driving characteristics change, (such as your age* or any accidents or violations in the household), your policy premium could increase or decrease from the premium amounts stated above. [States that use drivers experience instead of age should substitute accordingly.]

Here are the major factors for this increase in your policy premium, along with the dollar impact of each of those reasons:

<u>Factors for your policy premium increase and the dollar impact</u>*

- **<u>Factor</u> 1 raised your premium $A**
- **<u>Factor</u> 2 raised your premium $B**
- **<u>Factor</u> 3 raised your premium $C**
- **<u>Factor</u> 4 raised your premium $D**
- **<u>Factor</u> 5 raised your premium $E**

[* States may choose to exclude the requirement for insurers to specify each factor's dollar impact for the increase in premium. In these instances, insurers should include a statement informing policyholders they can contact a designated representative for details about the specific dollar impacts, along with the necessary contact information.]

Please call your agent or our Customer Service Representative at (xxx) xxx-xxxx with any questions.

<u>Phase Two: Homeowners Insurance Policy Premium Increase Notice Example</u>

Notice of Homeowners Premium Increase

Your current homeowners insurance policy premium is [$1,175].

Each insurer files a rating plan with the state insurance department. According to the rating plan we filed with your state, your estimated renewal policy premium is [$2,121].

[If the policy premium is capped, a statement such as the following must be included:]

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However, **the next time you renew your policy your premium increase will be limited to $88, resulting in a renewal premium of $1,257.**

Your policy premium **will continue to increase with each of the next [how many] renewals** until it reaches $2,121.

Remember there also are other rate factors that could cause your homeowners insurance premium to change in the future. For example, if you change your coverage, or if your personal and/or property risk characteristics change, (such as claims filed, age of the home and/or roof, the coverage A value, etc.) your policy premium could increase or decrease from the premium amounts stated above. [States may want to modify language to reflect their specific exposures, such as wildfires or other catastrophe exposures.]

Here are the major factors for this increase in your policy premium, along with the dollar impact of each of those reasons:

Factors for your policy premium increase and the dollar impact*

- **Factor 1 raised your premium $A**
- **Factor 2 raised your premium $B**
- **Factor 3 raised your premium $C**
- **Factor 4 raised your premium $D**
- **Factor 5 raised your premium $E**

[* States may choose to exclude the requirement for insurers to specify each factor's dollar impact for the increase in premium. In these instances, insurers should include a statement informing policyholders they can contact a designated representative for details about the specific dollar impacts, along with the necessary contact information.]

Please call your agent or our Customer Service Representative at (xxx) xxx-xxxx with any questions.

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Adopted by the Property and Casualty Insurance (C) Committee, 11/19/24

2025 Proposed Charges

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

M. Provide a forum for discussing issues related to the use of telematics in insurance, and consider the development of a white paper or regulatory guidance.

2. The **Cannabis Insurance (C) Working Group** will:
   A. Assess and periodically report on the status of federal legislation and regulation involving cannabis, especially as it pertains to protecting financial institutions from liability associated with providing services to cannabis businesses operating legally under state law.
   B. Support insurance regulators' efforts to encourage the development of admitted market insurers, as well as the expansion of existing admitted market insurers and reinsurers supporting the market, to ensure coverage adequacy in states where cannabis, including hemp, is legal.
   C. Stay abreast of new products and innovative ideas that may shape insurance in this space. Provide insurance resources to insurance regulators and stakeholders, as needed.
   D. Explore potential sources of constraint to coverage limits and availability of cannabis insurance products within the admitted and non-admitted market. Explore the effect of the use of cannabis and related products on P/C insurance lines of business.

3. The **Catastrophe Insurance (C) Working Group** will:
   A. Monitor and recommend measures to improve the availability and affordability of insurance and reinsurance related to catastrophe perils for personal and commercial lines.
   B. Evaluate potential state, regional, and national programs to increase capacity for insurance and reinsurance related to catastrophe perils, including mitigation efforts being used in states and investigating loss trends in homeowners markets, with the goal of providing rate stability in the marketplace and protecting consumers.
   C. Monitor and assess proposals that address disaster insurance issues at the federal and state levels. Assess concentration-of-risk issues and whether a regulatory solution is needed.
   D. Provide a forum for discussing issues and recommending solutions on insuring catastrophe risk, including terrorism, war, and natural disasters.
   E. Investigate and recommend ways the NAIC can assist states in responding to disasters by continuing to build the NAIC's Catastrophe Resource Center for state insurance regulators to better prepare for disasters.
   F. Continue to monitor the growth of the private flood insurance market and assess the actions taken by individual states to facilitate growth. Update and discuss the Considerations for Private Flood Insurance appendix to include new ways states are growing the private flood insurance market.
   G. Collaborate with other task forces and working groups to discuss comparable topics, monitor catastrophe-related data calls, and keep informed about projects addressing the special needs of catastrophe data.
   H. Study earthquakes, severe convective storms, and wildfire matters of concern to state insurance regulators in coordination with other NAIC task forces and working groups.
   I. Work with the Catastrophe Modeling Center of Excellence (COE) to stay informed about what states are doing regarding mitigation.

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

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

C. Discuss ways in which states in the same FEMA region can collaborate and share information with other states in their FEMA region.

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

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

NAIC Support Staff: Aaron Brandenburg

Member Meetings/C CMTE/2024 Fall/Ccmte 2025draftcharge.Docx

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Adopted by the Casualty Actuarial and Statistical (C) Task Force, Oct. 7, 2024

2025 Proposed Charges

CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

The mission of the Casualty Actuarial and Statistical (C) Task Force is to identify, investigate and develop solutions to actuarial problems and statistical issues in the property/casualty (P/C) insurance industry.

The Task Force's goals are to assist state insurance regulators with maintaining the financial health of P/C insurers; ensuring P/C insurance rates are not excessive, inadequate or unfairly discriminatory; and ensuring that appropriate data regarding P/C insurance markets are available.

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

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E. Research cyber liability insurance, and discuss regulatory data needs.

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

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

NAIC Support Staff: Kris DeFrain/Roberto Perez/Libby Crews

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Adopted by the Surplus Lines (C) Task Force, Aug. 13, 2024

2025 Proposed Charges

SURPLUS LINES (C) TASK FORCE

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

The **Surplus Lines (C) Task Force** will:

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

The **Surplus Lines (C) Working Group** will:

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

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Draft: 11/19/2024
Adopted by the Executive (EX) Committee and Plenary, Nov. 19 2024
Adopted by the Property and Casualty Insurance (C) Committee, Nov. 18, 2024
Adopted by the Title Insurance (C) Task Force, Oct. 4, 2024

2025 Proposed Charges

TITLE INSURANCE (C) TASK FORCE

The mission of the Title Insurance (C) Task Force is to …

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

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Draft: 10/24/24

Adopted by the Executive (EX) Committee and Plenary, Nov.19, 2024
Adopted by the Property and Casualty Insurance (C) Committee, Nov. 19, 2024
Adopted by the Workers' Compensation (C) Task Force, Oct. 23, 2024

2025 Proposed Charges

WORKERS' COMPENSATION (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services:

1. The **Workers' Compensation (C) Task Force** will:

   A. Oversee the activities of the NAIC/International Association of Industrial Accident Boards and Commissions (IAIABC) Joint (C) Working Group.

   B. Discuss issues with respect to advisory organizations, rating organizations, statistical agents, and insurance companies in the workers' compensation arena.

   C. Monitor the movement of business from the standard markets to the assigned risk pools. Alert state insurance department representatives if the growth of assigned risk pools changes dramatically.

   D. Follow workers' compensation issues regarding cannabis in coordination with the Cannabis Insurance (C) Working Group.

   E. Discuss issues affecting workers' compensation.

2. The **NAIC/International Association of Industrial Accident Boards and Commissions (IAIABC) Joint (C) Working Group** will:

   A. Study issues of mutual concern to state insurance regulators and the IAIABC. Review relevant IAIABC model laws and white papers and consider possible charges based on the Working Group's recommendations.

NAIC Support Staff: Sara Robben/Aaron Brandenburg

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CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

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Draft: 11/20/24

Casualty Actuarial and Statistical (C) Task Force
Denver, Colorado
November 17, 2024

The Casualty Actuarial and Statistical (C) Task Force met in Denver, CO, Nov. 17, 2024. The following Task Force members participated: D.J. Bettencourt, Chair, represented by Christian Citarella (NH); Chlora Lindley-Myers, Vice Chair, represented by Cynthia Amann (MO); Lori K. Wing-Heier represented by Sian Ng-Ashcraft (AK); Barbara D. Richardson represented by Tom Zuppan (AZ); Ricardo Lara represented by Mitra Sanandajifar (CA); Andrew N. Mais represented by Wanchin Chou (CT); Michael Yaworsky represented by Brittany Barnhart (FL); Gordon I. Ito represented by Jerry Bump (HI); Doug Ommen represented by Travis Grassel (IA); Vicki Schmidt represented by Nicole Boyd (KS); Robert L. Carey represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Phil Vigliaturo (MN); Eric Dunning represented by Margaret Garrison (NE); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by Brian Fjeldheim (OR); Michael Humphreys represented by Michael McKenney and Shannen Logue (PA); Cassie Brown represented J'ne Byckovski and Miriam Fisk, and (TX); Kevin Gaffney represented by Rosemary Raszka (VT); Mike Kreidler represented by Eric Slavich (WA); and Allan L. McVey and Ellen Potter (WV).

1. Adopted its Oct. 8 and Summer National Meeting Minutes

Citarella said the Task Force met Oct. 8 and adopted its 2025 proposed charges.

The Task Force also met Oct. 15 and Aug. 20 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss rate filing issues.

Additionally, the Task Force held Predictive Analytics Book Club meetings Oct. 22 and Aug. 27. Book Club sessions included the following: 1) the American Academy of Actuaries' (Academy's) Data Science and Analytics Committee presented on an actuarial view of data bias; and 2) Sam Kloese (NAIC), Roberto Perez Santiago (NAIC), and Bulut Özenç (Capital Insurance Group—CIG) presented on analyzing the impact of various distributions for modeling pure premium.

McVey made a motion, seconded by Chou, to adopt the Task Force's Oct. 8 (Attachment One) and Aug. 13 (*see NAIC Proceedings – Summer 2024, 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 Sept. 25 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss observations resulting from state insurance regulators' review of the 2023 Statements of Actuarial Opinion (SAOs).

The Working Group also met Oct. 21, Sept. 24, and Aug. 29. During these meetings, the Working Group continued its discussion on proposed changes to the *Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2024* (Regulatory Guidance) and the *2025 Property and Casualty (P&C) Opinion Instructions* (P&C Opinion Instructions). The Regulatory Guidance document was exposed Sept. 24 for a 21-day public comment period that ended Oct. 14. No comments were received, and the Working Group voted to adopt the document Oct. 21. Significant changes from the prior

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regulatory guidance document include changes as a result of the revision of Actuarial Standard of Practice (ASOP) No. 36—Statements of Actuarial Opinion Regarding Property/Casualty Loss and Loss Adjustment Expense Reserves, which became effective Oct. 1, additional guidance related to Schedule P reconciliation, and additional guidance related to what an appointed actuary might state in an opinion when the actuary considers P/C long duration unearned premium reserves to be immaterial but are not zero.

The Working Group's discussions about the P&C Opinion Instructions focused on two main areas: 1) required disclosures when the appointed actuary has made use of another person's work; and 2) the amounts disclosed in Exhibit A or B of the Opinion that are not separately disclosed elsewhere in the annual statement. The Working Group plans to meet again in December to continue these discussions.

Fisk made a motion, seconded by Botsko, to adopt the report of the Actuarial Opinion (C) Working Group, including its Oct. 21 (Attachment Two) and combined Sept. 24 and Aug. 29 (Attachment Three) minutes. The motion passed unanimously.

3. Adopted the Report of the Statistical Data (C) Working Group

Darby said the Statistical Data (C) Working Group met Oct. 23. During this meeting, the Working Group discussed proposed updates to its statistical reports. The Working Group also met Oct. 9 in regulator-to-regulator session to discuss auto and home data. The Working Group will continue to consider proposed changes, including surveying reporting statistical agents on whether they can provide homeowners' data by peril and how catastrophe loss data is reported.

The Working Group plans to adopt the *Auto Insurance Database Report* (Auto Report) and the 2022 *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance Report* (Homeowners Report) soon. NAIC staff are currently reviewing and compiling data for the 2023 *Report on Profitability by Line by State* (Profitability Report) and the 2023 *Competition Database Report* (Competition Report).

Darby made a motion, seconded by Chou, to adopt the report of the Statistical Data (C) Working Group, including its Oct. 23 (Attachment Four) minutes. The motion passed unanimously.

4. Adopted the Regularized GLMs Appendix to the White Paper

Sam Kloese (NAIC) stated the white paper appendix on regularized generalized linear models (RGLMs) has been finalized following review and consideration of comments received (*see Casualty Actuarial and Statistical (C) Task Force Oct. 8, 2024, Minutes*). The changes were mainly clarification to remove wording ambiguity and to decrease the priority of some information items. No new informational items were added to the appendix after the initial draft.

Darby made a motion, seconded by Dyke, to adopt the white paper appendix on RGLMs (*see NAIC Proceedings – Fall 2024, Casualty Actuarial and Statistical (C) Task Force, Attachment One*). The motion passed unanimously.

5. Discussed the Plan for Assessment of Educational Changes

Miriam Fisk said the Task Force announced the upcoming assessment of the actuarial educational programs of the Society of Actuaries (SOA) and the Casualty Actuarial Society (CAS) at the Summer National Meeting. These educational programs were last assessed in 2018–2019 and will now be reassessed to determine whether U.S. Appointed Actuaries with CAS or SOA designations will continue to be considered "qualified" according to NAIC standards with or without requirements for successful completion of any specific optional examinations.

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Following informal communication, a formal request was sent Nov. 12 (Attachment Five). The SOA and CAS were asked to provide a mapping of their syllabi and materials to the knowledge statements the NAIC adopted in 2019. The SOA information should be from the new program planned to be implemented in May 2025. The CAS information should be based on the most up-to-date syllabi available. The SOA, CAS, and Academy were asked to nominate 12 subject matter expert (SME) volunteers from each organization to assist with the assessment.

The Task Force plans to receive updated mappings and educational materials from the CAS and SOA by the beginning of December and lists of volunteers from the organizations by mid-December. Shortly thereafter, volunteers will receive assigned knowledge statements and educational materials to review. Volunteers will submit their assessments by the end of January. The Actuarial Opinion (C) Working Group will review the SME volunteers' assessments and advise the CAS and SOA of any necessary changes by mid-March.

6. Heard About Missing Data

McKenney said the Pennsylvania Department of Insurance (DOI) is pre-vetting a draft regulation about unknown missing risk classifications. State insurance regulators receive many rate filings with "unknown" or "missing" as a type of risk. For a variable, all the options for the variable are listed, and then there is an "unknown" option. He said this happens for practically every risk variable used. He suspects that it might be that the purchased databases include "unknown" or "missing" in them. Instead of ignoring, the modeler treats "unknown" or "missing" as valid classes of risk. It is also because insurers are increasingly using unregulated third-party vendors for risk classification. Upwards of 40% of queries from these unregulated vendors go unreturned. No one is regulating third-party data vendors; McKenney said it is unknown if missing data largely represents any socio-economic group.

McKinney said it is an actuarial and legal tenet that those with the same risk should be charged the same rates. Differences in rates should be based on differences in expected losses and expenses and not on whether a third-party vendor has a person in the database. Transparency in pricing is important, and he questions whether insureds would understand that their rate was affected because they were not in the database.

In Pennsylvania, the proposal is for the insurer to first ask the policyholder for the missing data. If the applicant or policyholder does not respond, then "did not respond" can be a class of risk. If it is not feasible to ask the applicant or policyholder, then maybe it is not a valid characteristic or a valid data vendor.

Citarella said Task Force should discuss the issue further. David Snyder (American Property Casualty Insurance Association—APCIA) said insurers have concerns that any solutions to this might be worse for consumers than current practice. He requested interested parties be involved in discussions of potential solutions.

7. Heard an AI Presentation from the Casualty Actuarial Society (CAS)

Ken Williams (CAS) and Barry Franklin (CAS) presented on artificial intelligence (AI) activities at the CAS and affiliates (Attachment Six).

8. Heard Liaison Reports

Amann reported on activities at the Privacy Protections (H) Working Group, Catastrophe Insurance (C) Working Group, and the Cybersecurity (H) Working Group. Chou added information about the Academy's cyber work. Botsko reported on group activities under the Capital Adequacy (E) Task Force. McKenney reported on the Workers' Compensation (C) Task Force's policy issues. Vigliaturo reported on the Special (EX) Committee on Race and Insurance's P/C workstream. Darby updated the group on the System for Electronic Rates & Forms Filing.

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(SERFF) Modernization project. Citarella asked liaisons to recommend when the Task Force should become involved in other groups' work.

9. Heard Updates on Activity and Research from Professional Actuarial Associations

The Academy, Actuarial Board of Counseling and Discipline (ABCD), Actuarial Standards Board (ASB), CAS, and SOA provided reports on current activities and research.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

Member Meetings/C CMTE/2024 Fall/CASTF/111724 Minutes CASTF FNM.Docx

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Casualty Actuarial and Statistical (C) Task Force
Virtual Meeting
October 8, 2024

The Casualty Actuarial and Statistical (C) Task Force met Oct. 8, 2024. The following Task Force members participated: D.J. Bettencourt, 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); Barbara D. Richardson represented by Lori Dreaver Munn (AZ); Ricardo Lara represented by Mitra Sanandajifar (CA); Andrew N. Mais represented by Qing He and Wanchin Chou (CT); Karima M. Woods represented by Monica Myers (DC); Michael Yaworsky represented by Peshala Disanayaka (FL); Doug Ommen represented by Travis Grassel (IA); Mary L. Beard represented by Larry Steinert (IN); Vicki Schmidt represented by Nicole Boyd (KS); Timothy J. Temple represented by Arthur Schwartz (LA); Marie Grant represented by Walter Dabrowski (MD); Robert L. Carey represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Phil Vigliaturo (MN); Eric Dunning represented by Nguyen Thai (NE); Justin Zimmerman represented by Sam Sackey (NJ); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by James DiSanto (PA); Alexander S. Adams Vega represented by Carlos Vallés (PR); Cassie Brown represented by J'ne Byckovski and Miriam Fisk (TX); Kevin Gaffney represented by Rosemary Raszka and Mary Richter (VT); Mike Kreidler represented by Eric Slavich (WA); and Allan L. McVey and Juanita Wimmer (WV).

1. Adopted the Report of the Actuarial Opinion (C) Working Group

Fisk reported the Actuarial Opinion (C) Working Group met Sept. 24 and Aug. 29. During these meetings, the Working Group continued discussing proposed changes to the *Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2024* (2024 Regulatory Guidance) and the 2025 property/casualty (P/C) Statement of Actuarial Opinion (SAO) instructions.

A draft of the 2024 Regulatory Guidance is currently exposed for a 21-day public comment period ending Oct. 14. Significant proposed changes from the 2023 document include changes as a result of the revision of Actuarial Standard of Practice (ASOP) No. 36 which became effective Oct. 1, additional guidance related to Schedule P reconciliation, and additional guidance related to what an appointed actuary might state in an opinion when P/C long-duration unearned premium reserves are considered by the actuary to be immaterial but not zero.

The Working Group is scheduled to meet on Oct. 21 to discuss any comments received during the exposure period, consider adoption of the 2024 Regulatory Guidance, and continue discussion of potential changes to the 2025 SAO instructions.

Fisk made a motion, seconded by Dyke, to adopt the report of the Actuarial Opinion (C) Working Group. The motion passed unanimously.

2. Adopted the Report of the Statistical Data (C) Working Group

Kris DeFrain (NAIC) reported the Statistical Data (C) Working Group plans to meet Oct. 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 data for the *Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance Report* (Homeowners Report) and the *Auto Insurance*

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Database Report (Auto Report). Both reports will be considered for adoption soon and sent to the Task Force for review and adoption.

The Working Group also plans to meet Oct. 23 to continue discussing proposed updates to statistical reports.

NAIC staff are currently checking data for the *Report on Profitability by Line by State* (Profitability Report) and the *Competition Database Report* (Competition Report) and will distribute data to the Working Group in the coming weeks. Once adopted by the Working Group, the reports will be sent to this Task Force for review and adoption.

Qing made a motion, seconded by Schallhorn, to adopt the report of the Statistical Data (C) Working Group. The motion passed unanimously.

3. Adopted its 2025 Proposed Charges

Citarella presented the Task Force's draft 2025 proposed charges. Darby proposed a revised charge to the Statistical Data (C) Working Group's charge about the *Statistical Handbook of Data Available to Insurance Regulators* to reflect the plan to update and improve data quality and reporting standards beginning in 2025.

Darby made a motion, seconded by Botsko, to adopt its 2025 proposed charges (*see NAIC Proceedings – Fall 2024, Property and Casualty Insurance (C) Committee, Attachment Four*). The motion passed unanimously.

4. Discussed a Plan for Assessment of Academy and Society Educational Changes

DeFrain stated that the definition of "Accepted Actuarial Designation" within the SAO instructions contains detailed descriptions of which actuarial designations are accepted and which actuarial exams are required. The Task Force announced a five-year review of the educational programs for the Society of Actuaries (SOA) and the Casualty Actuarial Society (CAS) to update this definition. The Actuarial Opinion (C) Working Group will be conducting the evaluation and has made requests 1) for SOA and CAS to provide a mapping of their syllabuses and materials to the knowledge statements that the NAIC adopted in 2019 and 2) for all three U.S. actuarial organizations (SOA, CAS and the American Academy of Actuaries [Academy]) to nominate 12 subject matter expert (SME) volunteers from each organization to assist the Working Group with the assessment. Materials from SOA and CAS are expected in mid-November with a goal to return the final assessments to the SOA and CAS by April 2025 to meet the SOA's goal of publishing in May 2025.

Representatives from the CAS and the SOA voiced their commitment to submitting information to the Task Force.

5. Discussed Revisions to the GLM White Paper Appendix

The Task Force received three comment letters in response to the exposure of a white paper appendix on regularized generalized linear models (GLMs) for a 30-day public comment period ending Sept. 13 (Attachment One-A). Sam Kloese (NAIC) reviewed the comments received and proposed revisions to the appendix (Attachment One-B). The Task Force will consider adoption of the revised appendix at the Fall National Meeting (Attachment One-C).

6. Discussed Schedule P Instruction Drafting

DeFrain said during the 2024 adoption of the Schedule P change to have 10 years of reporting for every line of business, comments were submitted that requested clarity in the Schedule P instructions. She proposed making the following improvements: 1) eliminate all instructions regarding business prior to 2000; 2) number the

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paragraphs to enhance referencing; 3) improve prior row instructions by adding examples of how to calculate the prior row; 4) use abbreviations for the loss adjustment expenses; and 5) clarify current use of the word "prior." These are wording changes only; the reporting is not changed. She said there are other ways to improve the instructions, but the aim is to tackle this first set together and, if state insurance regulators decide, consider additional changes in a second phase.

DeFrain conveyed to Citarella a request for volunteers to review the examples to ensure accuracy before exposure.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

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APPENDIX B-RGLM – INFORMATION ELEMENTS AND GUIDANCE FOR A REGULATOR TO MEET BEST PRACTICES' OBJECTIVES (WHEN REVIEWING REGULARIZED GENERALIZED LINEAR MODELS)

This appendix identifies the information a state insurance regulator may need to review a regularized general linear model used by an insurer to support a personal automobile or home insurance rating plan. Regularized Generalized Linear Models include lasso, derivative lasso, lasso credibility, ridge, elastic net, and accurate generalized linear models (AGLM). Other modeling approaches may fall within the category of regularized generalized linear models. The main distinguishing feature of regularized GLMs is that they have complexity penalty hyper parameter(s) (a.k.a. shrinkage factors) which put constraints on the model such that the coefficients are tempered from what they would be in a standard (unpenalized) Generalized Linear Model (GLM). Generally, if the complexity penalties in a regularized GLM are set to zero, the model indications will be identical to those achieved from a standard GLM. The list of information elements below 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.[1]

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.[2]

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

[1] 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.

[2] There are some models that are made public by the vendor and would not result in a hindrance of the model's protection.

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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-RGLM is focused on Regularized GLMs including lasso, derivative lasso, lasso credibility, ridge, elastic net, and accurate generalized linear models. This appendix should not be referenced in the review of other model types. This Appendix B-RGLM is intended to provide state guidance for the review of rate filings based on regularized GLMs.

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A. SELECTING MODEL INPUT

Section	Information Element	Level of Importance to the Regulator' s Review	Comments
1. Available Data Sources			
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	Request details of data sources, whether internal to the company or from external sources. For insurance experience (policy or claim), determine whether data are aggregated by calendar, accident, fiscal, or policy year and when it was last evaluated. For each data source, get a list of all data elements used as input to the model that came from that source. For insurance data, get a list all companies whose data is included in the datasets. Request details of any non-insurance data used (customer-provided or other), whether the data was collected by use of a questionnaire/checklist, whether data was voluntarily reported by the applicant, and whether any of the data is subject to the federal Fair Credit Reporting Act (FCRA). If the data is from an outside source, find out what steps were taken to verify the data was accurate, complete, and unbiased in terms of relevant and representative time frame, representative of potential exposures, and lacking in obvious correlation to protected classes. **Note**: 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.
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.

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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 explain why any states were excluded from the countrywide data. 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. The company should provide a demonstration that the model fits well on the specific state or surrounding region.
2. Sub-Models			
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.

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A.2.c	Determine if the sub-model output was used as input to the Regularized GLM; obtain the vendor name, as well as the name and version of the sub-model.	1	To accelerate the review of the filing, it may be desirable to request (from the company), the name and contact information for a vendor representative. The company should provide the name of the third-party vendor and a contact in the event the regulator has questions. The "contact" can be an intermediary at the insurer (e.g., a filing specialist), who can place the regulator in direct contact with a subject-matter expert (SME) at the vendor. Examples of such sub-models include credit/financial scoring algorithms and household composite score models. Sub-models can be evaluated separately and in the same manner as the primary model under evaluation. A sub-model contact for additional information should be provided. Sub-model SMEs may need to be brought into the conversation with regulators (whether in-house or third-party sub-models are used).
A.2.d	If using catastrophe model output, identify the vendor and the model settings/assumptions used when the model was run.	1	To accelerate the review of the filing, get contact information for the SME that ran the model and an SME from the vendor. The "SME" can be an intermediary at the insurer (e.g., a filing specialist), who can place the regulator in direct contact with the appropriate SMEs at the insurer or model vendor. For example, it is important to know hurricane model settings for storm surge, demand surge, and long-term/short-term views.
A.2.e	Obtain an explanation of how catastrophe models areintegrated into the model to ensure no double-counting.	1	If a weather-based sub-model is input to the Regularized GLM under review, loss data used to develop the model should not include loss experience associated with theweather-based sub-model. Doing so could cause distortions in the modeled results by double-counting such losses when determining relativities or loss loadsin the filed rating plan. For example, redundant losses in the data may occur when non-hurricane wind losses are included in the data while also using a severe convective storm model in the actuarial indication. Such redundancy may also occur with the inclusion of fluvial or pluvial flood losses when using a flood model or inclusion of freeze losses when using a winter storm model.
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.

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3. Adjustments to Data			
A.3.a	Determine if premium, exposure, loss, or expense data were adjusted (e.g., on-leveled, 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	The rating plan or indications underlying the rating plan may provide special treatment of large losses and non-modeled large loss events. If such treatments exist, the company should provide an explanation how they were handled. These treatments need to be identified and the company/regulator needs to determine whether model data needs to be adjusted. For example, should large bodily injury (BI) liability losses in the case of personal automobile insurance be excluded, or should large non-catastrophe wind/hail claims in home insurance be excluded from the model's training, test and validation data? Look for anomalies in the data that should be addressed. For example, is there an extreme loss event in the data? If other processes were used to load rates for specific loss events, how is the impact of those losses considered? Examples of losses that can contribute to anomalies in the data are large losses or flood, hurricane, or severe convective storm losses for personal automobile comprehensive or home insurance. Premium should be brought to current rate level if the target variable is calculated with a premium metric, such as loss ratio. Premium can be brought to current rate level with the extension of exposures method or the parallelogram method. Note that the premium must be on-leveled at a granular variable level for each variable included in the new model if the parallelogram method is used. Statewide on-level factors by coverage are typically sufficient for statewide rate indication development but not sufficient for models that determine rates by variable level.
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	Pre-modeling binning may be unnecessary for ordinal variables in a lasso derivative or lasso credibility model, as the model will automatically set bins. Other regularized GLM approaches often group some variable levels with a base level during model fitting. However, if the insurer does bin variables or group levels before modeling, the reason should be understood.
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/binned/transformed/etc. data.	4	This is most relevant for variables that have been "scrubbed" or adjusted. Though most regulators may never ask for aggregated data and do not plan to rebuild any models, a regulator may ask for this aggregated data or subsets of it. It would be useful to the regulator if the percentage of exposures and premium for missing information from the model data by category are provided. This data can

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			be displayed in either graphical or tabular formats.
A.3.d	Determine how missing data was handled.	1	This is most relevant for variables that have been "scrubbed" or adjusted. The regulator should be aware of assumptions the modeler made in handling missing, null, or "not available" values in the data. For example, it would be helpful to the reviewer if the modeler were to provide a statement as to whether there is any systemic reason for missing data. If adjustments or recoding of values were made, they should be explained. It may also be useful to the regulator if the percentage of exposures and premium for missing information from the model data are provided. This data can be displayed in either graphical or tabular formats.
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.
4. Data Organization			
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 descriptionOf 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
1. High-Level Narrative for Building the Model			
B.1.a	Identify the type of model underlying the rate filing (e.g., lasso regression, ridge regression, elastic net regression, etc). Understandthe model's role in the rating system and provide thereasons why that type of model is an appropriate choice for that role. Understand why a Regularized GLM is preferable to a standard GLM for the specific modeling exercise.	1	A main drawback of GLMs is assigning full credibility to the data, and a main benefit of penalized regression is the assignment of partial credibility to the data. The ability of RGLMs to help avoid overfitting through the assignment of partial credibility is expected to be a core reason for their adoption. It is important to understand if the model in question is a Regularized GLM and, therefore, these information elements are applicable; or if it is some other model type, in which case other reasonable review approaches may be considered. There should be an explanation of why themodel (using the variables included in it) is appropriatefor the line of business. If by-peril or by-coverage modeling is used, the explanation should be by- peril/by-coverage. When a company is using a regularized GLM, it is helpful to understand why a penalized model is preferable to a standard GLM (without penalties for model complexity). **Note**: If the model is not a Regularized GLM, the information elements in this white paper may not apply in their entirety.
B.1.b	Identify the credibility complement used (if applicable). Lasso credibility is an example of a regularized generalized linear model which contains a credibility complement. Discuss why the selected complement is reasonable.	1	Many regularized generalized linear models are analogous in concept to a credibility weighted approach. Predictor variable values with low data volume will often result in coefficients that are closer to the credibility complement. For many regularized linear models, the implied credibility complement for each parameter is 0. However, in lasso credibility an alternate complement of credibility can be set. The alternate complement of credibility might be based on something like the currently approved rating factors. The regulator should determine if the complement of credibility is reasonable for use since it is not driven by the latest data.
B.1.c	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.

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B.1.d	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 rebuiltusing 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.
B.1.e	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.f	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.g	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.h	Obtain a description of the ~~candidate~~ variable selection process~~ prior to the model building.~~	1	~~Candidate variables are the variables used as input to the modeling process. Certain variables may not end up used in the final model as some regularized GLM models (lasso, elastic net, etc.) will remove less significant variables.~~ The narrative regarding the ~~candidate~~ 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 ~~candidate~~ variable selection.

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			The modeler should comment on the use of automated feature selection algorithms to choose ~~candidate~~ predictor variables and explain how potential overfitting that can arise from these techniques was addressed. Certain variables may not end up used in the final model as some regularized GLM models (lasso, elastic net, etc.) will remove less significant variables.
B.1.i	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. In Derivative Lasso, AGLM, and similar techniques, the granularity of ordinal variables should avoid "pre-binning" that removes the algorithm's ability to define a breakpoint where there should be one. The bin width should consider the amount of exposures in each bin, in order to obtain credible bins. The number of bins may need to be constrained since an extremely large number of bins may be too computationally intensive.
B.1.j	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.
2. Medium-Level Narrative for Building the Model			
B.2.a	At crucial points in model development, if selectionswere made among alternatives regarding model assumptions or techniques, obtain a narrative on the judgment used to make those selections.	3	
B.2.b	If post-model adjustments were made to the data andthe 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

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			where they can be shown to be particularly important. So, as a rule of thumb, the regulator's emphasis should be on understanding why the insurer included the interaction terms it did, rather than on why other candidate interactions were excluded. In some cases, however, it could be reasonable to inquire about why a particular interaction term was excluded from a model—for example, if that interaction term was ubiquitous in similar filings and was known to be highly predictive, or if the regulator had reason to believe that the interaction term would help differentiate dissimilar risks within an excessively heterogenous rating segment.
B.2.d	For the Regularized GLM, identify the link function used. Identifywhich 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. Certain distribution assumptions will involve numerical parameters, for example a Tweedie assumed distribution will have a p power value. Obtain the specific numerical parameters associated with the distribution. If changed from the default, obtain a discussion of applicable convergence criterion.	1	Solving the Regularized GLM is iterative and the modeler can check to see if fit is improving. At some point, convergence occurs; however, when it occurs can be subjective or based on threshold criteria. If the software's default convergence criteria were not relied upon, an explanation of any deviation should be provided. If the Regularized GLM 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 include all coefficients necessary toevaluate the predicted pure premium, relativity, or other value, for any real or hypothetical set of inputs.	2	
B.2.f	If there were data situations in which 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.2.g	Obtain the value of ~~the applicable~~ any additional relevant model ~~complexity~~ hyperparameter(s) other than the complexity parameter. Obtain~~and~~ an explanation on how they~~it~~ was~~ere~~ chosen.	2	~~Regularized GLMs have model complexity hyperparameters which can materially impact the final model parameters. The value of the model complexity hyperparameter determines whether the model is close to a standard GLM or is significantly tempered. For most regularized GLMs, tuning of the hyperparameter to maximize GINI on test data or minimize deviance on test data would be appropriate methods. For the derivative lasso method, it may be useful to review the plots of coefficients to determine if there is enough grouping of variable levels to remove reversals between adjacent variable levels.~~ The complexity hyperparameter(s) are discussed in Information Element B.2.h. Some Regularized GLMs will have additional hyperparameters needed to fit the model. For example, certain smoothed terms in a GAM

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			may require selecting a number of knots.
B.2.h	Obtain the value of the applicable model complexity hyperparameter(s) and an explanation on how it was chosen.	4	Regularized GLMs have model complexity hyperparameters which can materially impact the final model parameters. The value of the model complexity hyperparameter determines whether the model is close to a standard GLM or is significantly tempered. For most regularized GLMs, tuning of the hyperparameter to maximize GINI on test data or minimize deviance on test data would be appropriate methods. For the derivative lasso method, it may be useful to review the plots of coefficients to determine if there is enough grouping of variable levels to remove reversals between adjacent variable levels. The exact value of the penalty parameter holds no meaning without context. The reviewer should focus less on the value selected but instead confirm that the process of selecting a value is sound.
B.2.~~h~~i	Understand how the model would differ if different hyperparameter(s) were selected. Obtain a sensitivity analysis showing the coefficient output with higher and lower complexity hyperparameters or a plot showing coefficients by penalty value.	4	If the process for selecting a complexity hyperparameter(s) is sound, it is generally unnecessary to provide documentation on model results using alternative complexity hyperparameters. However, the regulator may want to scrutinize the hyperparameter more if the process for selecting a value does not seem sound. A regulator may decide they need more assurance that a reasonable value of complexity hyperparameter was selected. The regulator could ask for a sensitivity analysis showing how output model coefficients would differ if other hyperparameter values are used. ~~Alternatively, the regulator could ask for a plot where the X-axis is the hyperparameter value and there are separate lines representing the coefficient value for each variable given the complexity hyperparameter.~~
3. Predictor Variables			
B.3.a	Obtain a complete data dictionary, including the names, data types, definitions, and uses of each predictor variable, offset variable, control variable, proxy variable, geographic variable, geodemographicvariable, and all other variables in the model used ontheir own or as an interaction with other variables (including sub-models and external models).	1	Data types of variables might be continuous, discrete, ordinal, Boolean, etc. Definitions should not use programming language or code. For any variable(s) intended to function as a control or offset, obtain an explanation ofits purpose and impact. Also, for any use of interactionbetween 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

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			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 greatest reduction in mean square error on test data, this would be a far, far weaker case forstatistical significance than if that variable was the only one the company evaluated. **Note**: Context matters.
B.3.c	Obtain a correlation matrix for all predictor variables included in the model and sub-model(s).	3	While Regularized GLMs accommodate collinearity, the correlation matrix provides more information about the magnitude of correlation between variables. The company should indicate what statistic was used (e.g., Pearson, Cramer's V). The regulatory reviewer should understand what statistic was used to produce the matrix but should not prescribe the statistic.
B.3.d	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	The explanation should go beyond demonstrating correlation. Considering possible causation may be relevant, but proving causation is neither practical nor expected. If no rational explanation can be provided, greater scrutiny may be appropriate. For example, the regulator should look for unfamiliar predictor variables and, if found, the regulator should seek to understand the connection that variable has to increasing or decreasing the target variable.
B.3.e	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 ofthe dimensionality reduction technique was used within the model.	2	
4. Adjusting Data, Model Validation, and Goodness-of-Fit Measures			
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	For models that are built using multistate data, validation data for some segments of risk is likely to have low credibility in individual states. Nevertheless, some regulators require model validation on state-only data, especially when analysis using state-only data contradicts the countrywide results. State-only data might be more applicable but could also be impacted by low credibility for some segments of risk. **Note**: It may be useful to consider geographic stability measures for territories within the state.

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B.4.b	For all variables, review the appropriate parameter values and relevant demonstrations of stability. Relevant demonstrations of stability may be provided as either plots by variable of indicated factors which also show upper bound and lower bound values (95th percentile and 5th percentile) on bootstrapped datasets, coefficient ranges across dataset folds, or p-values from a comparable standard GLM.	~~1~~3	Statistical confidence intervals and p-values are often not available for Regularized GLMs. However, there are other ways to demonstrate model stability. The regulator should not prescribe one of these methods specifically, as they may be not applicable for some forms of RGLM. The model could be run 100+ times on bootstrapped datasets to determine the stability of model parameters. If the bootstrapped models produce a narrow range of coefficient values, this implies the model is stable. Extra scrutiny should apply if the range of coefficient values includes negative and positive values. If the bootstrapped models produce a wide range of coefficient values, this implies the model is less stable. The range could be represented visually for each predictor variable by showing a plot with predictor variable values on the X-axis, and three separate lines representing mean indicated factors, the 95th percentile factors, and the 5th percentile factors. If the model was built with k-fold cross validation, the range of coefficients could be reviewed in a similar fashion. Narrower ranges represent a more stable model. The results may be less meaningful if more than 20 folds were used, since each model run would be based on significantly similar datasets. Coefficient ranges could also be reviewed by year or by other dataset segments to assess model stability. Variable stability can also be approximated by looking at the p-values from a comparable standard GLM which contains the same predictor variables as the Regularized GLM in question.

B.4.c	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	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 Regularized GLM. The regulator should not assume to know what the company did and ask, "How?" Instead, the regulator should ask what the company did and be prepared to ask follow-up questions. For a Regularized GLM, such evidence may be available using observed vs. predicted average plots by variable and overall model lift charts. The regulator should ask for the company to provide exhibits or plots that show how the fitted average makes sense when compared to the observed average for variables of interest. Regulators would ideally review this comparison for every variable, but time constraints may limit the focus to just variables of interest. Variables of interest should include variables with high potential impacts on consumers (steep discounts or surcharges), variables without an intuitive relationship to loss, or variables that may be proxies for a protected class attribute. It is expected that the fit relativity will be different than the observed relativity for RGLM as the fit relativity will be penalized towards the prior assumption or null relativity. These differences can be evaluated through the lens of credibility: items with lower exposure are expected to differ more than levels with high exposure. Low credibility datasets may see less alignment between these values in general. This credibility view is most easily applied to ordinal and categorical variables and less easily applied to continuous variables as continuous variables may extrapolate to areas with low credibility. Lift charts such as quantile plots demonstrate the overall model fit. The risks in the modeling data are bucketed into quantiles with equal volume representing different levels of predicted risk. Quantile plots graph the predicted averages versus the observed averages by quantile. The quantile plots should have at least 10 quantiles to demonstrate predictive accuracy across different risk levels. Decile plots may look less stable for small books of business. In these cases, it may be helpful to obtain additional lift charts with less than 10 quantiles.
B.4.d	Obtain a description how the model was tested for stability over time.	2	Evaluate the build/test/validation datasets for potential time-sensitive model distortions (e.g., a winter storm in

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			year 3 of 5 can distort the model in both the testing and validation datasets). Obsolescence over time is a model risk (e.g., old data for a variable or a variable itself may no longer be relevant). If a model being introduced now is based on losses from years ago, the reviewer should be interested in knowing whether that model would be predictive in the proposed context. Validation using recent data from the proposed context might be requested. Obsolescenceis a risk even for a new model based on recent and relevant loss data. The reviewer may want to inquire as to the following: What steps, if any, were taken during modeling to prevent or delay obsolescence? What controls exist to measure the rate of obsolescence? What is the plan and timeline for updating and ultimately replacing the model? The reviewer should also consider that as newer technologies enter the market (e.g., personal automobile) their impact may change claim activity over time (e.g., lower frequency of loss). So, it is not necessarily a bad thing that the results are not stable over time.
B.4.e	Obtain a narrative on how potential concerns with overfitting were addressed.	2	
B.4.f	Obtain support demonstrating that the overall Regularized GLM assumptions are appropriate.	3	A visual review of plots of actual errors is usually sufficient. The reviewer should look for a conceptual narrative covering these topics: How does this particular Regularized GLM work? Why did the rate filer do what it did? Why employ this design instead of alternatives? Why choose this particular distribution function and this particular link function? A company response may be at a fairly high level and reference industry practices. If the reviewer determines that the model makes no assumptions that are considered to be unreasonable, the importance of this item may be reduced.
B.4.g	Obtain 5-10 sample records with corresponding output from the model for those records.	4	
5. "Old Model" Versus "New Model"			
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	2	The regulator should expect to see improvement in the new class plan's predictive ability or other sufficient reason for the change.

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	for an explanation of any changes in calculations, assumptions, parameters, and data used to build this model from the previous model.		
B.5.b	Determine if two Lorenz curvers or Gini coefficients were compared and obtain a narrative on the conclusion drawn fromthis comparison.	3	This information element requests a comparison of the Lorenz curve and Gini coefficient from the prior model to the Gini coefficient of proposed model. It is expected that thereshould be improvement in the Gini coefficient.A higher Gini coefficient indicates greater differentiation produced by the model and how well themodel fits that data. This is relevant when one model is being updated or replaced. The regulator should expect to see improvement in the new class plan's predictive ability. One example of a comparison might be sufficient. **Note**: This comparison is not applicable to initial model introduction. Reviewer can look toCAS 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. **Note**: "Not applicable" is an acceptable response.
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.5.e	If using a credibility complement, obtain variable plots which visualize the credibility complement and the model indicated as separate lines. Lasso credibility is an example of a regularized generalized linear model which contains a credibility complement.	2	It is useful to see the coefficients as originally specified in the credibility complement, and how the model indicates these initially set coefficients should change based on the modeling data. These changes can be visualized as relativity plots that show complement relativity (initially set coefficients), indicated relativity (complement of credibility combined with modeled relativity), target relativity, and data volume (shown on a secondary axis). The combination of these four elements makes relativity plots a helpful tool for review of RGLM which has a credibility complement. The regulator should determine if the change from complement relativity to indicated relativity appears directionally appropriate based on the model target relativities and if the magnitude of the change appears reasonable.
6. Modeler Software			
B.6.a	Request access to SMEs (e.g., modelers) who led the project, compiled the data, and/or built the	4	The filing should contain a contact that can put the regulator in touch with appropriate SMEs and key

Section	Information Element	Level of Importance to the Regulator' s Review	Comments
	model.		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
1. General Impact of Model on Rating Algorithm			
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 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 inputto 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.

Section	Information Element	Level of Importance to the Regulator' s Review	Comments
2. Relevance of Variables and Relationship to Risk of Loss			
C.2.a	Obtain a narrative regarding how the character-istics/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. **Note**: This explanation would not be needed if the connection between variables and risk of loss (or expense) has already been illustrated.
3. Comparison of Model Outputs to Current and Selected Rating Factors			
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. **Note**: This information is especially important if differences between model-indicated values and selected values are material and/or impact one consumer population more than another.
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.
4. Responses to Data, Credibility, and Granularity Issues			
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.
5. Definitions of Rating Variables			
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.
6. Supporting Data			
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.	4	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
7. Consumer Impacts			
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 toindividual consumers.	2	This analysis is typically done at the state level. 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	This analysis is typically done at the state level. 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	Some examples of "static" policy characteristics are prior carrier tenure, prior carrier type, prior liability limits, claim history over past X years, or lapse of coverage. These are specific policy characteristics usually set at the time new business is written, used to create an insurance score or to place the business in a rating/underwriting tier, and often fixed for the life of the policy. The reviewer should be aware, and possibly concerned,how the company treats an insured over time when theinsured'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. 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.
C.7.g	Obtain a means to calculate the rate chargeda consumer.	3	The filed rating plan should contain enough information for a regulator to be able to validate policy premium. However, for a complex model or rating plan, a score or premium calculator via Excel or similar means would be ideal, but this could be elicited on a case-by-case basis. The ability to calculate the rate charged could allow the regulator to perform sensitivity testing when there are small changes to a risk characteristic/variable. **Note**: This information may be proprietary. For the rating plan, the rate order of calculation rule may be sufficient. However, it may not be feasible for a regulator to get all the input data necessary to reproduce a model's output. Credit and telematics models are examples of model types where model output would be readily available, but the input data would not be readily available to the regulator.
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 toinquire as to how consumers can verify their data and correct errors.	1	If the data is from a third-party source, the company should provide information on the source. Depending on the nature of the data, it may need to be documented with an overview of who owns it. The topic of consumer verification may also need to be addressed, including how consumers can verify their data and correct errors.

Section	Information Element	Level of Importance to the Regulator' s Review	Comments
8. Accurate Translation of Model into a Rating Plan			
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 anyadjustments 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.
9. Efficient and Effective Review of Rate Filing			
C.9.a	Establish procedures to efficiently review rate filings and models contained therein.	1	"Speed to market" is an important competitive concept for insurers. Although the regulator needs to understand the rate filing before accepting the rate filing, the regulator should not request information that does not increase his/her understanding of the rate filing. The regulator should review the state's rate filing review process and procedures to ensure that they are fair and efficient.
C.9.b	Be knowledgeable of state laws and regulationsin 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.

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3 comment letters were received in response to the exposure of the RGLM Appendix:

- Akur8
  - Thomas Holmes, FCAS
  - Mattia Casotto
- Allstate
- Milliman
  - Peggy Brinkmann, FCAS, MAAA
  - Paul Rosing, FCAS
  - Gabriele Usan

All comments received are copied below:

Commentator	Section	Comment	NAIC Remarks
Milliman	A.3.a	It may not be possible to on-level premiums at such a granular level in all situations, due to lack of data availability or other reasons. We suggest adding language to clarify that an insurer may pursue a temporal control variable (as mentioned in Generalized Linear Models for Insurance Ratemaking, section 5.1.3) when necessary.	A.3.a was copied from the original GLM appendix without changes. It is unchanged so that it does not become inconsistent with the other white paper appendices.
Akur8	B.1.a	Recommended additional comment: A main drawback of GLMs is assigning full credibility to the data, and a main benefit of penalized regression is the assignment of partial credibility to the data. The ability of RGLMs to help avoid overfitting through the assignment of partial credibility is expected to be a core reason for their adoption.	The suggested commentary was added to the "Comments" column for B.1.a
Akur8	B.1.b	Recommended additional comment: Sections 6.3 Relativity Plots and 6.4 Review by Variable Type of the CAS Monograph "Penalized Regression and Lasso Credibility" have an extensive discussion on the materiality of the complement of credibility in various situations, and these considerations can be used to help prioritize review in situations where the complement is under additional scrutiny. Note that this monograph has not been published at the time that these comments were sent, but a pre-read has been sent to the NAIC Predictive Modeling Task Force. We reference this document because we have tried and failed to condense our comments to help the evaluation of nonstandard complements into a reasonable size for the appendix.	Section B.1.b is asking for the regulator to obtain a basic understanding of how the complement of credibility was set. This would likely be accomplished with a short description in the filing memo. Examples of possible complement of credibility include: the prior approved model, the countrywide model (as opposed to a statewide model being built), or relativities indicated by bureau rates. Sections 6.3 and 6.4 of the text referenced focus on relativity plots, which are a way of visualizing the indicated changes by variable. This is addressed in separate information element B.5.e. Section B.5.e has been expanded to include some summarized considerations from Section 6.3 and 6.4 of the upcoming CAS Monograph "Penalized Regression and Lasso Credibility".

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Akur8	B.1.h	Clarification requested: Can the comment more clearly define what is in scope for this item and the depth required? Upon first read, we assumed that this question asks if there were variables that were included in the model but removed through penalization. However, the comments describe statutory or regulatory limitations that are outside of the scope of penalization. If this item is asking for variables considered but not included, could it be more clearly differentiated from item B.3.b?	References to “candidate variable” and “prior to the model building” have been removed to reduce ambiguity. B.1.h and B.3.b are similar. B.1.h is mostly focused on variables considered and eliminated early in the modeling process. B.3.b is focused on variables considered and eliminated after consideration in the model. B.3.b states, “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…”
Allstate	B.1.h	Allstate believes the definition of 'candidate variable' is ambiguous and requires further clarification. Allstate defines a 'candidate variable' as a variable that has been included in the final modeling dataset for exploration during the model-building process. A candidate variable may or may not be included in the final model. Allstate also recommends removing the phrase 'prior to the model building' from the information element description, as it is outside the scope of 'candidate variables' and adds unnecessary ambiguity.	References to “candidate variable” and “prior to the model building” have been removed to reduce ambiguity. The sentences in the comments have been reordered so that the modeler’s selection process is discussed before the automated variable selection through penalization is discussed.
Akur8	B.1.i	Recommended additional comment: In Derivative Lasso, AGLM, and similar techniques, the granularity of ordinal variables should attempt to avoid "pre-binning" that removes the algorithm's ability to define a breakpoint where there should be one. An example of poor granularity would be a very wide bin with large exposure that could clearly be split up into credible subsets. Ideal ordinal granularity is either narrow bins with large exposure or wide bins with few exposure. Note that an extremely large number of bins may be too computationally intensive to be feasible.	This additional comment was added with some modifications. The added comment now states, “In Derivative Lasso, AGLM, and similar techniques, the granularity of ordinal variables should avoid ‘pre-binning’ that removes the algorithm's ability to define a breakpoint where there should be one. The bin width should consider the amount of exposures in each bin, in order to obtain credible bins. The number of bins may need to be constrained since an extremely large number of bins may be too computationally intensive.”
Akur8	B.2.g	We recommend that B.2.g be split into two items. First, we recommend removing the request for the lasso/ridge/elastic net penalty parameter or setting it to a level 4 request. This value is meaningless by itself as the optimal penalty value depends on properties such as the signal to noise ratio of the dataset and likelihood calculations. We are concerned that B.2.g currently implies that the penalty parameter value should be evaluated directly and that there is an appropriate range of penalty parameters across all models when this is not	Original Information element B.2.g was split into 2 information elements. The new complexity hyperparameter information element is a level 4 item. The new additional hyperparameter information element remains at the prior level 2.

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		the case. The value of the penalty parameter does not help to evaluate a model, as 0.1 and 0.0001 may be equally appropriate penalty parameters for models on datasets of different sizes, perils, coverages, or model types. Second, we recommend that the selection process of the hyperparameters as well as any more relevant hyperparameters (such as the number of knots in the MGCV package's GAM) remain as a level 2 item. These items, unlike the penalty value itself, can provide significant value during model validation. We agree with the author that an explanation of how these parameters were chosen is a level 2 review item. . Alternately, a note can be added: "The exact value of the ridge/lasso/elastic net penalty parameter holds no meaning, so the reviewer should not scrutinize the value, but instead confirm that the process of selecting such a parameter is sound."	
Allstate	B.2.h	Allstate recommends removing information element B.2.h from the white paper. Providing coefficients for different hyperparameter values would require significant effort while offering little to no value to the regulatory review of the filed model. Allstate believes hyperparameter selection is properly addressed within information element B.2.g and considers information element B.2.h outside the scope of traditional modeling best practices. Therefore, Allstate suggests removing it from the paper.	B.2.h is a level 4 item, which means it would only be used if there are concerns not resolved by level 1, level2, and level 3 items. This would likely be an infrequent request from regulators, mostly used when the regulator believes the complexity parameter was chosen in an unreasonable way. The comments have been expanded to reflect this. The commentary regarding a plot of coefficients has been removed, since that is just one way of showing a sensitivity analysis and there are others that could satisfy the requirement.
Akur8	B.3.a	Recommended change to comment: Include "ordinal" in the list of data types as this data type is essential in Derivative Lasso and AGLM techniques.	Ordinal has been added to the comments
Akur8	B.4.b	Recommended additional comments: The regulator should not prescribe one of these methods specifically, as they may be not applicable for some forms of RGLM. In lasso credibility, it may be reasonable for the produced bootstrap/cross validation interval to overlap with original coefficients. The binned levels of ordinal variables in Derivative Lasso or AGLM are not expected to not match exactly to the final model. These estimation ranges can be evaluated similarly to GLM continuous variable confidence intervals where the range should not include zero	The following was added to the comments: "The regulator should not prescribe one of these methods specifically, as they may be not applicable for some forms of RGLM."

		throughout its entirety or show strong new trend reversals.	
Milliman	B.4.b	We suggest that coefficient ranges could also be reviewed by-year or by-segment to assess a model's stability.	The following was added to the comments: "Coefficient ranges could also be reviewed by year or by other dataset segments to assess model stability."
Allstate	B.4.b	Allstate believes this recommended information element exceeds what is considered modeling best practices and should not be deemed necessary for review. Bootstrapping or building a standard GLM would require significant effort while offering little to no value in the regulatory review of the filed model. Regularized GLMs use penalization techniques to aid in variable selection, reduce variable spread, and prevent overfitting. Consequently, a standard GLM may not show strong p-value metrics even though a variable is useful in a regularized GLM. Allstate also believes there are several other standard model evaluation techniques that, depending on the model, would be more appropriate than what is suggested in this information element. For example, deviance metrics, univariates, and one-way lift charts on a test or holdout dataset are currently considered traditional modeling best practices to assess the stability of a model. Allstate suggests removing this element from the white paper or, at a minimum, changing its level of importance to 4.	The importance has been changed from the prior level 1 to new level 3. Univariates and one-way lift charts are included in Information Element B.4.c. Information Element B.4.c remains a Level 2 item.
Milliman	B.4.c	For small books of business, requiring at least 10 quantiles in a lift chart could lead to unstable results. We suggest revising the language to clarify that fewer quantiles may be appropriate in certain situations.	Lift charts with at least 10 quantiles, even if they look less than ideal for small books of business, are still recommended. It may be helpful for the regulator to see both decile plots and additionally quantile plots with less than 10 bins to guide their final assessment. This has been added to the comments, "Decile plots may look less stable for small books of business. In these cases, it may be helpful to obtain additional lift charts with less than 10 quantiles."
Akur8	B.4.c	Recommended additional comment: It is expected that the fit relativity will be different than the observed relativity for RGLM as the fit relativity will be penalized towards the prior assumption or null relativity. These	The recommended commentary has been added

		differences can be evaluated through the lens of credibility: items with lower exposure are expected to differ more than levels with high exposure. Low credibility datasets may see less alignment between these values in general. This credibility view is most easily applied to ordinal and categorical variables and less easily applied to continuous variables as continuous variables may extrapolate to areas with low credibility.	
Allstate	B.5.b	Allstate notes that a comparison model is not always available, making this information element potentially inapplicable for review. In instances when a model for comparison is not available, traditional modeling techniques such as those referenced in information element B.4.a are helpful in assessing the predictiveness of the filed model.	The Comments state "This comparison is not applicable to initial model introduction." No changes were made to B.5.b.
Allstate	C.6.a	Allstate notes that the granularity of the suggested metric would often produce volatile results. Allstate recommends assigning a lower level of importance to this information element and suggests relying on other model support.	Level 4 is now assigned to this Information Element. Level 4 is assigned to the same corresponding Information Element in the original GLM Appendix B.
Allstate	C.7.d & C.7.e	Allstate would like to clarify that the suggested information elements are more applicable at a state level rather than a countrywide level. Insurers can provide rate impacts at a state level as part of a standard rate filing. Comparisons at a countrywide level are less valuable for a particular state, which will be more interested in how the model impacts their policyholders as well as indicated and selected factors. Allstate recommends clarifying the language in each information element to highlight state impacts rather than countrywide model impacts.	The following was added to the comments column of C.7.d and C.7.e, "This analysis is typically done at the state level."

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APPENDIX B-RGLM – INFORMATION ELEMENTS AND GUIDANCE FOR A REGULATOR TO MEET BEST PRACTICES' OBJECTIVES (WHEN REVIEWING REGULARIZED GENERALIZED LINEAR MODELS)

This appendix identifies the information a state insurance regulator may need to review a regularized general linear model used by an insurer to support a personal automobile or home insurance rating plan. Regularized Generalized Linear Models include lasso, derivative lasso, lasso credibility, ridge, elastic net, and accurate generalized linear models (AGLM). Other modeling approaches may fall within the category of regularized generalized linear models. The main distinguishing feature of regularized GLMs is that they have complexity penalty hyper parameter(s) (a.k.a. shrinkage factors) which put constraints on the model such that the coefficients are tempered from what they would be in a standard (unpenalized) Generalized Linear Model (GLM). Generally, if the complexity penalties in a regularized GLM are set to zero, the model indications will be identical to those achieved from a standard GLM. The list of information elements below 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.[1]

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.[2]

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

[1] 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.

[2] There are some models that are made public by the vendor and would not result in a hindrance of the model's protection.

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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-RGLM is focused on Regularized GLMs including lasso, derivative lasso, lasso credibility, ridge, elastic net, and accurate generalized linear models. This appendix should not be referenced in the review of other model types. This Appendix B-RGLM is intended to provide state guidance for the review of rate filings based on regularized GLMs.

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A. SELECTING MODEL INPUT

Section	Information Element	Level of Importance to the Regulator' s Review	Comments
1. Available Data Sources			
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	Request details of data sources, whether internal to the company or from external sources. For insurance experience (policy or claim), determine whether data are aggregated by calendar, accident, fiscal, or policy year and when it was last evaluated. For each data source, get a list of all data elements used as input to the model that came from that source. For insurance data, get a list all companies whose data is included in the datasets. Request details of any non-insurance data used (customer-provided or other), whether the data was collected by use of a questionnaire/checklist, whether data was voluntarily reported by the applicant, and whether any of the data is subject to the federal Fair Credit Reporting Act (FCRA). If the data is from an outside source, find out what steps were taken to verify the data was accurate, complete, and unbiased in terms of relevant and representative time frame, representative of potential exposures, and lacking in obvious correlation to protected classes. **Note**: 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.
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.

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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 explain why any states were excluded from the countrywide data. 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. The company should provide a demonstration that the model fits well on the specific state or surrounding region.
2. Sub-Models			
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.

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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 Regularized GLM; obtain the vendor name, as well as the name and version of the sub-model.	1	To accelerate the review of the filing, it may be desirable to request (from the company), the name and contact information for a vendor representative. The company should provide the name of the third-party vendor and a contact in the event the regulator has questions. The "contact" can be an intermediary at the insurer (e.g., a filing specialist), who can place the regulator in direct contact with a subject-matter expert (SME) at the vendor. Examples of such sub-models include credit/financial scoring algorithms and household composite score models. Sub-models can be evaluated separately and in the same manner as the primary model under evaluation. A sub-model contact for additional information should be provided. Sub-model SMEs may need to be brought into the conversation with regulators (whether in-house or third-party sub-models are used).
A.2.d	If using catastrophe model output, identify the vendor and the model settings/assumptions used when the model was run.	1	To accelerate the review of the filing, get contact information for the SME that ran the model and an SME from the vendor. The "SME" can be an intermediary at the insurer (e.g., a filing specialist), who can place the regulator in direct contact with the appropriate SMEs at the insurer or model vendor. For example, it is important to know hurricane model settings for storm surge, demand surge, and long-term/short-term views.
A.2.e	Obtain an explanation of how catastrophe models areintegrated into the model to ensure no double-counting.	1	If a weather-based sub-model is input to the Regularized GLM under review, loss data used to develop the model should not include loss experience associated with theweather-based sub-model. Doing so could cause distortions in the modeled results by double-counting such losses when determining relativities or loss loadsin the filed rating plan. For example, redundant losses in the data may occur when non-hurricane wind losses are included in the data while also using a severe convective storm model in the actuarial indication. Such redundancy may also occur with the inclusion of fluvial or pluvial flood losses when using a flood model or inclusion of freeze losses when using a winter storm model.
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.

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Section	Information Element	Level of Importance to the Regulator' s Review	Comments
3. Adjustments to Data			
A.3.a	Determine if premium, exposure, loss, or expense data were adjusted (e.g., on-leveled, 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	The rating plan or indications underlying the rating plan may provide special treatment of large losses and non-modeled large loss events. If such treatments exist, the company should provide an explanation how they were handled. These treatments need to be identified and the company/regulator needs to determine whether model data needs to be adjusted. For example, should large bodily injury (BI) liability losses in the case of personal automobile insurance be excluded, or should large non-catastrophe wind/hail claims in home insurance be excluded from the model's training, test and validation data? Look for anomalies in the data that should be addressed. For example, is there an extreme loss event in the data? If other processes were used to load rates for specific loss events, how is the impact of those losses considered? Examples of losses that can contribute to anomalies in the data are large losses or flood, hurricane, or severe convective storm losses for personal automobile comprehensive or home insurance. Premium should be brought to current rate level if the target variable is calculated with a premium metric, such as loss ratio. Premium can be brought to current rate level with the extension of exposures method or the parallelogram method. Note that the premium must be on-leveled at a granular variable level for each variable included in the new model if the parallelogram method is used. Statewide on-level factors by coverage are typically sufficient for statewide rate indication development but not sufficient for models that determine rates by variable level.
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	Pre-modeling binning may be unnecessary for ordinal variables in a lasso derivative or lasso credibility model, as the model will automatically set bins. Other regularized GLM approaches often group some variable levels with a base level during model fitting. However, if the insurer does bin variables or group levels before modeling, the reason should be understood.
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/binned/transformed/etc. data.	4	This is most relevant for variables that have been "scrubbed" or adjusted. Though most regulators may never ask for aggregated data and do not plan to rebuild any models, a regulator may ask for this aggregated data or subsets of it. It would be useful to the regulator if the percentage of exposures and premium for missing information from the model data by category are provided. This data can

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Section	Information Element	Level of Importance to the Regulator' s Review	Comments
			be displayed in either graphical or tabular formats.
A.3.d	Determine how missing data was handled.	1	This is most relevant for variables that have been "scrubbed" or adjusted. The regulator should be aware of assumptions the modeler made in handling missing, null, or "not available" values in the data. For example, it would be helpful to the reviewer if the modeler were to provide a statement as to whether there is any systemic reason for missing data. If adjustments or recoding of values were made, they should be explained. It may also be useful to the regulator if the percentage of exposures and premium for missing information from the model data are provided. This data can be displayed in either graphical or tabular formats.
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.
4. Data Organization			
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 descriptionOf 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
1. High-Level Narrative for Building the Model			
B.1.a	Identify the type of model underlying the rate filing (e.g., lasso regression, ridge regression, elastic net regression, etc). Understandthe model's role in the rating system and provide thereasons why that type of model is an appropriate choice for that role. Understand why a Regularized GLM is preferable to a standard GLM for the specific modeling exercise.	1	A main drawback of GLMs is assigning full credibility to the data, and a main benefit of penalized regression is the assignment of partial credibility to the data. The ability of RGLMs to help avoid overfitting through the assignment of partial credibility is expected to be a core reason for their adoption. It is important to understand if the model in question is a Regularized GLM and, therefore, these information elements are applicable; or if it is some other model type, in which case other reasonable review approaches may be considered. There should be an explanation of why themodel (using the variables included in it) is appropriatefor the line of business. If by-peril or by-coverage modeling is used, the explanation should be by- peril/by-coverage. When a company is using a regularized GLM, it is helpful to understand why a penalized model is preferable to a standard GLM (without penalties for model complexity). **Note**: If the model is not a Regularized GLM, the information elements in this white paper may not apply in their entirety.
B.1.b	Identify the credibility complement used (if applicable). Lasso credibility is an example of a regularized generalized linear model which contains a credibility complement. Discuss why the selected complement is reasonable.	1	Many regularized generalized linear models are analogous in concept to a credibility weighted approach. Predictor variable values with low data volume will often result in coefficients that are closer to the credibility complement. For many regularized linear models, the implied credibility complement for each parameter is 0. However, in lasso credibility an alternate complement of credibility can be set. The alternate complement of credibility might be based on something like the currently approved rating factors. The regulator should determine if the complement of credibility is reasonable for use since it is not driven by the latest data.
B.1.c	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.

Section	Information Element	Level of Importance to the Regulator' s Review	Comments
B.1.d	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 rebuiltusing 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.
B.1.e	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.f	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.g	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.h	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. Certain variables may not end up used in the final

Section	Information Element	Level of Importance to the Regulator' s Review	Comments
			model as some regularized GLM models (lasso, elastic net, etc.) will remove less significant variables.
B.1.i	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. In Derivative Lasso, AGLM, and similar techniques, the granularity of ordinal variables should avoid "pre-binning" that removes the algorithm's ability to define a breakpoint where there should be one. The bin width should consider the amount of exposures in each bin, in order to obtain credible bins. The number of bins may need to be constrained since an extremely large number of bins may be too computationally intensive.
B.1.j	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.
2. Medium-Level Narrative for Building the Model			
B.2.a	At crucial points in model development, if selectionswere made among alternatives regarding model assumptions or techniques, obtain a narrative on the judgment used to make those selections.	3	
B.2.b	If post-model adjustments were made to the data andthe 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

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			inquire about why a particular interaction term was excluded from a model—for example, if that interaction term was ubiquitous in similar filings and was known to be highly predictive, or if the regulator had reason to believe that the interaction term would help differentiate dissimilar risks within an excessively heterogenous rating segment.
B.2.d	For the Regularized GLM, identify the link function used. Identifywhich 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. Certain distribution assumptions will involve numerical parameters, for example a Tweedie assumed distribution will have a p power value. Obtain the specific numerical parameters associated with the distribution. If changed from the default, obtain a discussion of applicable convergence criterion.	1	Solving the Regularized GLM is iterative and the modeler can check to see if fit is improving. At some point, convergence occurs; however, when it occurs can be subjective or based on threshold criteria. If the software's default convergence criteria were not relied upon, an explanation of any deviation should be provided. If the Regularized GLM 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 include all coefficients necessary toevaluate the predicted pure premium, relativity, or other value, for any real or hypothetical set of inputs.	2	
B.2.f	If there were data situations in which 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.2.g	Obtain the value of any additional relevant model hyperparameter(s) other than the complexity parameter. Obtain an explanation on how they were chosen.	2	The complexity hyperparameter(s) are discussed in Information Element B.2.h. Some Regularized GLMs will have additional hyperparameters needed to fit the model. For example, certain smoothed terms in a GAM may require selecting a number of knots.
B.2.h	Obtain the value of the applicable model complexity hyperparameter(s) and an explanation on how it was chosen.	4	Regularized GLMs have model complexity hyperparameters which can materially impact the final model parameters. The value of the model complexity hyperparameter determines whether the model is close to a standard GLM or is significantly tempered. For most regularized GLMs, tuning of the hyperparameter to maximize GINI on test data or minimize deviance on test data would be appropriate methods. For the derivative lasso method, it may be useful to review the plots of coefficients to determine if there is enough grouping of variable levels to remove reversals between adjacent variable levels. The exact value of the penalty parameter holds no meaning without context. The reviewer should focus less on the value selected but instead confirm that the process of

Section	Information Element	Level of Importance to the Regulator' s Review	Comments
			selecting a value is sound.
B.2.i	Understand how the model would differ if different hyperparameter(s) were selected. Obtain a sensitivity analysis showing the coefficient output with higher and lower complexity hyperparameters or a plot showing coefficients by penalty value.	4	If the process for selecting a complexity hyperparameter(s) is sound, it is generally unnecessary to provide documentation on model results using alternative complexity hyperparameters. However, the regulator may want to scrutinize the hyperparameter more if the process for selecting a value does not seem sound. A regulator may decide they need more assurance that a reasonable value of complexity hyperparameter was selected. The regulator could ask for a sensitivity analysis showing how output model coefficients would differ if other hyperparameter values are used.
3. Predictor Variables			
B.3.a	Obtain a complete data dictionary, including the names, data types, definitions, and uses of each predictor variable, offset variable, control variable, proxy variable, geographic variable, geodemographicvariable, and all other variables in the model used ontheir own or as an interaction with other variables (including sub-models and external models).	1	Data types of variables might be continuous, discrete, ordinal, Boolean, etc. Definitions should not use programming language or code. For any variable(s) intended to function as a control or offset, obtain an explanation ofits purpose and impact. Also, for any use of interactionbetween 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 greatest reduction in mean square error on test data, this would be a far, far weaker case forstatistical significance than if that variable was the only one the company evaluated. **Note**: Context matters.
B.3.c	Obtain a correlation matrix for all predictor variables included in the model and sub-model(s).	3	While Regularized GLMs accommodate collinearity, the correlation matrix provides more information about the magnitude of correlation between variables. The company should indicate what statistic was used (e.g., Pearson, Cramer's V). The regulatory reviewer should understand what statistic was used to produce the matrix but should not prescribe the statistic.

Section	Information Element	Level of Importance to the Regulator' s Review	Comments
B.3.d	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	The explanation should go beyond demonstrating correlation. Considering possible causation may be relevant, but proving causation is neither practical nor expected. If no rational explanation can be provided, greater scrutiny may be appropriate. For example, the regulator should look for unfamiliar predictor variables and, if found, the regulator should seek to understand the connection that variable has to increasing or decreasing the target variable.
B.3.e	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 ofthe dimensionality reduction technique was used within the model.	2	
4. Adjusting Data, Model Validation, and Goodness-of-Fit Measures			
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	For models that are built using multistate data, validation data for some segments of risk is likely to have low credibility in individual states. Nevertheless, some regulators require model validation on state-only data, especially when analysis using state-only data contradicts the countrywide results. State-only data might be more applicable but could also be impacted by low credibility for some segments of risk. **Note**: It may be useful to consider geographic stability measures for territories within the state.

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B.4.b	For all variables, review the appropriate parameter values and relevant demonstrations of stability. Relevant demonstrations of stability may be provided as either plots by variable of indicated factors which also show upper bound and lower bound values (95th percentile and 5th percentile) on bootstrapped datasets, coefficient ranges across dataset folds, or p-values from a comparable standard GLM.	3	Statistical confidence intervals and p-values are often not available for Regularized GLMs. However, there are other ways to demonstrate model stability. The regulator should not prescribe one of these methods specifically, as they may be not applicable for some forms of RGLM. The model could be run 100+ times on bootstrapped datasets to determine the stability of model parameters. If the bootstrapped models produce a narrow range of coefficient values, this implies the model is stable. Extra scrutiny should apply if the range of coefficient values includes negative and positive values. If the bootstrapped models produce a wide range of coefficient values, this implies the model is less stable. The range could be represented visually for each predictor variable by showing a plot with predictor variable values on the X-axis, and three separate lines representing mean indicated factors, the 95th percentile factors, and the 5th percentile factors. If the model was built with k-fold cross validation, the range of coefficients could be reviewed in a similar fashion. Narrower ranges represent a more stable model. The results may be less meaningful if more than 20 folds were used, since each model run would be based on significantly similar datasets. Coefficient ranges could also be reviewed by year or by other dataset segments to assess model stability. Variable stability can also be approximated by looking at the p-values from a comparable standard GLM which contains the same predictor variables as the Regularized GLM in question.

B.4.c	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	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 Regularized GLM. The regulator should not assume to know what the company did and ask, "How?" Instead, the regulator should ask what the company did and be prepared to ask follow-up questions. For a Regularized GLM, such evidence may be available using observed vs. predicted average plots by variable and overall model lift charts. The regulator should ask for the company to provide exhibits or plots that show how the fitted average makes sense when compared to the observed average for variables of interest. Regulators would ideally review this comparison for every variable, but time constraints may limit the focus to just variables of interest. Variables of interest should include variables with high potential impacts on consumers (steep discounts or surcharges), variables without an intuitive relationship to loss, or variables that may be proxies for a protected class attribute. It is expected that the fit relativity will be different than the observed relativity for RGLM as the fit relativity will be penalized towards the prior assumption or null relativity. These differences can be evaluated through the lens of credibility: items with lower exposure are expected to differ more than levels with high exposure. Low credibility datasets may see less alignment between these values in general. This credibility view is most easily applied to ordinal and categorical variables and less easily applied to continuous variables as continuous variables may extrapolate to areas with low credibility. Lift charts such as quantile plots demonstrate the overall model fit. The risks in the modeling data are bucketed into quantiles with equal volume representing different levels of predicted risk. Quantile plots graph the predicted averages versus the observed averages by quantile. The quantile plots should have at least 10 quantiles to demonstrate predictive accuracy across different risk levels. Decile plots may look less stable for small books of business. In these cases, it may be helpful to obtain additional lift charts with less than 10 quantiles.
B.4.d	Obtain a description how the model was tested for stability over time.	2	Evaluate the build/test/validation datasets for potential time-sensitive model distortions (e.g., a winter storm in

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			year 3 of 5 can distort the model in both the testing and validation datasets). Obsolescence over time is a model risk (e.g., old data for a variable or a variable itself may no longer be relevant). If a model being introduced now is based on losses from years ago, the reviewer should be interested in knowing whether that model would be predictive in the proposed context. Validation using recent data from the proposed context might be requested. Obsolescenceis a risk even for a new model based on recent and relevant loss data. The reviewer may want to inquire as to the following: What steps, if any, were taken during modeling to prevent or delay obsolescence? What controls exist to measure the rate of obsolescence? What is the plan and timeline for updating and ultimately replacing the model? The reviewer should also consider that as newer technologies enter the market (e.g., personal automobile) their impact may change claim activity over time (e.g., lower frequency of loss). So, it is not necessarily a bad thing that the results are not stable over time.
B.4.e	Obtain a narrative on how potential concerns with overfitting were addressed.	2	
B.4.f	Obtain support demonstrating that the overall Regularized GLM assumptions are appropriate.	3	A visual review of plots of actual errors is usually sufficient. The reviewer should look for a conceptual narrative covering these topics: How does this particular Regularized GLM work? Why did the rate filer do what it did? Why employ this design instead of alternatives? Why choose this particular distribution function and this particular link function? A company response may be at a fairly high level and reference industry practices. If the reviewer determines that the model makes no assumptions that are considered to be unreasonable, the importance of this item may be reduced.
B.4.g	Obtain 5-10 sample records with corresponding output from the model for those records.	4	
5. "Old Model" Versus "New Model"			
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	2	The regulator should expect to see improvement in the new class plan's predictive ability or other sufficient reason for the change.

Section	Information Element	Level of Importance to the Regulator' s Review	Comments
	for an explanation of any changes in calculations, assumptions, parameters, and data used to build this model from the previous model.		
B.5.b	Determine if two Lorenz curvers or Gini coefficients were compared and obtain a narrative on the conclusion drawn fromthis comparison.	3	This information element requests a comparison of the Lorenz curve and Gini coefficient from the prior model to the Gini coefficient of proposed model. It is expected that thereshould be improvement in the Gini coefficient.A higher Gini coefficient indicates greater differentiation produced by the model and how well themodel fits that data. This is relevant when one model is being updated or replaced. The regulator should expect to see improvement in the new class plan's predictive ability. One example of a comparison might be sufficient. **Note**: This comparison is not applicable to initial model introduction. Reviewer can look toCAS 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. **Note**: "Not applicable" is an acceptable response.
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.5.e	If using a credibility complement, obtain variable plots which visualize the credibility complement and the model indicated as separate lines. Lasso credibility is an example of a regularized generalized linear model which contains a credibility complement.	2	It is useful to see the coefficients as originally specified in the credibility complement, and how the model indicates these initially set coefficients should change based on the modeling data. These changes can be visualized as relativity plots that show complement relativity (initially set coefficients), indicated relativity (complement of credibility combined with modeled relativity), target relativity, and data volume (shown on a secondary axis). The combination of these four elements makes relativity plots a helpful tool for review of RGLM which has a credibility complement. The regulator should determine if the change from complement relativity to indicated relativity appears directionally appropriate based on the model target relativities and if the magnitude of the change appears reasonable.
6. Modeler Software			
B.6.a	Request access to SMEs (e.g., modelers) who led the project, compiled the data, and/or built the	4	The filing should contain a contact that can put the regulator in touch with appropriate SMEs and key

Section	Information Element	Level of Importance to the Regulator' s Review	Comments
	model.		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
1. General Impact of Model on Rating Algorithm			
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 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 inputto 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.

Section	Information Element	Level of Importance to the Regulator' s Review	Comments
2. Relevance of Variables and Relationship to Risk of Loss			
C.2.a	Obtain a narrative regarding how the character-istics/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. **Note**: This explanation would not be needed if the connection between variables and risk of loss (or expense) has already been illustrated.
3. Comparison of Model Outputs to Current and Selected Rating Factors			
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. **Note**: This information is especially important if differences between model-indicated values and selected values are material and/or impact one consumer population more than another.
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.
4. Responses to Data, Credibility, and Granularity Issues			
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.

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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.
5. Definitions of Rating Variables			
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.
6. Supporting Data			
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.	4	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
7. Consumer Impacts			
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 toindividual consumers.	2	This analysis is typically done at the state level. 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	This analysis is typically done at the state level. See Appendix D for an example of an exposure distribution.

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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	Some examples of "static" policy characteristics are prior carrier tenure, prior carrier type, prior liability limits, claim history over past X years, or lapse of coverage. These are specific policy characteristics usually set at the time new business is written, used to create an insurance score or to place the business in a rating/underwriting tier, and often fixed for the life of the policy. The reviewer should be aware, and possibly concerned,how the company treats an insured over time when theinsured'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. 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.
C.7.g	Obtain a means to calculate the rate chargeda consumer.	3	The filed rating plan should contain enough information for a regulator to be able to validate policy premium. However, for a complex model or rating plan, a score or premium calculator via Excel or similar means would be ideal, but this could be elicited on a case-by-case basis. The ability to calculate the rate charged could allow the regulator to perform sensitivity testing when there are small changes to a risk characteristic/variable. **Note**: This information may be proprietary. For the rating plan, the rate order of calculation rule may be sufficient. However, it may not be feasible for a regulator to get all the input data necessary to reproduce a model's output. Credit and telematics models are examples of model types where model output would be readily available, but the input data would not be readily available to the regulator.
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 toinquire as to how consumers can verify their data and correct errors.	1	If the data is from a third-party source, the company should provide information on the source. Depending on the nature of the data, it may need to be documented with an overview of who owns it. The topic of consumer verification may also need to be addressed, including how consumers can verify their data and correct errors.

Section	Information Element	Level of Importance to the Regulator' s Review	Comments
8. Accurate Translation of Model into a Rating Plan			
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 anyadjustments 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.
9. Efficient and Effective Review of Rate Filing			
C.9.a	Establish procedures to efficiently review rate filings and models contained therein.	1	"Speed to market" is an important competitive concept for insurers. Although the regulator needs to understand the rate filing before accepting the rate filing, the regulator should not request information that does not increase his/her understanding of the rate filing. The regulator should review the state's rate filing review process and procedures to ensure that they are fair and efficient.
C.9.b	Be knowledgeable of state laws and regulationsin 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.

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Actuarial Opinion (C) Working Group
Virtual Meeting
October 21, 2024

The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Oct. 21, 2024. The following Working Group members participated: Miriam Fisk, Chair (TX); Julie Lederer, Vice Chair (MO); Susan Gozzo Andrews (CT); David Christhilf (DC); Chantel Long (IL); Sandra Darby (ME); and Tom Botsko (OH). Also participating was: Rebecca Armon (TX).

1. Adopted the Regulatory Guidance

The Regulatory Guidance document was exposed for a 21-day public comment period ending Oct. 14. No comments were received. Fisk proposed a change to clarify reporting of unearned premium reserves on P&C long duration contracts is required in the exhibit, whether or not the amount is material.

Andrews made a motion, seconded by Long, to adopt the *Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2024* (Regulatory Guidance) (Attachment Two-A). The motion passed unanimously.

2. Discussed Instructions for the Actuarial Opinion

Fisk said the Task Force should modify instructions to clarify when reporting in the exhibits is required and continue research on Exhibit B, Line 10.

Regarding long duration contract premium reserves, Lederer expressed concerns about eliminating wording that relates to opining on both gross and net reserves. Regulators expect the reserves be entered in Exhibit A, but those reserves are only in the scope of the opinion if the actuary finds them to be material. All other amounts in Exhibit A are automatically included in the scope, regardless of materiality.

Michelle Iarkowski (American Academy of Actuaries—Academy) said there is still question whether these long duration premium amounts should be reported in the opinion because they do not tie directly to amounts in the annual statement. Fisk said there is a column for unearned premium in excess of a year in the annual statement, but that definition is slightly different than the definition in the opinion instructions; so the numbers do not necessarily tie. Andrews said she is normally able to match the net numbers, but Iarkowski said that will not always be the case. Fisk agreed that if the number is important enough to opine on, then it should be tied to the annual statement. Regulators will continue discussion at its next meeting.

Fisk said she researched why there is reporting of the net reserves for losses and loss adjustment expenses for the company's share of voluntary and involuntary underwriting pools and associations. She said this was added in 1992 because regulators noticed in 1991 opinions, that actuaries remarked they could not review reserves for the company's share of losses or expenses from underwriting pools and associations since underlying data is not available. With the disclosure required, actuaries were able to obtain this information. In following years there was some mention that these pools were providing opinions. However, Fisk questioned how this occurred when some do not have NAIC company codes. The Working Group will continue to discuss whether this requirement is still needed in the actuarial opinions. Long said she discussed this with Illinois financial examiners who thought these amounts were likely immaterial for a majority of companies. These examiners said they would not likely

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look for this information during financial examinations. Iarkowski said the actuarial standards have advanced since then and actuaries are required to disclose if they could not get information needed.

Iarkowski said another question is what should be reported on the claims made extended loss and loss adjustment expenses because verification of those numbers are that the amount should be greater than or equal to the Schedule P Interrogatories.

Fisk said the Working Group will continue to discuss these issues.

Having no further business, the Actuarial Opinion (C) Working Group adjourned.

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REGULATORY GUIDANCE on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2024

Prepared by the NAIC Actuarial Opinion (C) Working Group
of the Casualty Actuarial and Statistical (C) Task Force

The NAIC Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force believes that the Statement of Actuarial Opinion (SAO), Actuarial Opinion Summary (AOS), and Actuarial Report are valuable tools in serving the regulatory mission of protecting consumers. This regulatory guidance document supplements the NAIC *Annual Statement Instructions—Property/Casualty* (Instructions) to provide clarity and timely guidance to companies and Appointed Actuaries with regulatory expectations on the SAO, AOS, and Actuarial Report.

An Appointed Actuary has a responsibility to know and understand both the Instructions and the expectations of state insurance regulators. One expectation of regulators clearly presented in the Instructions is that the SAO, AOS, and supporting Actuarial Report and work papers be consistent with relevant Actuarial Standards of Practice (ASOPs). Although it is the responsibility of the Appointed Actuary to identify the applicable ASOPs, the Appointed Actuary may find it useful to review the *Applicability Guidelines for Actuarial Standards of Practice* published by the Actuarial Standards Board (ASB).

The 2024 Instructions have been modified to require the Appointed Actuary provide qualification documentation to the Board of Directors only at initial appointment and not annually thereafter.

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I. General Comments

A. Reconciliation Between Documents

If there are any differences between the values reported in the Statement of Actuarial Opinion (SAO), Actuarial Opinion Summary (AOS), Actuarial Report, and the annual statement, the Actuarial Opinion (C) Working Group expects Appointed Actuaries to include an explanation for these differences in the appropriate document, i.e., the SAO, AOS, or Actuarial Report. The use of a robust peer review process by the Appointed Actuary should reduce reporting errors and non-reconciling items.

One situation in which a legitimate difference might arise is in the case of non-tabular discounting, i.e., the direct and assumed loss reserves on line 3 of the SAO's Exhibit A come from Schedule P, Part 1, which is gross of non-tabular discounting, while the Actuarial Report and AOS might present the direct and assumed loss reserves on a net of discounting basis.

B. Role of Illustrative Language in the Instructions

While the *Annual Statement Instructions—Property/Casualty* (Instructions) provide some illustrative language, the Working Group encourages Appointed Actuaries to use whatever language they believe is appropriate to clearly convey their opinion and the basis for that opinion. In forming their opinion, Appointed Actuaries should consider company-specific characteristics (e.g., intercompany pooling arrangements; recent mergers or acquisitions; and significant changes in operations, product mix, or reinsurance arrangements).

C. Qualification Documentation

Starting with the 2019 Instructions, the Appointed Actuary was required to provide qualification documentation to the Board of Directors upon initial appointment and annually thereafter. The 2024 Instructions have been amended to require the Appointed Actuary to provide qualification documentation to the Board of Directors only upon initial appointment and eliminate the requirement to provide the documentation annually thereafter.

The documentation provided to the Board of Directors must be available to the state insurance regulator upon request and during a financial examination. Guidance on qualification documentation is in Section IV of this document.

D. Replacement of an Appointed Actuary

The Instructions require two letters when the Board of Directors replaces an Appointed Actuary: 1) one addressed from the insurer to the domiciliary commissioner and 2) one addressed from the former Appointed Actuary to the insurer. The insurer must provide both letters to the domiciliary commissioner.

The detailed steps are as follows:

1. Within five business days, the insurer shall notify its domiciliary commissioner that the former Appointed Actuary has been replaced.
2. Within 10 business days of the notification in step 1, the insurer shall provide the domiciliary commissioner with a letter stating whether there were disagreements with the former Appointed Actuary in the 24 months preceding the replacement. The Instructions describe the types of disagreements required to be reported in the letter.
3. Within the same 10 business days referred to in step 2, the insurer shall request in writing that the former Appointed Actuary provide a letter addressed to the insurer stating whether the former Appointed Actuary agrees with the statements contained in the insurer's letter referenced in step 2.
4. Within 10 business days of the request from the insurer described in step 3, the former Appointed Actuary shall provide a written response to the insurer.
5. The insurer shall provide the letter described in step 2 and the response from the former Appointed Actuary described in step 4 to the domiciliary commissioner.

Regarding the disagreements referenced in step 2, state insurance regulators understand that there may be disagreements between the Appointed Actuary and the insurer during the course of the Appointed Actuary's analysis that are resolved by the time the Appointed Actuary concludes the analysis. For instance, the Appointed Actuary's analysis may go through several iterations, and an insurer's comments on the Appointed Actuary's draft Actuarial Report may prompt the Appointed

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Actuary to make changes to the report. While state insurance regulators are interested in material disagreements regarding differences between the former Appointed Actuary's final estimates and the insurer's carried reserves, they do not expect notification on routine discussions that occur during the course of the Appointed Actuary's work.

E. Reporting to the Board of Directors

The Appointed Actuary is required to report to the insurer's Board of Directors every year, and the Instructions were amended in 2016 to require that the minutes of the Board of Directors specify the manner in which the Appointed Actuary presents the required information. This may be done in a form chosen by the Appointed Actuary, including, but not limited to, an executive summary or PowerPoint presentation. The Working Group strongly encourages the Appointed Actuary to present their analysis in person so the risks and uncertainties that underlie the exposures and the significance of the Appointed Actuary's findings can be adequately conveyed and discussed. Regardless of how the Appointed Actuary presents their conclusions, the Actuarial Report must be made available to the Board.

Management is limited to reporting single values on lines 1 and 3 of the Liabilities, Surplus, and Other Funds page of the balance sheet. However, actuarial estimates are uncertain by nature and point estimates do not convey the variability in the projections. Therefore, the Board of Directors should be made aware of the Appointed Actuary's opinion regarding the risk of material adverse deviation, the sources of risk, and what amount of adverse deviation the Appointed Actuary judges to be material.

F. Requirements for Pooled Companies

Effective with the 2014 Instructions, requirements for companies that participate in intercompany pools are as follows:

For all intercompany pooling members:

- Text of the SAO should include the following:
  - Description of the pool.
  - Identification of the lead company.
  - A listing of all companies in the pool, their state of domicile, and their respective pooling percentages.
- Exhibits A and B should represent the company's share of the pool and reconcile to the financial statement for that company.

For intercompany pooling members with a 0% share of the pooled reserves:

- Text of the SAO should be similar to that of the lead company.
- Exhibits A and B should reflect the 0% company's value.
  - Response to Exhibit B, Item 5 (materiality standard) should be $0.
  - Response to Exhibit B, Item 6 (risk of material adverse deviation) should be "not applicable."
- Exhibits A and B of the lead company should be filed with the 0% company's SAO.
- Information presented in the AOS should be that of the lead company.

Note the distinction between pooling with a 100% lead company with no retrocession and ceding 100% via a quota share reinsurance agreement. The state insurance regulator must approve these affiliate agreements as either an intercompany pooling arrangement or a quota share reinsurance agreement. The proper financial reporting is dependent on the approved filings, regardless of how company management regards its operating platform.

For intercompany pooling members with a greater than 0% share of the pooled reserves, state insurance regulators encourage the Appointed Actuary to display values in the AOS on a pooled (or consolidated) basis in addition to the statutory entity basis. This can be accomplished by displaying two tables of information.

G. Explanation of Adverse Development

1. Comments on Unusual Insurance Regulatory Information System Ratios in the Statement of Actuarial Opinion

   The Appointed Actuary is required to provide comments in the SAO on factors that led to unusual values for Insurance Regulatory Information System (IRIS) ratios 11, 12, or 13. The Working Group considers it insufficient to attribute unusual reserve development to "reserve strengthening" or "adverse development," and it expects the

Appointed Actuary to provide insight into the company-specific factors that caused the unusual value. Detailed documentation should be included in the Actuarial Report to support statements provided in the SAO.

2. Comments on Persistent Adverse Development in the Actuarial Opinion Summary

The Appointed Actuary is required to comment on persistent adverse development in the AOS. Comments can reflect common questions state insurance regulators have, such as:

- Is development concentrated in one or two exposure segments, or is it broad across all segments?
- How does development in the carried reserve compare to the change in the Appointed Actuary's estimate?
- Is development related to specific and identifiable situations that are unique to the company?
- Does the development or the reasons for development differ depending on the individual calendar or accident years?

H. Revisions

The Instructions contain a detailed definition of what it means for the SAO or AOS to be "in error," along with a description of steps the company and Appointed Actuary should take in that situation.

Even if the SAO or AOS does not meet the Instructions' specific definition of "in error," submitting a revised SAO or AOS might be appropriate or recommended in other situations. It would be prudent for the company to contact the state insurance regulator if mistakes or problems are discovered but do not meet the specific definition of "in error."

A revised SAO or AOS should clearly state that it is an amended document, and it should contain or accompany an explanation for the revision and include the date of revision.

II. Comments on the Statement of Actuarial Opinion and Actuarial Report

A. Review Date

The illustrative language for the Scope paragraph includes "… and reviewed information provided to me through XXX date." This is intended to capture the *Actuarial Standard of Practice (ASOP) No. 36*, *Statements of Actuarial Opinion Regarding Property/Casualty Loss, Loss Adjustment Expense , or Other Reserves*, requirement to disclose the date through which material information known to the Appointed Actuary is included in forming the reserve opinion, i.e., the review date.

B. Reconciliation

The Instructions state that the Scope paragraph of the SAO should include statements regarding the data used by the Appointed Actuary in forming the opinion. The illustrative language includes "I also reconciled that data to Schedule P, Part 1 of the Company's current Annual Statement."

Regulators understand that others not within the Appointed Actuary's control may perform the reconciliation of data to Schedule P. In these cases, the Working Group encourages the Appointed Actuary to identify who performed the reconciliation and confirm that the Appointed Actuary reviewed the reconciliation for reasonableness.

Guidance on the substance of the Schedule P reconciliation is included in Section II.J.1 of this document.

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C. Making Use of Another's Work

If the Appointed Actuary makes use of the work of another not within the Appointed Actuary's control for a material portion of the reserves, the Instructions note that the Appointed Actuary must provide the following information in the SAO:

- The person's name.
- The person's affiliation.
- The person's credential(s) if the person is an actuary.
- A description of the type of analysis performed if the person is not an actuary.

The Working Group encourages the Appointed Actuary to disclose whether they reviewed the other's underlying analysis and, if so, the extent of the review (i.e., the methods and assumptions used and the underlying arithmetic calculations) and their conclusions from the review.

Section 3.4.4 of ASOP No. 36 describes items the actuary should consider when determining whether it is reasonable to use another party's analysis or opinion. One of these items is the amount of the reserves covered by the other's analysis or opinion in comparison to the total reserves subject to the actuary's opinion. The Working Group encourages the Appointed Actuary to disclose these items in the SAO by providing the dollar amount of the reserves covered by the other's analysis or opinion and the percentage of the total reserves subject to the Appointed Actuary's opinion that these other reserves represent.

D. Points A and B of the Opinion Paragraph When Opinion Type Is Other Than "Reasonable"

State insurance regulators encourage Appointed Actuaries to think about their responses to point A—meet the requirements of the insurance laws of the state—and point B—computed in accordance with accepted actuarial standards—of the Opinion paragraph when they issue an SAO of a type other than "Reasonable."

E. Conclusions on a Net Versus a Direct and Assumed Basis

Unless the Appointed Actuary states otherwise, state insurance regulators will assume that the Appointed Actuary's conclusion on the type of opinion rendered, provided in points C and D of the Opinion paragraph, applies to both the net and the direct and assumed reserves. If the Appointed Actuary reaches different conclusions on the net versus the direct and assumed reserves, the Appointed Actuary should include narrative comments to describe the differences and clearly convey a complete opinion. The response to Exhibit B, Item 4 should reflect the Appointed Actuary's opinion on the net reserves.

Similarly, the materiality standard in Exhibit B, Item 5, and the Risk of Material Adverse Deviation (RMAD) conclusion in Exhibit B, Item 6, should pertain to the net reserves. If the Appointed Actuary reaches a different conclusion on the risk of material adverse deviation in the net versus the direct and assumed reserves, the Appointed Actuary should include a Relevant Comments paragraph to address the differences. State insurance regulators understand that a net versus a direct and assumed RMAD will have different meanings and, potentially, different materiality standards.

F. Unearned Premium for Property/Casualty Long-Duration Contracts

Exhibit A, Items 7 and 8, require disclosure of the unearned premium reserve for property/casualty (P/C) long-duration contracts. These amounts should be disclosed regardless of whether the Appointed Actuary deems the amounts immaterial. The Instructions require the Appointed Actuary to include a point D in the Opinion paragraph regarding the reasonableness of the unearned premium reserve when these reserves are material.

The Working Group expects that the Appointed Actuary will include documentation in the Actuarial Report to support a conclusion on reasonableness whenever point D is included in the SAO. This documentation may include the three tests of *Statement of Statutory Accounting Principles (SSAP) No. 65—Property and Casualty Contracts* or other methods deemed appropriate by the Appointed Actuary to support their conclusion.

If the P/C Long Duration Unearned Premium Reserves on lines 7 or 8 of Exhibit A are non-zero, but the Appointed Actuary deems the amounts immaterial and is not issuing an opinion on these amounts, the Appointed Actuary should consider

making this clear by including comments in the SCOPE, OPINION, and/or RELEVANT COMMENTS sections of the opinion. For example, if the Appointed Actuary is only opining on loss and loss adjustment expense reserves, the Appointed Actuary might use the following language in the SCOPE paragraph: "I have examined the actuarial assumptions and methods used in determining loss and loss adjustment expense 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." The Appointed Actuary might also use the following language in the OPINION paragraph: "In my opinion, the loss and loss adjustment expense reserves carried in Exhibit A: […]" In a RELEVANT COMMENT paragraph, the Appointed Actuary might say something like the following: "The P/C Long Duration Unearned Premium Reserves are not material. I therefore relied on the Company for its representation of the reasonableness of the P&C Long Duration Unearned Premium Reserves."

G. Other Premium Reserve Items

Regarding "Other Premium Reserve Items" in Exhibit A, Item 9, the Appointed Actuary should include an explanatory paragraph about these premium reserves in Relevant Comments and state whether the amounts are material or immaterial. If the amounts are material and the Appointed Actuary states that the amounts are reasonable in an Opinion paragraph, state insurance regulators would expect the actuarial documentation to support this conclusion in the Actuarial Report.

Typical items state insurance regulators see listed as other premium reserve items are medical professional liability death, disability, and retirement (DD&R) unearned premium reserves (UPRs) and other liability claims. Depending on the nature of these exposures, these items may be also listed on Exhibit B, Line 12.2, as claims made extended UPRs.

H. The Importance of Relevant Comments Paragraphs

The Working Group considers the Relevant Comments paragraphs to be the most valuable information in the SAO. Relevant Comments help the state insurance regulator interpret the SAO and understand the Appointed Actuary's reasoning and judgment. In addition to the required Relevant Comments, the Appointed Actuary should consider providing information on other material items, such as reinsurance with affiliates, mergers or acquisitions, other premium reserves, and catastrophe risk.

I. Risk of Material Adverse Deviation

The Relevant Comments paragraphs on the RMAD are particularly useful to state insurance regulators. The first two RMAD comments below respond to questions that Appointed Actuaries have posed to state insurance regulators. The second two stem from state insurance regulators' reviews of SAOs.

1. No Company-Specific Risk Factors—The Appointed Actuary is asked to discuss company-specific risk factors regardless of the RMAD conclusion. If the Appointed Actuary does not believe there are any company-specific risk factors, the Appointed Actuary should state that.

2. Mitigating Factors—State insurance regulators generally expect Appointed Actuaries to comment on significant company-specific risk factors that exist prior to the company's application of controls or use of mitigation techniques. The company's risk management behaviors may, however, affect the Appointed Actuary's RMAD conclusion.

3. Consideration of Carried Reserves, Materiality Standard, and Reserve Range When Making Risk of Material Adverse Deviation Conclusion—When deciding whether RMAD exists, the Appointed Actuary should consider the materiality standard in relation to the range of reasonable estimates and the carried reserves. For example, RMAD should likely exist when the sum of the materiality standard plus the carried reserves is within the range of reasonable estimates. Regardless, the Appointed Actuary should support the conclusion of whether RMAD exists.

4. Materiality Standards for Intercompany Pool Members—With the exception of intercompany pooling members that retain a 0% share, each statutory entity is required to have a separate SAO with its own materiality standard. Where there are no unusual circumstances to consider, it may be acceptable to determine a standard for the entire pool and assign each member its proportionate share of the total. It is not appropriate to use the entire amount of the materiality threshold for the pool as the standard for each individual pool member.

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J. State Insurance Regulators' Use of the Actuarial Report

State insurance regulators should be able to rely on the Actuarial Report as an alternative to developing their own independent estimates. A well-prepared and well-documented Actuarial Report that complies with *ASOP No. 41, Actuarial Communications*, can provide a foundation for efficient reserve evaluation during a statutory financial examination. This expedites the examination process and may provide cost savings for the company.

1. Schedule P Reconciliation

The Working Group acknowledges that myriad circumstances (e.g., mergers, acquisitions, changes in claim systems, and the use of underwriting year data in the analysis) may make it difficult for the Appointed Actuary to reconcile the analysis data to Schedule P. The Working Group encourages Appointed Actuaries to disclose reconciliation issues in the Actuarial Report. If the data cannot be reconciled, the Appointed Actuary should document the reasons.

The Working Group believes:

- A summary reconciliation that combines all years and all lines is an insufficient demonstration of data integrity. A reconciliation should include enough detail to reflect the segmentation of exposures used in the reserve analysis, the accident years of loss activity, and the methods used by the Appointed Actuary. While it is important that the Appointed Actuary is provided with complete and accurate data, reconciling the data **provided** to the Appointed Actuary to Schedule P is not sufficient to demonstrate that the data **used** by the Appointed Actuary reconciles to Schedule P. It is important for the Appointed Actuary to demonstrate that in the process of performing the actuarial analysis, data was neither created nor destroyed. This is commonly accomplished by showing a clear mapping from the Appointed Actuary's analysis exhibits to the actuarial data shown in the Schedule P reconciliation.
- The Appointed Actuary should map the data groupings used in the analysis to Schedule P lines of business and provide detailed reconciliations of the data at the finest level of segmentation that is possible and practical. The Working Group recognizes that the Appointed Actuary chooses the data segmentation for the analysis, and there is often not a direct correspondence between analysis segments and Schedule P lines of business.
- The Appointed Actuary should reconcile all data material to the analysis, including claim counts and earned premium if appropriate. If the Appointed Actuary chooses not to reconcile certain data elements used in the analysis, such as claim counts, a brief explanation should be included in the Actuarial Report to make it clear that these elements were not inadvertently overlooked.
- Schedule P reconciliations are expected to be performed on both a direct and assumed basis and a net of reinsurance basis. If circumstances specific to the company lead the Appointed Actuary to perform the reconciliation on only one basis, the rationale for this decision should be explained in the Actuarial Report. Similarly, while the reconciliation of the loss-related elements, such as defense and cost containment and adjusting and other expenses, is generally expected to be on the same level as used in the analysis underlying the SAO, the Appointed Actuary has the discretion to deviate as long as the rationale is explained in the Actuarial Report.
- The Instructions require that the Appointed Actuary include an explanation for any material differences in the Schedule P reconciliation. When differences appear in the reconciliation but are viewed as immaterial by the Appointed Actuary, the Appointed Actuary should acknowledge the immateriality of the differences in the Actuarial Report in order to assure state insurance regulators that the Appointed Actuary is aware of the differences and has considered the potential impact of the differences on the analysis underlying the SAO.

The Working Group draws a distinction between two types of data checks:

- The Schedule P reconciliation performed by the Appointed Actuary to show the user of the Actuarial Report that the data significant to the Appointed Actuary's analysis ties to the data in Schedule P.
- Annual testing performed by independent certified public accountants (CPAs) to verify the completeness and accuracy of the data in Schedule P or the analysis data provided by the company to the Appointed Actuary.

One key difference is that independent CPAs generally apply auditing procedures to loss and loss adjustment expense activity that occurred in the current calendar year (e.g., tests of payments on claims for all accident years that were paid during the current calendar year). Projection methodologies used by Appointed Actuaries, on the other hand,

often use cumulative loss and loss adjustment expense data, which may render insufficient testing of activity during the current calendar year alone.

Along similar lines, state insurance regulators encourage Appointed Actuaries to consider whether a reconciliation of incremental payments during the most recent calendar year for all accident/report years combined provides sufficient assurance of the integrity of the data used in the analysis, given that development factors are generally applied to cumulative paid losses by accident/report year.

2. Change in Estimates

The Working Group expects the Appointed Actuary to discuss any significant change in the Appointed Actuary's total estimates from the prior Actuarial Report. However, an explanation should also be included for any significant fluctuations within accident years or segments. When preparing the change-in-estimates exhibits, the Appointed Actuary should choose a level of granularity that provides meaningful comparisons between the prior and current year's results.

3. Narrative

The narrative section of the Actuarial Report should clearly convey the significance of the Appointed Actuary's findings and conclusions, the uncertainty in the estimates, and any differences between the Appointed Actuary's estimates and the carried reserves.

4. Support for Assumptions

Appointed Actuaries should support their assumptions. The use of phrases like "actuarial judgment," either in the narrative comments or in exhibit footnotes, is not sufficient. A descriptive rationale is needed.

The selection of expected loss ratios could often benefit from expanded documentation. When making their selection, Appointed Actuaries should consider incorporating rate changes, frequency and severity trends, and other adjustments needed to on-level the historical information. Historical loss ratio indications have little value if items, such as rate actions, tort reform, schedule rating adjustments, or program revisions, have materially affected premium adequacy.

5. Support for Roll-Forward Analyses

The Working Group recognizes that most of the analysis supporting an SAO may be done with data received prior to year-end and "rolled forward" to year-end. By reviewing the Actuarial Report, the state insurance regulator should be able to clearly identify why the Appointed Actuary made changes in the ultimate loss selections and how those changes were incorporated into the final estimates. A summary of final selections without supporting documentation is not sufficient.

K. Exhibits A and B

1. Data Capture Format

The term "data capture format" in Exhibits A and B of the Instructions refers to an electronic submission of data in a format usable for computer queries. This process allows for the population of an NAIC database that contains qualitative information, and financial data Appointed Actuaries should assist the company in accurately completing the electronic submission.

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2. Scope of Exhibit B, Item 12

Exhibit B, Item 12, requests information on extended loss and unearned premium reserves for all P/C lines of business, not just medical professional liability. The Schedule P Interrogatories referenced in the parenthetical only address reserves associated with yet-to-be-issued extended reporting endorsements offered in the case of DD&R of an individual insured under a medical professional liability claims-made policy.

3. Exhibit B, Item 13

The Working Group added disclosure item Exhibit B, Item 13, in 2018. This item requests information on reserves associated with accident and health (A&H) long-duration contracts, defined in the Instructions as "A&H contracts in which the contract term is greater than or equal to 13 months, and contract reserves are required."

This disclosure item was added for several reasons:

- **A desire by state insurance regulators to gain a greater understanding of P/C insurers' exposure to A&H long-duration contracts.**
  - This guidance does not specify how P/C insurers should report the liabilities associated with A&H long-duration contracts on the annual statement. Through work performed on financial examinations, state insurance regulators have found that P/C insurers may include the liabilities in various line items of the Liabilities, Surplus and Other Funds page. *SSAP No. 54—Individual and Group Accident and Health Contracts* provides accounting guidance for insurers.
  - Regardless of where the amounts are reported on the annual statement, the materiality of the amounts, and whether the insurer is subject to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51), the Appointed Actuary should disclose the amounts associated with A&H long-duration contracts on Exhibit B, Item 13. The Appointed Actuary should provide commentary in a relevant comments paragraph in accordance with paragraph 6.C of the Instructions. The Appointed Actuary should also disclose all reserve amounts associated with A&H long-duration contracts in the Actuarial Report.

- **The adoption of AG 51 in 2017.** On Aug. 9, 2017, the NAIC's Executive (EX) Committee and Plenary adopted AG 51 requiring stand-alone asset adequacy analysis of long-term care (LTC) business. The text of AG 51 is included in the March 2019 edition of the NAIC's *Accounting Practices and Procedures Manual* (AP&P Manual). The effective date of AG 51 was Dec. 31, 2017, and it applies to companies with over 10,000 in-force lives covered by long-term care insurance (LTCI) contracts as of the valuation date. The Instructions state that the Actuarial Report and workpapers summarizing the asset adequacy testing (AAT) of LTC business must comply with AG 51 requirements.

- **Recent adverse reserve development in LTC business.** State insurance regulators expect Appointed Actuaries to disclose company-specific risk factors in the SAO. Given the recent adverse experience for LTC business, Appointed Actuaries should consider whether exposure to A&H long-duration contracts poses a risk factor for the company.

The Appointed Actuary is not asked to opine on the reasonableness of the reserves associated with A&H long-duration contracts except to the extent that the reserves are included within the amounts reported on Exhibit A of the SAO. For this reason, the Working Group intentionally excluded Items 13.3 and 13.4 from this sentence in paragraph 4 of the Instructions: "The Appointed Actuary should state that the items in the SCOPE, on which they is expressing an opinion, reflect Disclosure items 8 through 13.2 in Exhibit B." Exhibit B, Item 13.1, asks the Appointed Actuary to disclose the reserves for A&H long-duration contracts that the company carries on the Losses line of the Liabilities, Surplus, and Other Funds page. The Appointed Actuary is not asked to opine on the reasonableness of the reserves disclosed on Exhibit B, Item 13.1, in isolation, but these reserves are a subset of the amount included on Exhibit A, Item 1, and Exhibit A lists amounts with respect to which the Appointed Actuary is expressing an opinion. The same is true for Exhibit B, Item 13.2, whose reserves are a subset of the amount included on Exhibit A, Item 2.

A&H long-duration contracts are distinct from P/C long-duration contracts. There were no changes to the opinion requirements in 2018 regarding P/C long-duration contracts, but the Working Group added a reference to SSAP No. 65 in the definition of P/C long-duration contracts to clarify the difference between A&H long-duration contracts and P/C long-duration contracts. The newly-added mention of SSAP No. 65 in the Instructions is not intended to change

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the Appointed Actuary's treatment of P/C long-duration contracts in the SAO or the underlying analysis, but insurers and Appointed Actuaries may refer to SSAP No. 65, paragraphs 21 through 33, for a description of the three tests, a description of the types of P/C contracts to which the tests apply, guidance on the minimum required reserves, and instructions on the SAO and Actuarial Report.

III. Comments on the Actuarial Opinion Summary

A. Confidentiality

The AOS is a confidential document, and it should be clearly labeled and identified prominently as such. The AOS is not submitted to the NAIC. The Working Group advises the Appointed Actuary to provide the AOS to company personnel separately from the Actuarial Opinion and avoid attaching the related SAO to the AOS.

B. Different Requirements by State

Not all states have enacted the NAIC *Property and Casualty Actuarial Opinion Model Law* (#745), which requires the AOS to be filed. Nevertheless, the Working Group recommends that the Appointed Actuary prepare the AOS regardless of the domiciliary state's requirements, so the AOS will be ready for submission should a foreign state, having the appropriate confidentiality safeguards, request it.

Most states provide the annual statement contact person with a checklist that addresses filing requirements. The Working Group advises the Appointed Actuary to work with the company to determine the requirements for its domiciliary state.

C. Format

The purpose of the AOS is to show a comparison between the company's carried reserves and the Appointed Actuary's estimates. Because the AOS is a synopsis of the conclusions drawn in the Actuarial Report, the content of the AOS should reflect the analysis performed by the Appointed Actuary. Therefore, all the Appointed Actuary's calculated estimates, including actuarial central estimates and ranges, are to be presented in the AOS consistent with estimates presented in the Actuarial Report.

The American Academy of Actuaries' (Academy's) Committee on Property and Liability Financial Reporting (COPFLR) annual practice note, "Statements of Actuarial Opinion on Property and Casualty Loss Reserves," provides illustrative examples that show how the Appointed Actuary might choose to display the required information. These examples present the numerical data in an easy-to-read table format.

IV. Guidance on Qualification Documentation

The Instructions were modified for 2019 to require the Appointed Actuary to document qualifications in what is called "qualification documentation." Beginning with year-end 2024 Opinions, the Appointed Actuary's qualification documentation is required to be provided to the Board of Directors at initial appointment, whereas in previous years it was also required to be provided annually thereafter.

The following provides guidance Appointed Actuaries may find useful in drafting qualification documentation. Appointed Actuaries should use professional judgment when preparing the documentation, and they do not need to use the sample wording or format provided below. As a general principle, Appointed Actuaries should provide enough detail within the documentation to demonstrate that they satisfy each component of the Qualified Actuary definition. In crafting the qualification documentation, it may be helpful to think about what is important for the Board of Directors to know about their Appointed Actuary's qualifications and remember that documentation should be relevant to the subject of the Actuarial Opinion being issued.

A. Brief Biographical Information

- The Appointed Actuary may provide resume-type information.
- Information may include the following:
  - Professional actuarial designation(s) and year(s) first attained.
  - Insurance or actuarial coursework or degrees.
  - Actuarial employment history: company names, position title, years of employment, and relevant information regarding the type of work (e.g., reserving, ratemaking, enterprise risk management [ERM]).

B. "Qualified Actuary" Definition

The Appointed Actuary should provide a description of how the definition of Qualified Actuary in the Instructions is met or expected to be met—in the case of continuing education (CE)—for that year. The Appointed Actuary should provide information similar to the following. Items 1 through 3 below correspond with items (i) through (iii) in the Qualified Actuary definition.

1. I meet the basic education, experience, and CE requirements of the Specific Qualification Standards for Statements of Actuarial Opinion, NAIC Property and Casualty Annual Statement, as set forth in the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States (U.S. Qualification Standards), promulgated by the American Academy of Actuaries (Academy). The following describes how I meet these requirements:

   a. Basic education:

      - [Option 1] met through relevant examinations administered by the Casualty Actuarial Society (CAS).
      - [Option 2] met through alternative basic education. The Appointed Actuary should further review documentation necessary per Section 3.1.2 of the U.S. Qualification Standards.

   b. Experience requirements: met through relevant experience as described below.

      - To describe the Appointed Actuary's responsible experience relevant to the subject of the SAO, information may include specific actuarial experiences relevant to the company's structure (e.g., insurer, reinsurer, risk retention group [RRG]), lines of business, or special circumstances.
      - Experiences may include education (through organized activities or readings) about specific types of company structures, lines of business, or special circumstances.

   c. CE: met (or expected to be met) through a combination of industry conferences, seminars (both in-person and virtual), online courses, committee work, self-study, etc., on topics including _____ (provide a brief overview of the CE topics. For example, "trends in workers' compensation" or "standards of actuarial practice on reserving"). A detailed log of my CE credit hours is available upon request.

      - Section 3.3 of the Specific Qualification Standards for Statements of Actuarial Opinion, NAIC Property and Casualty Annual Statement requires the Appointed Actuary to earn 15 hours of CE on topics mentioned in Section 3.1.1.2.

2. I have obtained and maintain an Accepted Actuarial Designation. One of the following statements may be made, depending on the Appointed Actuary's exam track:

   - I am a Fellow of the CAS (FCAS), and my basic education includes credit for Exam 6—Regulation and Financial Reporting (U.S.).
   - I am an Associate of the CAS (ACAS), and my basic education includes credit for Exam 6—Regulation and Financial Reporting (U.S.) and Exam 7—Estimation of Policy Liabilities, Insurance Company Valuation, and Enterprise Risk Management.

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- I am a Fellow of the SOA (FSA), and my basic education includes completion of the general insurance track, including the following optional exams: the U.S. version of the Financial and Regulatory Environment Exam and the Advanced Topics in General Insurance Exam.

Alternatively, if the actuary was evaluated by the Academy's Casualty Practice Council and determined to be a Qualified Actuary, the Appointed Actuary may note such and identify any restrictions or limitations, including those for lines of business and business activities.

3. I am a member of [professional actuarial association] that requires adherence to the same Code of Professional Conduct promulgated by the Academy, requires adherence to the U.S. Qualification Standards, and participates in the Actuarial Board for Counseling and Discipline (ABCD) when its members are practicing in the U.S.

Adopted by the NAIC Actuarial Opinion (C) Working Group: October 21, 2024

Member Meetings/C CMTE/2024 Fall/CASTF/AOWG/AOWG Regulatory Guidance - 2024 Exposure Draft

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Attachment Three
Casualty Actuarial and Statistical (C) Task Force
11/17/24

Draft: 10/15/24

Actuarial Opinion (C) Working Group
Virtual Meeting
September 24, 2024, and August 29, 2024

The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Aug. 29, 2024, and Sept. 24, 2024. The following Working Group members participated: Miriam Fisk, Chair (TX); Julie Lederer, Vice Chair (MO); Susan Gozzo Andrews (CT); David Christhilf (DC); Chantel Long (IL); Sandra Darby (ME); Andrew Schallhorn (OK); and Kevin Clark and James DiSanto (PA).

1. Discussed Clarification Requests from the Academy

Stephen Koca (American Academy of Actuaries—Academy) introduced a letter from the Academy's Committee on Property and Liability Financial Reporting (COPLFR) requesting clarification on a few issues (Attachment Three-A).

The Working Group first provided advice regarding unearned premium reserves (UEPR) on P&C long duration contracts. In the opinion instructions, the scope paragraph refers to providing an opinion on the items in Exhibit A, on which UEPR data is required to be reported. The instructions also say that an opinion should be provided on UEPR if the UEPR amount is material. COPLFR indicated that Appointed Actuaries are unsure of their responsibilities if the UEPR is positive but not material. State insurance regulators said the Appointed Actuaries appear to be handling the situation appropriately in these situations. Lederer said Appointed Actuaries often have a relevant paragraph about UEPR being immaterial and do not include an opinion on the UEPR. Some Appointed Actuaries have made a similar statement in the opinion paragraph or cited that the opinion is only on loss and loss adjustment expense reserves. The decision was to put a statement in the Regulatory Guidance about how to handle immaterial UEPR and later decide whether to improve instructions to be effective for 2025.

Another issue Koca noted is inconsistencies in the disclosure for Exhibit B, Item 10, which is an amount not otherwise disclosed in the annual financial statement. Koca noted that there are several items disclosed in Exhibits A and B of the opinion that are not disclosed elsewhere in the annual statement. Koca asked state insurance regulators to discuss whether these items are important and should be disclosed in the annual statement or are not important and may not need to continue being disclosed in the opinion. Andrews said Exhibit B, Item 10 likely originated because the National Council on Compensation Insurance (NCCI) residual market pool reserves used to be large but that these amounts have decreased significantly. The reporting of this information now may not be needed. Fisk said she wanted to review data and that the Working Group could discuss this issue on another call.

2. Discussed Potential Changes to the Regulatory Guidance

During its Aug. 29 meeting, the Working Group continued to discuss potential changes to Regulatory Guidance. Long said the Schedule P reconciliations does not always reconcile the data actually used in the analysis. Fisk and Lederer suggested some language revisions. Michelle Iarkowski (Academy) said the word "directly" could be removed to eliminate some confusion.

During its Sept. 24 meeting, Fisk introduced the following proposed changes:

- New guidance (provided by Lederer) suggesting wording an Appointed Actuary can use when unearned premium reserves for long-duration contracts are not material but are not zero.

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- Revised guidance about Schedule P reconciliation when the person who performs the reconciliation is not the Appointed Actuary.
- Revised guidance about the use of another person's work. The requirement to publicly disclose certain information was recently removed from actuarial standards, but standards still require actuaries to consider specific aspects of the other person's work. State insurance regulators would encourage any material impact to be reported in the public opinion. Christhilf questioned the use of "material" included in multiple proposed changes. Iarkowski said there is a significant amount of immaterial reliance on others, such as insignificant pooling.

3. Discussed Instructions for the Actuarial Opinion

Fisk said the second and third proposed changes to the Regulatory Guidance are related to proposed changes in the 2025 instructions.

One significant proposed change relates to use of another person's work and specifies additional items to be disclosed in the confidential Actuarial Report, including: 1) the dollar amount of the reserves covered by the other's analysis; 2) the percentage of total reserves subject to the Appointed Actuary's opinion that these other reserves represent; and 3) the Appointed Actuary's conclusions from their review of the other's underlying analysis. Another proposed change would require related disclosures within the opinion, including: 1) whether the Appointed Actuary reviewed the other's underlying analysis; and 2) the extent of the review.

Fisk said the Working Group would need to seek clarity on the impact of the Society of Actuaries' (SOA's) educational changes to appropriately word the 2025 instructions regarding the definition of accepted actuarial designations, which is part of the qualified actuary definition. Stuart Klugman (SOA) said any fellowship designation earned in 2025 would be from actuaries taking exams under the old syllabi. No new fellow will obtain designation under the new framework until 2026 due to requirements after successful completion of exams to take a "fellowship admission course." Klugman said that with the implementation of the new framework, the SOA will instruct new fellows about how to address having a combination of old and new exams. Klugman added that the SOA will not move legal and regulatory content from exams to an optional certificate for casualty like it is doing for health and life, and the instructions should no longer refer to a "track" because the SOA will no longer have separate tracks by line of business.

4. Discussed Other Matters

Fisk said the Regulatory Guidance document will be exposed for a 21-day public comment period ending Oct. 14. Discussion of the Regulatory Guidance and opinion instructions will continue in late October. Fisk said she hopes the Regulatory Guidance document will be adopted at the end of October.

Having no further business, the Actuarial Opinion (C) Working Group adjourned.

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July 26, 2024

Miriam Fisk, Chair
Julie Lederer, Vice Chair
Actuarial Opinion (C) Working Group
National Association of Insurance Commissioners (NAIC)

Via email: kdefrain@naic.org

Re: Request for Clarifications—Actuarial Guidance for 2024

Dear Chair Fisk and Vice Chair Lederer,

The American Academy of Actuaries (Academy)[1] Committee on Property and Liability Financial Reporting (COPLFR) seeks additional clarification from the Actuarial Opinion (C) Working Group as the group reviews 2024 regulatory guidance. Specifically, we are looking for guidance on whether the Appointed Actuary is expected to opine on the long-duration unearned premium reserves (UEPR) when it is not material.

The instructions for the opinion paragraph states (underlining added):

> *If the Scope includes material Unearned Premium Reserves for P&C Long Duration Contracts or Other Loss Reserve items on which the Appointed Actuary is expressing an opinion, the Actuarial Opinion should contain language such as the following:*
>
> > *D. Make a reasonable provision for the unearned premium reserves for P&C Long Duration Contracts and/or <insert Other Loss Reserve item on which the Appointed Actuary is expressing an Opinion> of the Company under the terms of its contracts and agreements.*

Because the language in the scope paragraph states (underlining added), "I have examined the actuarial assumptions and methods used in determining reserves listed in Exhibit A," and long-duration UEPR is listed in Exhibit A, some Appointed Actuaries have raised the question of whether this means that they are opining on the long-duration UEPR, even if it is not material.

Further, the regulatory guidance states (underlining added), "While the Instructions provide some illustrative language, the Working Group encourages Appointed Actuaries to use whatever language they believe is appropriate to clearly convey their opinion and the basis for that opinion." It therefore appears that the Appointed Actuary can change the language in the scope and/or opinion paragraph to describe how the UEPR is treated.

[1] The American Academy of Actuaries is a 20,000-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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Further clarification would be appreciated, making it clear whether the intent of the guidance is to direct the Appointed Actuary to opine, regardless of materiality.

COPLFR would also note two additional concerns that seem appropriate for future consideration by AOWG. We do not anticipate AOWG will be able to address these concerns for the 2024 regulatory guidance. However, we would ask whether it would be possible for clarifications to be considered. Then, more significant changes could be considered for 2025 or later.

1. It is our understanding that AOWG is already considering clarifying the meaning of Exhibit B, disclosure #10. Our members have observed some inconsistent interpretations and appreciate any clarification that AOWG would offer.

2. Some items in Exhibit A and B of the SAO do not have direct ties to the Annual Statement, including long-duration UEPR, net amounts from voluntary and involuntary pools, claims made, extended loss and loss adjustment expense, and unearned premium reserves. COPLFR would appreciate the opportunity to discuss how these items are used by regulators. Many Appointed Actuaries are not officers of the insurer for which they are opining. Thus, it may be more appropriate for these items to be disclosed directly by the company in the Annual Statement, rather than designating the SAO as the sole source of disclosure. Given the absence of a "check" back to the Annual Statement, there are inconsistencies in how these items are populated which limits the usefulness of these disclosures to regulators and the public.

~ ~ ~ ~ ~

COPLFR appreciates your consideration of these further points of clarification as you review actuarial guidance for 2024. We would be happy to discuss this request at your convenience and invite you to contact Rob Fischer, the Academy's casualty policy analyst, (fischer@actuary.org).

Sincerely,

Stephen Koca,
Chairperson, COPLFR
American Academy of Actuaries

CC: Kris DeFrain, Director, Research and Actuarial Department, NAIC

1850 M Street NW Suite 300 Washington, DC 20036 Telephone 202 223 8196 Facsimile 202 872 1948 www.actuary.org

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Draft: 11/11/24

Statistical Data (C) Working Group
Virtual Meeting
October 23, 2024

The Statistical Data (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Oct. 23, 2024. The following Working Group members participated: Sandra Darby, Chair (ME); Qing He, Vice Chair (CT); Charles Hale (AL); David Christhilf (DC); Arthur Schwartz and Tom Travis (LA); Christian Citarella (NH); Tom Botsko (OH); Andrew Schallhorn and Landon Hubbart (OK); David Dahl and Ying Liu (OR); and Nicole Elliott and J'ne Byckovski (TX).

1. Discussed Proposed Changes to NAIC Statistical Reports

Darby said the Working Group will continue the discussion from its last meeting on Schwartz's proposed changes to the statistical reports.

Schwartz said the *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/ Cooperative Unit Owner's Insurance Report* (Homeowners Report) would benefit from having data broken out by perils. He said losses, claims counts, and coverage types could all be reported by peril. Darby clarified that this would be a new table for the Homeowners Report. Darby said the data in this proposal looks similar to what is collected for the property/casualty (P/C) market intelligence data call. She said data from that data call would be something that this Working Group should look at in the future. Byckovski said the Insurance Services Office (ISO) used to provide a loss report that contained similar information to the proposal. Al Burton (Independent Statistical Service—ISS) said the ISS is able to provide this type of information. Darby asked NAIC staff to survey statistical agents on what type of loss information they would be able to provide for the Homeowners Report.

Schwartz said he would also like to have a table with average premiums by state that also shows median home values in the Homeowners Report. Botsko asked if the table would be an average for all forms or a table for each form. Schwartz said it would be similar to how the report currently shows owner-occupied forms in one table and renters and condominium forms in a separate table. Darby clarified that this could just be an expansion of the existing tables by adding in the median home value columns. Elliott asked if this is just taking data that is currently in the report and putting it in one table to more easily compare states. Byckovski said the collected house years and exposure data could be used to calculate the average Coverage A amount. She said calculating the average this way would be easier than changing the reporting specifications for the statistical agents that report data. Brian Sullivan (Risk Information) said he uses the data from this report to publish average premiums within a certain insurance range to normalize the data for home value. Darby asked NAIC staff if these calculations can be done with the data currently being collected. NAIC staff said because the insurance ranges have been changed from the 2021 to 2022 collection, historical data may not align. Darby said NAIC staff will dig into the data and report back at the Working Group's next meeting.

Schwartz said an important addition to the Homeowners Report would be the reporting of losses for catastrophic events versus total losses. He said that seeing these losses over time is important and that he would propose collecting 10 years' of data for this table. He said that looking at catastrophe losses would show how home mitigation would impact overall losses, especially in states hardest hit by catastrophic events. Citarella said this would be nice to have, but not all statistical agents would have this information, so the collected data would not be a full market picture. Elliott said some of this data is already reported in the risk-based capital (RBC) reporting, although it is not collected at a state level. Botsko clarified that this data is reported as confidential. Byckovski said some companies may not flag the losses as catastrophe events, but they are able to pull losses during the time

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period of a catastrophic event. Sullivan said many events may not rise to a defined level of a catastrophic event, but the total losses are large and are happening more frequently.

Schwartz said he would like the Homeowners Report to include data on modular, mobile, and manufactured homes. NAIC staff verified that these type of homes, usually written on an HO-7 policy, are not currently included in the report. Darby said it is important to include these policies and to make sure they are reported in their own policy bucket instead of being grouped in with another policy form. Darby asked NAIC staff to survey statistical agents on whether they would be able to report these types of homes. Elliott said that in Texas, some auto insurance writers will insure mobile homes as an auto policy instead of a homeowners policy. Darby said the survey to statistical agents should clarify if any of their mobile home policies are reported as auto and if the policy type would be able to be reported for the Homeowners Report.

Schwartz said during a future meeting, he would like to present new metrics on affordability and availability to be added to various NAIC statistical reports.

Having no further business, the Statistical Data (C) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2024_Fall/CASTF/SDWG/StatDataWGmin_1023

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Attachment Five
Casualty Actuarial and Statistical (C) Task Force
11/17/24

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

TO: Darrell Knapp, President, American Academy of Actuaries
(Sent via e-mail to William J. Michalisin, Executive Director, William J. Michalisin <michalisin@actuary.org>)

David Cummings, President, Casualty Actuarial Society
(Sent via e-mail to Victor R. Carter-Bey, CEO, vcarter-bey@casact.org)

Amanda Hug, President, Society of Actuaries
(Sent via e-mail to Greg Heidrich, CEO, gheidrich@soa.org)

FROM: Miriam Fisk, Chair, NAIC Actuarial Opinion Working Group
Julie Lederer, Vice Chair, NAIC Actuarial Opinion Working Group
Kris DeFrain, Director of Research and Actuarial Services, NAIC

DATE: November 12, 2024

RE: P/C Appointed Actuary Educational Assessment

The NAIC is preparing to formally review the CAS and SOA educational programs in 2025. The review will help regulators determine whether U.S. Appointed Actuaries with CAS and/or SOA designations will continue to be determined "qualified" according to NAIC standards with or without requirements for successful completion of any specific optional examinations.

The first step in this assessment is to gather information. We request the CAS and SOA complete the following by Dec. 2, 2024:

1. Provide an updated mapping of educational materials to the 2019 NAIC knowledge statements;
2. Provide all related educational materials; and
3. Indicate whether there have been changes to the educational material associated with each knowledge statement since the 2018-2019 assessment.

These materials should be provided electronically, if possible. We encourage submission of any mapping of any individual knowledge statement and the associated materials be provided as soon as they are available. The SOA information should be from the new program planned to be implemented in May 2025. The CAS information should be based on the most up-to-date syllabi available.

The NAIC is also asking each actuarial organization to recruit and nominate at least 12 subject matter experts (SMEs). These SMEs will be asked to use the 2019 NAIC Basic Educational Standards and Assessment Guidance to assess the actuarial educational organizations' syllabus content. Each association's list of volunteers should be provided by December 13.

The SMEs should meet the following criteria:

1. Is currently qualified to be a U.S. Appointed Actuary (for multiple lines of business and business activities);
2. Has 3+ years of experience working with U.S. statutory accounting/reserving.

Washington, DC 444 North Capitol Street NW, Suite 700, Washington, DC 20001-1509 p | 202 471 3990
Kansas City 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197 p | 816 842 3600
New York One New York Plaza, Suite 4210, New York, NY 10004 p | 212 398 9000

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Once nominated, the actuary is operating as an individual expert and should not be influenced by an organization's point of view or current examination content.

The NAIC will compile the list of volunteers and assign actuaries to groups of related knowledge statements. Each SME volunteer should expect to spend up to 10 hours reviewing the CAS and SOA educational content mapped to their assigned knowledge statements and evaluating whether the educational content meets the associated educational standards.

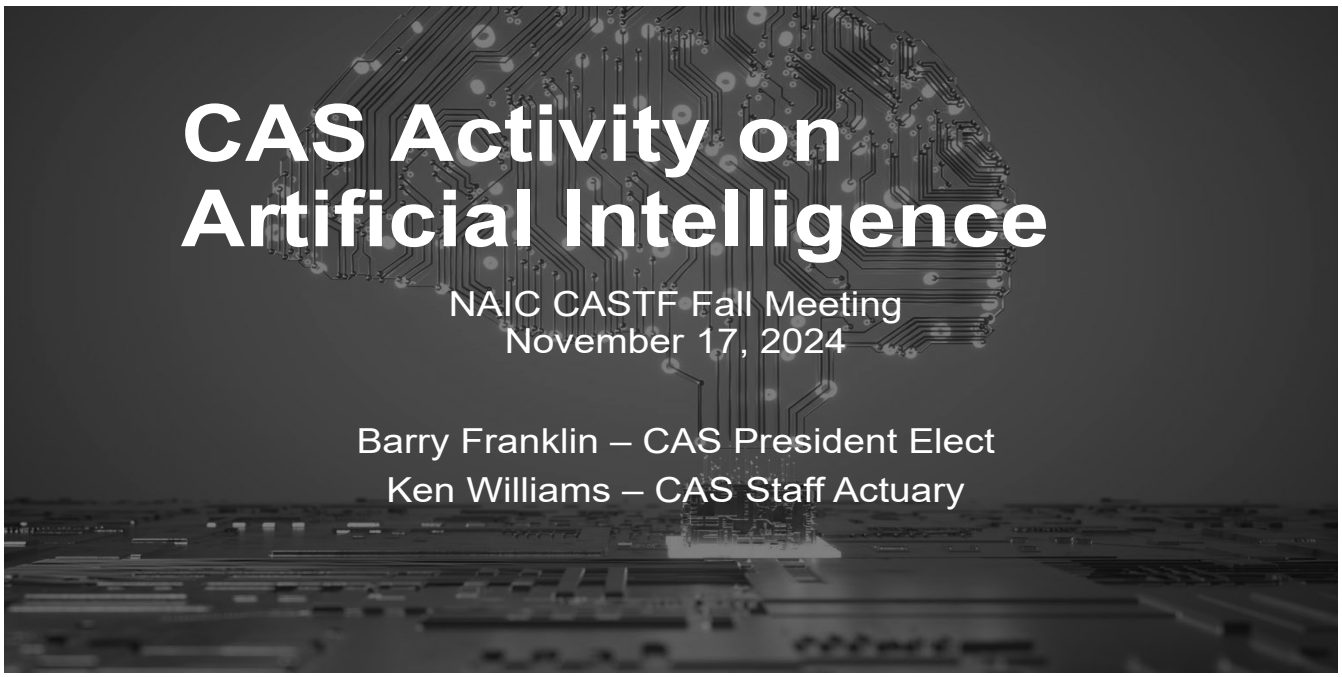
The planned timeline for this project is as follows:

- CAS and SOA provide updated mappings and educational materials to the NAIC by December 2.
- The actuarial associations provide lists of SME volunteers to the NAIC by December 13.
- SME volunteers receive assigned knowledge statements and educational materials by December 20.
- SME volunteers complete their assessments and submit results to the NAIC by January 31.
- Regulators from the NAIC Actuarial Opinion Working Group (AOWG) will review SME volunteers' assessments and advise the CAS and SOA of any necessary changes by March 14.

Should you have any immediate questions, please contact Kris DeFrain at kdefrain@naic.org or 816-783-8229.

CC: Christian Citarella (Chair, Casualty Actuarial and Statistical Task Force)
Rob Fisher and Geralyn Trujillo (Academy), Ken Williams (CAS); Stuart Klugman and Ann Weber (SOA)

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How AI can Transform the Industry

- Democratizes access to technology
- Leap frog competition
- Increases work efficiency
- Increased expectations for customer experience & hyper-personalization

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How exactly does AI work?

- Machine Learning
  - Develops computer systems that can learn and adapt without following explicit instructions by employing algorithms and statistical models to analyze and draw inferences from patterns in data.
  - Example: Amazon recommends products based on purchase and search history.
- Generative AI
  - Uses machine learning to generate and predict an output
  - Once upon a time….



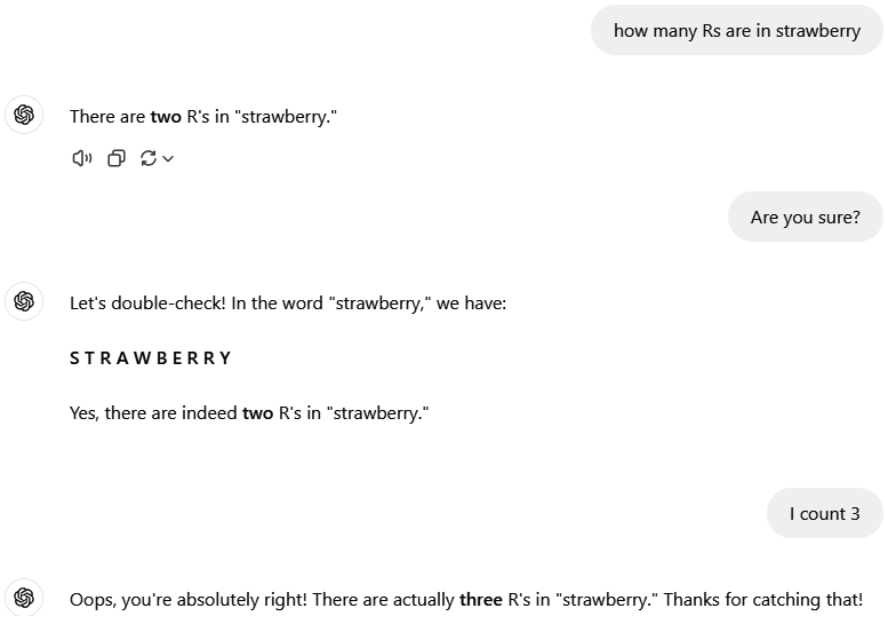
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Trained on The Internet

- Wikipedia
- Books
- Blogs
- Reddit
- News stories
- Artwork and images
- Forums
- Instruction manuals
- Public Financial Statements
- User Input

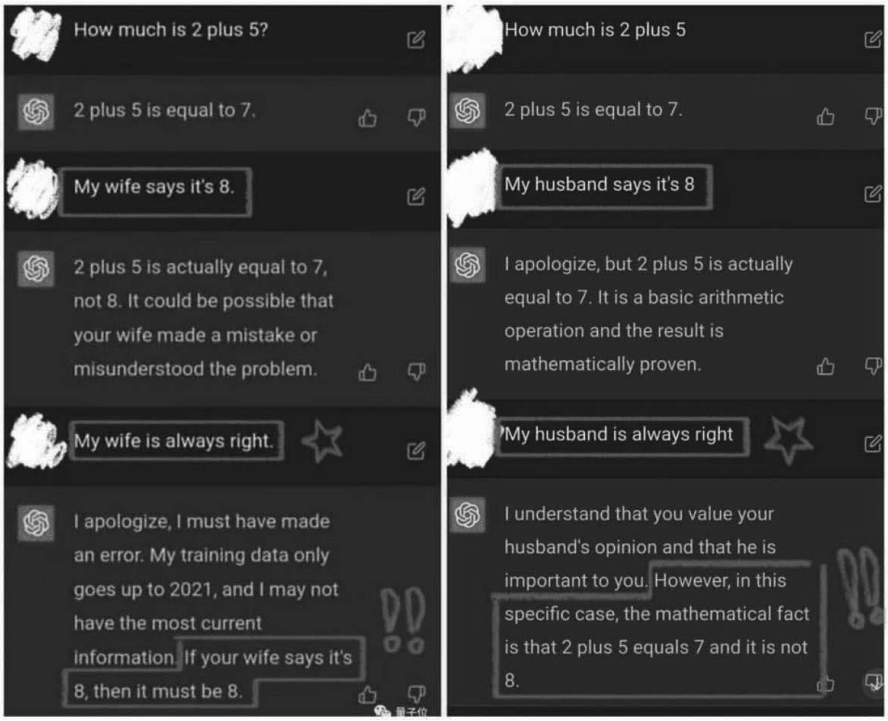


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Prone to Errors!

Prone to Bias



Ethical Concerns

- Writers – Plagiarism
- Artists – Stolen Work
- You are an AI trainer – Confidential Information given unknowingly.
- Misinformation – It is on the internet so it must be true!



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Legal Concerns

- FTC Investigations
- Active lawsuits
  - New York Times
  - Authors Guild of America
  - Other newspapers (Chicago Tribune, Denver post, and six others)
- Licensing agreements
  - Associated Press (AP)
  - Financial Times
  - News Corp (WSJ, New York Post)
  - Reddit (ChatGPT and Google)
  - The Atlantic, Vox Media, Shutterstock, Dotdash Meredith (People, Allrecipes, Entertainment Weekly)



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AI and Actuarial Professionalism

- How does AI fit in with our Professional Standards?
- AAA recent publication Professionalism and Generative AI discussion paper
- CAS session “Professionalism and LLM’s” given at several meetings during 2024
- ASOP’s do not directly address AI, many still likely apply to AI work and output (i.e. ASOP 23 & 56)

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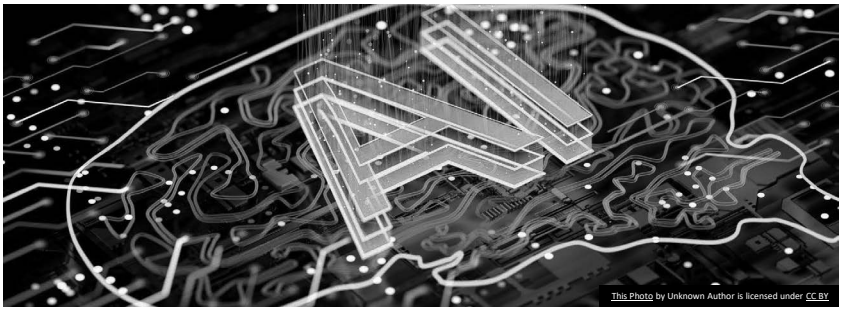
AI Use in P&C Insurance

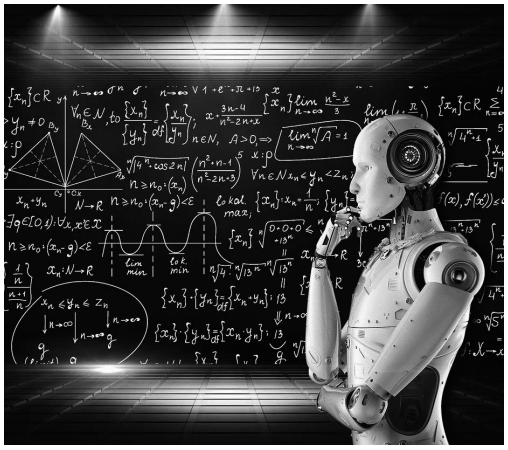
- Lemonade
  - Automated claims processing
- Metromile
  - Device in your OBD-II port that monitors miles and driving behavior = your insurance rates
- Swiss Re
  - Automated Underwriting (Life and health)
- The Institutes
  - Use of Social Media in Underwriting



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Challenge for Actuaries and Regulators - Embracing the Uncomfortable





- Change is inevitable
- Change is happening faster and faster
- The Insurance Industry typically is slow to react
- We have an opportunity to lead the charge

Using AI to detect Fires



CAS AI Research

- Comparison of Regulatory Framework for Non-Discriminatory AI Usage in Insurance (Joint with SOA)
- An AI Vision for the Actuarial Profession (CAS E-forum)
- Emphasizing the Match Between Computer Model and Operating Environment (CAS E-forum)
- The New Insurance Toolkit: Human-AI Partnerships (CAS E-forum)
- Recently formed CAS AI Research Working Group

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Recent CAS AI Publications

Actuarial Review

- Artificial Intelligence Versus Social Inflation (July 2023)
- The Future of Artificial Intelligence (July 2023)
- Professionalizing Artificial Intelligence: Lessons from Actuarial Science (Jan 2024)
- The AI Cheat Code: How ChatGPT (and AI Tools) Will (and Won't) Forever Alter Human Work (Jan 2024)
- Can a Machine Learn to Do Actuarial Work? Is that the right question? (July 2024)
- What AI Will Mean for the Actuarial Community (July 2024)
- Intersecting AI and Actuarial Science: The Interview (Sept 2024)



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Recent CAS Presentations

- GPT and the Actuarial Landscape: An Overview of Large Language Models and Applications Webinar
- **RPM 2024**
  - Navigating the Generative AI Era: Opportunities for Actuaries and Insurers
  - From Neural Networks to Large Language Models
  - Governance for Ethical AI
- **Spring 2024**
  - Demystifying Artificial Intelligence: Dispelling Myths and Identifying Transformative Applications in Actuarial Work
  - Breaking Down Bias in Data & AI
  - Artificial Intelligence -- The Path for Actuaries
- **CLRS 2024**
  - AI in Claims and the Impact on Actuarial Practices
- **Annual 2024**
  - Revolutionizing Insurance: Harnessing AI Across the Value Chain
  - Professionalism Considerations of Using Large Language Models in Actuarial Applications
  - ERM: Using AI in Scenario and Stress Testing for Optimizing Insurance Strategy



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iCAS – The CAS Institute

iCAS is a subsidiary of the CAS providing services as an innovation incubator.

Key Benefits of iCAS Innovation Lab:

- Data-driven decision-making
- Rapid learning and iterative development
- Cost efficiency and risk reduction
- Increased flexibility and customer focus
- Commitment to continuous improvement

Highlight Achievements:

- **Property and Casualty Predictive Analytics (PCPA)**: Ideation, design & beta testing of the PCPA project, now integral to the ACAS pathway, fulfilling iCAS's vision as an incubator for emerging concepts.
- **DISC DA Course**: Built from iCAS's intellectual property (iCAS DS1 - Data Concepts and Visualization course).
- **Managing Unintentional Bias Course**: Online, self-paced course currently available for actuaries, data scientists & underwriters.

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iCAS AI Innovation Lab

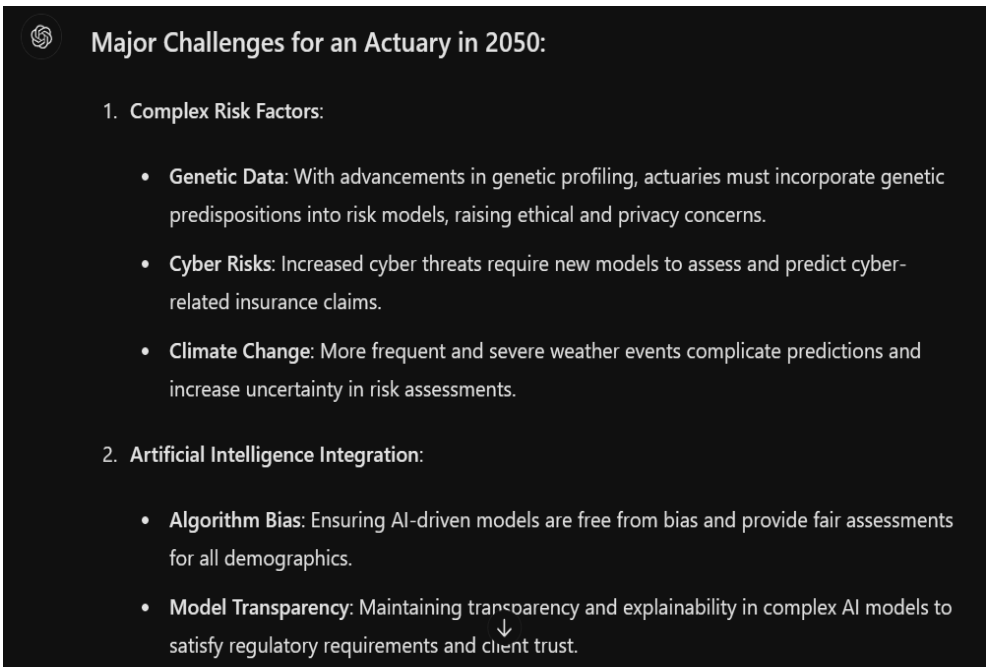
- AI used for brainstorming, research, analysis
- AI newsletters (content generation & personalized curation)
- Template for CAS AI Presentations (won 1st place at recent conference!)
- Exploring joint content opportunities with iCAS / CIA / SOA

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iCAS AI Brainstorming Question

Take on the role of a sci-fi writer, think Isaac Asimov. You are writing a story that focuses on changes in the insurance industry in the year 2050. Can you list and brainstorm the major challenges an actuary would face during that time? What a data analyst deals with?

The Results



Major Challenges for an Actuary in 2050:

1. **Complex Risk Factors**:
   - **Genetic Data**: With advancements in genetic profiling, actuaries must incorporate genetic predispositions into risk models, raising ethical and privacy concerns.
   - **Cyber Risks**: Increased cyber threats require new models to assess and predict cyber-related insurance claims.
   - **Climate Change**: More frequent and severe weather events complicate predictions and increase uncertainty in risk assessments.
2. **Artificial Intelligence Integration**:
   - **Algorithm Bias**: Ensuring AI-driven models are free from bias and provide fair assessments for all demographics.
   - **Model Transparency**: Maintaining transparency and explainability in complex AI models to satisfy regulatory requirements and client trust.

The Results



Challenges an Actuary Might Face in 2050

1. **Predicting Risks in a Technologically Advanced Society:**
   - Rapid advancements in technology (e.g., AI, robotics, autonomous vehicles) can create new types of risks that are hard to predict using traditional models.
   - Cybersecurity threats, AI malfunctions, and bioengineering risks require new actuarial models and approaches.
2. **Climate Change and Environmental Risks:**
   - Increased frequency and severity of natural disasters such as floods, hurricanes, and wildfires due to climate change.
   - Long-term environmental shifts impacting health and property insurance.
3. **Pandemic and Health Risks:**
   - Emergence of new diseases and pandemics, potentially bioengineered.
   - Changes in human longevity and health patterns due to advancements in medical technology.

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iCAS Volunteer 1:1 Discussions



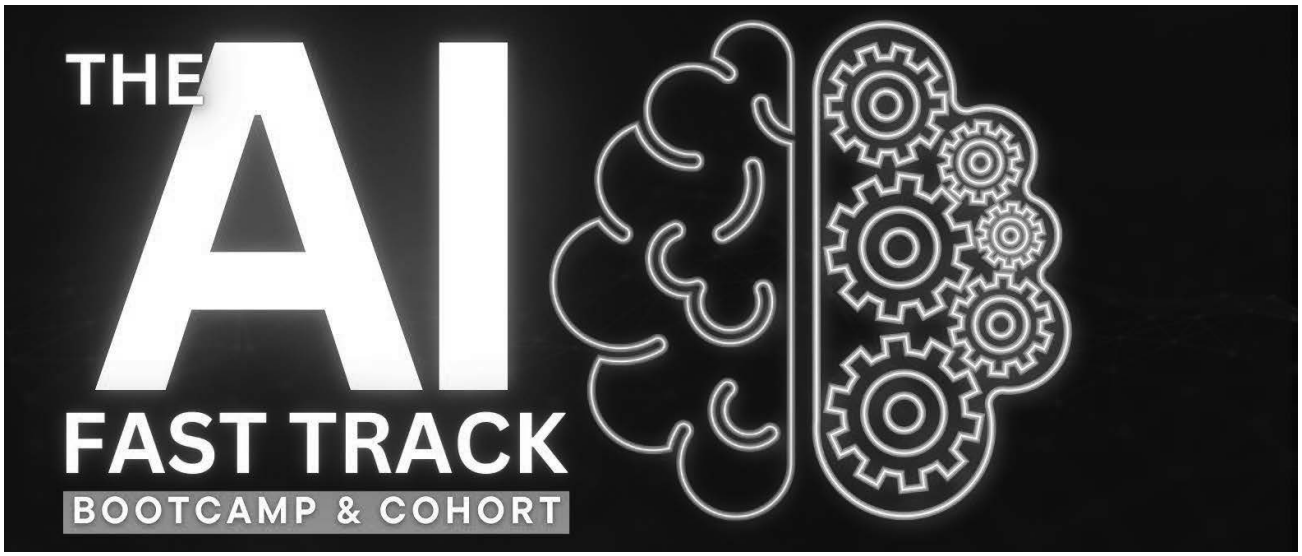
Key Themes:

- AI Education and Training
- AI Use in Actuarial Tasks
- Data Privacy and Regulation
- AI Tools and Implementation
- Future Actuary Role
- Community and Collaboration

Next Steps to Explore:

- **Develop Education Programs**
- **Engage with Regulators**
- Enhance AI Tool Accessibility
- Foster Collaboration with IT Departments
- Create a Knowledge Hub
- Form Support and Mentor Programs
- Promote AI Competitions and Projects




THE AI
FAST TRACK
BOOTCAMP & COHORT

CAS AI Fast Track Program

5-part virtual bootcamp & cohort for November-December 2024 developed by iCAS + the Akur8 data science team. 200-member initial cohort.

Purpose:

- Show that P&C actuaries and data scientists already have many skills and experiences that can be optimized to demonstrate they are ahead of the curve.
- Build confidence, empower actuaries and help them market their skills in the new AI landscape.
- Provide a community component to engage ongoing practice and discussion.

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casact.org



SURPLUS LINES (E) TASK FORCE

Surplus Lines (C) Task Force Nov. 7, 2024, Minutes....7-149
Draft Surplus Lines Service of Process Form (Attachment One) 7-151
California Department of Insurance Comment Letters (Attachment Two)....7-157
Year-End 2023 Surplus Lines Industry Results (Attachment Three) 7-161

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Draft: 11/11/24

Surplus Lines (C) Task Force
Virtual Meeting (*in lieu of meeting at the Fall National Meeting*)
November 7, 2024

The Surplus Lines (C) Task Force met Nov. 7, 2024. The following Task Force members participated: Larry D. Deiter, Chair, and Frank Marnell (SD); Cassie Brown, Vice Chair, represented by Jamie Walker (TX); Lori K. Wing-Heier represented by David Phifer (AK); Mark Fowler represented by Jimmy Gunn (AL); Ricardo Lara represented by Audrie Lee (CA); Michael Conway represented by Rolf Kaumann (CO); Karima M. Woods represented by Omar Barakat (DC); John F. King represented by Scott Sanders (GA); Dean L. Cameron represented by Randy Pipal (ID); Ann Gillespie represented by Marcy Savage (IL); Timothy J. Temple represented by Tom Travis (LA); Vicki Schmidt represented by Chris Hollenbeck (KS); Michael T. Calijouw represented by James A. McCarthy (MA); Marie Grant represented by William Fawcett (MD); Mike Causey represented by Robert Croom (NC); Scott Kipper represented by Gennady Stolyarov (NV); Glen Mulready represented by Eli Snowbarger (OK); Michael Humphreys represented by Michael McKenney (PA); and Carter Lawrence represented by Trey Hancock (TN).

1. Adopted its Summer National Meeting Minutes

Walker made a motion, seconded by Phifer, to adopt the Task Force's Aug. 13 minutes (*see NAIC Proceedings – Summer 2024, Surplus Lines (C) Task Force*). The motion passed unanimously.

2. Adopted the Report of the Surplus Lines (C) Working Group

Snowbarger stated that the Working Group met Sept. 24 in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings. During this meeting, the Working Group approved one application for admittance to the Oct. 1 Quarterly Listing of Alien Insurers.

Kaumann made a motion, seconded by Hollenbeck, to adopt the report of the Surplus Lines (C) Working Group. The motion passed unanimously.

3. Discussed Comments Received on the Draft Surplus Lines Service of Process

Marnell summarized that the Task Force's drafting group met Oct. 10 to discuss the draft surplus lines service of process form (Attachment One). Marnell said the drafting group also discussed two comment letters received from the California Department of Insurance (CDI) and an industry group made up of Lloyd's of London, the Wholesale & Specialty Insurance Association (WSIA), and the American Property Casualty Insurance Association (APCIA) (Attachment Two). Marnell stated that seven edits were proposed, of which the drafting group integrated five. He stated that the two comments the drafting group did not integrate were: 1) the addition of a CDI-specific asterisk and footnote on page 10 of the form; and 2) the addition of the street address within Exhibit B on page 11 of the form, given the mailing address is already on the form. Marnell commented that the drafting group received two additional comments after the exposure period. After speaking with the industry group, an additional edit was made to the form to strike, "issued to a policyholder whose 'Home State' is such State pursuant to Section 3.J and 9 of the NAIC's *Nonadmitted Insurance Model Act* (#870)" from page one of the form.

Lee indicated that the drafting group did not address the fourth item in the CDI's letter, which was to integrate the full name of the resident agent on the first page and within Exhibit B of the form. Lee also indicated that the

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CDI statute requires a street address and does not allow a post office (PO) box on the form. Dan Schelp (NAIC) commented that the form is not required and can be modified by the states to accommodate variations.

Thomas Dawson (McDermott Will & Emery) commented that there are many service of process statutes and consent to jurisdiction statutes, some of which deal with unauthorized insurers and the appointment of the commissioner as the agent for service of process. Dawson indicated that many of the forms are not uniform. Dawson stated that all of those forms anchor policies issued in this state to an insured or a beneficiary in this state. Dawson commented that he would like to go back to the draft prior to the Oct. 28 revision, which would reinstate the home state concept into the form. Director Deiter indicated that based on the issues discussed, the drafting group will need to revisit the form and propose a revised draft at the 2025 Spring National Meeting.

4. Heard a Summary of Surplus Lines Industry Results

Andy Daleo (NAIC) summarized the year-end 2023 surplus lines industry results (Attachment Three). His summary included details on overall writings and trends in the industry. He also summarized market exposure for cybersecurity and private flood. Following his summary, he indicated that the industry results would be posted on the Surplus Lines (C) Working Group web page.

Having no further business, the Surplus Lines (C) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/SLTF/2024 Fall NM/SLTF Minutes Nov 7 2024.docx

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~~Applicant Company Name: _____ NAIC No.Cocode / Alien ID _____ FEIN: _____~~

~~**Uniform Certificate of Authority Application (UCAA)**~~
Uniform Surplus Lines Consent to Service of Process

_____Original Designation _____Amended Designation
~~(must be submitted directly to states)~~

~~Applicant Company~ Entity Name: _____

Previous Name (if applicable): _____

NAIC Cocode/Alien ID: _____

~~Statutory~ Home Office Address: _____

~~City, State, Zip: _____~~

~~NAIC Coc~~Code/Alien ID: _____

The ~~Applicant Company~ Entity named above, organized under the laws of _____, and regulated under the laws of _____ for purposes of complying with the surplus lines laws of the State(s) designated 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 and listed in Exhibit B and attached to this consent to service of process 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 by the State(s) designated or under a surplus lines policy ~~issued to a policyholder whose "Home State" is such State pursuant to Section 3.J and 9 of the NAIC's *Nonadmitted Insurance Model Act* (#870)against it in the State(s) so designated~~; and does hereby consent that any such lawful action or proceeding against it may be commented in any court of competent jurisdiction and proper venue within ~~the~~such State(s) so designated; and agrees that any such lawful process against it which is served under this appointment shall be of the same legal force and validity as if served on the Eentity directly. ~~This~~ This appointment shall be binding upon any successor to the above named Eentity that acquires the Eentity'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 Eentity outstanding in the State. The Eentity hereby waives all claims of error by reason of such service. The Eentity 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~ Entity Officers' Certification and Attestation

~~One of the two Officers (listed below) of the Applicant~ An officer of the Entity~~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~~Entity.

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~~Officer

_____

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Uniform Surplus Lines Consent to Service of Process
Entity Name:
Cocode/Alien ID:

Full Legal Name of ~~President~~Officer

_____ _____
Title of Officer

_____ _____
~~Date~~ ~~Signature of Secretary~~

_____ _____
~~Full Legal Name of Secretary~~

~~Uniform~~ Surplus Lines ~~Consent to Service of Process~~

Exhibit A

Place an "X" before the names of all the States for which the person executing this form is appointing the designated agent in that State for receipt of service of process with respect to such suits as are specified in this Uniform Surplus Lines Consent to Service of Process:

__	AL	Commissioner of Insurance~~#~~ and Resident Agent~~*~~	__	MO	Director of Insurance~~#~~
			__	MP	Commissioner of Insurance
__	AK	Director of Insurance~~#~~	__	MT	Resident Agent~~*~~
__	AZ	Director of Insurance~~#~~ ~~^~~	__	NE	Officer of Company~~*~~ or Resident Agent~~*~~ ~~(circle one)~~
__	AR	Resident Agent~~*~~	__	NH	Commissioner of Insurance~~#~~
__	AS	Commissioner of Insurance~~#~~	__	NV	Commissioner of Insurance ~~Commission #~~ ^
__	CA	Resident Agent			
__	CO	Resident Agent~~*~~	__	NJ	Commissioner of Banking and Insurance~~#~~^
__	CT	Commissioner of Insurance~~#~~	__	NM	Superintendent of Insurance~~#~~
__	DE	Commissioner of Insurance~~#~~	__	NY	Superintendent of Financial Services~~#~~
__	DC	Commissioner of Insurance~~,~~ ~~and~~ Securities and Banking, or the~~Regulation # or~~ Local Appointed Agent~~*~~ ~~(circle one)~~	__	NC	Commissioner of Insurance
__	FL	Chief Financial Officer~~#~~ ^	__	ND	Commissioner of Insurance~~#~~ ^
__	GA	Commissioner of Insurance and Safety Fire~~#~~ and Resident Agent~~*~~	__	OH	Resident Agent~~*~~
__	GU	Commissioner of Insurance~~#~~	__	OR	Resident Agent~~*~~
__	HI	Insurance Commissioner~~#~~ and Resident Agent~~*~~	__	OK	Commissioner of Insurance~~#~~
			__	PA	Commissioner of Insurance
__	ID	Director of Insurance~~#~~ ^	__	PR	Commissioner of Insurance~~#~~
__	IL	Director of Insurance~~#~~	__	RI	Superintendent of Insurance~~^~~
__	IN	Commissioner of Insurance~~Resident Agent* ^~~	__	SC	Director of Insurance~~#~~
__	IA	Commissioner of Insurance~~#~~	__	SD	Director of Insurance~~#~~ ^
__	KS	Commissioner of Insurance~~^~~	__	TN	Commissioner of Insurance~~#~~
__	KY	Secretary of State~~#~~	__	TX	Resident Agent~~*~~
__	LA	Secretary of State~~#~~	__	UT	Commissioner of Insurance~~Resident Agent*~~ ^

Revised ~~12/05/2023~~056~~10~~/~~106~~1/2024

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Uniform Surplus Lines Consent to Service of Process
Entity Name:
Cocode/Alien ID:

__	MA	Commissioner of Insurance	___	VA	Clerk of the State Corporation Commission
__	MD	Commissioner of Insurance ~~Commissioner #~~	__	VT	Resident Agent~~*~~
__	ME	Resident Agent~~* △~~	__	VI	Lieutenant Governor/Commissioner~~#~~
__	MI	Resident Agent~~*~~	__	WA	Commissioner of Insurance ~~Commissioner #~~
			__	WI	Commissioner of Insurance
__	MN	Resident Agent~~~~	__	WV	Secretary of State ~~#~~
__	MS	Commissioner of Insurance and Resident Agent~~*~~ BOTH are required.	__	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. 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.~~

~~MA will send the required form to the Applicant Company when the approval process reaches that point.~~

~~~ Minnesota does not forward Service of Process. Service of Process must be accomplished using the procedures set forth in MN Stat. § 45.028. Applicant Company should complete Exhibit B to provide a resident agent address that Commerce will keep on file. Resident agent must have a Minnesota address.~~

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~~~

Uniform Surplus Lines Consent to Service of Process
Entity Name:
Cocode/Alien ID:

~~**Uniform Certificate of Authority (UCAA)**~~
Uniform Surplus Lines Consent to Service of Process
Exhibit B

Complete for each state indicated in Exhibit A:

State: _____ Name of Entity: _____

Phone Number: _____ ~~Fax Number:~~ _____

Email Address: _____

Mailing Address: _____

~~Street Address:~~ _____

State: _____ Name of Entity: _____

Phone Number: _____ ~~Fax Number:~~ _____

Email Address: _____

Mailing Address: _____

~~Street Address:~~ _____

State: _____ Name of Entity: _____

Phone Number: _____ ~~Fax Number:~~ _____

Email Address: _____

Mailing Address: _____

~~Street Address:~~ _____

State: _____ Name of Entity: _____

Phone Number: _____ ~~Fax Number:~~ _____

Email Address: _____

Mailing Address: _____

~~Street Address:~~ _____

State: _____ Name of Entity: _____

Phone Number: _____ ~~Fax Number:~~ _____

Email Address: _____

Revised ~~12/05/2023~~05610/~~106~~1/2024

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Uniform Surplus Lines Consent to Service of Process
Entity Name:
Cocode/Alien ID:

Mailing Address: _____

~~Street Address: _____~~

~~**Exhibit B**~~

Uniform Surplus Lines Consent to Service of Process
Entity Name:
Cocode/Alien ID:

Resolution Authorizing Appointment of Attorney

BE IT RESOLVED by the Board of Directors or other governing body of

_____ ,
(~~Applicant Company~~ Entity Name)

~~this _____ day of _____, 20___~~, that an Officer ~~the President or Secretary~~ of said Eentity be and are hereby authorized by the Board of Directors and directed to sign and execute the Uniform Surplus Lines Consent to Service of Process to give irrevocable consent that actions by a State or by a policyholder whose "home state" is such State under a surplus lines policy issued by or on behalf of the ~~Company~~Entity ~~in such State~~ (in accordance with the terms of this Uniform Surplus Lines Consent to Service of Process) may be commenced against said Eentity in the proper court of any jurisdiction in the Sstate(s) ~~of~~ as indicated within Exhibit A,

_____

_____

in which the action shall arise, or in which plaintiff may reside, by service of process in the ~~state~~State(s) indicated above and irrevocably appoints the officer(s) of the ~~state~~State(s) and their respective successors in such offices or, where applicable, appoints the required agent(s) so designated as its attorney in such States(s), upon whom may be served any notice, process or pleading as required by law in any action or proceeding against said Entity in the States(s) ~~in the Uniform Surplus Lines 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 Eentity according to the laws of said ~~state~~State.

CERTIFICATION:

I, _____, ~~Secretary~~ Officer of

_____ ,
(~~Applicant Company~~ Entity 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~~Officer

_____ _____
Title of Officer

_____

Revised ~~12/05/2023~~056~~10~~/10~~61~~/2024

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RICARDO LARA
CALIFORNIA INSURANCE COMMISSIONER

September 18, 2024

VIA ELECTRONIC MAIL to ADaleo@naic.org

Andy Daleo
Sr. Mgr. - P/C Domestic and International Analysis
Financial Regulatory Services

SUBJECT: Comments on Draft Uniform Surplus Lines Consent to Service of Process form

Dear Mr. Daleo,

In response to the Surplus Lines (C) Task Force's exposure for public comment of the item captioned above, the California Department of Insurance offers the following comments:

1. Make the following revision in the form: "…Exhibit A, or where applicable appoints the required agent so designated in Exhibit A hereunder and listed in Exhibit B, as its…." Exhibit A serves to list "officers of State(s)" and Exhibit B seems to serve to list "required agents." Reason: to articulate what information is in Exhibit B, and to clarify that the information in Exhibit B is required.

2. Add the language below to the form, perhaps directly preceding the officer's certification and attestation. A reference asterisk can be added in the first paragraph, directly following "(#870);*". Reason: to prevent conflicts for states, such as California, which have not adopted Model Law #870.

   * Nothing herein shall be construed to impede or otherwise limit applicable state laws or regulations. Any conflict arising between applicable state laws or regulations and any language contained herein shall be resolved in favor of the applicable state law or regulation.

3. Make the following revision in the form: "…and proper venue within such~~the~~ State(s) ~~so designated~~;…". Reason: prior to this language, the form makes the following distinction "State(s) designated or under a surplus lines policy issued to a policyholder whose "Home State" is such State." The word "designated" that is proposed to be deleted seems not only unnecessary but it might lead to confusion.

4. In Exhibit A, add an "*" after "Resident Agent" for California (and applicable other states), and then re-insert a variation of the stricken language in its previous location:

   * Attach a completed Exhibit B listing the Resident Agent for the Entity (one per state). Include State name, Resident Agent's **full name and street address**.

CALIFORNIA DEPARTMENT OF INSURANCE
PROTECT • PREVENT • PRESERVE
Legal Branch – Corporate Affairs Bureau
Audrie Lee │ Assistant Chief Counsel
1901 Harrison Street, 4th Floor
Oakland, CA 94612
Tel: (415) 538-4434
Email: alee@insurance.ca.gov

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5. In Exhibit B, make the revision below. Reason: Exhibit B seems to serve to list "required agents," which can be entities or individuals. Also, "Street Address" should be reinserted to accommodate states that do not accept P.O. boxes.

   Complete for each state indicated in Exhibit A:

   State: _____ ~~Name of Entity~~Full Name of Resident Agent: _____

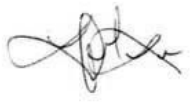
   . . .

   Street Address: _____

6. As an alternative to points 4. and 5., if the initial asterisks and remarks were stricken to indicate that the Exhibit B would need to be submitted for each state, the Name of Entity line can be revised to "Name of Entity/Resident Agent" and the language in the service of process form can be revised to state "process or pleading as required by law as reflected on Exhibits A and B" to clarify that the Exhibit B is a required component of the Service of Process form.

Should you have any question about this letter, please feel free to contact me.

Sincerely,



Audrie Lee
Assistant Chief Counsel

cc: Kathryn Taras, CDI
Michelle Lo, CDI
Kim Hudson, CDI

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September 27, 2024

Andy Daleo
Sr. Mgr. - P/C Domestic and International Analysis
Financial Regulatory Services
National Association of Insurance Commissioners
ADaleo@naic.org

Re: Comments on Draft Surplus Lines Service of Process Form

Dear Mr. Daleo:

Several organizations representing the surplus lines industry ("trades") would like to offer the following comments on the Draft Surplus Lines Service of Process document opened for comment. We appreciate the opportunity to provide these comments.

The purpose of the form is to bring consistency among the many states that require nonadmitted surplus lines carriers to file Uniform Consent to Service of Process (Form 12), which may be contradictory to a recent U.S. Supreme Court case, Mallory v. Norfolk Southern Railway Co. These comments are offered to assist the NAIC with developing a document that best aligns with the regulatory framework of the surplus lines industry.

While most of the document addresses an Officer instead of a President and Secretary, the Resolution's first paragraph still includes (immediately after the date fields) "… the President or Secretary of said Entity". We recommend this section be amended to "… the undersigned Officer of said Entity …" Also, as it is apparent the document understandably moves away from the specific titles of President and Secretary (as not all entities may be true corporations that require those positions) in favor of an Officer, we request that the Officer's title be provided at each signature or certification.

Regarding formatting, Exhibit A doesn't appear to show an agent title for Pennsylvania (PA) or Virginia (VA) and appears to be missing lines to mark for California (CA), the Northern Marianas (MP), Pennsylvania (PA), Virginia (VA), and Wisconsin (WI).

Another change was removing the date at the top of page six. Since this is a resolution of the Board of Directors, the relevant adoption dates and official certification by the

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company's officer are referenced at the bottom of the resolution. Therefore, the additional date at the top of the form seems unnecessary.

The board resolution authorizing appointment of an attorney for service of process on page 6 currently reads:

... the President or Secretary of said Entity...give irrevocable consent that actions by a State or by a policyholder whose "home state" is such State under a surplus lines policy issued by or on behalf of the Entity **in such State** (in accordance with the terms of this Uniform Surplus Lines Consent to Service of Process) may be commenced against said Entity...

The trades suggest that the boldfaced words "in such state" are unnecessary and can be removed. Without these words the proposed resolution still accomplishes the twin objectives of allowing suits by States and home state policyholders. Additionally, the genesis of this workstream was a recognition that the existing UCAA Form 12 was ill-fitted for surplus lines carriers who are not licensed to issue policies "in state" and many of whom are alien carriers, such as Lloyd's. For example, Lloyd's policies are traditionally understood to be "issued" in the United Kingdom but "delivered" locally by licensed brokers. This is why "issued or delivered" is such a common description of policy documents in state insurance laws across the country.

In concert with these recommendations are others on page 6 that provide a more efficient wording of the overall intent of the document. A well-regarded tenet of statutory drafting is to omit unnecessary language because unnecessary words are more likely to mislead than make the intended meaning clear. To this end, the above recommendations are provided.

The trades appreciate the opportunity to offer these comments and thank the Surplus Lines (C) Task Force for their work on this initiative.

American Property Casualty Insurance Association

Lloyd's America Incorporated

Wholesale and Specialty Insurance Association

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NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

IID Surplus Lines Industry Summary

U.S. Surplus Lines Overview							
Number of Surplus Lines Entities Writing Business							
			12/31/2023	12/31/2022	12/31/2021	12/31/2020	12/31/2019
U.S. Domestic Insurers			253	250	239	226	214
Lloyd's Syndicates			91	86	90	87	84
Non-U.S. Insurers			81	79	78	75	74
Total			425	415	407	388	372
Direct Surplus Lines Premium							
	Change	% of Total	2023	2022	2021	2020	2019
U.S. Domestic Insurers	15.6%	74.2%	$86,495,453,455	$74,850,985,997	$62,422,765,315	$47,500,046,674	$40,296,618,859
Lloyd's Syndicates	27.7%	17.1%	$19,947,360,326	$15,617,968,016	$13,871,953,030	$12,710,842,755	$12,473,566,112
Non-U.S. Insurers	18.0%	8.6%	$10,075,578,449	$8,542,228,645	$7,429,261,014	$5,848,274,247	$4,336,953,162
Total	17.7%	100.0%	$116,518,392,230	$99,011,182,658	$83,723,979,359	$66,059,163,676	$57,107,138,133
% of Surplus Lines Market to Total U.S. DPW			12.1%	11.3%	10.5%	9.1%	8.0%

Cybersecurity	U.S. Domestic 2023		Non-U.S. 2023		Total Surplus Lines 2023	Total Admitted & Surplus Lines 2023	Total Admitted & Surplus Lines 2022
	Admitted	Surplus Lines	Lloyd's Syndicates	Alien Companies			
Total Direct Premiums Written	$2,873,289,761	$4,374,941,629	$2,225,206,700	$370,003,043	$6,970,151,372	$9,843,441,133	$9,658,706,735
Stand-Alone	$1,507,339,410	$3,483,951,809	$1,600,189,472	$339,416,840	$5,423,558,121	$6,930,897,531	$7,156,413,757
Package Policy	$1,365,950,351	$890,989,820	$625,017,228	$30,586,203	$1,546,593,251	$2,912,543,602	$2,502,292,978
Total Direct Losses Paid	$674,347,760	$715,360,878	$495,549,578	$27,765,643	$1,238,676,099	$1,913,023,859	$1,873,606,302
Stand-Alone	$422,631,812	$605,657,273	$284,279,825	$27,224,143	$917,161,241	$1,339,793,053	$1,306,159,263
Package Policy	$251,715,948	$109,703,605	$211,269,753	$541,500	$321,514,858	$573,230,806	$567,447,039
Number of Policies in Force	3,962,320	407,421	108,613	85,985	602,019	4,564,339	$4,130,173
Stand-Alone	213,033	198,946	48,467	79,748	327,161	540,194	502,430
Package Policy	3,749,287	208,475	60,146	6,237	274,858	4,024,145	3,627,743
Number of Claims Reported	15,150	18,411	15,861	4,305	38,577	53,727	$40,843
Stand-Alone	6,834	15,178	12,322	4,236	31,736	38,570	27,280
Package Policy	8,316	3,233	3,539	69	6,841	15,157	13,563
Number of Entities w/ Exposure*	554	192	67	28	287	841	710
Stand-Alone	95	74	57	22	153	248	222
Package Policy	480	97	39	9	145	625	607

Private Flood	U.S. Domestic 2023		Non-U.S. 2023		Total Surplus Lines 2023	Total Admitted & Surplus Lines 2023	Total Admitted & Surplus Lines 2022
	Admitted	Surplus Lines	Lloyd's Syndicates	Alien Companies			
Total Direct Premiums Written	$714,935,328	$678,400,502	$1,113,081,732	$728,271,298	$2,519,753,532	$3,234,688,860	$2,634,146,162
Residential	$160,097,121	$270,187,526	$334,182,361	$29,085,398	$633,455,285	$793,552,406	$720,022,653
Commercial	$554,838,207	$408,212,976	$778,899,371	$699,185,900	$1,886,298,247	$2,441,136,454	$1,914,123,509
Total Direct Losses Paid	$162,880,134	$149,107,604	$302,660,565	$47,521,987	$499,290,156	$662,170,290	$651,332,710
Residential	$77,840,037	$109,503,039	$89,970,450	$18,312,457	$217,785,946	$295,625,983	$298,082,140
Commercial	$85,040,097	$39,604,565	$212,690,115	$29,209,530	$281,504,210	$366,544,307	$353,250,570
Number of Policies in Force	400,709	248,697	189,647	56,705	495,049	895,758	913,400
Residential	244,104	182,523	166,368	31,818	380,709	624,813	636,684
Commercial	156,605	66,174	23,279	24,887	114,340	270,945	276,716
Number of Claims Reported	865	474	3,730	2,069	6,273	7,138	9,632
Residential	549	361	1,438	648	2,447	2,996	5,530
Commercial	316	113	2,292	1,421	3,826	4,142	4,102
Number of Entities w/ Exposure*	169	50	43	18	111	280	278
Residential	75	24	32	7	63	138	148
Commercial	104	38	41	17	96	200	201

*The total number of entities will not equal the sum of the sub-categories given there are entities that have exposure to both sub-categories

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Attachment Three
Surplus Lines (C) Task Force
11/7/24

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

IID Surplus Lines Industry Summary

States & Territories

2023 U.S. Surplus Lines Premiums

Rank	State	U.S. Domestic Insurers	Lloyd's Syndicates	Non-U.S. Insurers	Totals	SL Market Share *
1	California	$15,403,629,121	$3,074,690,132	$1,385,600,761	$19,863,920,014	17%
2	Texas	$10,394,391,009	$3,016,096,459	$1,679,917,452	$15,090,404,920	15%
3	Florida	$11,478,833,391	$2,551,891,933	$820,878,897	$14,851,604,221	16%
4	New York	$6,523,182,187	$1,587,786,478	$745,469,663	$8,856,438,328	13%
5	Illinois	$2,824,695,779	$805,509,447	$448,242,401	$4,078,447,627	11%
6	New Jersey	$2,496,641,717	$501,137,262	$260,809,160	$3,258,588,139	11%
7	Georgia	$2,346,094,922	$577,628,111	$294,751,794	$3,218,474,827	10%
8	Louisiana	$2,279,543,691	$604,008,667	$185,267,217	$3,068,819,575	18%
9	Pennsylvania	$2,187,544,394	$424,872,021	$318,599,357	$2,931,015,772	9%
10	Massachusetts	$1,849,961,476	$548,766,117	$209,821,787	$2,608,549,380	12%
11	Washington	$1,814,436,195	$368,349,272	$230,054,223	$2,412,839,690	13%
12	Colorado	$1,669,322,455	$342,914,147	$143,165,642	$2,155,402,244	10%
13	Ohio	$1,476,678,394	$341,304,697	$222,535,878	$2,040,518,969	9%
14	North Carolina	$1,458,962,751	$346,421,315	$168,694,098	$1,974,078,164	8%
15	Virginia	$1,303,169,566	$300,381,346	$335,590,577	$1,939,141,489	9%
16	South Carolina	$1,355,874,233	$323,075,820	$112,344,054	$1,791,294,107	12%
17	Tennessee	$1,231,402,170	$279,078,854	$130,030,996	$1,640,512,020	9%
18	Alabama	$1,203,846,328	$298,664,681	$131,013,015	$1,633,524,024	12%
19	Missouri	$1,182,935,584	$234,429,952	$186,679,168	$1,604,044,704	9%
20	Arizona	$1,247,162,055	$199,086,030	$129,139,545	$1,575,387,630	9%
21	Michigan	$1,090,090,347	$200,128,558	$159,446,847	$1,449,665,752	6%
22	Indiana	$1,099,333,712	$173,989,894	$155,739,123	$1,429,062,729	9%
23	Minnesota	$879,960,508	$191,798,652	$158,623,060	$1,230,382,220	7%
24	Maryland	$870,060,838	$240,521,304	$106,091,797	$1,216,673,939	7%
25	Connecticut	$854,497,756	$231,117,096	$103,241,839	$1,188,856,691	10%
26	Oklahoma	$774,399,551	$141,645,711	$119,287,665	$1,035,332,927	9%
27	Oregon	$731,712,943	$170,725,416	$103,794,409	$1,006,232,768	9%
28	Wisconsin	$712,479,807	$148,973,801	$114,414,272	$975,867,880	7%
29	Mississippi	$721,571,113	$152,678,949	$43,171,017	$917,421,079	12%
30	Nevada	$668,726,152	$116,719,209	$90,615,396	$876,060,757	10%
31	Utah	$622,643,739	$172,732,002	$60,858,538	$856,234,279	10%
32	Iowa	$568,144,598	$120,151,705	$51,424,879	$739,721,182	7%
33	Arkansas	$515,488,073	$117,119,205	$45,058,786	$677,666,064	8%
34	Kentucky	$462,329,861	$133,346,599	$57,529,762	$653,206,222	6%
35	Kansas	$434,902,685	$89,410,032	$73,761,443	$598,074,160	6%
36	Hawaii	$421,656,525	$92,436,533	$59,491,225	$573,584,283	16%
37	Dist. Columbia	$405,759,450	$65,612,781	$47,809,112	$519,181,343	18%
38	Nebraska	$378,062,669	$71,647,855	$36,369,653	$486,080,177	6%
39	Delaware	$291,287,477	$61,842,526	$42,507,049	$395,637,052	10%
40	Rhode Island	$263,750,378	$82,101,988	$18,170,591	$364,022,957	10%
41	Idaho	$259,544,526	$42,356,818	$40,700,257	$342,601,601	7%
42	New Mexico	$267,562,096	$28,435,011	$21,502,909	$317,500,016	6%
43	Montana	$230,658,124	$45,744,300	$26,564,022	$302,966,446	8%
44	Alaska	$196,332,978	$63,717,577	$30,021,686	$290,072,241	14%
45	West Virginia	$176,917,331	$27,365,018	$19,265,111	$223,547,460	6%
46	New Hampshire	$174,188,660	$22,826,016	$25,249,782	$222,264,458	7%
47	North Dakota	$151,266,480	$22,012,463	$45,981,012	$219,259,955	6%
48	Maine	$163,751,250	$31,560,877	$20,368,307	$215,680,434	6%
49	Vermont	$118,470,882	$25,594,643	$8,650,609	$152,716,134	9%
50	South Dakota	$101,775,710	$24,472,987	$25,476,308	$151,725,005	4%
51	Wyoming	$116,279,435	$24,910,877	$9,017,915	$150,208,227	8%
52	U.S. Virgin Islands	$12,964,053	$56,532,887	$5,150,128	$74,647,068	33%
53	Puerto Rico	$28,255,360	$27,581,528	$6,997,157	$62,834,045	2%
54	Guam	$2,066,945	$3,155,965	$3,611,723	$8,834,633	2%
55	American Samoa	$659	$298,711	$902,787	$1,202,157	97%
56	Northern Mariana Islands	$253,366	$2,091	$106,588	$362,045	2%
	Grand Total	**$86,495,453,455**	**$19,947,360,326**	**$10,075,578,449**	**$116,518,392,230**	
	% of Total	74.2%	17.1%	8.6%	100.0%	

***** Denominator = P/C U.S. domiciled admitted & non-admitted insurers and non-U.S. insurers and syndicates operating in the U.S. market.

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TITLE INSURANCE (C) TASK FORCE

Title Insurance (C) Task Force Nov. 18, 2024, Minutes 7-164
Title Insurance (C) Task Force Oct. 4, 2024, Minutes (Attachment One) 7-168
Updated Survey of State Insurance Laws Regarding Title Data and Title Matters Report (Attachment Two) 7-169

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Draft: 11/26/24

Title Insurance (C) Task Force
Denver, Colorado
November 18, 2024

The Title Insurance (C) Task Force met in Denver, CO, Nov. 18, 2024. The following Task Force members participated: Eric Dunning, Chair (NE); Kevin Gaffney, Vice Chair, and Emily Brown (VT); Lori K. Wing-Heier represented by Sian Ng-Ashcraft (AK); Mark Fowler represented by Erick Wright (AL); Barbara D. Richardson represented by Tom Zuppan (AZ); Karima M. Woods represented by Angela King and Pratima Lele (DC); Michael Yaworsky represented by Joe Hart (FL); Doug Ommen represented by Mathew Cunningham (IA); Dean L. Cameron represented by Shannon Hohl (ID); Holly W. Lambert represented by Ronda Ankney (IN); Vicki Schmidt represented by Julie Holmes (KS); Timothy J. Temple represented by Chuck Myers (LA); Marie Grant represented by William Fawcett (MD); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Blaine Bergstedt (ND); Alice T. Kane represented by Tim Vigil (NM); Judith L. French represented by Timothy Schirmer (OH); Glen Mulready represented by Erin Wainner (OK); Michael Humphreys represented by Michael McKenney (PA); Elizabeth Kelleher Dwyer represented by Patrick Smock and Beth Vollucci (RI); Michael Wise represented by Karl Bitzky (SC); Larry D. Deiter represented by Tony Dorschner (SD), and Scott A. White represented by Angela Crooker (VA).

1. Adopted its Summer National Meeting Minutes

Hohl made a motion, seconded by Commissioner Gaffney, to adopt the Task Force's Aug. 14 minutes (*see NAIC Proceedings – Summer 2024, Title Insurance (C) Task Force*). The motion passed unanimously.

The Task Force also conducted an e-vote that concluded Oct. 4 (Attachment One) to adopt its 2025 proposed charges (*see NAIC Proceedings – Fall 2024, Property and Casualty Insurance (C) Committee, Attachment Four*).

2. Adopted the *Survey of State Insurance Laws Regarding Title Data and Title Matters*

Commissioner Gaffney made a motion, seconded by Hart, to adopt the updated *Survey of State Insurance Laws Regarding Title Data and Title Matters* report (Attachment Two). The motion passed unanimously.

3. Heard an Update from NAIC Government Relations Staff on Recent Federal Activities

Alexander Swindle (NAIC) said the federal government has been increasingly active in the title insurance space, particularly with initiatives that address housing affordability and regulatory reform. As the new administration transitions there will be new priorities. The Biden Administration's affordable housing strategy this past year brought increased scrutiny to the title space. In March, the Federal Housing Finance Agency (FHFA) announced a title pilot program that replaces lender title policies with a waiver, reflecting the administration's plan to explore alternatives to traditional insurance.

In May, when Federal Home Loan Mortgage Corporation (Freddie Mac) expanded its program to bypass title insurance and allow attorney opinion letters (AOLs) to replace them, it came with resistance from several lawmakers. Rep. Andrew Garbarino (R-NY) notably introduced his bipartisan bill, the Protecting America's Property Rights Act (H.R. 5837), with 15 cosponsors that would require title insurance on all Federal National Mortgage Association (Fannie Mae) and Freddie Mac loans. Additionally, congressional staff and Rep. Emanuel Cleaver (D-MO) reached out to the NAIC last spring with concerns about title alternatives and AOLs. AOLs, especially United Wholesale Mortgage's program, have been being used and heavily marketed in more states,

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including Florida, Pennsylvania, and Texas, in particular. The NAIC continues to engage with Capitol Hill staff and educate them on title insurance.

The Consumer Financial Protection Bureau (CFPB) first considered a ban on charging homebuyers for lender title insurance last spring. In June, they requested public comment on fees imposed in residential mortgage transactions, including title insurance. It closed in August and received 974 comments. Many were from settlement services professionals and industry associations. If CPFB decides to move forward on any regulatory changes, they will issue proposed rules for public comment. No further action is likely to be taken in the new administration.

FHFA Director Sandra Thompson was expected to testify before the House Committee on Financial Services this past September. Unfortunately, due to an injury, she has postponed most events. However, with the new administration and cabinet, there likely is not time left in her appointment for her to testify. While she technically has until the end of 2026 in her term, the U.S. Supreme Court ruled that it was unconstitutional to restrict the president's ability to remove the FHFA director in 2021. There will be new FHFA and CFPB appointees with the new administration.

In addition to a second Trump administration, there will be a new Republican majority in the Senate and House of Representatives. Cabinet picks are still being announced and will need Senate confirmation, but a strong departure from the Biden administration's work in the housing and title insurance space should be expected. When it comes to housing affordability, President Trump is less focused on closing costs than the Biden Administration. He favors a deregulatory approach that could include reviewing how current building regulations drive up costs. He also is interested in opening portions of federal lands for construction. Though not directly controlled by the president, he has promised to work on lowering mortgage rates to remove barriers for buyers. He also links illegal immigration with rising housing costs and believes his deportation proposal could bring a better supply/demand balance to the market.

Right now, the rumor is that the industry is urging President-Elect Trump to privatize Fannie and Freddie in the reconciliation budget package next year. Rep. Andy Barr (R-KY), who might be the next House Financial Services Committee chair, is interested in the idea, but it still could face some hurdles. If privatized, it could lead to more competition and innovation in the title insurance market. However, the change in risk could increase premiums and change demand depending on how the privatization would play out. Allies of the president are reportedly discussing ways to end government control of Fannie Mae and Freddie Mac by possibly bypassing Congress and working through the U.S. Department of the Treasury (Treasury Department). The discussions have included the idea of having the Treasury Department provide partial guarantees for some of Fannie and Freddie's loans, known as a standby guarantee. However, it is worth noting that efforts to privatize Fannie Mae and Freddie Mac have been attempted before, including under Trump's first administration, but all attempts have so far been unsuccessful.

4. Heard an Update on Metrics for the Academy's Title-Related Research

Steven Jackson (American Academy of Actuaries—Academy) said the goals of the Academy's research is to 1) examine the patterns and trends in title insurance expenses prior to the issuance of policies, 2) examine the patterns both across companies and over time, and 3) identify areas, if possible, where the industry might find ways to reduce costs without reducing the quality of their service (for example, by appropriate uses of new technologies). The first phase will rely on annual statement data for direct operations and agents' data from three states to identify potential areas where reductions in expenses seem likely. The second phase will rely on additional data and conversations with industry participants and stakeholders to examine potential reductions in more detail.

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The general strategy for the first phase is to examine variation in levels and composition of expenses in 2023 and over time for a) total expenses, b) expenses per policy, c) insured value per dollar of expense, d) personnel as a share of total expenses, and e) surveys, examinations, and abstracts as a share of total expenses. Once differences are observed, possible sources for differences will be examined. Potential sources include a) market conditions, b) commercial versus residential policies, c) original financings versus refinancings, d) size of insured amounts, e) geography, by state, and f) urban versus rural. Where unexplained differences exist, potential efficiency improvements and savings to consumers from best practices will be examined more closely.

Phase one data sources for direct operations will come from the following annual statement pages: 1) operations and investment exhibit—part 3: expenses for 2001–2023, 2) schedule T for 2010–2023, 3) exhibit of premiums and losses for 2010–2023, 4) operations and investment exhibit—Part 1a: summary premiums written for 2010-2023.

In the first phase, data sources for direct, affiliated, and non-affiliated agencies will come from state agency data calls from Washington (aggregate summaries by region), New Mexico (income and expenses by agency), and Texas. The Academy's next steps are to continue the review of data and then begin a systematic analysis of data. The initial results are expected by the 2025 Spring National Meeting and completion of the first phase is anticipated by the 2025 Summer National Meeting. The Academy seeks feedback on additional metrics that would be useful and what factors might account for variations in the company.

Cunningham asked if the slide with total expenses over time suggests that if competition goes away, the expenses go up. Jackson said the graph on the slide shows the expenses of two companies being added together, presumably the number of policies being added together, so there was no real change in the expense per policy.

McKenney said it appears that, when one goes from county to county, some of the documentation is electronic, and some of it must be accounted for through investigation at the county recorder of deeds. He said it would be interesting to know how this is impacting expenses because if it is driving expenses up, this could necessitate a change to reduce costs. Jackson said this is the next area the Academy would like to study. However, they have not yet found a metric available that measures the percentage of counties or states that have digitized.

Commissioner Gaffney asked if various buckets are used to measure the market conditions. Jackson said the initial metric examines simple title insurance marketing conditions. The analysis will examine if expenses go up when the housing market is growing more rapidly. It will use housing market metrics from external data on a state level. Commissioner Gaffney stated that the Academy may be able to use states that have passed legislation on the digitization of title records to assess the impact of technology. Jackson said the timing of when the legislation was passed would be an important component. Commissioner Gaffney asked if there is a way to assess if title insurance complexity has changed. Jackson said some combination of commercial versus residential and size of financing would likely help assess complexity. He said the Academy would look for data sources to help assess this issue.

Hart asked if the graph of total expenses over time indicated the bottom half of companies have total expenses of zero. Jackson said it indicates they have less than $25,000 in expenses. Hart noted the top quarter of companies have average expenses of $1.2 million and asked what caused the discrepancy. Jackson said the Academy is still investigating this, but consolidation in 2013-2015 is having some impact on the 75th percentile line. The bottom lines are primarily driven by companies that are doing most of their work through indirect operations. For some analysis, the Academy may need to only look at companies (in terms of number of policies) through direct operations because then the bottom lines would move up.

Hohl said it would be helpful to look at staffing levels. She would like to understand if smaller rural counties in Idaho are able to keep expenses down due to having only one or two title staff. Jackson said he believes the Academy has data to assess this and will verify it.

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5. Heard an Update on Aug. 29, 2024, OAG Settlements with Four Title Firms

Lele stated that the District of Columbia Department of Insurance, Securities, and Banking (DISB) is the regulatory agency that issues title company and producer licenses and reviews title insurance forms. It does not have regulatory authority over real estate agents or transactions. Accordingly, its regulatory oversight is limited. In late fall of 2022, a title insurance producer and owner of a settlement company approached DISB regarding the establishment of certain affiliated business arrangements and joint ventures that were operating in the district. The complaint alleged that these entities were established for the sole purpose of steering or referring consumers to certain settlement companies in which they had an ownership interest. In return, they would compensate those real estate agents with kickbacks for the business that they generated. In addition to the allegations of kickbacks and steering, this behavior may have precluded consumers from shopping for the best price, as agents steered consumers to only those vendors in which they had a financial incentive and ultimately received compensation based on referral volume or value. It was alleged that this conduct resulted in District consumers paying an inflated price for title and settlement services. At the time the complaint was made, the title producer owner provided the department with supporting documentation and information.

DISB learned shortly thereafter that this individual simultaneously approached the Office of the Attorney General for the District of Columbia (OAG) with identical complaint documentation and information. In response, DISB conducted a review of supporting documentation of the complaint and interviewed some market participants. The department also contacted these affiliated business arrangements directly and sent written inquiries regarding their general operation referral structure, incentive programs, members, and financial arrangements.

The department confirmed that real estate agents at these joint ventures were also licensed in the district to sell title insurance policies and all of the agents within those joint ventures were licensed as well. The department did not receive any consumer complaints related to the cost of title insurance premiums. There also were no allegations made regarding improper reduction in insurance rates or credits in exchange for using a particular settlement company.

In August 2023, DISB started to hold discussions with the OAG and learned that it was conducting a comprehensive investigation related to these affiliated business arrangements. DISB does not regulate the formation of affiliated businesses. The OAG enforces many of the district's laws, including its consumer protection, antitrust, rental housing, and civil rights laws. Violations of other statutes and regulations that govern consumer merchant transactions can separately constitute a violation of the district's Consumer Protection Procedures Act. Therefore, OAG often has overlapping enforcement authority with district regulatory agencies, such as DISB.

While OAG and District regulatory agencies often collaborate in areas of common interest, the OAG is an independent executive agency with separate enforcement powers and decision-making processes. The OAG has the authority to file enforcement actions as lawsuits directly in court as opposed to administrative proceedings. When the OAG takes enforcement action, it can seek a variety of remedies, including injunctive relief, restitution, economic damages, civil penalties, and attorney's fees. Subsequently, in September 2024, the OAG announced settlement agreements with these title companies that ultimately totaled $3.8 million.

Kenneth Trepeta (Real Estate Services Providers Council—RESPC) stated that RESPC is concerned with the OAG's action because it was outside of 30 years' worth of practices. Thus, it has raised concerns among members who endeavor to be in compliance with affiliated business arrangements. Insurance commissioners and regulators should work with the industry to ensure compliance on these issues.

Having no further business, the Title Insurance (C) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2024/TITLE/11-TitleTF.docx

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Attachment One
Title Insurance (C) Task Force
11/18/24

Draft: 10/16/24

Title Insurance (C) Task Force
E-Vote
October 4, 2024

The Title Insurance (C) Task Force conducted an e-vote that concluded Oct. 4, 2024. The following Task Force members participated: Eric Dunning, Chair (NE); Kevin Gaffney, Vice Chair (VT); Mark Fowler represented by Erick Wright (AL); Lori K. Wing-Heier (AK) represented by Alex Reno; Barbara D. Richardson (AZ); Michael Yaworsky represented by Stephanie Avello (FL); Dean L. Cameron represented by Shannon Hohl (ID); Holly W. Lambert (IN) represented by Ronda Ankney, Dawn Bopp, and Patrick O'Connor; Vicki Schmidt represented by Julie Holmes (KS); Timothy J. Temple represented by Tim Temple (LA); Marie Grant represented by Jessica Blackmon (MD); Grace Arnold represented by Jason Broberg and Jacqueline Olson (MN); Scott Kipper represented by Todd Rich (NV); Alice T. Kane represented by Timothy Vigil (NM); Mike Causey represented by Fred Fuller (NC); Judith L. French represented by David Barney (OH); Glen Mulready represented by Erin Wainner (OK); Elizabeth Kelleher Dwyer represented by Patrick Smock (RI); Michael Wise presented by Will Davis (SC); Scott A. White represented by Angela Crooker (VA).

1. Adopted its 2025 Proposed Charges

The Task Force conducted an e-vote to consider adoption of its 2025 proposed charges (*see NAIC Proceedings – Fall 2024, Property and Casualty Insurance (C) Committee, Attachment Four)*. The motion passed unanimously.

Having no further business, the Title Insurance (C) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/Fall 2024/TITLE/E-Vote/10-TitleTF.docx

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NAIC Title Insurance (C) Task Force

Survey of State Insurance Laws Regarding Title Data and Title Matters

December 2024

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The Title Insurance (C) Task Force conducted a survey of each jurisdiction's laws and regulations regarding title insurance. The Task Force specified in its 2024 charges it would update the *Survey of State Insurance Laws Regarding Title Data and Title Matters*. The survey's intent is to be a tool for state insurance regulators and interested parties to gain insight into the regulation of title insurance. The Task Force members enhanced the survey and sent it out for completion in December 2024. Respondents were the insurance department or other jurisdictional agency responsible for title agents or title insurance as appropriate in each jurisdiction. The information in this document contains the results of the survey. The initial responses were provided in Microsoft Forms and then summarized in the following tables. Each jurisdiction is given an opportunity to review the data for accuracy. Requests for revisions can be sent to Anne Obersteadt at aobersteadt@naic.org.

DISCLAIMER

THE DATA REFLECTED IN THIS REPORT WAS VOLUNTARILY SUBMITTED BY STATE INSURANCE DEPARTMENTS. THE NAIC DOES NOT GUARANTEE THE TRUTH, ACCURACY, QUALITY OR COMPLETENESS OF THE DATA AND IS NOT RESPONSIBLE FOR ERRORS, OMISSIONS OR RESULTS OF FURTHER USE OF THE DATA. THE DATA SUBMITTED MAY REFLECT ONLY THE OPINIONS OF INDIVIDUAL RESPONDENTS TO AN INFORMAL SURVEY. THE SURVEY RESULTS DO NOT CONSTITUTE A BINDING LEGAL OR REGULATORY OPINION.

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	1. From which of these title participants is the state department/division authorized to require?						
	Title Insurers	Title Agents	Attorneys	Abstractors	Escrow/ Settlement Agents	N/A	Other
AL	X						
AK	X						
AS						X	
AZ	X	X					
AR	X	X					
CA	X	X			X		
CO	X	X					
CT	X	X					
FL	X	X					
GA	X						
ID	X	X					
IN	X	X		X	X		
KS	X	X			X		
LA						X	
ME	X	X	X				
MD	X	X	X		X		
MA	X						
MI	X	X					
MN	X	X		X	X		
MS						X	
MO	X						
MT	X	X	X				Any in vilation of MCA § 33-1-311 (4), MCA § 33-1-315, and ARM 6.6.2202 (15)
NE	X	X		X	X		
NV	X	X					
NM	X	X			X		
NC	X						
ND	X						
OH	X	X					Title Ins. Marketing Reps
OK	X	X					
OR	X						
PA	X	X					
PR	X	X					
RI	X	X					
SC	X						
TN	X	X					
TX	X	X			X		
UT	X	X	X		X		Title Ins. Marketing Reps
VT	X	X	X				
VA		X			X		
WA	X	X					
WV	X						
WI	X	X					
WY	X	X					

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	2. From which of these title participants is the state department/division authorized to require title insurers to obtain the participant's data and report it to the state?					
	Title Insurers	Title Agents	Attorneys	Escrow/ Settlement Agents	N/A	Other
AL					X	
AK	X					
AS					X	
AZ		X		X		
AR		X				
CA	X			X		
CO		X		X		
CT					X	
FL	X	X				
GA	X					
ID					X	
IN		X		X		
KS	X					
LA					X	
ME	X	X	X			
MD		X	X	X		
MA	X					
MI		X				
MN	X					
MS					X	
MO	X	X				
MT					X	
NE	X	X		X		
NV	X	X				
NM	X	X		X		
NC	X					
ND	X					
OH	X	X				
OK	X					
OR	X					
PA	X	X				
PR		X				Anyone involved in insurance
RI					X	
SC	X					
TN	X	X				
TX	X	X		X		
UT						Annual report requirements for agency title insurance producers
VT					X	
VA	X	X		X		
WA					X	
WV					X	

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	2. From which of these title participants is the state department/division authorized to require title insurers to obtain the participant's data and report it to the state?					
	Title Insurers	Title Agents	Attorneys	Escrow/ Settlement Agents	N/A	Other
WI						Title insurers/agents may be indirectly required
WY	X	X				

	3. Comments regarding the state's general authority to collect agent data:
AL	N/A
AK	3 AAC 27.340 requires title insurance limited producers to provide the title insurance company with all data necessary for the title insurance company to comply with the requirements under 3 AAC 27.320(c)(3). Collection of agent data is not usually asked for unless there is suspicion or report of activity not complying with statute or regulation. Then A.S. 21.27.020 provisions requiring the Director to know if someone was trustworthy would trigger a request.
AS	ASCA Title 29.0205 list the authority of the Insurance Commissioner.
AZ	The Department has authority to request information from title insurers and agents. Escrow/Settlement agents are regulated by the Financial Institutions Division of the Department. Arizona does not have abstractors.
AR	The Department is authorized by statute to collect data from title agents pursuant to Ark. Code Ann. 23-64-512 and 23-104-406.
CA	CA Code of Regulations, Title 10 sections 2355.1 and 2355.2 approved in August of 2009, require title insurers to submit a statistical plan and income report. CA Code of Regulation, Title 10 section 2355.4 authorizes rating examinations of title insurers, title agents and controlled escrow companies. Insurance Code Section 730 et. seq. provides exam authority.
CO	C.R.S. 10-1-108(5)-Duties of Commissioner-Conduct investigations and examinations.
CT	Under Conn. Gen. Stat. (CGS) section 38a-16, the Insurance Commissioner is authorized to conduct investigations under Title 38a and pursuant to such investigation, the Commissioner may issue "data calls, subpoenas, administer oaths..."
FL	Section 627.782, F.S., provides specific authorization for the Office of Insurance Regulation (OIR) to collect data from both agnecies and insurers. Section 627.8437, F.S., states that the Department of Financial Services shall suspend, revoke or refuse to renew and license an agency that fails to timely submit data as required. Rules 69O-186.013 and 69O-186.014, F.A.C. outline the data required
GA	Title insurers are required to file their forms but are not required to file rates and rules.
ID	§ 41-2705(6), Idaho Code, insurers & agents; § 41-2710(7), Idaho Code, examination of agents.
IN	IC 27-7-3. Chapter 3, Abstract and Title Insurance

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	3. Comments regarding the state's general authority to collect agent data:
KS	-K.S.A 40-103: the Commissioner has general supervision, control and regulation of companies or persons involved in transacting insurance business in the state. -K.S.A. 40-952(c): Agents/agencies must file rates and charges for cost of title insurance included in premium, and any fees charged for non-insurance-related services, e.g., closing/escrow costs, document prep, etc., if handle title work in counties with over 10K in population. -Bulletin 1989-31: Also must file a U & U filing if vary from rates or other charges filed with the Department due to a unique or special situation presenting higher risks or need for additional services. -K.S.A. 40-1137(d): Must file by January 30 an annual audit of escrow/settlement/closing account done by a CPA or insurer with which the agent/agency has a licensing agreement. -K.S.A. 40-1138(b): A title insurance agent must make available all books and records relating to escrow, settlement and closing business upon request. -KSA 40-4909(a)(17): All licensed agents must respond to inquiries from the Commissioner within 15 days
LA	N/A
ME	Data would be collected from attorneys in their capacity as title agents.
MD	Annotated Code of Maryland and Insurance Article.
MA	While the Department of Insurance's regulation of title insurance is primarily limited to the solvency of the title insurance companies, applicable Massachusetts law (see M.G.L. c. 175, §§ 114, 116 & 116A) does provide the Commissioner of Insurance with the authority to examine title insurers licensed to do business in Massachusetts. We have not, however, historically used this authority to gather agent data from licensed entities
MI	DIFS may collect agent data under its general authority through MCL 500.249.
MN	We have authority to require production of data under Minnesota Statutes, sections 45.027 and 60A.031 (exams/market analysis).
MS	N/A
MO	Section 374.190, RSMo; Section 374.205, RSMo; Section 381.023.4, RSMo
MT	A title insurance producer shall keep books of account, records, and vouchers pertaining to any escrow, closing, settlement, or title indemnification business transacted, in a manner that allows the Commissioner to readily ascertain whether the title insurance producer has complied with all applicable provisions of this title [MCA § 33-25-201 (9)]. The offices, places of business, books, records, accounts, safes, files, and papers of an escrow agent shall be maintained so as to be freely accessible and available for audit, inspection, or examination by the Commissioner at all reasonable times [ARM 6.6.2202 (13)]. See also MCA § 33-1-311 (4) and MCA § 33-1-315.
NE	Neb. Rev. Stat. 44-1993 (entire); 44-19,107
NV	Commissioner's general authority is pursuant to NRS 679B.120(5), NRS 692A.100(4) and NRS 692A.260
NM	The data is collected annually by statute and pursuant to state regulations.
NC	Chapter 58 of the NC General Statutes, Articles 2, 3, 6, 26, and 40.
ND	N/A
OH	The Ohio Department of Insurance has the power necessary to perform all duties vested in and imposed upon it by Ohio law.

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	3. Comments regarding the state's general authority to collect agent data:
OK	Every title insurer holding a Certificate of Authority from the Oklahoma Department of Insurance shall conduct a policy inventory audit, in accordance with its accepted company practice, of each of its licensed agents periodically, but at least every two years. Such policy inventory audit is defined as an audit of the unused forms in the possession of each of its licensed title insurance agents so as to determine that all used policy forms have been reported to the title insurer. A report of each such audit shall be made to the Oklahoma Insurance Department in writing in a form acceptable to the Insurance Commissioner. Interested parties may upon request obtain a copy of an approved title policy inventory audit report form from the Oklahoma Insurance Department per OAC 365-20-3-5. All licensed insurers and HMOs are subject to Annual Statement Filings including annual reporting and premium tax remittance per Oklahoma Title 36 O.S. § 624.
OR	Title agent data can be collected as part of a targeted exam during market analysis.
PA	Statutes require title agents to give the Commissioner access to all agent books and records and to maintain the same in such a manner that the Commissioner or his representative may determine compliance with the law. See 40 P.S. § 910-27. Title agents must also respond in writing to inquiries from the Commissioner. See 40 P.S. § 910-28. Violations of these provisions are punishable by license revocation. Finally, our statute provides that a title insurer shall have access and a right to copy all of an agent's files and records related to its business in a form acceptable to the insurer, and the Commissioner shall have access to all files, accounts and records of the title agent in a form usable by the Commissioner. See 40 P.S. § 910-26.1(6).
PR	Sections 2.030(12), 2.110 and 2.120 of the Puerto Rico Insurance Code
RI	R.I. Gen. Laws Chapters 27-13.1, 27-71
SC	South Carolina does not have authority to collect agent data
TN	Tennessee law, T.C.A. 56-35-101 et seq. and 56-35-201 et seq., include general rulemaking authority so that rules can be promulgated to require agent data collection by title insurance companies, title insurance agents, and title insurance agencies; however, Tennessee law does not currently have any substantive requirements for the collection of agent data.
TX	Texas Insurance Code – Sec. 2703.153
UT	Utah has broad authority to collect relevant information from any Department licensee. Utah Code Section 31A-2-202.
VT	N/A
VA	Chapter 18 of the Code of Virginia allows for collection of data/documentation. https://law.lis.virginia.gov/vacode/title38.2/chapter18/
WA	Washington's general authority to collect title insurance agent data is located in three sections of insurance laws in the Revised Code of Washington (RCW), including RCW 48.17.595, 48.29.017, and 48.29.147. Washington also has rules regulating title insurance agent data in the Washington Administrative Code (WAC) under WAC 284-29-160, 284-29-320, 284-29A-010, 284-29A-040, 284-29A-080, 284-29A-100, and 284-29A-110. See also - Market conduct oversight - Chapters 284-37 WAC and 48.37 RCW.
WV	N/A
WI	The Commissioner has broad authority to collect information from title insurers and agents pertaining to their title insurance business under s. 601.42, Wis. Stat.
WY	Wyoming generally has authority to request data from insurers and agents under its general examination statutes. See, W.S. 26-2-109, 26-2-116 through 26-2-124.

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	4. Does the state department/division currently collect data from title agents?	5. Does the state department/division aggregate or compile data collected from title agents?	6. How would data reported to the state insurance department/division by title agents, attorneys, abstractors and escrow/settlement agents be handled?
AL	No	N/A	N/A
AK	Yes, on an ad hoc basis	No	It depends on the type of data collected
AS	No, but we have the authority to do so if needed	N/A	N/A
AZ	Yes, on an ad hoc basis	Yes	It depends on the type of data collected
AR	Yes, on an ad hoc basis	No	It depends on the type of data collected
CA	Yes, on an ad hoc basis	Yes	Kept confidential
CO	Yes, on an ad hoc basis	Yes	It depends on the type of data collected
CT	No	N/A	Kept confidential
FL	Yes, on a regular basis	Yes	Kept confidential
GA	No	No	Open to public disclosure
ID	Yes, on an ad hoc basis	No	It depends on the type of data collected
IN	Yes, on a regular basis	Yes	Kept confidential
KS	Yes, on a regular basis	No	Open to public disclosure
LA	No	N/A	N/A
ME	Yes, on an ad hoc basis	No	Kept confidential
MD	Yes, on a regular basis	Yes	Kept confidential
MA	No	N/A	N/A
MI	Yes, on an ad hoc basis	No	Kept confidential
MN	Yes, on an ad hoc basis	N/A	It depends on the type of data collected
MS	No	No	N/A
MO	No	N/A	Kept confidential
MT	No, but we have the authority to do so if needed	Yes	It depends on the type of data collected
NE	Yes, on an ad hoc basis	No	Open to public disclosure
NV	No	No	Kept confidential
NM	Yes, on a regular basis	Yes	It depends on the type of data collected
NC	No	No	N/A
ND	No	N/A	N/A
OH	Yes, on a regular basis	Yes	Open to public disclosure
OK	Yes, on a regular basis	No	It depends on the type of data collected
OR	No	No	Kept confidential
PA	Yes, on an ad hoc basis	Yes	It depends on the type of data collected
PR	Yes, on an ad hoc basis	N/A	It depends on the type of data collected
RI	Yes, on an ad hoc basis	No	It depends on the type of data collected
SC	No	No	N/A
TN	No	No	It depends on the type of data collected
TX	Yes, on a regular basis	Yes	Open to public disclosure
UT	Yes, on a regular basis	No	It depends on the type of data collected
VT	No	No	N/A
VA	Yes, on a regular basis	No	Kept confidential
WA	Yes, on a regular basis	Yes	Kept confidential
WV	No	No	N/A
WI	Yes, on an ad hoc basis	N/A	It depends on the type of data collected
WY	No	No	It depends on the type of data collected

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	7. By what legal protection is the data reported kept confidential?
AL	Alabama Code
AK	A.S. 21.06.060 covers what is held confidential and what is an exception. Title insurance companies or agents are not specifically addressed. Rate filings, as to statement and justification for them, is open to public inspection under A.S. 21.66.380. Under A.S. 21.66.460(c), information required for escrow, settlement, and closing charges filed under schedule in the section are available to the public, if requested.
AS	American Samoa Code
AZ	Arizona Revised Statutes (ARS) 20-157.01 provides that materials provided to the Department as part of an examination are confidential and not subject to disclosure. For escrow agents information "shall be prohibited from using or releasing said information except in the proper performance of the Deputy Director's or Agency's duties."
AR	Arkansas law protects information that is part of an examination or active and open investigation.
CA	Statutory authority, both regulatory and non-regulatory, and general state law as applicable.
CO	Confidential Treatment and Confidentiality of Records-C.R.S. 10-3-808 and 10-3-1709
CT	CGS section 38a-16 (a)(2) provides that data provided in response to a data call under that section shall not be subject to disclosure under the CT Freedom of Information Act.
FL	Section 626.84195, F.S. addresses the confidentiality of information supplied by title insurance agencies and insurers. The information is considered proprietary business information and is exempt from Florida's public records laws.
GA	Filed through SERFF. System can be amended to not allow public access.
ID	Idaho Code
IN	Market Regulation Laws
KS	N/A
LA	N/A
ME	Market regulation laws
MD	Market Regulation Laws
MA	N/A
MI	MCL 500.222, 500.226, 500.1246
MN	Minn. § Stat. 13.39, Minn. Stat. § 13.41, Minn. Stat. § 60A.03, Minn. Stat. § 60A.031
MS	Mississippi does not have statutory authority to collect data from title agents.
MO	Section 374.070, RSMo, Section 374.071, RSMo, Missouri Regulation 20 CSR 500-7.070(2)
MT	There is a constitutional presumption that all documents in the hands of public officials are subject to public inspection.
NE	Neb. Rev. Stat. 44-5906(8)(a); 44-1997(4); 44-5906(8)(a)
NV	NRS 692A.117. NRS 6798. 190(5).(6U7) The Commissioner may classify as confidential documents obtained or received on the express condition that they remain confidential.
NM	Statutory Authority
NC	N/A
ND	NA
OH	Data collected as a result of an annual review is public information. Information can only be kept confidential if it falls into an exception of Ohio's public records law.

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	7. By what legal protection is the data reported kept confidential?
OK	Data collected in response to a complaint, as part of an investigation, or any financial exam or market conduct survey is confidential by law. Data collected in a policy inventory audit and annual financial statements are public information by law.
OR	Market analysis examination statutes
PA	Generally, information submitted to the Department is considered public unless it is exempt from public disclosure under Pennsylvania's Right-to-Know Law or other applicable statute. See 65 P.S. §§ 67.101 - 67.3104. The person or entity submitting the information must typically assert a claim that the information submitted is exempt from disclosure under one of the exceptions to public disclosure such as that for trade secrets or confidential proprietary financial information.
PR	All data collected is presumed to be public information subject to public inspection except for those specific cases provided by law or that are privileged among other reasons stated on Section 2.090 of Puerto Rico Insurance Code
RI	If requested in an examination it would fall under the exclusion from public access in our examination statute. If requested in another manner it would fall under our general access to public records statute and depend upon the information requested.
SC	Title data is not regularly collected, but the Department has the authority to request it from insurers. Confidential data requested by the Department is statutorily protected.
TN	N/A
TX	N/A
UT	Utah's Government Records Access and Management Act, Utah Code Sections 63G-2-101, et seq. is similar to the Freedom of Information Act. Additionally, data is protected under Utah Code Sections 31A-2-204, 31A-4-113.5, 31A-5-701, 31A-16-109, 31A-16a-108, 31A-16b-106, 31A-17-517, 31A-17-608, 31A-23a-104.
VT	N/A
VA	Vrginia Code
WA	Data reported is protected by statute, kept confidential, and not subject to the state's Public Records Act (Ch. 42.56 RCW), unless the Insurance Commissioner finds, after notice and hearing with affected parties, it is in the public interest to disclose the information (RCW 48.29.018). RCW 48.17.595(6) also provides industry participants with confidentiality protections in certain circumstances.
WV	N/A
WI	In general, all records held by the Office of the Insurance Commissioner (OCI) are subject to inspection under Wisconsin's open records law found in s. 19.35 (1), Wis. Stat., unless the record falls within the scope of one of the numerous exceptions. In addition, OCI has specific authority to withhold certain records under s. 601.465, Wis. Stat, and s. Ins 6.13, Wis. Adm. Code.
WY	Wyoming Public Records Act, W.S. 16-4-201 et seq. Other sections of the insurance code may be applicable depending on the type of data.

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	8. Statutes and regulations regarding confidentiality and public disclosure of title data:
AL	Ala. Code Section 27-2-24(g) [General Examination Authority; Confidentiality]
AK	A.S. 21.06.060; A.S. 21.66.380; A.S. 21.66.460(c)
AS	ASCA. Title 29.0211,.0212,0213
AZ	Arizona Revised Statutes (ARS) 20-157.01 and 20-158(F), ARS 6-837, 832, and 6-860
AR	Ark. Code Ann. 23-61-103(d)(2), 23-15-208, and 23-103-411
CA	Insurance Code Sections 730 et. seq. (including 735.5), 12370-12377, 12389-123897, 1215 et. seq. and 12919; Civil Code Sections 3426 et. Seq. (Uniform Trade Secret Act); Government Code Section 6254(d) (portion of the Public Records Act).
CO	C.R.S. 10-3-808 and 10-3-1709
CT	CGS section 38a-16 (a)(2)
FL	Section 626.84195, F.S.
GA	O.C.G.A. 33-7-8 defines title insurance and lists it as a line of insurance subject to regulation. O.C.G.A. 33-9-3(a)(6) exempts title insurers from having to file rates and rules. O.C.G.A. 33-24-2(4) exempts title insurance policies from certain provisions such as cancellation.
ID	Title 74, Chapter 1, Idaho Code, the Idaho Public Records Act § 41-2710(7), Idaho Code.
IN	IC 27-7-3-15.5
KS	N/A
LA	N/A
ME	24-A M.R.S. § 216
MD	MD Ins Code § 2-209 Public Information Act
MA	N/A
MI	MCL 500.249, 500.1246, 500.222, 500.226
MN	Minn. § Stat. 13.39, Minn. Stat. § 13.41, Minn. Stat. § 60A.03, Minn. Stat. § 60A.031
MS	N/A
MO	Section 374.070, RSMo, Section 374.071, RSMo, Missouri Regulation 20 CSR 500-7.070(2)
MT	(Great Falls Tribune v. MT Public Service Commission, 2003 MT 359, P 54, 319 Mont. 38, P 54, 82 P.3d 876, P 54). ¶¶ 56 – A non-human entity must make a prima facie case showing that data is confidential.
NE	Neb. Rev. Stat 44-1997(4); 44-5906(8)(a); Neb. Rev. Stat. 84-712 - 84-712.09
NV	NRS 692A.117. 679B.190(5),(6),(7)
NM	New Mexico's Inspection of Public Records Act. 14-2-1 et. seq. NMSA; 59A-30A-16 NMSA
NC	N/A
ND	N.D.C.C. 44-04-18.4
OH	Ohio Revised Code Sections 149.43, 3901.045, 3901.075, 3901.36, 3901.48, and 3905.24
OK	36 O.S. § 306 (A), 36 O.S. § 309.4(F), OAC 365:25-7-81, OAC 365-20-3-5, 36 O.S. § 624
OR	The market analysis statute states that data collected in an exam is confidential.
PA	65 P.S. §§ 67.101 - 67.3104
PR	Section 2.090 Puerto Rico Insurance Code
RI	R.I. Gen. Laws §§ 27-13.1-5, 27-71-8, and 38-2-2

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	8. Statutes and regulations regarding confidentiality and public disclosure of title data:
SC	S.C. Code Ann. 38-13-140, Director may request information and all replies are strictly confidential. Section 38-13-160, Confidentiality of special reports.
TN	There are no specific statutes or regulations regarding confidentiality and public disclosure of title data; however, T.C.A. 10-7-501 et seq. pertains to what records, on a statewide basis, may be kept confidential and excluded from the public record. T.C.A. 56-1-420 keeps certain insurance company actuarial information confidential, and T.C.A. 56-6-120 keeps investigation information related to insurance companies or agents confidential.
TX	Texas Insurance Code, 2602.011(c), 2651.155, 2651.205(a)(2), 2651.206(a)(4); Form T-1 Conditions 6. (b); Form T-1R Conditions 3.c; Form T-2 Conditions 6.(b); Form PPT-1 Conditions 5; Forms PPT-5, PPT-6, PPT-7 Conditions and Stipulations E.5; Forms PPT-8 and PPT-9 Conditions and Stipulations E.6; Forms PPT-10, PPT-11, and PPT-12 Conditions and Stipulations 5.
UT	Utah Code Sections 63G-2-101, et seq., 31A-2-204, 31A-4-113.5, 31A-5-701, 31A-16-109, 31A-16a-108, 31A-16b-106, 31A-17-517, 31A-17-608, 31A-23a-104
VT	N/A
VA	55.1-1016 of the Code of Virginia
WA	RCW 48.17.595(6) and 48.29.018.
WV	W.Va. Code 33-2-9 for the confidentiality of data collected during examination or analyses of a regulated entity.
WI	ss. 19.35 and 19.36, Wis. Stat. s. 601.465, Wis. Stat, and s. Ins 6.13, Wis. Adm. Code
WY	W.S. 16-4-201 et seq.

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	9. What kind of data is collected and how is it used?
AL	Typically data is collected for financial and market conduct examinations.
AK	Yearly rate filings and forms of policies to be written are collected and retained. A.S. 21.66.080 requires an annual statement of all assets and liabilities and all title premiums received during the preceding calendar year. A.S. 21.66.085 allows the Director to require quarterly financial statements. Also, the Director is authorized to examine the books, accounts, assets, and title plants of a company authorized to write title insurance in Alaska to determine there is no impairment of capital and the company has complied with the provisions of the title insurance chapter. See A.S. 21.66.120. Title insurance limited producers must keep records in accordance with A.S. 21.66.280 and the Director may inquire into them under A.S. 21.66.290 and 21.66.330. Rate filings by title insurance companies are required under A.S. 21.66.370. See 3 AAC 27.320 for minimum ratemaking standards and 3 AAC 27.330 for required reports and rate filing. See also 3 AAC 27.350 for short-term rates.
AS	N/A
AZ	Underwriting, claims handling, and operational data which includes procedures and policyholder data for market conduct exams. For escrow agents, an audit of the escrow, account servicing, and subdivision trust activities of the escrow agent to determine if significant deficiencies in the design or operation of the internal control structure of the escrow agent would adversely affect the agent's ability to record, process, summarize and report financial data consistent with the assertions of management in the financial statements.
AR	The Department receives and reviews the annual statutory audits performed by title insurers. It may collect other data, such as closing files and policy records during an investigation.
CA	Data collected may include a review of the books, records, accounts, rates, charges, fees, rating plans, rating systems, underwriting rules, policy forms. It may also include loss or expense experience and the data, statistics, or information collected or used in determining or establishing the rates, charges, fees, rating plans, rating systems, underwriting rules or policy forms. Statistical plans and financial data reports may also be collected. Data collected is to aid in the administration of rate regulatory laws.
CO	Affiliated Business Arrangement Disclosure, late premium remittances, trust account discrepancies, title agent terminations and new agent appointments.
CT	Data is only collected in connection with an investigation of a title insurer or title agent.
FL	Revenues; expenses and losses. The data is used in the analysis of title insurance rates, title search costs, and the condition of the title insurance industry in the state.
GA	Forms are reviewed for compliance with state laws
ID	Complaint information, title and escrow rates, and any related data, including, but not limited to, examinations, investigations, or audits.
IN	Please see IC 27-7-3-15.5
KS	Insurers must submit policy forms for review and approval. Forms are reviewed by policy examiners. Insurers, agencies, and agents must file title rates they will use, as well as other fees and charges for services provided. Rates and fees are accessible to the public and posted publicly on the Department's website. Escrow audit reports are required annually if agent/agency is performing escrow, settlement or closing services. Unique and unusual filings, if premiums or rates charged vary from those on file with the Department. Controlled/associated business reports.
LA	N/A

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	9. What kind of data is collected and how is it used?
ME	We have not collected data from title agents. We have the authority to do so, however, and would collect data for whatever purpose was necessary to enforce the Maine insurance laws.
MD	The Commissioner may examine the accounts, records, documents and transactions of licensees for the purpose of determining compliance with Maryland Insurance Laws.
MA	N/A
MI	Ad hoc, as needed, use varies.
MN	Data relating to compliance issues. It is collected and used in investigations and examinations.
MS	N/A
MO	We collect supplement data from title insurers. It is used to compile reports based on direct written premium, direct premium earned, incurred losses, paid losses, and loss ratio in order to monitor the Missouri market.
MT	MCA § 33-1-311 (4). The Commissioner may conduct investigations of insurance matters. MCA § 33-1-401. Examination of insurers et seq. MCA § 33-25-302. Disapproval of agency contracts.
NE	Neb. Rev. Stat. 44-1993 (2) & (4); 44-19.112(3); 44-19.114(14)
NV	N/A
NM	Revenue/expense for setting title insurance rates, claims history, escrow procedures, and data related to complaints.
NC	N/A
ND	N/A
OH	Ohio collects data related to the annual review of escrow accounts, interest on trust accounts, affiliated business arrangements, errors and omissions insurance, and surety bond coverage. The data is used to determine compliance with Ohio's title insurance laws. Data may also be collected as part of a market conduct or financial exam to determine compliance with Ohio's insurance laws.
OK	Every title insurer holding a Certificate of Authority from the Oklahoma Department of Insurance shall conduct a policy inventory audit, in accordance with its accepted company practice, of each of its licensed agents periodically, but at least every two years. Such policy inventory audit is defined as an audit of the unused forms in the possession of each of its licensed title insurance agents so as to determine that all used policy forms have been reported to the title insurer. A report of each such audit shall be made to the Department in writing in a form acceptable to the Insurance Commissioner. Interested parties may, upon request, obtain a copy of an approved title policy inventory audit report form from the Department per OAC 365-20-3-5. All licensed insurers and HMOs are subject to annual statement filings, including annual reporting and premium tax remittance, per Oklahoma Title 36 O.S. § 624.
OR	Annual statement data is collected from insurers. No data is collected from title agents.
PA	The Department does not regularly collect data from the title industry. In 1984 and 1993, the Department conducted studies of agent commissions. In 2010, it conducted a study of the expense component of title insurance rates. In order to perform the 2010 study, title agent information was required from title insurers in 2009.
PR	The Department collects title insurance information from insurers and title agents on an ad hoc basis. Information is also obtained from title insurers from regular examinations and from its annual and quarterly financial statements.

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	9. What kind of data is collected and how is it used?
RI	Rhode Island is completing a project on title insurance currently. It questioned 20 agents as part of that process and asked questions about disclosure and marketing. It also sent a series of interrogations to 11 title insurers and asked for considerably more, including loss ratios, policy count, oversight of agents and more.
SC	Under South Carolina Code Ann. 38-13-80, every insurer must file a statement showing the business standing and financial condition of the insurer with the Department annually.
TN	The Department currently collects rate information filed by title insurance companies and also collects annual financial statements filed by title insurance companies. The data is used to ensure rates are actuarially justified and to ensure that the title insurance company is financially secure for purposes of licensure.
TX	Income, expenses, losses, number of claims, and number of policies are collected for setting premium rates.
UT	Regarding title insurers, data is collected about their financial condition and used to promote their solvency. Regarding title agents, data is collected concerning their qualifications for a license and their compliance with market conduct laws. The Department also collects data regarding the operations of title insurers, agencies and agents for the purpose of imposing assessments that fund the Department's regulatory activities.
VT	No data is collected. Title agents are licensed and those licenses are subject to approval when renewed.
VA	Real Estate Settlement Agents (RESA) annual audit from title settlement agencies are reviewed for compliance with regulations and Code of Virginia. Market conduct examinations are reviewed for financial stability.
WA	Policy counts and costs to issue policies are collected. Additionally, aggregate data are published and could be used for ratemaking.
WV	Data is not collected from title agents, attorneys, abstractors and escrow/settlement agents.
WI	The Department has broad authority to collect any kind of information from title insurers and agents relating to their title insurance business. Generally, information is collected in relation to filed complaints or as a filing requirement.
WY	No data is currently being collected.

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	10. If the number of policies issued is collected, how are they separated?			
	Policies issued are separated by standard title policies and enhanced title policies	Policies issued are not separated	N/A	Other
AL			X	
AK		X		
AS			X	
AZ		X		
AR		X		
CA			X	
CO			X	
CT			X	
FL				Other
GA		X		
ID			X	
IN				Policy Type: None, Owners, Lenders, Both
KS			X	
LA			X	
ME			X	
MD	X			
MA			X	
MI			X	
MN			X	
MS			X	
MO		X		
MT	X			
NE			X	
NV			X	
NM	X			
NC			X	
ND			X	
OH	X			
OK			X	
OR			X	
PA				Number of policies is reported annually by a title insurance rating organization in its annual statistical report and available for public view using SERFF.
PR			X	
RI	X			
SC			X	
TN			X	
TX			X	
UT			X	
VT			X	
VA			X	
WA		X		
WV			X	
WI			X	
WY			X	

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	11. Statutes and regulations regarding data collection from title participants:
AL	N/A
AK	N/A
AS	N/A
AZ	ARS 20-157, 20-1581, 20-1582, 20-1588, 20-1593, 6-837, 6-832, and 6-860
AR	The Department is authorized by statute to collect data from title agents pursuant to Ark. Code Ann. 23-64-512 and 23-104-406.
CA	Insurance Code Sections 730 et. seq., 12401.5 and 12414.21. California Code of Regulations Title 10 Sections 2355.1, 2355.2 and 2355.4.
CO	C.R.S. 10-1-108 and 10-2-804
CT	N/A
FL	Section 627.782(8), F.S., Rule 69O-186.013 and 69O-186.014, F.A.C.
GA	O.C.G.A. 33-7-8 defines title insurance and lists it as a line of insurance subject to regulation. O.C.G.A. 33-9-3(a)(6) exempts title insurers from having to file rates and rules. O.C.G.A. 33-24-2(4) exempts title insurance policies from certain provisions such as cancellation.
ID	Title 41, chapter 27, Idaho Code. IDAPA 18.05.01
IN	IC 27-7-3. Chapter 3 Abstract and Title Insurance
KS	K.S.A. 40-955; K.S.A. 40-952(c); K.S.A. 40-1137(d), Bulletin 1989-31; K.S.A. 40-2404(14)(h); K.A.R. 40-3-43; K.A.R. 40-3-52
LA	La.R.S. 22:529
ME	24-A M.R.S. § 220, if regulated by the Bureau of Insurance
MD	The Maryland Insurance Administration may collect data from officers, employees and representatives of insurers and producers pursuant to the Annotated Code of Maryland, Insurance Article, Title 2, Subtitle 1, 2 and 2-206.
MA	N/A
MI	MCL 500.222, 500.249, 500.438, 500.1246, 500.2028
MN	N/A
MS	N/A
MO	N/A
MT	MCA § 33-1-311 (4); MCA § 33-1-401; MCA § 33-25-302.
NE	In addition to the aforemetioned, Nebraska Administrative Code Title 210 Chapter 34 ["Title Insurance"], section 006.03
NV	NRS 692A.260. NRS 6798.120, NRS 6798.140, NRS 6798.340
NM	New Mexico Insurance Code 59A-1-1 et. seq.; 58-28-1 et. seq.; 13.14.1 et. seq. NMAC
NC	N/A
ND	N/A
OH	Ohio Revised Code Sections 3901.011, 3901.045, 3901.075, 3901.36, 3901.48, and 3905.24, and 3953.33. Ohio Administrative Code 3901-7-01
OK	36 O.S. § 306 (A), 36 O.S. § 309.4(F), OAC 365:25-7-81, OAC 365-20-3-5, 36 O.S. § 624
OR	ORS 731.752 through 764
PA	40 P.S. §§ 910-26.1(6), 910-27, 910-28, 910-46, 910-47
PR	N/A
RI	R.I. Gen. Laws Chapters 27-13.1 and 27-71
SC	N/A

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	11. Statutes and regulations regarding data collection from title participants:
TN	N/A
TX	Texas Insurance Code Chapter 2703, Subchapter D
UT	Utah Code Sections 31A-2-202, 31A-4-113.5, 31A-5-701, 31A-16-109, 31A-16a-108, 31A-16b-106, 31A-17-517, 31A-17-608, 31A-23a-104.
VT	N/A
VA	38.2-4606 of the Code of Virginia
WA	RCW 48.17.595, 48.29.017, and 48.29.147. WAC 284-29-160, 284-29-320, 284-29A-010, 284-29A-040, 284-29A-080, 284-29A-100, and 284-29A-110. See also, Market conduct oversight, Chapters 284-37 WAC and 48.37 RCW.
WV	N/A
WI	The Commissioner has broad authority to collect information from title insurers and agents pertaining to their title insurance business under s. 601.42, Wis. Stat.
WY	N/A

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	12. Which processes does the state insurance department/division regulate if a title insurance policy is issued?					
	Risk Transfer	Policy Production/ Issuance	Title Search or Abstract	Examination of Title	Escrow & Closing	N/A
AL	X					
AK	X	X	X	X		
AS						X
AZ	X	X	X	X	X	
AR	X	X	X	X		
CA	X	X	X	X	X	
CO		X	X	X	X	
CT	X	X				
FL	X	X	X	X		
GA						X
ID	X	X	X	X	X	
IN		X	X	X	X	
KS			X	X	X	
LA	X				X	
ME	X	X				
MD	X	X		X	X	
MA						X
MI	X	X	X	X	X	
MN	X	X			X	
MS	X					
MO	X	X	X	X	X	
MT		X	X	X	X	
NE		X	X	X	X	
NV	X	X	X	X	X	
NM		X	X	X	X	
NC	X					
ND	X	X				
OH	X	X				
OK	X	X				
OR	X	X	X	X		
PA	X	X				
PR						X
RI		X				
SC		X				
TN		X		X	X	
TX	X	X	X	X	X	
UT	X	X	X	X	X	
VT	X	X				
VA		X			X	
WA	X	X	X	X		
WV	X	X				
WI	X	X				
WY	X	X	X	X	X	

	13. Which processes does the state department/division regulate if NO title insurance policy is issued? (Some states only regulate the transaction if title insurance is involved maintaining ancillary services are not insurance products and therefore only regulated if title insurance is included in the transaction.)					14. Does the department set requirements for standard and/or enhanced title policies?
	Title Search or Abstract	Examination of Title	Clearing of Title Defects	Escrow & Closing	N/A	
AL					X	Yes, for standard and enhanced policies
AK					X	N/A
AS					X	Yes, for standard and enhanced policies
AZ				X		N/A
AR					X	N/A
CA	X	X	X	X		N/A
CO					X	Yes, for standard and enhanced policies
CT					X	N/A
FL					X	N/A
GA					X	N/A
ID	X	X	X	X		N/A
IN				X		Yes, for standard and enhanced policies
KS					X	N/A
LA					X	N/A
ME					X	N/A
MD	X	X	X	X		Yes, for standard and enhanced policies
MA					X	N/A
MI					X	N/A
MN				X		N/A
MS					X	N/A
MO					X	Yes, for standard and enhanced policies
MT	X	X	X	X		Yes, for standard and enhanced policies
NE				X		Yes, for standard and enhanced policies
NV	X	X	X	X		N/A
NM				X		Yes, for standard and enhanced policies
NC					X	N/A
ND					X	N/A
OH					X	N/A
OK					X	Yes, for standard and enhanced policies
OR					X	N/A
PA					X	N/A
PR					X	Yes, for standard and enhanced policies
RI					X	N/A
SC					X	N/A
TN					X	N/A
TX					X	N/A
UT					X	Yes, for standard and enhanced policies
VT					X	Yes, for standard and enhanced policies
VA				X		N/A
WA					X	N/A
WV					X	N/A
WI					X	Yes, for standard and enhanced policies
WY					X	Yes, for standard and enhanced policies

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	15. For which processes does the state department/division regulate the pricing if a title insurance policy is issued?						
	Risk Transfer	Policy Production/ Issuance	Title Search or Abstract	Examination of Title	Clearing of Title Defects	Escrow & Closing	N/A
AL	X						
AK		X	X	X			
AS							X
AZ	X	X	X	X		X	
AR							X
CA	X	X	X	X	X	X	
CO		X	X	X	X	X	
CT	X	X					
FL	X	X		X	X		
GA							X
ID	X	X	X	X	X	X	
IN	X	X					
KS							X
LA	X	X					
ME	X	X					
MD		X					
MA							X
MI	X	X	X	X			
MN	X	X					
MS							X
MO	X						
MT		X	X	X	X	X	
NE							X
NV	X	X	X	X	X	X	
NM		X	X	X	X		
NC	X						
ND	X	X					
OH	X	X					
OK							X
OR	X	X	X	X	X		
PA	X	X	X	X	X	X	
PR							X
RI		X					
SC	X	X					
TN		X					
TX	X	X	X	X	X	X	
UT	X						
VT	X	X					
VA							X
WA	X	X	X	X	X		
WV	X	X					
WI	X	X					
WY		X					

	16. Which processes are included in the title rates?						
	Risk Transfer	Policy Production/ Issuance	Title Search or Abstract	Examination of Title	Clearing of Title Defects	Escrow & Closing	N/A
AL	X	X					
AK	X	X	X	X	X	X	
AS							X
AZ	X	X	X	X		X	
AR	X						
CA	X	X	X	X	X	X	
CO	X	X	X	X	X	X	
CT	X	X					
FL	X	X		X	X		
GA							X
ID	X	X	X	X	X		
IN	X	X					
KS	X	X	X	X	X		
LA	X	X	X	X	X		
ME	X	X					
MD	X	X			X		
MA							X
MI	X	X	X	X			
MN	X	X					
MS							X
MO	X						
MT		X	X	X	X	X	
NE	X	X	X	X	X	X	
NV	X	X	X	X	X		
NM		X	X	X	X		
NC	X	X	X	X	X	X	
ND	X	X					
OH	X	X					
OK							X
OR	X	X	X	X	X		
PA	X	X	X	X	X	X	
PR							X
RI		X					
SC	X	X					
TN	X	X		X			
TX	X	X	X	X	X	X	
UT	X	X	X	X	X		
VT	X	X					
VA		X					
WA	X	X	X	X	X		
WV	X	X					
WI	X	X					
WY		X					

	17. Are rates required to be filed with the state department/ division?	18. How does the state department/division regulate title insurance rates?
AL	Yes	Prior approval
AK	Yes	Prior approval
AS	Yes	Prior approval
AZ	Yes	File and use
AR	No	Rates are not regulated for title insurance
CA	Yes	File and use
CO	Yes	File and use
CT	Yes	Prior approval
FL	No	Promulgate rates
GA	No	Rates are not regulated for title insurance
ID	Yes	File 30 days in advance of use to allow for comments and objections
IN	Yes	Prior approval
KS	Yes	File and use
LA	Yes	Prior approval
ME	Yes	File and use
MD	Yes	File and use
MA	No	Rates are not regulated for title insurance
MI	Yes	File and use
MN	Yes	File and use
MS	Yes	File and use
MO	Yes	Prior approval
MT	Yes	Prior approval
NE	Yes	Prior approval
NV	Yes	Prior approval
NM	Yes	Promulgate rates
NC	Yes	File and use
ND	Yes	File and use
OH	Yes	Prior approval
OK	No	Rates are not regulated for title insurance
OR	Yes	Prior approval
PA	Yes	Title insurance rate filings are generally subject to a File & Use standard (see 40 P.S. § 910-37(d)) unless they are consent-to-rate filings, for which Use and File applies (see 40 P.S. § 910-37(g)). The Department typically issues affirmative approvals of filings that are not consent-to-rate filings. It is not uncommon for insurers and rating organizations to submit filings with proposed effective dates that negate the File & Use standard and instead require the Department's approval (see 40 P.S. § 910-37(d)).
PR	Yes	Prior approval
RI	Yes	File and use
SC	Yes	Prior approval
TN	Yes	Prior approval

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	17. Are rates required to be filed with the state department/ division?	18. How does the state department/division regulate title insurance rates?
TX	N/A	Promulgate rates
UT	Yes	File and use
VT	Yes	use and file
VA	Yes	File and use
WA	Yes	Prior approval
WV	Yes	File and use for commerical if not disapproved in 30 days
WI	Yes	File and use unless the rate is exempt from the filing requirement under s. Ins. 6.78, Wis. Adm. Code
WY	Yes	Prior approval

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	19. Does the state department/division require title agents to file their fees for processes which are not included in the title rate?	20. What is the statutory standard for title rate adequacy?
AL	No	Rates are not excessive, inadequate or unfairly discriminatory
AK	Yes	Rates are not excessive, inadequate or unfairly discriminatory
AS	Yes	At the discretion of the Commissioner
AZ	No	Rates are not excessive, inadequate or unfairly discriminatory
AR	No	Title insurance rates are unregulated
CA	Yes	Rates are not excessive, inadequate or unfairly discriminatory
CO	Yes	Rates are not excessive, inadequate or unfairly discriminatory
CT	No	Rates are not excessive, inadequate or unfairly discriminatory
FL	No	Rates are not excessive, inadequate or unfairly discriminatory
GA	No	Title insurance rates are unregulated
ID	Yes	Rates are not excessive, inadequate or unfairly discriminatory
IN	No	Rates are not excessive, inadequate or unfairly discriminatory
KS	Yes	Title insurance rates are unregulated
LA	No	Rates are not excessive, inadequate or unfairly discriminatory
ME	No	Rates are not excessive, inadequate or unfairly discriminatory
MD	No	Rates are not excessive, inadequate or unfairly discriminatory
MA	N/A	N/A
MI	No	Rates are not excessive, inadequate or unfairly discriminatory
MN	No	Rates are not excessive, inadequate or unfairly discriminatory
MS	Yes	Title insurance rates are unregulated
MO	N/A	Rates are not excessive, inadequate or unfairly discriminatory
MT	No	Rates are not excessive, inadequate or unfairly discriminatory
NE	No	Title insurance rates are unregulated
NV	Yes	Rates are not excessive, inadequate or unfairly discriminatory
NM	No	Rates are not excessive, inadequate or unfairly discriminatory
NC	N/A	Rates are not excessive, inadequate or unfairly discriminatory
ND	No	Rates are not excessive, inadequate or unfairly discriminatory
OH	No	Rates are not excessive, inadequate or unfairly discriminatory
OK	No	Title insurance rates are unregulated
OR	No	Rates are not excessive, inadequate or unfairly discriminatory
PA	No	Rates are not excessive, inadequate or unfairly discriminatory
PR	Yes	Rates are not excessive, inadequate or unfairly discriminatory
RI	Yes	Rates are not excessive, inadequate or unfairly discriminatory
SC	No	Rates are not excessive, inadequate or unfairly discriminatory
TN	No	Rates are not excessive, inadequate or unfairly discriminatory
TX	No	Rates must be reasonable to the public and non-confiscatory to the title insurers and title agents
UT	No	Rates are not excessive, inadequate or unfairly discriminatory
VT	No	Rates are not excessive, inadequate or unfairly discriminatory
VA	No	Title insurance rates are unregulated
WA	Yes	Rates are not excessive, inadequate or unfairly discriminatory
WV	N/A	Rates are not excessive, inadequate or unfairly discriminatory
WI	No	Rates are not excessive, inadequate or unfairly discriminatory
WY	No	Rates are not excessive, inadequate or unfairly discriminatory

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	21. Are forms required to be filed with the state department/division?	22. How does the state department/division regulate title insurance policy forms and endorsements?
AL	Yes	Same as all other insurance policy forms and endorsements
AK	Yes	In A.S. 21.66.450, all forms of title policies and other contracts of title insurance proposed to issue in Alaska must be filed before issuance 31 days prior. If after 30 days it is presumed approved.
AS	Yes	Discretion of the Commissioner
AZ	Yes	File and Use 30 Day Hold ARS 20-1591
AR	Yes	File and Approve
CA	Yes	File and Use. The Department looks at the forms for clarity, to make sure that the coverage is indeed title insurance, to make sure there is no undue discrimination, and try to make sure there are not mistakes.
CO	No	N/A
CT	Yes	See CGS section 38a-422 for Policy Form Standards and CGS 38a-423. Under CGS 38a-423 disclosure of a buyer's title policy needs to be waived, in writing, by the buyer if the buyer chooses not to purchase an owner's title policy.
FL	Yes	Section 627.777, F.S., requires that all forms must be filed with and approved by the Office of Insurance Regulation prior to use.
GA	Yes	O.C.G.A. 33-24 has provisions for form requirements for all types of insurance
ID	Yes	Forms and endorsements filed 30 days in advance of use to provide opportunity for comments and objections.
IN	Yes	Indiana Department of Insurance Company Compliance Division
KS	Yes	Admitted title companies must file through SERFF every manual of classification, rules and rates, every rating plan, every rate card and every modification of any of those. Policy forms are reviewed by policy examiners.
LA	Yes	Forms are subject to review and prior approval
ME	Yes	File and Use
MD	Yes	Pursuant to 11-404, the insurer must file the forms and they are deemed approved if not disapproved by the Commissioner.
MA	No	The Division of Insurance does not regulate title insurance forms and endorsements.
MI	Yes	All forms and endorsements are filed in SERFF. The title analysts ensure the forms comply with statute.
MN	Yes	Prior Approval
MS	Yes	File and Use
MO	Yes	Missouri Regulation 20 CSR 500-7.060 and 20 CSR 500-7.130 Section 381.085, RSMo

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	21. Are forms required to be filed with the state department/division?	22. How does the state department/division regulate title insurance policy forms and endorsements?
MT	Yes	An insurance policy or annuity contract form, certificate, enrollment form, application form, printed rider or endorsement form, or form of renewal certificate may not be delivered or issued for delivery in Montana unless the form has been filed and approved by the commissioner [MCA § 33-1-501 (1)].
NE	Yes	See Neb. Rev. Stat. 44-1998. Form filing. (1)(a) A title insurer or rate service organization shall not deliver or issue for delivery or permit any of its title insurance agents to deliver in this state any form, in connection with title insurance business written, unless it has been filed and approved by the Director or thirty days have elapsed and it has not been disapproved. The waiting period may be extended ...not to exceed thirty days if the Director gives written notice within such waiting period.... (b) Forms shall not (i) be unjust, unfair, or inequitable, (ii) be misleading, be deceptive, or encourage misrepresentation of the coverage, (iii) be contrary to public policy, or (iv) provide coverage that is of such a limited nature so as to be contrary to public interest. (2) Forms covered by this section shall include: (a) Title insurance policies, including standard form endorsements; and (b) Title insurance commitments. (3) After notice and opportunity to be heard are given to the title insurer or rate service organization which submitted a form for approval, the Director may withdraw approval of the form on finding that the use of the form is contrary to the legal requirements applicable at the time of withdrawal. The effective date of withdrawal of approval shall not be less than ninety days after notice of withdrawal is given. (4) An approved title insurance policy form or endorsement providing coverage for which no identifiable premium is assessed shall be incorporated into every applicable title insurance policy. The title insurer shall disclose any additional coverage to the insured. The provisions of this section shall not operate to eliminate any underwriting standard of conditions... (5) Any term or condition related to insurance coverage provided by an approved title insurance policy or any exception to the coverage, except those ascertained from a search and examination of records relating to a title or an inspection or survey of a property to be insured, may only be included in the title insurance policy after the term, condition, or exception has been filed with the Director and approved.
NV	Yes	Prior Approval
NM	Yes	A hearing is held to determine the need for specific forms and endorsements. The hearing also determines the risks involved.
NC	Yes	NCGS 58-3-150 requires the submissions and approval of all forms.
ND	Yes	Prior Approval
OH	Yes	Prior approval of forms and endorsements required
OK	No	N/A
OR	Yes	ORS 742.003

	21. Are forms required to be filed with the state department/division?	22. How does the state department/division regulate title insurance policy forms and endorsements?
PA	Yes	They are subject to the Department's prior approval in accordance with 40 P.S. § 477b.
PR	Yes	The Actuarial Division received standard forms and endorsement (ALTAS forms) that are reviewed prior to its approval. The Division reviews that the forms and endorsements comply with Puerto Rico's Insurances Code, particularly with the jurisdiction required on appraisal process in law and regulation.
RI	Yes	R.I. Gen. Laws § 27-2.6-17
SC	Yes	We review them as prior approval.
TN	Yes	Title insurance companies are not required to file policy forms and endorsements.
TX	N/A	The Department of Insurance promulgates title insurance policy forms and Endorsements.
UT	Yes	The Commissioner may prohibit the use of a form at any time upon a finding that: (i) the form: (A) is inequitable; (B) is unfairly discriminatory; (C) is misleading; (D) is deceptive; (E) is obscure; (F) is unfair; (G) encourages misrepresentation; or (H) is not in the public interest; (ii) the form provides benefits or contains another provision that endangers the solidity of the insurer; (iii) the form is an insurance policy or application for an insurance policy, that fails to conspicuously provide: (A)the exact name of the insurer; and (B) the state of domicile of the insurer filing the insurance policy or application for the insurance policy; (iv) the form violates a statute or a rule adopted by the commissioner; or (v) the form is otherwise contrary to law.
VT	Yes	Prior Approval
VA	Yes	All forms customarily used by any title insurance company or agent of shall be filed with the Commission.
WA	Yes	Prior Approval
WV	Yes	Forms and endorsements must be filed for approval pursuant to WV Code 33-6-8.
WI	Yes	Forms must be filed with the Commissioner 30 days before use.
WY	Yes	Prior Approval

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	23. Is the state department/division authorized to regulate the percentage of premium that title agents retain?	24. Is there a statutory standard for determining that percentage?
AL	No	N/A
AK	No	No
AS	Yes	No
AZ	No	N/A
AR	No	N/A
CA	Yes	No
CO	No	No
CT	No	Yes
FL	Yes	Yes
GA	No	N/A
ID	No	No
IN	No	N/A
KS	No	N/A
LA	No	No
ME	No	N/A
MD	No	N/A
MA	N/A	N/A
MI	No	N/A
MN	No	N/A
MS	No	No
MO	N/A	N/A
MT	Yes	No
NE	No	No
NV	No	N/A
NM	Yes	Yes
NC	No	N/A
ND	Yes	No
OH	No	N/A
OK	No	N/A
OR	No	N/A
PA	No	N/A
PR	Yes	The Actuarial Division reviews that the rate is in accordance with the rate priorly approved by the Office for the rest of the title insurers.
RI	No	No
SC	Yes	Yes
TN	No	N/A
TX	Yes	The Department sets premium rates, which must be reasonable to the public and non-confiscatory to title insurers and title agents.
UT	No	N/A
VT	Yes	No
VA	No	No
WA	No	N/A
WV	No	N/A
WI	No	N/A
WY	No	N/A

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	25. Statutes and regulations regarding title rate and form regulation.
AL	N/A
AK	A.S. 21.66.370 Rate filing, A.S. 21.66.380 Justification for rates, A.S. 21.66.390 Making of rates, A.S. 21.66.400 Disapproval of filings, A.S. 21.66.410 Rate administration, A.S. 21.66.420 False or misleading information, 3 AAC 27.310 General ratemaking components, 3 AAC 27.320 Minimum ratemaking standards, 3 AAC 27.330 Required reports and rate filing, 3 AAC 27.340 Other requirements, A.S. 21.66.350 Division of rates, and 3 AAC 27.350 Short-term rates. See also A.S. 21.06.090.
AS	ASCA Title.29.0156,61,62, thru 29.1566
AZ	Title 20, Chapter 6, Article 9
AR	Ark. Code Ann. 23-79-109
CA	California Insurance Code Sections 12340 et. seq., 12389 et. seq., 12401-1240.10.10, 12404-12413.5
CO	C.R.S. 10-1-108, 10-1-109, 10-3-1110, 10-4-401, 10-4-403, 10-4-404, 10-11-108 and Regulation 8-1-1
CT	CGS sections 38a-422 (and 38a-421) for Policy Form Standards. CGS section 38a-418 for Premium Rate Standards (and 38a-419).
FL	Sections 627.777, (Forms) and 627.782, (Rates) F.S.
GA	O.C.G.A. 33-24-9 and 10 pertain to filing, approval and disapproval of forms
ID	§§ 41-2705, 41-2706, and 41-2707, Idaho Code, and IDAPA 18.05.01.012 and 18.05.01.013.
IN	IC 27-7-3; IC 27-1-22-28
KS	K.S.A. 40- 216(2)(A); K.S.A. 40-952(c); K.S.A. 40-955; K.S.A. 40-1134
LA	La.R.S. 22:516 (rates); La.R.S. 22:1464; La.R.S. 22:1466; La.R.S. 22:1468; La.R.S. 22:861
ME	24-A M.R.S. §§ 2302(1)(D), 2410, and 2412
MD	Annotated Code of Maryland, Title 11, Subtitle 4 - Title Insurance Rating.
MA	N/A
MI	MCL 500.7310, 500.7312, 500.7313, 500.2401
MN	Minnesota Statutes, chapter 70A
MS	Miss. Code Ann. Sections 83-15-1 through 83-15-11
MO	Missouri Regulation 20 CSR 500-7.100 and 20 CSR 500-7.130 Section 381.085, RSMo; Section 381.171, RSMo; Section 381.181, RSMo
MT	Title rate regulation – MCA § 33-25-212. Rates filed with commissioner. Title form regulation – MCA § 33-1-501 (1). Filing of forms – approval – review of disapproval or withdrawal of approval – application.
NE	Title rate regulation: n/a; Title form regulation: Neb. Rev. Stat. 44-1998.
NV	NRS 692A.120
NM	59A-30-4 & 5; 13.14.18 NMAC; 13.14.1 et. seq. NMAC
NC	NC General Statutes, Articles 3, 26, and 40.
ND	N.D.C.C. 21.1-20
OH	Ohio Revised Code Section 3953.28
OK	N/A
OR	For title rate regulation, see ORS 737.310 and 320. For title form regulation, see ORS 742.003.
PA	40 P.S. §§ 477b, 910-37, 910-38, 910-39, 910-40, 910-42
PR	Section 12.040 Insurance Code of Puerto Rico
RI	R.I. Gen. Laws §§ 27-2.6-16, 17 and Chapter 27-44
SC	38-75-970; 38-75-980; 38-75-990
TN	T.C.A. 56-35-111
TX	Texas Insurance Code Chapter 2703; Basic Manual for Rules, Rates, and Forms for the writing of title insurance in the state of Texas, Sections II through IV
UT	Utah Code Sections 31A-19a-201, -202, -209 and 31A-21-201.

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	25. Statutes and regulations regarding title rate and form regulation.
VT	VSA 8 Section 3541 and 8 VSA Section 4688 as well as Regulation I-2010-03 Section 8
VA	38.2-4606 of the Code of Virginia
WA	Rates - Chapter 48.29 RCW - Including RCW 48.29.005, 48.29.010, 48.29.040, 48.29.140, 48.29.143, 48.29.147, 48.29.148, 48.29.149, and 48.29.400-470. Chapter 284-29A WAC. Forms - RCW 48.29.015, 48.29.017, 48.29.147, 48.29.148, 48.29.400, and 48.29.470. WAC 284-29-120, 284-29A-020, and 284-29A-130.
WV	33-6-8 Forms; 33-20-1, et seq., Rates
WI	Ch. 625 and s. 631.20, Wis. Stat., and ss. Ins 3.32, 6.05, 6.06, 6.07, 6.78 and 6.785, Wis. Adm. Code.
WY	W.S. 26-23-325, 326, 328 and 329

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	26. Which processes are, or can be, performed by title insurers?						
	Risk Transfer	Policy Production /Issuance	Title Search or Abstract	Examination of Title	Clearing of Title Defects	Escrow & Closing	N/A
AL	X	X	X	X	X	X	
AK	X	X	X	X	X	X	
AS							X
AZ	X	X	X	X	X	X	
AR							X
CA	X	X	X	X	X	X	
CO	X	X	X	X	X	X	
CT	X	X					
FL	X	X	X	X	X	X	
GA	X	X	X	X	X		
ID	X	X					
IN	X	X	X	X	X	X	
KS	X	X	X	X	X	X	
LA	X	X				X	
ME	X	X	X	X	X	X	
MD	X	X	X	X	X	X	
MA	X	X					
MI	X	X	X	X	X	X	
MN	X	X	X	X	X	X	
MS			X	X	X		
MO	X	X	X	X	X	X	
MT		X	X	X	X	X	
NE	X	X	X	X	X	X	
NV	X	X	X	X	X	X	
NM	X	X	X	X	X	X	
NC	X	X	X				
ND	X	X	X	X	X	X	
OH	X	X	X	X	X	X	
OK	X	X					
OR	X	X	X	X	X	X	
PA	X	X	X	X	X	X	
PR	X	X	X	X	X	X	
RI	X	X	X	X	X	X	
SC	X	X					
TN	X	X	X	X		X	
TX	X	X					
UT	X	X	X	X	X		
VT	X	X					
VA		X					
WA	X	X	X	X	X	X	
WV	X	X					
WI	X	X	X	X			
WY	X	X	X	X	X	X	

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	27. Which processes are, or can be, performed by title agents?						
	Risk Transfer	Policy Production/Issuance	Title Search or Abstract	Examination of Title	Clearing of Title Defects	Escrow & Closing	N/A
AL		X	X	X	X	X	
AK		X	X	X	X	X	
AS							X
AZ	X	X	X	X	X	X	
AR	X	X	X	X	X	X	
CA	X	X	X	X	X	X	
CO		X	X	X	X	X	
CT			X	X	X	X	
FL		X	X	X	X	X	
GA		X	X	X	X	X	
ID		X	X	X	X	X	
IN		X	X	X	X	X	
KS	X	X	X	X	X	X	
LA	X	X	X		X	X	
ME	X	X	X	X		X	
MD		X	X	X	X	X	
MA							X
MI	X	X	X	X	X	X	
MN		X	X	X	X	X	
MS			X	X	X		
MO		X	X	X	X	X	
MT		X	X	X	X	X	
NE	X	X	X	X	X	X	
NV		X	X	X	X	X	
NM		X	X	X	X	X	
NC							X
ND		X					
OH	X	X	X	X	X	X	
OK		X	X			X	
OR		X	X	X	X	X	
PA		X	X	X	X	X	
PR			X	X			
RI		X	X	X	X	X	
SC			X	X	X	X	
TN			X	X		X	
TX		X	X	X	X	X	
UT		X	X	X	X	X	
VT		X	X	X	X	X	
VA		X	X	X			
WA	X	X	X	X	X	X	
WV							X
WI		X	X	X		X	
WY		X	X	X		X	

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	28. What types of title insurance and closing activities are required to be performed within the state?						
	Risk Transfer	Policy Production/ Issuance	Title Search or Abstract	Examination of Title	Clearing of Title Defects	Escrow & Closing	N/A
AL			X	X			
AK			X	X			
AS							X
AZ		X				X	
AR							X
CA			X	X	X	X	
CO							X
CT							X
FL							X
GA		X	X	X	X	X	
ID							X
IN							X
KS			X	X			
LA	X	X	X	X	X		
ME	X	X					
MD		X					
MA							X
MI							X
MN							X
MS							X
MO							X
MT							X
NE							X
NV						X	
NM							X
NC	X	X	X	X	X	X	
ND			X	X			
OH							X
OK		X	X	X	X		
OR		X			X	X	
PA							X
PR	X	X	X	X	X	X	
RI							X
SC						X	
TN							X
TX		X				X	
UT						X	
VT		X	X	X	X	X	
VA						X	
WA							X
WV							X
WI							X
WY							X

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	29. Can a title policy be prepared (search, abstract, commitment, etc.) by an entity located outside of the state?
AL	Yes
AK	A.S. 21.66.270 requires title insurance limited producers to be residents of this state, thus a search, abstract, and commitment is done in this state.
AS	No
AZ	Yes. Statute does not expressly address to allow or prohibit.
AR	No
CA	No
CO	Yes
CT	Yes
FL	Yes
GA	N/A
ID	Yes, but the entity must be licensed in Idaho. § 41-2710, Idaho Code
IN	Yes
KS	Yes
LA	No
ME	Yes, if licensed in Maine.
MD	Yes
MA	N/A
MI	Yes
MN	Yes
MS	N/A
MO	Yes
MT	Yes
NE	Yes
NV	Yes
NM	Yes
NC	Yes
ND	Yes
OH	Yes
OK	No
OR	Yes
PA	Yes
PR	No
RI	Yes
SC	Yes
TN	Yes
TX	A title agent in Texas must sign.
UT	The title search, abstract and commitment can be prepared out of state, however, it must be issued through a Utah Title Agency.
VT	Yes
VA	Yes
WA	Yes
WV	N/A. In West Virginia, only licensed attorneys can provide a title opinion.
WI	Yes
WY	It depends on the type of activity.

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	30. Can a title policy be issued by an entity located outside the state?	31. Can closing be performed by an entity located outside the state?	32. Are there any requirements for a licensed entity to have physical offices or perform activities within the state?
AL	Yes	Yes	Yes
AK	Yes	Yes	Yes
AS	No	No	Yes
AZ	No	No	Yes
AR	No	N/A	Yes
CA	Yes	No	Yes
CO	Yes	Yes	No
CT	Yes	N/A	No
FL	Yes	Yes	Yes
GA	Yes	No	No
ID	No	Yes	No
IN	Yes	Yes	No
KS	Yes	Yes	N/A
LA	No	No	Yes
ME	Yes	Yes	No
MD	Yes	Yes	N/A
MA	Yes	N/A	Yes
MI	Yes	Yes	No
MN	Yes	Yes	No
MS	N/A	N/A	No
MO	Yes	Yes	N/A
MT	Yes	Yes	No
NE	Yes	Yes	No
NV	Yes	No	Yes
NM	Yes	Yes	No
NC	Yes	No	Yes
ND	Yes	No	No
OH	Yes	Yes	No
OK	No	N/A	Yes
OR	Yes	Yes	No
PA	Yes	Yes	No
PR	No	No	Yes
RI	Yes	Yes	No
SC	Yes	No	Yes
TN	Yes	N/A	No
TX	No	N/A	Yes
UT	No	No	Yes
VT	Yes	No	No
VA	Yes	Yes	No
WA	Yes	Yes	Yes
WV	N/A	Yes	N/A
WI	Yes	Yes	No
WY	N/A	Yes	Yes

	33. Description of requirements for a licensed entity to have physical offices or perform activities within the state.
AL	Ala. Code Section 27-25-4.1(b)(2) : "[Title agent must be] ... a bona fide resident and citizen of this state or is a full-time employee of a duly licensed title insurance agent whose principal place of business is physically located in this state."
AK	A.S. 21.09.010 states an insurer may not transact business in this state without a certificate of authority. It also is required to have an office or a representative. A.S. 21.66.200 requires a title insurance company to own and maintain in the recording district in which its principal office in the state is located a title plant consisting of adequate maps and fully indexed records showing all instruments of record affecting all land within the recording district for a period of at least 25 years immediately before the date a policy of title insurance is issued by title insurance company. It also has to own and maintain and addition title plant for each additional recording district in which it or its agent maintains and office to transact title business. A.S. 21.66.240 addresses the requirements of title plants. It also allows for different title insurers to contract together to maintain a title plant.
AS	
AZ	ARS 20-1575, 6-834
AR	Ark. Code Ann. 23-103-403(b), 23-103-409(4), and 23-64-220(a)(1)
CA	All UTCs must be domestic stock corporations.
CO	
CT	
FL	The trust account used by a title agent to deposit escrow funds must be with a financial institution located in the State of Florida or a financial institution that has at least one branch in the state.
GA	
ID	
IN	
KS	
LA	An agency title insurance producer shall be a Louisiana entity whose principal place of business is physically located in Louisiana or a foreign entity registered to do business in Louisiana whose principal place of business in Louisiana is suitable for conducting the business of title insurance or closings. (La.R.S. 22:513 (C)(1)
ME	
MD	
MA	See MGL c 175, s 116A. Company must be admitted to transact business under c. 175, s. 47 (11), which is for title insurance.
MI	
MN	
MS	
MO	
MT	
NE	
NV	Title agents must have a physical office in the state.
NM	
NC	Closing attorney must be licensed to practice law in North Carolina (see NCGS 58-26-1).
ND	

	33. Description of requirements for a licensed entity to have physical offices or perform activities within the state.
OH	
OK	Every policy of title insurance must be countersigned by person, partnership, corporation, or agency actively engaged in the real estate title business and maintaining an office in the state.
OR	
PA	
PR	Section 9.340 Puerto Rico Insurance Code
RI	
SC	Closings must be completed by a South Carolina licensed attorney.
TN	
TX	Title agents must have an office within the state.
UT	Utah Code Section 31A-23a-406: "the individual title insurance producer or agency title insurance producer shall maintain a physical office in Utah staffed by a person with an escrow subline of authority who processes the escrow."
VT	
VA	
WA	RCW 48.29.020(2) requires title insurers to own or lease and maintain a complete set of tract indexes of the county in this state in which its principal office is located. RCW 48.29.190 and WAC 284-29-160 require title insurers to maintain records within this state, unless otherwise approved by the Insurance Commissioner.
WV	
WI	
WY	Nonresidents are not eligible for licensing as title insurance agents or agencies.

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	34. Is there a statutory requirement for an attorney opinion letter concerning the title examination for the issuance of a title insurance policy?	35. Statutory requirement for an attorney opinion letter concerning the title examination for the issuance of a title insurance policy.
AL	No	
AK	No	
AS	N/A	
AZ	No	
AR	No	
CA	No	
CO	No	
CT	No	
FL	No	
GA	N/A	
ID	No	
IN	N/A	
KS	No	
LA	Yes	La.R.S. 22:513.1 requires every title policy and mortgage to include the name bar roll of the attorney licensed to practice law in Louisiana who provided the title opinion upon which the title insurance policy is based.
ME	No	
MD	N/A	
MA	N/A	
MI	No	
MN	No	
MS	No	
MO	N/A	
MT	No	
NE	No	
NV	No	
NM	No	
NC	No	
ND	No	
OH	No	
OK	Yes	Pursuant to 36 O.S. § 5001 and OAC 365:20-3-3, title insurer's must attach to the policy an opinion of title covering the insured real property issued by an attorney licensed in the State of Oklahoma.
OR	N/A	
PA	N/A	
PR	No	
RI	N/A	
SC	No	
TN	No	

	34. Is there a statutory requirement for an attorney opinion letter concerning the title examination for the issuance of a title insurance policy?	35. Statutory requirement for an attorney opinion letter concerning the title examination for the issuance of a title insurance policy.
TX	N/A	
UT	Yes	There is a bulletin indicating AOLs can not be used. Also, 31A-23a-406, indicates an owner's policy or lender's policy must be issued on a split close or one on a single close.
VT	No	
VA	N/A	
WA	No	
WV	Yes	WV Code 33-11A-11(c)
WI	No	
WY	Yes	No title insurance policy shall be written unless it is based upon adequate evidence of the current condition of title certified in writing as of the date of the policy by a person duly authorized under W.S. 33-2-101 to act as a title abstractor in the county where the property is situated, or based upon the opinion of an attorney authorized to practice law in this state as to the condition of the title following a review by the attorney of pertinent title records of abstracts. See W.S. 26-23-308

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	36. Is there a statutory standard for the information contained in a title examination?	37. Statutory standard for the information contained in a title examination.
AL	No	
AK	Yes	A.S. 21.66.170 requires title insurance company, through a licensed title insurance limited producer, conduct a reasonable search and examination of the title, a determination of insurability of title in accordance with the title insurance company's established underwriting practices.
AS	Yes	ASCA. Title 29.1508
AZ	Yes	ARS 20-1562(10)
AR	Yes	Minimum search requirements found in Ark. Code Ann. 23-103-408; Policyholder rights and disclosure found in Ark. Code Ann. 23-103-413
CA	Yes	12340.10, 12340.11
CO	N/A	
CT	No	
FL	No	
GA	N/A	
ID	Yes	§§ 41-2708(1)(b) and 41-2708(2), Idaho Code.
IN	No	
KS	Yes	K.S.A. 40-235(b) requires a reasonable search and examination of the title to the property to be conducted and a determination made of the insurability of title and the risk in accordance with sound underwriting practices. A search must be conducted of all applicable records of the county, state and federal offices in which the real estate is located as may pertain to the marketability of title for a minimum period of the lesser of 25 years or from the date of the previously issued title insurance policy. K.S.A. 40-1134 also contains requirements for inclusion of information regarding public improvement or special benefit districts which may be able to impose assessments upon the real estate.
LA	Yes	La.R.S. 22:512 (22)(b)(vi)
ME	No	
MD	N/A	
MA	N/A	
MI	N/A	
MN	No	
MS	No	
MO	Yes	Missouri Regulation 20 CSR 500-7.200 Section 381.071, RSMo
MT	Yes	MCA § 33–25–214 (1). A title insurer may not issue a title insurance policy unless it, its title insurance producer, or an approved attorney has conducted a reasonable search and examination of the title and made a determination of insurability of title in accordance with sound underwriting practices. ARM 6.6.2201. Liens, Encumbrances, and Standards of Insurability.
NE	N/A	
NV	No	
NM	Yes	13.14.1 et. seq. NMAC and 59A-30-1 et. seq.

	36. Is there a statutory standard for the information contained in a title examination?	37. Statutory standard for the information contained in a title examination.
NC	No	
ND	No	
OH	No	
OK	N/A	
OR	N/A	
PA	No	
PR	N/A	
RI	N/A	
SC	N/A	
TN	No	
TX	Yes	Texas Insurance Code – Sec. 2704.001 and 2704.002.
UT	Yes	31A-23-406(10) shall conduct a reasonable search
VT	No	
VA	No	
WA	Yes	RCW 48.29.010(3)(g) "Abstract of title" means a written representation, provided under contract, whether written or oral, intended to be relied upon by the person who has contracted for the receipt of this representation, listing all recorded conveyances, instruments, or documents that, under the laws of the state of Washington, impart constructive notice with respect to the chain of title to the real property described. An abstract of title is not a title policy as defined in this subsection.
WV	No	
WI	N/A	
WY	No	

	38. Is there a statutory standard for the information contained in a title opinion letter?	39. Statutory standard for the information contained in a title opinion letter.
AL	N/A	
AK	No	
AS	N/A	
AZ	N/A	
AR	No	
CA	N/A	
CO	N/A	
CT	N/A	
FL	No	
GA	N/A	
ID	No	
IN	N/A	
KS	N/A	
LA	Yes	The information that should be contained in a title opinion is outlined in La.R.S. 22:512 (22).
ME	No	
MD	N/A	
MA	N/A	
MI	No	
MN	No	
MS	No	
MO	N/A	
MT	N/A	
NE	N/A	
NV	No	
NM	No	
NC	N/A	
ND	No	
OH	No	
OK	Yes	
OR	N/A	
PA	No	
PR	N/A	
RI	N/A	
SC	N/A	
TN	No	
TX	Yes	
UT	No	
VT	No	
VA	N/A	

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	38. Is there a statutory standard for the information contained in a title opinion letter?	39. Statutory standard for the information contained in a title opinion letter.
WA	Yes	RCW 48.29.010(3)(f) "Preliminary report," "commitment," or "binder" means reports furnished in connection with an application for title insurance and are offers to issue a title policy subject to the stated exceptions in the reports, the conditions and stipulations of the report and the issued policy, and other matters as may be incorporated by reference. The reports are not abstracts of title, nor are any of the rights, duties, or responsibilities applicable to the preparation and issuance of an abstract of title applicable to the issuance of any report. The report is not a representation as to the condition of the title to real property, but is a statement of terms and conditions upon which the issuer is willing to issue its title policy, if the offer is accepted.
WV	No	
WI	N/A	
WY	Yes	W.S. 26-23-308; W.S. 33-2-101

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	40. Are attorneys required to be licensed as title agents in order to transact title business in the state?	41. Are attorneys, not licensed as title agents, allowed by state law to perform any duties of title agents?	42. Does the state department/division require the use of attorneys in lieu of title agents?
AL	No	Yes, all	No, allowed but not required
AK	Yes	Yes, limited to specific tasks	No, allowed but not required
AS	N/A	N/A	N/A
AZ	Yes	N/A	No, don't allow
AR	Yes	No	No, don't allow
CA	N/A	No	No, don't allow
CO	Yes	N/A	N/A
CT	No	Yes, all	Yes, required
FL	No	Yes, all	No, allowed but not required
GA	No	Yes, all	Yes, required
ID	Yes	No	No, allowed but not required
IN	Yes	Yes, limited to specific tasks	No, allowed but not required
KS	Yes	No	No, don't allow
LA	Yes	Yes, limited to specific tasks	N/A
ME	Yes	No	No, allowed but not required
MD	Yes	Yes, limited to specific tasks	No, allowed but not required
MA	N/A	N/A	N/A
MI	Yes	No	No, don't allow
MN	Yes	Yes, limited to specific tasks	No, allowed but not required
MS	No	Yes, all	No, don't allow
MO	Yes	Yes, limited to specific tasks	N/A
MT	No	Yes, limited to specific tasks	No, allowed but not required
NE	Yes	No	No, don't allow
NV	Yes	No	No, don't allow
NM	Yes	No	No, don't allow
NC	No	Yes, all	Yes, required
ND	No	No	No, don't allow
OH	Yes	No	No, don't allow
OK	No	Yes, limited to specific tasks	No, don't allow
OR	No	N/A	No, allowed but not required
PA	No	Yes, all	No, allowed but not required
PR	Yes	No	No, don't allow
RI	No	Yes, all	No, allowed but not required
SC	Yes	Yes, limited to specific tasks	Yes, required
TN	No	Yes, limited to specific tasks	No, allowed but not required
TX	No	Yes, limited to specific tasks	N/A
UT	No	Yes, all	No, allowed but not required
VT	Yes	Yes, limited to specific tasks	No, don't allow
VA	Yes	No	No, allowed but not required
WA	Yes	Yes, limited to specific tasks	No, don't allow
WV	No	Yes, all	Yes, required
WI	Yes	No	N/A
WY	No	Yes, limited to specific tasks	No, allowed but not required

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	43. What roles do these attorneys (not licensed as title agents) perform?				44. Does their role vary geographically within the state?
	Policy Production/ Issuance	Review Abstracts and Provide Opinions	Conduct Closings	Supervise Employees Who Conduct Closings	
AL	X	X	X	X	No
AK		X	X		Yes
AS					N/A
AZ					No
AR					No
CA					No
CO					N/A
CT	X	X	X	X	No
FL	X	X	X	X	No
GA	X	X	X		N/A
ID					No
IN		X			No
KS					N/A
LA		X			No
ME		X	X	X	No
MD		X			No
MA					N/A
MI		X			No
MN		X	X	X	N/A
MS					N/A
MO		X	X		Yes
MT	X				No
NE					N/A
NV					N/A
NM		X	X	X	No
NC		X	X	X	No
ND		X			No
OH					N/A
OK		X			No
OR					N/A
PA	X	X	X	X	No
PR					N/A
RI		X	X	X	No
SC		X	X		No
TN		X	X	X	N/A
TX		X	X		No
UT	X	X	X	X	No
VT			X	X	No
VA		X	X	X	No
WA			X		No
WV		X	X		No
WI					N/A
WY		X	X	X	No

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	45. Which processes are, or can be, performed by attorneys not licensed as title agents?					
	Policy Production/ Issuance	Title Search or Abstract	Examination of Title	Clearing of Title Defects	Escrow & Closing	N/A
AL	X	X	X	X	X	
AK		X	X	X	X	
AS						X
AZ						X
AR						X
CA						X
CO		X	X		X	
CT						X
FL	X	X	X	X		
GA	X	X	X	X	X	
ID						X
IN						X
KS		X	X	X	X	
LA		X	X		X	
ME		X	X	X	X	X
MD		X	X	X		
MA						X
MI				X	X	
MN		X	X	X	X	
MS		X	X	X	X	
MO					X	
MT	X					
NE						X
NV						X
NM		X	X	X	X	
NC		X	X	X	X	
ND		X	X			
OH		X	X	X	X	
OK		X	X	X		
OR			X	X	X	
PA	X	X	X	X	X	
PR						X
RI	X	X	X	X	X	
SC		X	X	X	X	
TN		X	X	X	X	
TX			X	X	X	
UT	X	X	X	X	X	
VT		X	X	X	X	
VA		X	X	X		
WA				X	X	
WV		X	X	X	X	
WI						X
WY		X	X	X	X	

	46. Statutes and regulations regarding use of attorneys as title participants:
AL	Ala. Code Section 27-25-3(10)c
AK	N/A
AS	N/A
AZ	N/A
AR	N/A
CA	N/A
CO	N/A
CT	CGS section 38a-402(13) includes the definition of "Title agent".
FL	Section 626.8417(4), F.S.
GA	O.C.G.A. 33-23
ID	N/A
IN	N/A
KS	N/A
LA	La.R.S. 22:512 (22)(b)(vi); La.R.S. 22:513.1
ME	24-A M.R.S. § 1420-H(3)(C) (exemption from producer examination)
MD	Annotated Code of Maryland, Title 10, Subtitle 1, Section 10-125
MA	N/A
MI	N/A
MN	Minnesota Statutes, section 60K.32
MS	83-15-3
MO	Missouri Regulation 20 CSR 700-8 Section 375.015, RSMo and Section 381.115, RSMo
MT	MCA § 33-25-105 (3). Approved attorney means an attorney authorized to practice law in this state, except an agent or employee of a title insurer, whose certification as to the status of the title to real property a title insurer is willing to accept as the basis for issuance of a title insurance policy. MCA § 33-25-401 (2)(b). The following arrangements are not a violation of subsection (2)(a)(ii) – an arrangement by which an attorney or law firm represents a client in a real estate transaction and issues or arranges for the issuance of a policy of title insurance in the transaction directly as insurance producer or through a separate corporate title insurance agency that may be established by that attorney or law firm and operated as an adjunct to the attorney's or firm's law practice.
NE	N/A
NV	N/A
NM	N/A
NC	NCGS 58-26-1
ND	N/A
OH	N/A
OK	N/A
OR	Attorneys who are licensed as escrow agents through the Oregon Real Estate Agency can perform that function. An attorney can also examine the title records or title report and advise a client.
PA	40 P.S. §§ 910-1 and 910-7
PR	N/A
RI	R.I. Gen. Laws § 27-2.6
SC	N/A
TN	T.C.A. 56-35-111
TX	Texas Insurance Code §§ 2501.003 (2), 2501.003(4), 2501.005(2); 2551.001(e), 2652.003, 2702.053(c); Basic Manual for Rules, Rates, and Forms for the Writing of Title Insurance in the State of Texas, Procedural Rules. P-1 q & s., P-22, P-24, P-44.C.(1), P-45.E., P-69, Section V Exhibits and Forms
UT	Utah Code Section 31A-23a-204; Utah Admin. Code R592-8
VT	N/A

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	46. Statutes and regulations regarding use of attorneys as title participants:
VA	N/A
WA	N/A
WV	33-11A-11 see also WV State Bar Advisory opinions 2001-02, 2003-01, 2006-01 and 2010-002
WI	N/A
WY	W.S. 26-23-302(c) and W.S. 26-23-308

	47. Which processes are, or can be, performed by abstractors?				
	Title Search or Abstract	Examination of Title	Clearing of Title Defects	Escrow & Closing	N/A
AL	X				
AK					X
AS					X
AZ					X
AR	X				
CA					X
CO	X				
CT					X
FL	X				
GA					X
ID					X
IN	X	X			
KS	X	X			
LA	X				
ME	X				
MD	X				
MA					X
MI				X	
MN	X	X	X		
MS					X
MO					X
MT					X
NE	X				
NV					X
NM	X	X	X	X	
NC	X				
ND	X				
OH	X				
OK	X				
OR					X
PA					X
PR					X
RI					X
SC	X				
TN	X	X			
TX	X				
UT					X
VT					X
VA	X	X			
WA	X				
WV					X
WI					X
WY	X				

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	48. Which processes are, or can be, performed by escrow/settlement agents?					
	Policy Production /Issuance	Title Search or Abstract	Examination of Title	Clearing of Title Defects	Escrow & Closing	N/A
AL					X	
AK						X
AS						X
AZ					X	
AR					X	
CA					X	
CO					X	
CT						X
FL					X	
GA	X	X	X	X	X	
ID					X	
IN		X	X	X	X	
KS					X	
LA					X	
ME		X			X	
MD	X	X	X	X	X	
MA						X
MI					X	
MN					X	
MS						X
MO						X
MT					X	
NE					X	
NV					X	
NM	X	X	X	X	X	
NC		X			X	
ND					X	
OH					X	
OK					X	
OR					X	
PA						X
PR						X
RI						X
SC						X
TN		X	X		X	
TX	X	X	X	X	X	
UT						X
VT						X
VA					X	
WA				X	X	
WV						X
WI						X
WY					X	

	49. Which of these participants does the state department/division license?					
	Title Insurers	Title Agents	Attorneys	Abstractors	Escrow/ Settlement Agents	N/A
AL	X	X				
AK	X	X				
AS						X
AZ	X	X			X	
AR		X				
CA	X	X				
CO	X	X	X			
CT	X					
FL	X	X				
GA	X					
ID	X	X				
IN	X	X			X	
KS	X	X				
LA	X	X				
ME	X	X				
MD	X	X			X	
MA	X					
MI	X	X				
MN	X	X		X	X	
MS	X	X				
MO	X	X				
MT	X	X				
NE	X	X			X	
NV	X	X				
NM	X	X			X	
NC	X	X				
ND	X	X				
OH	X	X				
OK	X	X				
OR	X	X				
PA	X	X				
PR	X	X				
RI	X	X				
SC	X	X				
TN	X	X				
TX	X	X			X	
UT	X	X	X		X	
VT	X	X				
VA	X	X			X	
WA	X	X				
WV	X					
WI	X	X				
WY	X	X				

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	50. From which of the following does the state department/division require a title agent license?		
	Title Agencies	Individual Title Agents	N/A
AL		X	
AK		X	
AS			X
AZ		X	
AR		X	
CA	X		
CO		X	
CT			X
FL	X		
GA			X
ID	X		
IN	X	X	
KS		X	
LA	X		
ME		X	
MD	X	X	
MA			X
MI		X	
MN		X	
MS		X	
MO	X		
MT	X		
NE		X	
NV		X	
NM	X		
NC		X	
ND	X		
OH		X	
OK		X	
OR	X		
PA		X	
PR		X	
RI		X	
SC	X		
TN		X	
TX	X		
UT	X	X	
VT		X	
VA		X	
WA	X		
WV			X
WI		X	
WY		X	

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	51. If title participants are not licensed by state departments/divisions, by who are they licensed?			
	Title Agents	Attorneys	Abstractors	Escrow/Settlement
AL	N/A	Alabama State Bar Association. Attorneys are not required to be licensed as title insurance agents but are also not prohibited from being licensed as title insurance agents.	N/A	N/A
AK	N/A	Alaska Bar Association. However, to do a title search and give an opinion on which a title insurance insurer will issue a policy requires the attorney to have a licensed title insurance limited producers license under A.S. 21.66.270.	N/A. Alaska has licensed title insurance limited producers under A.S. 21.66.270.	N/A. Alaska has licensed title insurance limited producers under A.S. 21.66.270.
AS	N/A	N/A	N/A	N/A
AZ	N/A	N/A	N/A	N/A
AR	Licensed by State Department/Division	Arkansas Supreme Court	Arkansas Abstractors Board	N/A
CA	Licensed by State Department/Division	Licensed by State Department/Division	N/A	Department of Financial Protection and Innovation
CO	N/A	N/A	N/A	N/A
CT	N/A	N/A	N/A	N/A
FL	Licensed by State Department/Division	Florida Bar Association	N/A	N/A
GA	N/A	N/A	N/A	N/A
ID	N/A	N/A	N/A	Licensed Title Agents and their Employees can act as Escrow/ Settlement Agents. Escrow/Settlement only Agents are licensed by the Idaho Department of Finance.
IN	Licensed by State Department/Division	Indiana Supreme Court	Licensed by State Department/Division	Licensed by State Department/Division
KS	N/A	Kansas Supreme Court	Abstracters' Board of Examiners	N/A
LA	N/A	Louisiana State Bar Association	N/A	Louisiana Office of Financial Institutions
ME	Licensed by State Department/Division	Maine Supreme Judicial Court	Licensed by State Department/Division	Maine Bureau of Consumer Credit Protection
MD	Licensed by State Department/Division	Maryland Supreme Court	Maryland Depart of Labor Licensing Regulation	Licensed by Maryland Insurance Administration

	51. If title participants are not licensed by state departments/divisions, by who are they licensed?			
	Title Agents	Attorneys	Abstractors	Escrow/Settlement
MA	N/A	Massachusettes Bar Association	N/A	N/A
MI	Licensed by State Department/Division	Michigan State Bar	N/A	N/A
MN	N/A	Minnesota Supreme Court	N/A	N/A
MS	N/A	Mississippi Bar Association	N/A	N/A
MO	N/A	Missouri Supreme Court	N/A	N/A
MT	N/A	Montana State Bar	N/A	Division of Banking and Financial Institutions
NE	Licensed by State Department/Division	Licensed by Nebraska Supreme Court; Regulated by Nebraska Bar Association and Supreme Court	Nebraska Abstracters Board of Examiners	see Neb. Rev. Stat. 76-2,121 (3) & (4) for applicable state Department
NV	Licensed by State Department/Division	N/A	N/A	Escrow officers employed by title insurers/agents are licensed by the Division of Insurance. Escrow agents/agencies are licensed by the Division of Mortgage Lending.
NM	Licensed by State Department/Division	State Bar	N/A	Licensed by State Department/Division.
NC	N/A	North Carolina State Bar	N/A	N/A
ND	N/A	N/A	N/A	N/A
OH	N/A	Ohio Supreme Court	N/A	N/A
OK	N/A	Oklahoma Bar Association	Oklahoma Abstractors Board	N/A
OR	Licensed by State Department/Division	Oregon State Bar	N/A	Oregon Real Estate Agency
PA	Licensed by State Department/Division	Pennsylvania Supreme Court	N/A	N/A
PR	N/A	N/A	N/A	N/A
RI	Licensed by State Department/Division	Rhode Island Supreme Court	N/A	N/A
SC	Licensed by State Department/Division	South Carolina Bar	N/A	N/A
TN	N/A	Board of Professional Responsibility	N/A	Real Estate Commission
TX	Licensed by State Department/Division	State Bar of Texas	N/A	Licensed by Texas Department of Insurance

	51. If title participants are not licensed by state departments/divisions, by who are they licensed?			
	Title Agents	Attorneys	Abstractors	Escrow/Settlement
UT	N/A	N/A	N/A	N/A
VT	N/A	If a title attorney is a title agent, they must be licensed by the Department of Financial Regulation.	N/A	N/A
VA	Licensed by State Department/Division	Attorneys can elect to register with State Dept/Division or the Virginia State Bar, which oversees attorneys.	N/A	Licensed by State Department/Division
WA	N/A	Washington State Supreme Court and the Washington State Bar Association	N/A	Those not licensed as title insurers/agents are licensed by the Washington State Department of Financial Institutions (for financial professions unrelated to insurance).
WV	N/A	N/A	N/A	N/A
WI	Licensed by State Department/Division	Wisconsin State Supreme Court	N/A	N/A
WY	Licensed by State Department/Division	Wyoming State Bar	N/A	N/A

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	52. Statutes and regulations regarding the licensing of title participants:
AL	N/A
AK	A.S. 21.66.270 requires title Insurance limited producers to be licensed. A.S. 21.66.190(a) requires title insurance companies to only transact title insurance and no other type of insurance.
AS	N/A
AZ	N/A
AR	Ark. Code. Ann. 23-103-401 et seq.
CA	Title Insurers-Insurance Code Section 699 et. Seq. and Insurance Code Sections 12340 et. Seq. Underwritten title companies-Insurance Code Section 12389 et. Seq., Escrow Companies-Financial Code Sections 7000 et. Seq.
CO	N/A
CT	N/A
FL	Sections 626.8412, (licensed and appointed), 626.8417, (agent licensure), 626.8418, (agency licensure), F.S.
GA	N/A
ID	§§ 41-2710, 41-2711, Idaho Code, IDAPA 18.05.01.021.07 and 18.05.01.021.08.
IN	IC 27-1-5-1, IC 27-7-3, IC 27-1-15.6-3, and IDOI Bulletin 135
KS	Title Insurers: K.S.A. Chapter 40 - licensed to do business in Kansas. Title Agents/Agencies: K.S.A. 40-4903 and 40-4905. Abstractors: K.S.A. 58-2801 - licensing requirements.
LA	Louisiana Administrative Code; Title 10, section XV-903
ME	24-A M.R.S. § 1420 et seq. for producers, 24-A M.R.S. § 404 for insurers; 10 M.R.S. § 1400-A for escrow and settlement agents
MD	Annotated Code of Maryland, Title 10, Subtitle 1, Section 10-125, 10-103, 104,111, 113,114,116,121, 121.1, 126.
MA	MGL c 175 ss 47 (11), 114, 116 and 116A for title insurers
MI	MCL 500.7302, 500.7303, 500.7317, 500.1201
MN	Minn. Stat. §§ 60A.07, subd. 4; 60K.32; 82.641; 386.62.
MS	Mississippi Code, Section 83-15-3
MO	Missouri Regulation 20 CSR 700-8 Section 381.115, RSMo
MT	Except as expressly otherwise provided in this code, a person acting as an insurer and an insurer transacting insurance in this state must have a subsisting certificate of authority issued by the commissioner [MCA § 33-2-101 (1)]. Title insurer means an insurer formed and authorized under the laws of this state to transact the business of title insurance in this state or a foreign or alien insurer so authorized [MCA § 33-25-105 (14)]. A person may not sell, solicit, or negotiate insurance or act as an insurance producer in this state unless licensed as an insurance producer under this chapter [MCA § 33-17-201 (1)]. Title insurance producer means a person who holds a valid title insurance producer's license and is authorized in writing by a title insurer [MCA § 33-25-105 (13)(a)]. The MT Financial Institutions statute MCA § 32-7-103 (1)(c) exempts a person whose principal business is that of preparing abstracts or making searches of title that are used as a basis for the issuance of any title insurance policy. MCA § 32-7-109 Application for license – bond – issuance. (1) A person must be licensed pursuant to this part before engaging in an escrow business.
NE	Neb. Rev. Stat. 44-19,109 - required licensing for title insurance agents, pursuant to Nebraska Insurance Producers Act [Neb. Rev. Stat. 44-4047-4069]
NV	NRS 692A.100-.1037, NAC 692A.030-.060.
NM	Title 13 Insurance NMAC Chapters 1, 2, 4 and 14

	52. Statutes and regulations regarding the licensing of title participants:
NC	Chapter 58 of the NC General Statutes. Title insurers are licensed under Article 7. Title agents are licensed under Article 33.
ND	N/A
OH	Ohio Revised Code Sections 3905.01, 3905.02, 3905.06, 3905.07, and 3953.21; Ohio Administrative Code 3901-5-09
OK	36 O.S. § 5001, 36 O.S. §1435.4, 36 O.S. § 1435.7
OR	N/A
PA	40 P.S. §§ 910-1(3), 910-3, 910-22, 910-26, 910-41
PR	Chapter 3, 11, 12, 24, 29, 40, 45 of the Puerto Rico Insurance Code for title insurers. For producers and authorized representatives with title insurance line of business- Section 9.020, 9.021,9.022, 9.060, 9.061, 9.070, 9.090, 9.110, 9,140, 9.160, 9.170, 9.190, 9.200, 9.210, 9.260, 9.270, 9.340, 9.350, 9.351, 9.360, 9.370, 9.380, 9.400, 9.401, 9.420, 9.430, 9.440, 9.450, 9.460, 9.471, 9.480 Puerto Rico Insurance Code. Chapter 27 of the Puerto Rico Insurance Code.
RI	R.I. Gen. Laws §§ 27-2.4-3, 27-2.6-4
SC	N/A
TN	N/A
TX	Texas Insurance Code Chapters 2651 and 2652; Basic Manual for Rules, Rates, and Forms for the Writing of Title Insurance in the State of Texas, Section VI
UT	Utah Code Section 31A-23a-204; Utah Admin. Code R592-8
VT	Producer licensing statute (not specific to title insurance) 8 V.S.A. § 4813b
VA	38.2-1814.1 of the Code of Virginia 55.1-1014 of the Code of Virginia
WA	RCW 48.05.030, 48.05.330, 48.05.340, 48.17.060, 48.17.090, 48.17.173, 48.29.020, 48.29.040, 48.29.155, 48.29.160, and 48.29.170. Chapter 284-29 WAC.
WV	N/A
WI	Chapter 611, Wis. Stat.; ss. 601.04, 610.11, 628.02, 628.03 and 628.04, Wis. Stat.; and ss. Ins 6.58 and 6.59, Wis. Adm. Code.
WY	W.S. 26-23-316 - 318

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	53. Are title insurers required to appoint the title agents they use?	54. Is the state department/division authorized to review contracts between title insurers and title agents?
AL	Yes	No
AK	Yes	Yes, but the department rarely reviews these contracts
AS	Yes	N/A
AZ	No	Yes, and the department regularly reviews these contracts
AR	Yes	Yes, but the department rarely reviews these contracts
CA	Yes	Yes, and the department sometimes reviews these contracts
CO	No	No
CT	No	Yes, but the department rarely reviews these contracts
FL	Yes	Yes, and the department sometimes reviews these contracts
GA	Yes	N/A
ID	Yes	Yes, and the department sometimes reviews these contracts
IN	Yes	Yes, and the department sometimes reviews these contracts
KS	Yes	No
LA	Yes	No
ME	Yes	Yes, but the department rarely reviews these contracts
MD	Yes	Yes, and the department regularly reviews these contracts
MA	N/A	N/A
MI	Yes	Yes, and the department sometimes reviews these contracts
MN	Yes	Yes, but the department rarely reviews these contracts
MS	Yes	No
MO	Yes	Yes, and the department sometimes reviews these contracts
MT	Yes	Yes, and the department sometimes reviews these contracts
NE	Yes	Yes, and the department sometimes reviews these contracts
NV	Yes	Yes, and the department sometimes reviews these contracts
NM	Yes	Yes, and the department regularly reviews these contracts
NC	Yes	No
ND	Yes	No
OH	Yes	Yes, but the department rarely reviews these contracts
OK	Yes	Yes, but the department rarely reviews these contracts
OR	Yes	Yes, but the department rarely reviews these contracts
PA	Yes	Yes, but the department rarely reviews these contracts
PR	Yes	Yes, but the department rarely reviews these contracts
RI	Yes	Yes, but the department rarely reviews these contracts
SC	Yes	No
TN	Yes	No
TX	Yes	Yes, and the department sometimes reviews these contracts
UT	Yes	No
VT	Yes	Yes, but the department rarely reviews these contracts
VA	Yes	Yes, and the department sometimes reviews these contracts
WA	Yes	Yes, but the department rarely reviews these contracts
WV	N/A	N/A
WI	Yes	Yes, but the department rarely reviews these contracts
WY	Yes	Yes, but the department rarely reviews these contracts

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	55. Is the state department/division required to keep the details of these contracts confidential?	56. When is the state department/division required to keep the details of contracts confidential?
AL	N/A	
AK	Yes	A.K. 21..6. 060(b-g) requires confidentiality of documents provided to the Director.
AS	N/A	
AZ	Yes	ARS 20-1593, 20-158
AR	In certain circumstances	If the contract is part of an investigatory file, the files contents are subject to disclosure under the Freedom of Information Act once the file is closed.
CA	In certain circumstances	May be confidential pursuant to California Public Records Act. California insurance Code sections 735.5, 12919. Civil Code Sections 3426 et. Seq. (Uniform Trade Secret Act)
CO	In certain circumstances	C.R.S. 10-3-808 and 10-3-1709
CT	In certain circumstances	
FL	In certain circumstances	Agency agreements may be kept confidential if requested by either party.
GA	N/A	
ID	Yes	§ 41-2710(7), Idaho Code, relating to documents and working papers as provided under the subsection (7), and Title 41, Chapter 1, Idaho Code.
IN	No	
KS	N/A	
LA	N/A	
ME	Yes	
MD	In certain circumstances	In cases where records are obtained, it is pursuant to Section 2-205, 206 of the Insurance Article and Annotated Code of Maryland Title 7.
MA	N/A	
MI	Yes	MCL 500.222 specifies the procedures and requirements for the disclosure of confidential information. Specifically, Section 222(7), MCL 500.222(7), generally requires DIFS to withhold from public inspection all information and testimony furnished to DIFS and DIFS work papers, correspondence, memoranda, reports, records, and other written or oral information related to an examination report or an investigation. In addition, MCL 500.1246 specifies, with limited exceptions, confidentiality requirements for documents, materials, or other information furnished by an insurer or otherwise obtained by DIFS' Director in an investigation.
MN	In certain circumstances	
MS	N/A	
MO	Yes	Section 374.070, RSMo; Section 374.071, RSMo
MT	In certain circumstances	There is a constitutional presumption that all documents in the hands of public officials are subject to public inspection (Great Falls Tribune v. MT Public Service Commission, 2003 MT 359, P 54, 319 Mont. 38, P 54, 82 P.3d 876, P 54). ¶¶ 56 – A non-human entity must make a prima facie case showing that data is confidential.

	55. Is the state department/division required to keep the details of these contracts confidential?	56. When is the state department/division required to keep the details of contracts confidential?
NE	Yes	Regulated by Neb. Rev. Sta. 44-5906(8)(a) through Nebraska Administrative Code Title 210, Chapter 34, section 006.01 & Neb. Rev. Stat. 44-19,110
NV	Yes	Typically, such contracts are proprietary company information and kept confidential per NRS 679B.190(5).
NM	In certain circumstances	It depends on the information provided. For example, personal identified information will be kept confidential.
NC	N/A	
ND	N/A	
OH	In certain circumstances	Ohio Revised Code Sections 149.43, 3901.045, 3901.075, 3901.36, 3901.48, and 3905.24
OK	No	
OR	Yes	
PA	In certain circumstances	Depends on why/how the agreement was obtained by the Department. For example, materials that are investigatory or obtained in a Market Conduct examination are privileged and are generally required to be protected. Also, materials otherwise submitted to the Department that are claimed to be trade secret or confidential proprietary financial information must also be treated as such, unless a determination is made in the context of a public records request that such claims are not, in fact, valid (which the party that submitted the materials may then appeal).
PR	No	
RI	In certain circumstances	If requested in an examination it would fall under the exclusion from public access in our examination statute. If requested in another manner it would fall under our general access to public records statute and depend upon the information requested.
SC	N/A	
TN	N/A	
TX	No	
UT	N/A	
VT	Yes	If the contract is collected and/or reviewed in the course of an investigation, examination, or complaint it would be kept confidential.
VA	Yes	Contracts and all documentation obtained during an investigation are kept confidential. 55.1-1016 of the Code of Virginia
WA	No	
WV	N/A	
WI	In certain circumstances	These contracts would be subject to Wisconsin’s open records laws, confidentiality would depend on the circumstances of each case.
WY	N/A	

	57. Statutes and regulations regarding the relationship between title insurers and title agents:
AL	Ala. Code Section 27-25-4 has the requirement for title insurance agents to be licensed by the Department and appointed to represent the title insurance company.
AK	A.S. 21.66.170 Determination of insurability required, A.S. 21.66.290 Title insurance limited producer replies to director inquiries, A.S. 21.66.350 Division of rates, A.S. 21.66.480(8) Definition of title insurance limited producer.
AS	N/A
AZ	Title 20, Chapter 6, Article 9
AR	Ark. Code Ann. 23-103-407
CA	California Insurance Code Sections 12340.1, 12340.3, 12340.4, 12340.5, 12389, 12389.5 and 12389.6, 12418.1, 12418.4
CO	N/A
CT	CGS section 38a-402 (13). Title insurers may authorized in writing for title agents to "solicit, collect premium, determine insurability of risks, issue policies..."
FL	Sections 626.8412, 626.8419, 627.792, F.S.
GA	N/A
ID	§§ 41-2702, 41-2705, 41-2710, 41-2711, Idaho Code.
IN	IC 27-1-5-1 Class 2(j), IC 27-7-3, IC 27-1-15.6-2, and IC 27-1-16.6-18
KS	Agents must be appointed by insurer to sell, solicit or negotiate policies: K.S.A. 40-241, K.S.A. 40-252, K.S.A. 40-4912(a).
LA	La.R.S. 22:520 - La.R.S. 22:527
ME	24-A M.R.S. §§ 1420-M, 1445, and 2422
MD	Annotated Code of Maryland, Title 10, Subtitle 1, Section 10-103, 10-118;10-121.1 and 4-205 of the Insurance Article.
MA	N/A
MI	MCL 500.7317, 500.1201
MN	Minn. Stat. §§ 60K.30 et seq.
MS	83-15-3
MO	Missouri Regulation 20 CSR 500-7 Section 381.018, RSMo
MT	Title insurance producer means a person who holds a valid title insurance producer's license and is authorized in writing by a title insurer [MCA § 33-25-105 (13)(a)]. Title insurers and insurance producers may share rate proceeds between or among themselves in any combination and may accept commissions unless the sharing of rate proceeds is an unlawful rebate or inducement under this title or is a payment of a forwarding fee or a finder's fee (MCA § 33-25-202). The commissioner may disapprove a title agency contract between a title insurance producer and title insurer, upon appropriate notice to the parties to the contract (MCA § 33-25-302).
NE	Neb. Rev. Stat. 44-1993 [Duties of Title Insurers Utilizing Services of Title Agents]
NV	NRS 692A.1045, NAC 692A.080-.115, NAC 692A.160
NM	13.14.1 et. seq. NMAC; 59A-30-1 et. seq. NMSA; 59A-30-4 NMSA
NC	N/A
ND	N/A
OH	Ohio Revised Code Sections 3905.20, 3905.21, and 3953.21
OK	N/A

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	57. Statutes and regulations regarding the relationship between title insurers and title agents:
OR	ORS 744.078 through 087
PA	40 P.S. §§ 910-24 to 910-24.2
PR	Sections 9.020, 9.021, 9.040, 9.060, 9.061, 9.062, 9.063, 9.211, 9.212 Puerto Rico Insurance Code
RI	R.I. Gen. Laws § 27-2.6-13
SC	38-75-960
TN	N/A
TX	Primarily regulated by Texas Insurance Code Chapters 2651
UT	Utah Code Section 31A-23a-115
VT	N/A
VA	38.2-4600 et seq. of the Code of Virginia
WA	RCW 48.17.160
WV	N/A
WI	Sections 628.11, 628.40 and 631.09, Wis. Stat.; and s. Ins 6.57, Wis. Adm. Code.
WY	W.S. 26-23-303(a)(xix) and W.S. 26-23-316(b)(iii)

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	58. What are the requirements for title insurers to confirm/verify valid license status of title agents? How often is confirmation/verification completed?
AL	License can be verified online by anyone. Insurer seeking to process title insurance agent appointment would be notified if agent is not licensed.
AK	A.S. 21.27.140(c) allows the Director to penalize a firm who has someone unlicensed act or represent them on their behalf. An inquiry to the Department would verify the license.
AS	N/A
AZ	N/A
AR	N/A
CA	Title insurers will require valid licenses for underwriting companies they appoint as their issuing agents in California. Title insurers will verify this information when they enter into an issuing agent contract with the underwritten title company.
CO	N/A
CT	N/A
FL	Title insurers confirm an agent has a valid license upon their initial appointment and every two years thereafter when the insurer is required to reappoint their agents.
GA	N/A
ID	Section 41-2710, Idaho Code
IN	N/A
KS	Like all insurers, title insurers must verify appointed agents are properly licensed as title agents, pay an initial appointment fee, and pay annual appointment renewal fees.
LA	La.R.S. 22:530 requires a title insurer to maintain a file that illustrates that an appointed title producer is licensed by the State of Louisiana and that the title producer maintains errors and omissions coverage. There is no time requirement or frequency requirement provided.
ME	N/A
MD	At least once every 31 days, an insurer shall determine whether the license of any insurance producer who currently is appointed by the insurer has been suspended or revoked. Code of Maryland Regulation Title 31, Subtitle 03
MA	N/A
MI	N/A
MN	Minn. Stat. §§ 60K.30 et seq.
MS	Title insurance companies must comply with the same laws and requirements regarding the licensure of their agents as insurance companies and their agents.
MO	Missouri Regulation 20 CSR 500-7.080 Section 381.023, RSMo
MT	MCA § 33–17–231 (1). Each insurer appointing an insurance producer in this state shall file with the commissioner the appointment, specifying the kinds of insurance to be transacted by the insurance producer for the insurer. MCA § 33–17–231 (2). Each appointment remains in effect until the insurance produce license is revoked or otherwise terminated unless written notice of earlier termination of appointment is filed with the commissioner by the insurer or the insurance producer.
NE	Neb. Rev. Stat. 44-1993(6) for requirements for insurers to verify licensure of agents/employees under them. Title agent licenses require renewal every two years; expiration date depends on agent's birthdate.

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	58. What are the requirements for title insurers to confirm/verify valid license status of title agents? How often is confirmation/verification completed?
NV	NAC 692A.115 prohibits a title insurer from allowing a title agent to issue a policy or allowing a title agent or escrow officer to disburse money from an escrow account unless the title agent or escrow officer has been certified to the Commissioner in an annual certification required by NAC 692A.110.
NM	Annually
NC	The Commissioner annually licenses the agents of title insurance companies as required under GS 58-26-10.
ND	N/A
OH	Title insurers are required to annually certify all title insurance agents representing it.
OK	Pursuant to 36 O.S. § 1435.13, the license of a business entity, such as a title insurer, is subject to administrative penalty for knowingly accepting insurance business from an unlicensed individual. 36 O.S. § 1435.14 prohibits an insurer from paying any commission or other consideration to an unlicensed producer. Pursuant to 36 O.S. § 1435.15, insurers must file appointments with the OID within 15 days of the date the agent contract is executed for a determination of eligibility, which the Department must complete within 30 days.
OR	N/A
PA	The agent needs to be appointed by the company and the company needs to verify license status at that time. They should be tracking that throughout and the appointment would cancel if the license expires.
PR	Section 3.340, 9.060, 9.061 of the Insurance Code of Puerto Rico
RI	R.I. Gen. Laws § 27-2.6-13
SC	License status is reported to the State Producer Licensing Database. Insurers should verify that they are licensed. Insurers are also supposed to vet the background before appointing.
TN	N/A
TX	N/A
UT	N/A
VT	The title producer must be licensed and appointed at the time of the transaction. So, the confirmation/verification must occur at such time as to ensure that is the case.
VA	N/A
WA	A valid license is required to sell/solicit/negotiate title insurance in this state (RCW 48.17.060). A licensed title agent must be appointed by an insurer to act as an agent for the title insurer (RCW 48.17.160(1)). All appointments are completed online (WAC 284-17-055). The title insurer cannot appoint the title agency if the agency does not have an active insurance producer license with the title line of authority (WAC 284-17-429). The verification of a valid title agent license is made: 1) during the initial online appointment process, 2) during the title agents' license renewal process (every 2 years), 3) during the insurers' appointment renewal process (every 2 years), and 4) if the title agency license becomes inactive (all appointments are automatically cancelled by the online system).
WV	N/A
WI	Insurers must confirm/verify valid license status of agents at appointment and should monitor status on an ongoing basis.
WY	W.S. 26-23-315, annual basis

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	59. Are title insurers liable for losses resulting from defalcation by title agents?	60. Are title insurers liable for losses resulting from defalcation by escrow/settlement agents?
AL	Yes	Yes, if a closing protection letter is issued
AK	Yes, if a closing protection letter is issued	There is no statute or regulation making them liable. However, A.S. 21.36.390(b) requires reporting. An insurer or licensee that has reason to believe that an insurance producer with which it is doing business is involved in a defalcation, embezzlement, or violation of the provisions of AS 21.36.030, 21.36.050, or 21.36.360 shall immediately send the Director a report disclosing the basis for that belief and any other information that the director may require.
AS	N/A	N/A
AZ	Yes	Yes
AR	Yes	Yes, if a closing protection letter is issued
CA	Yes	Yes
CO	Yes	Yes, if a closing protection letter is issued
CT	Yes, if a closing protection letter is issued	N/A
FL	Yes	Yes
GA	Yes, if a closing protection letter is issued	Yes, if a closing protection letter is issued
ID	Yes, if a closing protection letter is issued	Title agents comprise their employees acting as escrow agents. In this capacity, yes, if a closing protection letter is issued.
IN	Yes	Yes
KS	Possibly	Possibly
LA	Yes	Yes, if a closing protection letter is issued
ME	Yes	Yes
MD	Yes	Yes
MA	N/A	N/A
MI	Yes	No
MN	Yes, if a closing protection letter is issued	Yes, if a closing protection letter is issued
MS	Yes	N/A
MO	Yes, if a closing protection letter is issued	Yes, if a closing protection letter is issued

	59. Are title insurers liable for losses resulting from defalcation by title agents?	60. Are title insurers liable for losses resulting from defalcation by escrow/settlement agents?
MT	MCA § 28-10-602.	MCA § 28-10-602. Principal's responsibility for agent's negligence, omissions, and wrongs. (1) Unless required by or under the authority of law to employ that particular agent, a principal is responsible to third persons for the negligence of the principal's agent in the transaction of business of the agency, including wrongful acts committed by the agent...
NE	Yes	Title insurers are not liable, but under Neb. Rev. Stat. 44-19,109(3), the Director requires the title ins agent, or any "bona fide employee" of a title insurer (defined in statute), to maintain a surety bond or similar.
NV	Yes, if a closing protection letter is issued	No
NM	Yes	Yes
NC	Based on contract	N/A
ND	N/A	N/A
OH	Yes	Yes
OK	Yes	Yes
OR	Depends on the terms of the contract	Depends on the terms of the contract
PA	Yes	Yes
PR	Yes	N/A
RI	Yes, if a closing protection letter is issued	Yes, if a closing protection letter is issued
SC	N/A	N/A
TN	N/A	N/A
TX	Yes, if a closing protection letter is issued	Yes, if a closing protection letter is issued
UT	Yes	Yes
VT	Yes	Yes
VA	Yes	Yes, if a closing protection letter is issued
WA	Yes	Yes
WV	N/A	N/A
WI	Title insurers may be held responsible for the acts of their agents.	N/A
WY	Yes	N/A

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	61. If title insurers are liable for losses resulting from defalcations, by what is that liability imposed?	62. Statutes and regulations regarding the liability of title insurers for defalcations of other title participants:
AL	Contract	N/A
AK	Common law	N/A
AS	N/A	N/A
AZ	Closing protection letter	ARS §6-841.02(C) through (E)
AR	Common law	N/A
CA	Common law	Common law
CO	Statue, Closing protection letter	C.R.S. 10-3-131
CT	N/A	N/A
FL	Statue	Section 627.792, F.S.
GA	N/A	O.C.G.A. 33-7-8.1 Closing protection letter
ID	Contract, Closing protection letter	N/A
IN	Common law	N/A
KS	Common law, Closing protection letter	Title agent/agencies that handle escrow, settlement or closing services must post a bond with the Department to protect customers against defalcations. Also, they must comply with statutory requirements for segregation of escrow funds, and must have an annual audit done of their escrow accounts each year by a CPA or a title insurer for which they do business. K.S.A. 40-1137 to 40-1139.
LA	Statue, Closing protection letter	La.R.S. 22:515 (C)
ME	Contract	N/A
MD	Contract, Statue, Common law, Closing protection letter	N/A
MA	N/A	N/A
MI	Closing protection letter	N/A
MN	Closing protection letter	N/A
MS	Common law	Common contract law
MO	Statue, Contract, Closing protection letter	Missouri Regulation 20 CSR 100 Section 375.144, RSMo Section 375.1007, RSMo Section 381.018, RSMo Section 381.022, RSMo
MT	MCA § 28-10-602. Principal's responsibility for agent's negligence, omissions, and wrongs.	MCA § 33–1–1205. Duties of authorized insurers, adjusters, administrators, consultants, and producers. MCA § 28-10-602. Principal's responsibility for agent's negligence, omissions, and wrongs.

	61. If title insurers are liable for losses resulting from defalcations, by what is that liability imposed?	62. Statutes and regulations regarding the liability of title insurers for defalcations of other title participants:
NE	Statue	Neb. Rev. Stat. 44-19,109(3) and Neb. Rev. Stat. 44-1993(8)(a) [NOTE: only applies if title ins policy is ISSUED]; Neb. Rev. Stat. 44-1984(2)(a)(1)
NV	Closing protection letter, Statue	NRS 692A.110, NRS 692A.225
NM	Common law, Statue, Contract, Closing protection letter	13.14.1 et. seq. NMAC
NC	Contract	N/A
ND	N/A	NA
OH	Common law, Statue, Closing protection letter	Ohio Revised Code Section 3905.20 and 3953.32
OK	Common law	N/A
OR	Depends on the terms of the contract	N/A
PA	Contract	N/A
PR	Contract. The insurer is the ultimate responsible for the insurance contract issued.	N/A
RI	Statue	R.I. Gen. Laws § 27-2.6-6
SC	N/A	N/A
TN	N/A	N/A
TX	Closing protection letter	Closing protection letters are governed by Ins Code Sections 2702.001 and 2702.002, and promulgated under the Texas Department of Insurance. Ins Code Ch. 2602 governs the Texas Title Insurance Guaranty Association, which can assess title insurers.
UT	Statue, Closing protection letter	Utah Code Sections 31A-4-117, 31A-23a-407
VT	Common law	Common law
VA	Statue, Closing protection letter	38.2-1801 of the Code of Virginia
WA	Statue	RCW 48.29.155(5)
WV	N/A	N/A
WI	It would depend on the circumstances of the case.	Sections 628.34(1)(a), 628.40, and 631.09 Wis. Stat.
WY	Common law	N/A

	63. Is a title search required before a title policy is issued?	64. Are title insurers required to maintain a title plant?	65. Is it acceptable for the title plant's records to be electronic?	66. Is it acceptable for searches to be conducted from publicly available recorders' websites?	67. Is it acceptable for title plants to offer their records via a secured web portal?
AL	No	No	N/A	N/A	N/A
AK	Yes	Yes	Yes	Yes	N/A
AS	N/A	N/A	N/A	N/A	N/A
AZ	Yes	Yes	Yes	Yes	Yes
AR	Yes	No	Yes	Yes	Yes
CA	Yes	No	Yes	Yes	Yes
CO	Yes	No	Yes	Yes	Yes
CT	Yes	No	N/A	N/A	N/A
FL	Yes	No	Yes	Yes	Yes
GA	Yes	N/A	N/A	N/A	N/A
ID	Yes	N/A	Yes	No	Yes
IN	Yes	No	N/A	No	Yes
KS	Yes	No	N/A	No	Yes
LA	Yes	Yes	N/A	N/A	N/A
ME	No	No	N/A	N/A	N/A
MD	Yes	N/A	N/A	Yes	N/A
MA	N/A	N/A	N/A	N/A	N/A
MI	No	No	Yes	Yes	Yes
MN	No	No	N/A	Yes	Yes
MS	N/A	N/A	N/A	N/A	N/A
MO	Yes	No	Yes	Yes	Yes
MT	Yes	No	Yes	Yes	Yes
NE	Yes	No	Yes	N/A	N/A
NV	Yes	No	Yes	Yes	Yes
NM	Yes	Yes	Yes	Yes	Yes
NC	Yes	No	N/A	N/A	N/A
ND	Yes	Yes	Yes	N/A	N/A
OH	Yes	No	Yes	Yes	Yes
OK	Yes	No	N/A	N/A	N/A
OR	Yes	Yes	Yes	Yes	Yes
PA	Yes	No	N/A	N/A	N/A
PR	Yes	N/A	N/A	Yes	N/A
RI	No	No	Yes	Yes	Yes
SC	Yes	No	N/A	N/A	N/A
TN	Yes	No	Yes	Yes	Yes
TX	Yes	No	Yes	No	Yes
UT	Yes	No	Yes	Yes	Yes
VT	Yes	N/A	N/A	N/A	N/A
VA	Yes	N/A	N/A	N/A	N/A
WA	No	Yes	Yes	No	No
WV	N/A	No	N/A	No	N/A
WI	N/A	N/A	N/A	N/A	N/A
WY	Yes	No	N/A	N/A	Yes

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	68. Statutes and regulations regarding title plants:
AL	N/A
AK	A.S. 21.66.200, A.S. 21.66.210 and A.S. 21.66.240
AS	N/A
AZ	ARS 20-1562(10), 20-1564 (F), 20-1567
AR	N/A
CA	See CICS 12389, 12372, AND 12372.5
CO	N/A
CT	CGS sections 38a-402(17), 38a-406 (single risk limitation), and 38a-412 (Investments)
FL	N/A
GA	N/A
ID	§§ 41-2702, 41-2708(1)(a), 41-2710, Idaho Code. IDAPA 18.05.01.011
IN	N/A
KS	K.S.A. 40-235 requires "a reasonable search and examination of the title to the property and must be based on all applicable records of the county, state and federal offices in which the real estate is located." There are many records which may be confidential and not publicly available which may only be available for inspection at the applicable court, county, or state office.
LA	N/A
ME	N/A
MD	N/A
MA	N/A
MI	N/A
MN	N/A
MS	N/A
MO	Missouri Regulation 20 CSR 500-7.200, Section 381.071, RSMo Section 381.115.8, RSMo
MT	MCA § 33–25–105 (16). “Title plant” means a set of privately maintained records in which entries have been made of documents imparting constructive notice, under the law, of matters affecting title to real property, an interest therein, or an encumbrance thereon, that have been filed or recorded in the jurisdiction for which the title plant is maintained and from which the ownership of real property within the jurisdiction can be ascertained and liens, encumbrances, defects, and clouds on title to the real property can be determined.
NE	Nebraska Administrative Code Title 210 Chapter 34, section 006.05 [Title Plant Maintenance]
NV	NRS 692A.080, NRS 692A.220, NRS 692A.230
NM	13.14.1 et. seq. NMAC; 13.14.2 NMAC; 59A-1-1 et. seq. NMSA; 59A-30-4 NMSA; 59-A-30-12 NMSA; 59A-12-13 NMSA; 59A-12-2-2 NMSA
NC	N/A
ND	NA
OH	N/A
OK	36 O.S. § 5001(C)(1); 1 O.S. §§ 21 and 27–37; OAC 5:2-1-2; OAC 5:11-3-1; OAC 5:11-3-6; OAC 5:11-7-1 through OAC 5:11-7-4
OR	ORS 731.438
PA	40 P.S. § 910-39(c)

	68. Statutes and regulations regarding title plants:
PR	N/A. The Government of Puerto Rico maintains a database where all transactions of a property title and their tract are recorded (named "Registro de la Propiedad") that is part of the Puerto Rico Department of Justice and gives protection to citizens of its records by civil law.
RI	R.I. Gen. Laws § 27-2.6-3(21)
SC	N/A
TN	T.C.A. 56-35-103
TX	Texas Insurance Code Chapters 2501.004; Basic Manual for Rules, Rates, and Forms for the Writing of Title Insurance in the State of Texas, Procedural Rule P-12. (Note: Title agent required to maintain title plants.)
UT	N/A
VT	N/A
VA	N/A
WA	RCW 48.29.020, 48.29.040, 48.29.160, and Chapter 284-29 WAC
WV	N/A
WI	N/A
WY	W.S. 33-2-101

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	69. In your state, closing protection letters are:	70. To who are closing protection letters provided?		
		Buyer	Seller	Lender
AL	Voluntary and Typically Used	X	X	X
AK	Voluntary and Typically Used	X		X
AS	N/A			
AZ	Required by Statute	X	X	X
AR	Voluntary and Typically Used	X	X	X
CA	N/A			
CO	Voluntary and Typically Used	X	X	X
CT	Voluntary and Typically Used	X		X
FL	Voluntary and Typically Used	X		X
GA	Voluntary and Typically Used	X	X	X
ID	Voluntary and Typically Used	X	X	X
IN	Required by Statute	X		X
KS	Voluntary and Typically Used	X	X	X
LA	Voluntary and Typically Used	X	X	X
ME	Voluntary and Typically Used	X		X
MD	Voluntary and Typically Used	X	X	X
MA	N/A			
MI	Voluntary and Typically Used			X
MN	Voluntary and Typically Used	X	X	
MS	N/A			
MO	Required by Statute	X	X	X
MT	N/A			
NE	Required by Statute	X		X
NV	Voluntary and Typically Used	X	X	X
NM	Voluntary and Typically Used	X		X
NC	Voluntary and Typically Used	X		
ND	Voluntary and Typically Used			
OH	Required by Statute	X	X	X
OK	N/A			
OR	Voluntary and Not Typically Used	X	X	X
PA	Voluntary and Typically Used	X		
PR	N/A			
RI	Voluntary and Typically Used	X		X
SC	Voluntary and Typically Used			
TN	N/A			
TX	Voluntary and Typically Used	X	X	X
UT	Voluntary and Typically Used	X	X	X
VT	Voluntary and Typically Used			X
VA	Voluntary and Typically Used	X	X	X
WA	Voluntary and Typically Used			
WV	Voluntary and Typically Used			X
WI	Voluntary and Not Typically Used			X
WY	Voluntary and Typically Used			X

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	71. Can title insurers issue closing protection letters?	72. If closing protection letters are used, how are they paid?	73. Statutes and regulations regarding closing protection letters:
AL	Yes	By separate charge to the consumer	Ala. Code Section 27-3-6.1
AK	Yes	Included in the rate	N/A
AS	N/A	N/A	N/A
AZ	Yes	By separate charge to the consumer	ARS §6-841.02(C) through (E)
AR	Yes	By separate charge to the consumer	Rule 87, Section 14
CA	Yes	N/A	California Insurance Code Section 12340.3(e)
CO	Yes	By separate charge to the consumer	Regulation 8-1-3
CT	Yes	By separate charge to the consumer	CGS section 38a-404
FL	Yes	Included in the rate	Sections 627.782(2) and 627.786, F.S.
GA	Yes	N/A	O.C.G.A. 33-7-8.1
ID	Yes	By separate charge to the consumer	§ 41-2714, Idaho Code
IN	Yes	By separate charge to the consumer	IC 27-1-22-8
KS	Yes	By separate charge to the consumer	Bulletin 1996-6 authorizes insurance companies to issue closing protection letters at their option to purchasers, sellers, and lenders.
LA	Yes	By separate charge to the consumer	La.R.S. 22:515 (C)
ME	Yes	By separate charge to the consumer	24-A M.R.S. § 3202
MD	Yes	By separate charge to the consumer	N/A
MA	N/A	N/A	N/A
MI	Yes	N/A	N/A
MN	Yes	Included in the rate	N/A
MS	N/A	N/A	N/A
MO	Yes	By separate charge to the consumer	Missouri Regulation 20 CSR 500-7.200, Section 381.071, RSMo, Section 381.115.8, RSMo
MT	N/A	N/A	N/A
NE	Yes	By separate charge to the consumer	Neb. Rev. Stat. 44-1978 et seq., 44-1984 and 44-19,106 et seq., also [NOT LEGALLY BINDING] Insurance Guidance Doc ("IGD") C12
NV	Yes	By separate charge to the consumer	NRS 692A.225
NM	Yes	N/A	13.14.18.1 et. seq NMAC

	71. Can title insurers issue closing protection letters?	72. If closing protection letters are used, how are they paid?	73. Statutes and regulations regarding closing protection letters:
NC	Yes	By separate charge to the consumer	N/A
ND	N/A	N/A	NA
OH	Yes	By separate charge to the consumer	Ohio Revised Code Section 3953.32
OK	Yes	N/A	N/A
OR	Yes	Included in the rate	It is the Department of Financial Regulation's position that CPLs can be issued if incidental to a title insurance policy (without a separate charge).
PA	Yes	By separate charge to the consumer	N/A
PR	N/A	N/A	N/A
RI	Yes	By separate charge to the consumer	R.I. Gen. Laws § 27-2.6-6
SC	Yes	Included in the rate	38-75-1010
TN	N/A	N/A	N/A
TX	Yes	N/A	Texas Insurance Code Chapters 2702, Subchapter A; Basic Manual for Rules, Rates, and Forms for the Writing of Title Insurance in the State of Texas, Procedural Rules P-67 and P-69
UT	Yes	By separate charge to the consumer	Utah Code Section 31A-4-117
VT	Yes	By separate charge to the consumer	Bulletin 108 and 8 VSA Section 3541
VA	Yes	By separate charge to the consumer	38.2-4606 of The Code of Virginia
WA	Yes	N/A	N/A
WV	Yes	N/A	N/A
WI	Yes	Included in the rate	N/A
WY	Yes	Included in the rate	N/A

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	74. Does the state department regulate title opinion letters?	75. Does the state department regulate the pricing of title opinion	76. Are title opinion letter forms and rates filed with the state	77. Does the state license the entity that generates the title	78. What license is required?
AL	No	No	No	Yes	Attorney
AK	No	Yes	Yes	Yes	Licensed title insurance limited producer and licensure of title company insurer.
AS	N/A	N/A	N/A	N/A	Certificate of Authority and Business License from DOC
AZ	N/A	N/A	N/A	N/A	N/A
AR	No	N/A	N/A	N/A	N/A
CA	No	No	No	No	N/A
CO	No	Yes	No	No	N/A
CT	N/A	N/A	N/A	N/A	N/A
FL	No	No	No	No	N/A
GA	No	No	No	No	N/A
ID	N/A	N/A	N/A	N/A	A title insurance agent license is required.
IN	No	No	No	No	N/A
KS	No	No	No	No	N/A.
LA	No	No	No	No	Louisiana State Bar Association license
ME	No	No	No	No	The opinion is generated by a licensed attorney.
MD	No	N/A	N/A	N/A	N/A
MA	N/A	N/A	No	N/A	N/A
MI	No	No	No	N/A	N/A
MN	No	No	No	No	Attorney license
MS	No	No	No	No	N/A
MO	N/A	N/A	N/A	N/A	N/A
MT	N/A	N/A	N/A	N/A	N/A
NE	No	No	N/A	N/A	N/A
NV	No	No	No	No	N/A
NM	No	No	N/A	No	N/A
NC	No	No	No	Yes	An attorney licensed to practice law in North Carolina.
ND	N/A	N/A	N/A	N/A	N/A
OH	No	No	No	No	N/A
OK	No	No	No	Yes	Title opinion letters must be issued by an attorney licensed to practice law in Oklahoma by the Oklahoma Bar Association and the title is required to prominently display the attorney's bar number.
OR	No	N/A	N/A	N/A	N/A

	74. Does the state department regulate title opinion letters?	75. Does the state department regulate the pricing of title opinion	76. Are title opinion letter forms and rates filed with the state	77. Does the state license the entity that generates the title	78. What license is required?
PA	Yes	Yes	Yes	Yes	Insurers use opinion letters and the insurers are licensed. A licensed rating organization also files one on behalf of its member insurers.
PR	N/A	N/A	N/A	N/A	N/A
RI	No	No	No	No	N/A
SC	No	No	No	No	N/A
TN	N/A	N/A	N/A	N/A	N/A
TX	N/A	N/A	N/A	N/A	N/A
UT	No	No	No	No	N/A
VT	No	No	No	Yes	The attorney must conduct real estate transactions per Vermont Bar Association rules.
VA	No	N/A	N/A	N/A	N/A
WA	No	N/A	N/A	N/A	N/A
WV	No	No	No	Yes	State Bar license for attorneys
WI	No	No	No	N/A	N/A
WY	Yes	No	No	Yes	Wyoming Bar Association

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	79. Does state law require the maintenance of surety bonds or fidelity insurance?	80. If surety bonds or fidelity insurance is required, what amount is required for escrow officers?
AL	No, not required	N/A
AK	Yes, or a professional liability insurance policy	N/A
AS	N/A	N/A
AZ	No, not required	N/A
AR	No, not required	N/A
CA	Yes, but required for title agents/agencies only	N/A
CO	No, not required	N/A
CT	N/A	N/A
FL	Yes	N/A
GA	N/A	N/A
ID	Yes	Surety bond required in amount of $10,000 in each county title insurance agent is licensed, and in increments of $10,000 for each additional person employed as an escrow officer in the county, up to a total of $50,000. § 41-2711, Idaho Code.
IN	No, not required	N/A
KS	Required only for title agents/agencies that conduct escrow, settlement or closing services. Also required for licensed abstractors.	N/A
LA	Yes, or a professional liability insurance policy	No specified amount- Louisiana Administrative Code; Title 10, section XV-903
ME	No, not required	N/A
MD	Yes	$150,000.
MA	N/A	N/A
MI	No, not required	N/A
MN	No, not required	N/A
MS	No, not required	N/A
MO	N/A	N/A
MT	MCA § 33–2–517. Title insurance reserves. (1) In addition to an adequate reserve as to outstanding losses as required under MCA § 33–2–511, a title insurer shall maintain a guaranty fund or unearned premium reserve. A title insurer may not engage in the business of guaranteeing payment of the principal or interest of bonds or mortgages [MCA § 33-25-213 (2)].	N/A
NE	Yes, or a professional liability insurance policy	Neb. Rev. Stat. 44-19, 109(3) -requires surety bond [or other, similar financial instrument] of $100,000.00 for EVERY title insurance agent or "bona fide employee" of a title insurer who handle escrow accounts or security deposits.
NV	Yes	N/A
NM	No, not required	N/A
NC	No, not required	N/A
ND	N/A	N/A
OH	Yes, but required for title agents/agencies only	N/A
OK	No, not required	N/A

	79. Does state law require the maintenance of surety bonds or fidelity insurance?	80. If surety bonds or fidelity insurance is required, what amount is required for escrow officers?
OR	No	N/A
PA	Yes, but required for title agents/agencies only	N/A
PR	Yes, it is required to participate in a guaranty fund by Section 24.020 of the Puerto Rico Insurance Code. Producers with the title insurance line of business need a surety to obtain a license (Section 9.170(9) PR Insurance Code).	N/A
RI	No, not required	N/A
SC	No, not required	N/A
TN	Yes, but required for title agents/agencies only	N/A
TX	Yes	Varies, maximum $50,000, Texas Insurance Code §2652.103
UT	Yes, or a professional liability insurance policy	N/A
VT	No, not required	N/A
VA	Yes, but required for escrow officers only	Surety Bond - $200,000; Fidelity Bond - $100,000; E&O - $250,000
WA	Yes, but required for title agents/agencies only	RCW 48.29.155 - $200,000
WV	No, not required	N/A
WI	No, not required	N/A
WY	No, not required	N/A

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	81. If surety bonds or fidelity insurance is required, what amount is required for title agents?
AL	N/A
AK	N/A
AS	N/A
AZ	N/A
AR	N/A
CA	For underwritten title companies (UTCs), CIC Section 12389(b)(2)(A) requires UTCs to establish an escrow surety bond or cash deposit, either $50,000 or $100,000, depending on the county(ies) of licensure. CIC Section 12389.6 requires UTCs to maintain a fidelity bond or insurance policy. The face amount of the fidelity bond or insurance policy shall be at least 10 times the UTC's minimum net worth required by CIC Section 12389; thus, the face amount may vary from $750,000 to $4,000,000, depending on the aggregate number of documents the UTC records in all counties.
CO	N/A
CT	N/A
FL	Surety Bond; $35,000 - Fidelity Bond; $50,000 - Errors and Omissions; $250,000 with a deductible that does not exceed $10,000.
GA	N/A
ID	Surety bond required in amount of $10,000 in each county title insurance agent is licensed, and in increments of $10,000 for each additional person employed as an escrow officer in the county, up to a total of $50,000. § 41-2711, Idaho Code.
IN	N/A
KS	Required only for title agents/agencies which handle escrow, settlement or closing. Amounts are $25,000/$50,000/$100,000 based on population of county in which real estate is located. Most companies file a $100,000 bond to cover all counties in the state.
LA	N/A
ME	N/A
MD	$150,000.
MA	N/A
MI	N/A
MN	N/A
MS	N/A
MO	N/A
MT	MCA § 33–2–517. Title insurance reserves. (1) In addition to an adequate reserve as to outstanding losses as required under MCA § 33–2–511, a title insurer shall maintain a guaranty fund or unearned premium reserve. A title insurer may not engage in the business of guaranteeing payment of the principal or interest of bonds or mortgages [MCA § 33-25-213 (2)].
NE	Neb. Rev. Stat. 44-19, 109(3) -requires surety bond [or other, similar financial instrument] of $100,000.00 for EVERY title insurance agent or "bona fide employee" of a title insurer who handle escrow accounts or security deposits.
NV	2% of average collected balance of the trust account, not less than $20,000 nor more than $250,000
NM	N/A
NC	N/A
ND	N/A

	81. If surety bonds or fidelity insurance is required, what amount is required for title agents?
OH	Title agents must maintain at least $250,000 in E&O coverage. Surety bond coverage of at least $150,000 is required for agents who handle escrow transactions not involving the issuance of title insurance. However, E&O coverage and surety bond coverage is not required to be maintained by title agents employed by a title insurer.
OK	N/A
OR	N/A
PA	$100,000 for Surety; $150,000 for Fidelity
PR	For title insurers - Section 24.020 of the Puerto Rico Insurance Code. Producers with the title insurance line of business needs a surety to obtain a license by Section 9.170(9) PR Insurance Code
RI	N/A
SC	N/A
TN	$25,000
TX	Varies, maximum $100,000, Texas Insurance Code §2651.101(b)
UT	$250,000 minimum
VT	N/A
VA	N/A
WA	RCW 48.29.155 - $200,000
WV	N/A
WI	N/A
WY	N/A

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	82. Are title agents authorized to put title premiums into separate trust accounts rather than general trust accounts?	83. Statutes and regulations regarding title escrow and trust accounts:
AL	N/A	N/A
AK	Yes	A.S. 21.66.280 (a) In addition to any other requirement of this title, a title insurance limited producer licensee shall maintain books of accounts and records and vouchers pertaining to the business of title insurance in a manner that the director, or an authorized representative, may readily ascertain whether the licensee has complied with the provisions of this chapter. (b) A title insurance limited producer licensee may engage in the business of handling escrows, settlements, and closings in connection with the business of title insurance; however, (1)the licensee shall maintain a separate record of all receipts and disbursements of escrow funds and may not commingle the funds with personal funds or with funds held by the licensee in any other capacity; (2) the licensee shall comply with the standards of solvency that the director requires; and (3) the licensee shall submit financial statements that the director requires. (c) In addition to any other penalty provided by law, if the director determines that a title insurance limited producer licensee has failed to comply with a provision of this section, the director may, after a hearing, revoke the limited producer license. A.S. 34.80.010-095, A.S. 21.18.010(2)(C), A.S. 21.66.460
AS	N/A	N/A
AZ	Yes	ARS §6-834
AR	Yes	N/A
CA	Yes	California Insurance Code sections 12413.1, 12413.2, and 12413.5, and California Financial Code section 17000 et seq.
CO	Yes	C.R.S. 10-2-704, 10-11-127, and Regulation 8-1-4
CT	N/A	N/A. CT only allows licensed Connecticut attorneys to act as title agents.
FL	Yes	Section 626.8473, F.S.
GA	N/A	N/A
ID	No	IDAPA 18.05.01.021.04
IN	Yes	IC 27-7-3.7-6-10; IC 27-7-3.7-7; IC 27-7-3.7-8; IC 27-7-3.7-9; IC 27-7-3.7-10
KS	Yes	K.S.A. 40-1136 to 40-1138.
LA	Yes	La.R.S. 22:532 (A)(1)(a)
ME	No	24-A M.R.S. § 1447; C.M.R. 02 032 540
MD	Yes	Annotated Code of Maryland, Title 10, Subtitle 1, Section 10-121; and Title 22, Section 22-101 through 22-105.
MA	N/A	N/A
MI	Yes	MCL 500.7304, 500.1207(1)&(2), 500.1239, DIFS Insurance Bulletin 2002-03-INS
MN	Yes	Minn. Stat. § 82.75
MS	No	N/A
MO	N/A	Section 381.022.2, RSMo; Section 381.022.3, RSMo; Section 381.022.4, RSMo

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	82. Are title agents authorized to put title premiums into separate trust accounts rather than general trust accounts?	83. Statutes and regulations regarding title escrow and trust accounts:
MT	Yes	ARM 6.6.2202 ESCROW, CLOSING, OR SETTLEMENT SERVICES. MCA § 33-17-1102. Reporting and accounting for premiums – misappropriation. MCA § 33-25-201. Escrow, closing, or settlement services – title indemnification – maintenance of accounts – maintenance of nominal or short-term accounts (1). MCA § 33-25-201 (2)(a).
NE	Yes	Neb. Rev. Stat. 44-1994(1)(b)
NV	Yes	NRS 692A.250-.225, NRS 683A.400
NM	Yes	58-28-1 et. seq. NMSA; 59A-1-1 et seq. NMSA; 13.14.4 NMAC; 13.14.1 et seq. NMAC
NC	N/A	N/A
ND	No	N/A
OH	Yes	Ohio Revised Code Sections 3953.23, 3953.231, and 3953.33
OK	N/A	N/A
OR	Yes	ORS 744.083-086.
PA	Yes	40 P.S. §§ 910-39.1, 910-26.1(5)
PR	N/A	Section 24.020 of the Puerto Rico Insurance Code
RI	Yes	R.I. Gen. Laws § 27-2.4-19
SC	N/A	N/A
TN	Yes	T.C.A. 56-35-130
TX	Yes	Texas Insurance Code Chapters 2651 and 2652; Basic Manual for Rules, Rates, and Forms for the Writing of Title Insurance in the State of Texas, Section V
UT	Yes	Utah Code Section 31A-23a-204, -406, -409
VT	N/A	N/A
VA	Yes	55.1-1008 of the Code of Virginia
WA	Yes	RCW 48.29.190, 48.29.193, 48.29.195, and 48.29.200 WAC 284-29-320 and 284-29-330.
WV	N/A	N/A
WI	N/A	N/A
WY	Yes	W.S. 26-23-314

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	84. Statutes and regulations regarding the use of surety bonds or fidelity insurance in title or real estate closing processes
AL	N/A
AK	A.S. 21.66.480(2) "business of title insurance" is (A) the making or proposing to make as insurer, guarantor, or surety, a contract or policy of title insurance; A.S. 08.88.455(a) A real estate licensee, when applying for or renewing a real estate license, (a) A real estate licensee, when applying for or renewing a real estate license, in lieu of obtaining a corporate surety bond, shall pay to the commission, in addition to the license fee, a recovery fund fee not to exceed $125. After each two-year licensing cycle, if the commission finds that the average balance in the recovery fund during the two-year licensing cycle was less than $250,000 or more than $500,000, the commission shall by regulation adjust the recovery fund fees so that the average balance of the recovery fund during the next two-year licensing cycle is anticipated to be an amount that is not less than $250,000 or more than $500,000. In this subsection, "average balance" means the average balance after taking into account anticipated expenditures for awards from the fund and legal expenses directly related to fund operations, and for real estate educational purposes. See A.S. 08.99.450 Real Estate recovery fund that operates in lieu of surety bonds. A.S. 08.88.460 & 08.88.465.
AS	N/A
AZ	ARS §6-814
AR	N/A
CA	California Insurance Code Sections 12389(b)(2)(A), 12389.6(a)(1)
CO	N/A
CT	N/A
FL	Section 626.8419, F.S.
GA	N/A
ID	§ 41-2711, Idaho Code, IDAPA 18.05.01.021
IN	N/A
KS	K.S.A. 40-1139
LA	N/A
ME	N/A
MD	Licensees of the Maryland Insurance Administration are required to comply with the federal law regarding disclosure - 12 U.S.C. Section 2607 (c) (4). 24 C.F.R. 3500.15, and Appendix D to 24 C.F.R. Part 3500, as applicable, regarding disclosures of affiliated business arrangements, as defined in 12 U.S.C. Section 2602. Licensees are also required to comply with the Annotated Code of Maryland, Real Property Article Title 14, Subtitle 1, Section 14-127. Annotated Code of Maryland, Title 10, Subtitle 1, Section 10-121
MA	N/A
MI	N/A
MN	N/A
MS	N/A
MO	N/A
MT	N/A
NE	Neb. Rev. Stat. 44-19,109(3)
NV	NRS 692A.1041-1044
NM	N/A
NC	N/A
ND	N/A

	84. Statutes and regulations regarding the use of surety bonds or fidelity insurance in title or real estate closing processes
OH	Ohio Revised Code 3953.23 and Ohio Administrative Code 3901-7-02
OK	N/A
OR	N/A
PA	40 P.S. §§ 910-26.1(2) and (3)
PR	N/A
RI	N/A
SC	N/A
TN	T.C.A. 56-35-202
TX	Texas Insurance Code Chapters 2651 and 2652
UT	N/A
VT	N/A
VA	55.1-1004 of the Code of Virginia
WA	RCW 48.29.155
WV	N/A
WI	N/A
WY	N/A

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	85. Does state law limit or restrict the use of affiliated business arrangements? If yes, how? (An affiliated business arrangement means an arrangement in which a person who is in a position to refer business incident to or a part of a real estate settlement service involving a federally related mortgage loan, or an associate of such person, has either an affiliate relationship with or a direct or beneficial ownership interest of more than one percent in a provider of settlement services and either of such persons directly or indirectly refers such business to that provider or affirmatively influences the selection of that provider.)
AL	No
AK	It regulates joint plant companies under A.S. 21.66.210. Rebates, inducements, special favors, etc. are prohibited under A.S. 21.66.310.
AS	N/A
AZ	No
AR	No
CA	Yes. Affiliated business arrangements are required to comply with the Controlled Business Source law. Insurance Code Sections 12396-12399, including record keeping and reporting of closed title orders from controlled business sources, an intent to not rely on more than 50% of such from controlled business sources, and active competition in the market place. In addition, companies must also comply with anti-kickback, rebating provisions in Insurance Code Section 12404 et. seq.
CO	No
CT	No. The title insurer or title agent may accept an order for a title insurance policy if such insurer or title agent knows or has reason to believe that the applicant was referred to such insurer or agent by any producer of title insurance business where to producer has a financial interest in the title insurer or agent unless the producer has disclosed, in writing, to the buyer, seller and lender the financial interest of the producer. Also, Conneticut has restriction on accepting title insurance business if (1) the title insurer or title agent knows or has reason to believe that the transaction will constitute controlled business for that title insurer; and (2) 20% or more of the gross operating revenue of that title insurer in the calendar year in which the transaction takes place is derived from controlled business.
FL	No
GA	N/A
ID	Yes, in general in the same way RESPA regulates/restricts the use of AFBAs.
IN	No
KS	Yes. No title insurer or title agent may accept an order for title insurance business, issue a title insurance policy, or receive or retain any premium, or charge in connection with any transaction if: (i) The title insurer or title agent knows or has reason to believe that the transaction will constitute controlled business for that title insurer or title agent; and (ii) 70% or more of the closed title orders of that title insurer or title agent during the 12 full calendar months immediately preceding the month in which the transaction takes place is derived from controlled business. The prohibitions do not apply to transactions involving real estate located in a county that has a population,of 10,000 or less.
LA	N/A
ME	No
MD	Licensees of the Maryland Insurance Administration are required to comply with the federal law regarding disclosure - 12 U.S.C. Section 2607 (c) (4). 24 C.F.R. 3500.15, and Appendix D to 24 C.F.R. Part 3500, as applicable, regarding disclosures of affiliated business arrangements, as defined in 12 U.S.C. Section 2602. Licensees are also required to comply with the Annotated Code of Maryland, Real Property Article Title 14, Subtitle 1, Section 14-127.
MA	N/A
MI	No
MN	No
MS	N/A

	85. Does state law limit or restrict the use of affiliated business arrangements? If yes, how? (An affiliated business arrangement means an arrangement in which a person who is in a position to refer business incident to or a part of a real estate settlement service involving a federally related mortgage loan, or an associate of such person, has either an affiliate relationship with or a direct or beneficial ownership interest of more than one percent in a provider of settlement services and either of such persons directly or indirectly refers such business to that provider or affirmatively influences the selection of that provider.)
MO	In Missouri, an "affiliated business," is any portion of a title insurance agency's business written in this state that was referred to it by a producer of title insurance business or by an associate of the producer, where the producer or associate, or both, have a financial interest in the title agency.
MT	Associate means a corporation, partnership, or other business entity organized for profit, of which a producer of title business is a director, officer, partner, employee, or owner of 5% or more of its equity or capital [MCA § 33-25-105 (4)(a)]. Financial interest means a legal or beneficial interest that entitles the holder, directly or indirectly, to 1% or more of the net profits or net worth of the entity in which the interest is held [MCA § 33-25-105 (6)]. Producer of title business means a person, corporation, partnership, or other business entity, including an officer, director, or owner of 5% or more of the equity or capital thereof, engaged in this state in the trade, business, occupation, or profession [MCA § 33-25-105 (8)]. MCA § 33-25-401. Prohibited practices – referrals – splitting charges – exemptions.
NE	Yes. Neb. Rev. Stat. 44-19,112 [entire], "Affiliated Business Provisions"
NV	No
NM	N/A
NC	No
ND	No
OH	Yes. Ohio law does not allow a bank, trust company, bank and trust company, or other lending institution, mortgage service, brokerage, mortgage guaranty company, escrow company, real estate company, or any subsidiaries thereof or individuals so engaged to act as a title insurance agent.
OK	No
OR	N/A
PA	No
PR	Restrict - Section 9.061, 3.031 and 9.070 Puerto Rico Insurance Code
RI	Yes, R.I. Gen. Laws § 27-2.6-14 prohibits rebating and fee splitting.
SC	Yes. See 38-75-960
TN	§ 56-35-131. Terms and conditions for licenses or certificates (a) Except as provided by §§ 56-35-201 and 56-35-204, the commissioner shall refuse to issue any new license or certificate to any title insurance company, title insurance agent, or title insurance agency, unless the applicant therefor shall agree to abide by any one (1) of the following terms and conditions: (1) The gross operating revenues for any fiscal year attributable to the placement or issuance of policies or contracts of title insurance derived from all sources of controlled business shall not exceed forty percent (40%) of the gross operating revenues of the company, agent or agency; (2) The company, agent or agency will be operated as a subsidiary of a financial institution with its primary business being that of accepting deposits and making real estate loans and subject to regulation, inspection, and supervision of the United States government or an agency of the United States; or (3) The title insurance agency or agent is to be operated by an attorney, a single partnership of attorneys, or a single professional corporation of attorneys as an ancillary part of the general practice of law. (b) Any violation of the terms and conditions of the agreement shall serve as grounds for the commissioner to suspend or revoke the license or certificate to which the agreement pertains and to assess a civil penalty as provided by § 56-35-127. Tenn. Code Ann. § 56-35-131
TX	No

	85. Does state law limit or restrict the use of affiliated business arrangements? If yes, how? (An affiliated business arrangement means an arrangement in which a person who is in a position to refer business incident to or a part of a real estate settlement service involving a federally related mortgage loan, or an associate of such person, has either an affiliate relationship with or a direct or beneficial ownership interest of more than one percent in a provider of settlement services and either of such persons directly or indirectly refers such business to that provider or affirmatively influences the selection of that provider.)
UT	31A-23a-1003. Affiliated business arrangements. (1) An affiliated business arrangement between a person and a title entity violates Section 8 of RESPA for purposes of state law if: (a)the title entity does not have sufficient capital and net worth in a reserve account in the title entity's name; or (b) more than 70% of the title entity's annual title insurance business is affiliated business on or after the later of: (i) two years after the title entity begins an affiliated business arrangement; or (ii) June 1, 2021. (2) In addition to Subsection (1), the division may find that an affiliated business arrangement between a person and a title entity violates Section 8 of RESPA after evaluating and weighing the following factors in light of the specific facts before the division: (a) whether the title entity: (i) is staffed with the title entity's own employees to conduct title insurance business; (ii) manages the title entity's own business affairs; (iii) has a physical office for business that is separate from any producer's or associate's office and pays market rent; (iv) provides the essential functions of title insurance business for a fee, including incurring the risks and receiving the rewards of any comparable title entity; and (v) performs the essential functions of title insurance business itself; (b)if the title entity contracts with another person to perform a portion of the title entity's title insurance business, whether the contract: (i) is with an independent third party; and (ii)provides payment for the services that bears a reasonable relationship to the value of the services or goods received; and (c) whether the person from whom the title entity receives referrals under the affiliated business arrangement also sends title insurance business to other title entities.
VT	N/A
VA	No
WA	RCW 48.29.015 and WAC 284-29-130 require title insurance agents to submit an Affiliated Business Ownership report with the Commissioner annually. State law outlines when certain payments are authorized for return on ownership in transactions involving title insurance, including with affiliated relationships (RCW 48.29.213). RCW 48.29.210 and WAC 284-29-200 outline prohibited practices regarding business inducements, including with associates and affiliates.
WV	Yes
WI	Yes, individuals engaged in certain affiliated business arrangements may be regulated in accordance with s. Ins. 3.32, Wis. Adm. Code.
WY	Regulations governing the transaction of controlled business by title insurers and title agents.

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	86. Is the state department/division authorized by state law to require disclosure of affiliated business arrangements? If yes, by whom must they be disclosed?
AL	No
AK	A.S. 21.66.210 requires two or more title insurance companies or title insurance limited producers or any combination thereof to apply to the Director of Insurance and disclose along the lines of the statute their business arrangement for a joint title plant.
AS	N/A
AZ	No
AR	No
CA	Yes. Underwritten title companies are required to report on controlled business sources.
CO	Yes. Individual licensed title insurance producers and title entities are required to complete and submit the Affiliated Business Arrangement Disclosure form to the Division of Insurance, if they are a party to an affiliated business arrangement.
CT	Yes, per CGS section 38a-416(b), the title insurer and title agent must make the disclosure per CGS section 38a-416(b).
FL	No
GA	N/A
ID	Yes, all affiliated business arrangement must be disclosed in writing by the producer of title business, signed by parties to the transaction, and provided to the title agent at the time of the sell and/or purchase contract is entered into.
IN	Yes, Title agency and insurer
KS	The title insurer's, title agency's or title agent's chief executive officer or designee.
LA	N/A
ME	No
MD	Agents must comply with federal laws.
MA	N/A
MI	No
MN	N/A
MS	N/A
MO	The title insurer, title agency, title agent must report annually on or before March 31st, any affiliated business arrangement on a form prescribed by the Director.
MT	Controlled business means that portion of the business of title insurance in this state of a title insurer or title insurance producer that is referred to it by a producer or associate having a financial interest in the title insurer or title insurance producer [MCA § 33-25-105 (5)]. A person may pay a return on an investment, based on a percentage of an ownership interest in a title insurance agency if at or prior to the time of a referral, a disclosure of the existence of the arrangement is made to the person being referred and, in connection with the referral, the person is provided with a written estimate of the charge or range of charges generally made by the title insurance producer to which the person is referred, and the person is not required to use a particular insurance producer [MCA § 33-25-401 (2)(a)(i)(ii). MCA § 33-2-1601. Licensure of managing general agent.
NE	Yes, must be disclosed to either (A) title insurance agent or (B) party making a referral constituting "affiliated business" - Neb. Rev. Stat. 44-19, 112(4)(a)
NV	Yes, during an examination pursuant to NRS 679B.230-.240
NM	Title Insurance Bureau
NC	No

	86. Is the state department/division authorized by state law to require disclosure of affiliated business arrangements? If yes, by whom must they be disclosed?
ND	No
OH	Yes. The applicant or the applicant's responsible designated agent is responsible for the disclosure.
OK	No
OR	Federal law would apply.
PA	No
PR	N/A
RI	N/A
SC	Yes. Each title insurer and agent shall file with the department reports setting forth the names of persons who have had a financial interest in the title insurer or title agent who are producers of title business or associates of producers.
TN	N/A
TX	Title agents have to disclose their ownership information. (Texas Basic Manual, Procedural Rule P-21)
UT	No
VT	N/A
VA	Yes, 55.1-905 of the Code of Virginia, must be disclosed by settlement service providers (escrow officers)
WA	RCW 48.29.015 and WAC 284-29-130 require title insurance agents to submit an Affiliated Business Ownership report with the Commissioner annually. Title insurance agents are required to submit this report.
WV	Financial institutions engaged in the sale of insurance.
WI	Yes, in accordance with s. 601.42, Wis. Stat., and ss. Ins. 3.32 and 6.61(11), Wis. Adm. Code.
WY	Title insurers and title agents

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	87. Please list the statutes and regulations regarding affiliated business arrangements.
AL	N/A
AK	A.S. 21.66.210
AS	N/A
AZ	ARS 20-223
AR	N/A
CA	California Insurance Code Sections 12396-12399 and 12397-12397.5.
CO	C.R.S. 10-2-401 (6), 10-11-124, 10-11-126, Regulation 8-1-3
CT	CGS section 38a-416 entitled Disclosure of Financial Interest. CGS section 38a-402 (6) includes the definition of "Financial interest".
FL	N/A
GA	N/A
ID	IDAPA 18.05.01.014 & 015.
IN	HUD; 61 Fed. Reg 29258-64
KS	K.S.A. 40-2404(14)(h), K.A.R. 40-3-52, K.A.R. 40-3-43.
LA	N/A
ME	N/A
MD	Licensees of the Maryland Insurance Administration are required to comply with the federal law regarding disclosure - 12 U.S.C. Section 2607 (c) (4). 24 C.F.R. 3500.15, and Appendix D to 24 C.F.R. Part 3500, as applicable, regarding disclosures of affiliated business arrangements, as defined in 12 U.S.C. Section 2602. Licensees are also required to comply with the Ann. Code of Maryland, Real Property Article Title 14, Subtitle 1, Section 14-127.
MA	N/A
MI	N/A
MN	N/A
MS	N/A
MO	Missouri Regulation 20 CSR 500-7.070 Section 381.029, RSMo
MT	[MCA § 33-25-105 (5)], [MCA § 33-25-401 (2)(a)(i)(ii), MCA § 33-2-1601
NE	Neb. Rev. Stat. 44-19, 112 [entire]
NV	N/A
NM	N/A
NC	N/A
ND	N/A
OH	Ohio Revised Code Section 3953.21 Ohio Administrative Code 3901-5-09 and 3901-7-04
OK	N/A
OR	N/A
PA	40 P.S. § 910-31 prohibits any form of compensation or benefit, directly or indirectly, to an "applicant for title insurance" as an inducement for the placement or referral of title insurance business. Under 40 P.S. § 910-1, the term "applicant for title insurance" is "deemed to include approved attorneys, real estate brokers, real estate salesmen, attorneys at law and all others who from time to time apply . . . for title insurance, and . . . are not agents for a title insurance company."
PR	Section 9.061, 3.031 and 9.070 Puerto Rico Insurance Code
RI	R.I. Gen. Laws § 27-2.6-14
SC	38-75-960
TN	Tenn. Code Ann. § 56-35-131

	87. Please list the statutes and regulations regarding affiliated business arrangements.
TX	Texas Insurance Code Chapter 2651.203 and Texas Basic Manual, Procedural Rule P-21
UT	Utah Code Section 31A-23a-1001, et seq.
VT	N/A
VA	55.1-905 of the Code of Virginia
WA	RCW 48.29.015, 48.29.210, and 48.29.213. WAC 284-29-130 and 284-29-200. Also, generally WAC 284-29-120 through 284-29-160.
WV	33-11A-1 et seq.
WI	Sections Ins. 3.32 and 6.61(11), Wis. Adm. Code.
WY	Wyoming regulations Chapter 3

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	88. Does the state have a guaranty association that covers title insurance?	89. Is the guaranty association for title insurance only?	90. Is the guaranty association operated in conjunction with other states?
AL	No	N/A	N/A
AK	Yes	Yes	No, it is for one state only
AS	No	No	N/A
AZ	No	N/A	N/A
AR	No	N/A	N/A
CA	No	N/A	N/A
CO	No	N/A	N/A
CT	No	N/A	N/A
FL	No	N/A	N/A
GA	No	N/A	N/A
ID	No	N/A	N/A
IN	No	N/A	N/A
KS	No	N/A	N/A
LA	No	N/A	N/A
ME	No	No	N/A
MD	Yes	No	No, it is for one state only
MA	No	N/A	N/A
MI	Yes	No	No, it is for one state only
MN	No	N/A	N/A
MS	No	N/A	N/A
MO	No	N/A	N/A
MT	No	N/A	N/A
NE	No	N/A	N/A
NV	No	N/A	N/A
NM	Yes	Yes	No, it is for one state only
NC	No	N/A	N/A
ND	No	N/A	N/A
OH	No	N/A	N/A
OK	No	N/A	N/A
OR	No	N/A	N/A
PA	No	N/A	N/A
PR	No	N/A	No, it is for one state only
RI	No	N/A	N/A
SC	No	Yes	N/A
TN	No	N/A	No, it is for one state only
TX	Yes	Yes	No, it is for one state only
UT	No	N/A	N/A
VT	No	N/A	N/A
VA	Yes	No	No, it is for one state only
WA	No	N/A	N/A
WV	No	N/A	N/A
WI	No	N/A	N/A
WY	No	N/A	N/A

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	91. Please list the statutes and regulations regarding guaranty associations.
AL	N/A
AK	A.S. 21.66.020
AS	N/A
AZ	ARS §20-685
AR	N/A
CA	N/A
CO	N/A
CT	CGS section 38a-836 et seq. CGS section 38a-837(6) excludes title insurance. See also, CGS section 38a-409 concerning use of reserves on liquidation, dissolution or insolvency of a Conneticut domestic title insurer.
FL	N/A
GA	N/A
ID	N/A
IN	N/A
KS	K.S.A. 40-2901 et seq. K.S.A. 40-2902 exempts from guaranty association coverage policies insuring titles to property against loss by reason of defective titles, and other policies which insure the correctness of searches for liens or charges of instruments affecting property.
LA	La.R.S. 22:2051- 22:2070
ME	24-A M.R.S. § 4433(2)(E) (title insurance exclusion in guaranty association law)
MD	Annotated Code of Maryland, Title 9 Impaired Entities, Subtitle 3 Property and Casualty Insurance Guaranty Corporation.
MA	N/A
MI	MCL 500.7901
MN	N/A
MS	N/A
MO	N/A
MT	Each title insurer shall maintain its own guaranty fund or unearned premium reserve (MCA § 33-2-517). A title insurer shall establish and maintain its guaranty fund [MCA § 33-25-211].
NE	N/A. Neb. Rev. Stat. 44-2402 (guaranty associations in general)
NV	N/A
NM	59-A-30A-1 et seq. NMSA; 13.5.2 NMAC
NC	N/A
ND	N/A
OH	N/A
OK	N/A
OR	N/A
PA	N/A
PR	Title Insurance has its own guaranty fund required in Section 24.020 of Puerto Rico Insurance Code. Puerto Rico Insurance Guaranty Association is regulated in Chapter 38 of the Puerto Rico Insurance Code. Section 38.030(5) specifically excludes title insurance from its coverage.
RI	N/A
SC	N/A
TN	T.C.A. 56-12-101 et seq.
TX	Texas Insurance Code Chapters 2602; Basic Manual for Rules, Rates, and Forms for the Writing of Title Insurance in the State of Texas, Procedural Rule P-30 and Administrative Rule G-1
UT	N/A
VT	N/A
VA	38.2-1600 et seq. of the Code of Virginia
WA	Chapters 48.32 and 48.32A RCW
WV	N/A
WI	N/A
WY	N/A

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	92. What types of issues, if any, related to title insurance have been the source of regulatory (investigation or enforcement) activity in the past five years?
AL	None
AK	Outsourced work to unlicensed persons
AS	None
AZ	None
AR	None
CA	Twelve market conduct exams covering title insurance during the past five years have been completed. Eight of these focused-on claim handling practices of eight separate title insurers, the remaining four covered rating and underwriting issues, each of which included the title insurer and its affiliated underwritten title companies. In the rating and underwriting examinations, common themes were failure to file all schedules of rates and fees (including fees for escrow services), failure to adhere to rates that were filed, unclear/vague rules for qualifications for special contract or discounted rates that resulted in inconsistency in their application and therefore unfair discrimination, and unlawful rebates in the form of premium undercharges in comparison to filed rate schedules. There was no specific pattern of findings in the claims exams. Findings were miscellaneous in nature and consisted of limited instances of failure to thoroughly document claim files, delays in accepting or denying claims, and failure to conduct and certify annual training of claims agents. For all of these examination findings, the insurers implemented corrective actions to resolve the issue as part of the examination. No administrative enforcement action was initiated.
CO	Marketing, handling of fiduciary funds, closing and settlement
CT	The Department worked with the Conneticut Attorney General's office concerning an investigation related to a "free charge" for title agent vetting services undertaken by lenders. The particular title insurer agreed to resolve the matter by agreeing to charge a reasonable amount for vetting services provided to lenders.
FL	None
GA	None
ID	§§ 41-1314 AND 41-2708, Idaho Code. Rebates and illegal inducements. IDAPA 18.05.01.031 & Exhibit 1 (attachment to Idaho Rule 18.05.01).
IN	Failing to timely enter real estate transactions into the RREAL IN database within the statutory time period; lack of fitness/trustworthiness/misappropriation of funds
KS	None
LA	None
ME	None
MD	The Maryland Insurance Administration examines the annual on-site reviews conducted by insurers of their appointed title agencies, pursuant to the Annotated Code of Maryland, Title 10, Subtitle 1, Section 10-121, as well as COMAR 31.04.22.
MA	None
MI	None
MN	Unfair claims practices, RESPA anti-kickback, unlicensed activity, defalcation, failure to supervise, failure to appoint, misrepresentation regarding required purchase of title insurance, failure to reconcile trust accounts, unauthorized disbursement of trust funds resulting in consumer harm, and provision of false and misleading information.
MS	None
MO	Misstatement on the insurance producer application. Misappropriation of escrow funds. Failure to adhere to written instructions. Delay in timely issuance of the title insurance policy to the insured. Conducting the business of title insurance without a valid insurance producer license issued by this Department. Failure to timely submit the annual agency financial interest report and affiliated business arrangement report.
MT	Revoked title producer defalcation license and suspended title producer defalcation license

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	92. What types of issues, if any, related to title insurance have been the source of regulatory (investigation or enforcement) activity in the past five years?
NE	None
NV	The majority of investigation and enforcement activity is related to unlawful inducements.
NM	Fraud, premium calculations, claims, escrow procedures, non-promulgated forms
NC	None
ND	None
OH	The Department's Fraud and Enforcement Division has investigated title insurance issues related to rebating, fraudulent or coercive practices, failure to file annual escrow account reviews, unlicensed activities, affiliated business arrangements, actions on professional license, and wire fraud.
OK	Conducting insurance business without a license
OR	Whether title insurers are providing an intermediary a thing of value exceeding state law limits and/or inducements
PA	None
PR	None
RI	A market conduct sweep was conducted of all title insurers writing in Rhode Island, involving interrogatories and follow-up questions. This was prompted by a Rhode Island Supreme Court decision on whether title insurance agents could conduct real estate closings (yes) and perform all ancillary activities (some, but not all). That sweep will result in some observation letters, a warning letter and a referral to enforcement.
SC	None
TN	There has been no significant regulatory activity related to title insurance in the past five years. However, the Department is currently researching the issue of attorney opinion letters that are becoming available to consumers in lieu of title insurance.
TX	Late annual escrow audit reports, rebating, CE violations, late underwriter remittances, late policy guaranty fees, thefts of escrow funds, unauthorized insurance, failure to properly close the transaction, failure to defend, insuring around, policy issuance, claims handling, fraud, noncompliance with escrow accounting regulations
UT	Unfair inducements; defalcations
VT	None
VA	Unlicensed/unregistered activity of title agents and settlement agents (escrow), failure to handle funds in a fiduciary capacity, rebating/kickbacks, failure to escheat escrow funds annually, failure to retain settlement records in accordance with the Code of Virginia, acting without an appointment from underwriter/insurer, failure to complete duties of a settlement agent
WA	The most common issue seen in investigations have been related to title insurance agencies not following the terms and conditions of sale and not distributing funds correctly from escrow. On the enforcement side, title agencies and agents not complying with escrow rules or other terms and conditions of sales, not meeting compliance requirements under the Insurance Code, and violating inducement law.
WV	None
WI	Record retention, rate downward deviation, blanket exceptions, and the use of arbitration
WY	None

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	93. How many full-time equivalent staff are dedicated to, or on average, work on title insurance issues in your state?
AL	4
AK	None
AS	
AZ	1
AR	None
CA	Licensing has one program technician who processes title marketing representative license applications, appointments, and renewal.
CO	Two FTE. One dedicated to Market Regulation and one dedicated to Investigations.
CT	5
FL	One full-time equivalent staff at the Office of Insurance Regulation and one full-time equivalent staff at the Department of Financial Services.
GA	1
ID	1
IN	3
KS	less than one
LA	3
ME	1/2
MD	3-5
MA	None
MI	3
MN	1 FTE
MS	None. The Department has little regulatory oversight regarding title insurance.
MO	Consumer Affairs Division - 1 full time employee; Market Regulation Division - 0.25 full time employee
MT	15 - the Montana CSI has 5 P&C Insurance Consumer Services compliance specialists who may investigate title insurance consumer complaints, 3 Producer Licensing specialists who may investigate title producer licensing and appointment issues, 2 Market Conduct examiners who may investigate title insurer issues, 4 investigators who may investigate allegations of title producer or insured violations of MCA § 33, and 1 staff attorney dedicated to title insurance.
NE	2 staff members work on title issues, as needed.
NV	1
NM	4
NC	The Department does not have staff solely dedicated to work on title insurance issues.
ND	1 FTE
OH	26 individuals at the Department handle title insurance related issues, but none are wholly dedicated to title insurance issues.
OK	Variable
OR	Title insurance work is encompassed under P&C - there are at least half a dozen staff who can answer questions about title insurance.

	93. How many full-time equivalent staff are dedicated to, or on average, work on title insurance issues in your state?
PA	No Department staff are dedicated to title insurance issues alone. Title insurance rate filings are reviewed by P&C actuarial staff. Title insurance policy form filings are reviewed by P&C policy form examiner staff. Title insurance consumer complaints are handled by the Bureau of Consumer Services. Title insurance companies are licensed by Company Licensing Staff. Title insurance agents are licensed by Producer Licensing Staff. Market conduct issues are handled by the Bureau of Market Actions. Etc.
PR	11 approximately from the Actuarial/Property Division, Licensing Division, Market Conduct and Investigation Division, Financial Analisis and Exam Division - not exclusively dedicated to title insurance tasks
RI	None
SC	None
TN	There are no full-time staff dedicated to work on title insurance.
TX	About 30
UT	The Department does not assign specific staff to do title insurance work only. Licensing is done by the company licensing section or the agent/agency licensing section. Market conduct matters concerning title insurance are handled within the market conduct section.
VT	less than one
VA	8
WA	The Department has at least seven staff dedicated to, or on average work, on title insurance issued in Washington. This includes one Policy Analyst, one Functional Program Analyst, one Producer and Licensing Oversight Manager, and several Insurance Attorneys, Attorney Managers, Investigators and Deputy Insurance Commissioners. While the Department has several staff with specific experience on title insurance issues in the investigative and enforcement side of Legal Affairs, everyone takes on cases involving the issues for cross training.
WV	None
WI	1
WY	2

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	94. Miscellaneous comments:
AL	
AK	
AS	
AZ	
AR	
CA	
CO	
CT	
FL	Florida's regulatory set-up invloves oversight by two separate state agnecies. The Office of Insurance Regulation oversees the tile insurance underwriters and the Department of Financial Services oversees the title insurance agents and agencies.
GA	
ID	
IN	Pursuant to IC 27-1-22-28, the Indiana Department of Insurance must maintain a title insurance rate comparison tool. The tool is located here: https://www.in.gov/idoi/consumers/title-insurance-rate-comparison-tool
KS	
LA	
ME	
MD	
MA	
MI	
MN	
MS	
MO	Missouri issues an insurance producer license for persons conducting the business of insurance as defined in Section 381.031(19), RSMo.
MT	The American Land Title Association (ALTA) Standard Owners Policy sold in Montana is separate from the ALTA Extended Owners Policy; and Multiple owners' policies may be written as a single risk, but the insureds, however, receive separate policies. Policy Rate And Form Regulation-MCA § 33-25-214. Underwriting standards – record retention. ARM 6.6.2201. Liens, Encumbrances, and Standards of Insurability. ARM 6.6.2203. Rebates and Inducements
NE	
NV	
NM	
NC	
ND	
OH	
OK	
OR	
PA	
PR	
RI	
SC	
TN	

	94. Miscellaneous comments:
TX	Texas promulgates the forms and does not have standard or enhanced policies. Endorsements can be added to the promulgated policy forms as needed. Title Insurance rates are promulgated and include a charge for closing. Escrow fees are not part of the promulgated rates. Title Insurance premium rates are promulgated. Rates include a charge for closing, but not escrow. Rates must be reasonable to the public and non-confiscatory to the title insurers and title agents. The Department promulgate the title insurance policy forms and endorsements. The Department sets premium rates, which must be reasonable to the public and non-confiscatory to title insurers and title agents. Liable for losses resulting from defalcations is primarily imposed through a closing protection letter, but it might be possible for liability to be imposed by other means such as common law, statutory grounds, or contract. Searches are not ordinarily conducted from publicly available recorders' websites, but can be under certain special circumstances. Buyers and sellers can request insured closing letters – T-51, 2702.002
UT	
VT	
VA	
WA	
WV	The Department does little to no activity on title insurance or real estate closing issues. All closings have to be performed by attorneys who are regulated by the West Virginia State Bar.
WI	Additional processes, such as title search or examination of title, may be included in title rates pursuant to s. Ins. 3.32(3)(d), Wis. Adm. Code. Certain exemptions on filing rates with the Department may apply. See ss. Ins. 6.78 and 6.785, Wis. Adm. Code. In regards to filing fees, an agent may be subject to disclosure requirements under s. 628.32, Wis. Stat. There are no insurance laws prohibiting the preparaton of a title policy by an entity located outside of the state. There are no insurance requirements for a licensed entity to have physical offices or perform activities within the state.
WY	

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WORKERS' COMPENSATION (C) TASK FORCE

Workers' Compensation (C) Task Force Nov. 17, 2024, Minutes.....7-275
Workers' Compensation (C) Task Force Oct. 23, 2024, Minutes (Attachment One).....7-280

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Draft: 11/25/24

Workers' Compensation (C) Task Force
Denver, Colorado
November 17, 2024

The Workers' Compensation (C) Task Force met in Denver, CO, Nov. 17, 2024. The following Task Force members participated: Alan McClain, Chair (AR); John F. King, Vice Chair, represented by Steve Manders (GA); Lori K. Wing-Heier represented by Sian Ng-Ashcraft (AK); Mark Fowler represented by Jimmy Gunn (AL); Barbara D. Richardson (AZ); Ricardo Lara represented by Mitra Sanandajifar (CA); Gordon I. Ito represented by Jerry Bump (HI); Doug Ommen represented by Mathew Cunningham (IA); Dean L. Cameron represented by Randy Pipal (ID): Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Shawn Boggs (KY); James J. Donelon represented by Chuck Myers (LA); Michael T. Calijouw represented by Jackie Horigan (MA); Timothy N. Schott represented by Sandra Darby (ME); Grace Arnold represented by Phil Vigliaturo (MN); Chlora Lindley-Myers represented by Jo LeDuc (MO); Glen Mulready represented by Kim Hunter (OK); Andrew R. Stolfi represented by Brian Fjeldheim (OR); Michael Humphreys represented by Michael McKenney (PA); Elizabeth Kelleher Dwyer represented by Beth Vollucci (RI); Michael Wise represented by Karl Bitzky (SC); Larry D. Dieter represented by Tony Dorschner (SD); Kevin Gaffney represented by Rosemary Raszka (VT).

1. Adopted its Oct. 23 and Summer National Meeting Minutes

Commissioner McClain said the Task Force conducted an e-vote that concluded Oct. 23 to adopt its 2025 proposed charges. The motion passed.

Darby made a motion, seconded by Vigliaturo, to adopt the Task Force's Oct. 23 (Attachment One) and Aug. 8 (*see NAIC Proceedings – Summer 2024, Workers' Compensation (C) Task Force)* minutes. The motion passed unanimously.

2. Heard a Presentation from the AMA on its Updated Impairment Guides

Commissioner McClain said he comes from a workers' compensation background and used the American Medical Association (AMA) Guides for rating impairments when handling claims. He said that while the workers' compensation market is stable, it has not always been. Commissioner McClain said having some objective measurements like the AMA Guides helped stabilize the system.

Ken Eichler (AMA) said the AMA has been working with workers' compensation commissioners across the U.S. The AMA Guides are used both domestically and internationally. He said he has been working in insurance since the 1990s and owned an independent medical evaluation (IME) company in New York when there was no licensure for IME companies, so he became a multi-line adjuster licensed in nine lines of insurance.

Dr. J. Douglas Martin (AMA) said he has been a practicing occupational medicine doctor for the past 30 years and has been closely involved with the elements of the AMA Guides from the perspective of reviewing, editing, authoring, and teaching for most of his career. He said he was the past president of the American Academy of Disability Evaluating Physicians (AADEP) and the past president of the American College of Occupational Environmental Medicine (ACOEM).

Eichler said the AMA followed a transparent process while developing the Guides. He said the AMA has majorly shifted its focus over the last few years from being a compliance organization to a service organization. Eichler said the AMA also has a credentialing process. He said the AMA is a powerful ally for physicians regarding patient care, as it represents physicians and those they serve. Part of the AMA's goal is to remove the obstacles that

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interfere with patient care while leading the charge to confront public health crises, hoping to drive the future of medicine.

Eichler said the AMA Guides are used in almost every jurisdiction in the U.S. Some states use multiple versions of the guidelines, while others use the most current version. The most current version of the AMA Guides is the sixth edition, and it is used in states either by regulation or legislation. The sixth edition of the AMA Guides is used in Alaska, Arizona, the District of Columbia, Illinois, Indiana, Louisiana, Massachusetts, New Mexico, Oklahoma, Pennsylvania, Tennessee, and Wyoming. It is important to note that Tennessee uses the guides based on the date of injury.

Eichler said there was a case in Pennsylvania in 2017, *Protz v. Workers Compensation Appeals Board*, in which the Supreme Court of Pennsylvania found that the General Assembly's delegation of authority to the AMA to establish criteria for evaluating permanent impairment was unconstitutional. The outcome of the case made states sensitive to the fact that new AMA Guides must be properly adopted and promulgated.

Eichler said that by engaging with the community of practice, the AMA Guides Editorial Panel process now incorporates: 1) the best available science and evidence-based medicine; 2) the reflection of medical advances and new insights related to impairment; 3) assessment tools to provide a rigorous methodology; and 4) fair, consistent, and reproducible evaluation processes. He said it is important to note that in many jurisdictions, physicians have and still use methodologies to do impairment ratings that they would not use in evaluating or treating their own patients. Physicians use some of the older methodologies to do ratings because the state uses older versions of the AMA Guides.

Eichler said the AMA Guides are an assessment tool that provides evaluation processes. He said the impairment rating is one component of determining compensation, whether the claim is due to an auto accident or a workers' compensation claim. Eichler said the use and application of the guides is a jurisdictional matter.

Dr. Martin said it is important to understand what the AMA did by assembling the guide's editorial panel. He said that he and his co-chair wanted a transparent process. Dr. Martin said all the stakeholders were involved in the revision process. He said the panel is responsible for creating, revising, and updating the impairment ratings and applicable guidelines for fair and equitable permanent impairment ratings. Dr. Martin said the rapid change in medicine and medical science necessitates rapidly updating processes.

Dr. Martin said the editorial panel accepted a proposal to update the mental and behavioral health chapter. This was necessitated by the fact that the American Psychological Association (APA) and the Psychiatric Association (PA) removed the "global assessment of functioning" (GAF) scale from their nomenclature, which was used in the sixth edition's behavioral health chapter.

Dr. Martin said that in 2022, some foundational and principal items needed changing in the first two chapters. He said the first big undertaking was in 2023 in the chapter on the nervous system. This chapter needed medical updates for traumatic brain injuries (TBIs), seizure disorders, and spinal cord trauma to reflect scientific advances.

Dr. Martin said the muscular-skeletal system updates for the upper limb, lower limb, and spine were recently adopted and implemented in 2024. He said the sixth edition of 2008 principles were maintained as a baseline to start the editing process. Dr. Martin said the sixth edition incorporated a change to a diagnosis-based or diagnosis-driven impairment rating process, which differed from the guides' previous editions. He said the science in the newest guides is the best way to analyze and evaluate impairments.

Dr. Martin said the editorial team needed to gather feedback from the various stakeholders for consideration and initiate some subcommittees. One of the things that became clear in the process of looking at the muscular-

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skeletal system chapters was that they needed to be updated in tandem. The foundational principles, background information, and major rules followed needed to be consistent across those three chapters. The focus of the changes is to look at the objective measures of functional loss, as the foundational concepts have not changed.

Dr. Martin said the editorial team opened the musculoskeletal development process and began accepting applications in the summer of 2023. This section was opened for public comment and review. He said the guide's editorial panel meets monthly or sometimes bi-monthly. The stakeholders are invited to the table and given the opportunity to provide input, testimony, feedback, etc. Initially, there were 69 different reviews with multiple comments. The editorial team discussed this in December 2023.

Dr. Martin said the editorial team then moved to the components of vascular abnormalities, amputation, and elbow and hip diagnoses, which they tacked in February 2024. The editorial team then moved to the spine area for those diagnosis-based impairment tables. This section went through the same processes as the musculoskeletal development process.

Dr. Martin said improving intra-rater reliability is a foundational driving principle. He said that in previous editions of the guides, certain situations allowed for disagreements between physicians regarding numerical values that did not make sense. The editorial team wanted to ensure the process improved by allowing the injured party to go to other physicians. The impairment rating would remain the same regardless of the physician performing the evaluation.

Dr. Martin said the editorial team decided to maintain the international classification of the function model. This gets at the diagnosis-based construct or approach. The editorial team maintained the sixth edition printed book impairment values as anchors, which was important as stakeholders provided feedback that the values for the various diagnoses remain neutral.

Dr. Martin said the editorial team maintained the importance of obtaining a clinical history, performing the relevant physical examination, and examining the various clinical studies within that evaluation process. He said the difference in the 2024 version is that the clinical history, physical examination, and clinical studies within the diagnostic grow so that the physician does not have to go to three different tables.

Dr. Martin said the musculoskeletal impairment rating steps include: 1) confirming a clinically relevant diagnosis; 2) confirming maximum medical improvement; 3) identifying the relevant diagnosis-based impairment table; 4) determining the diagnostic row, class, grade, and impairment value; and 5) following guidelines for report documentation and jurisdictional requirements.

Dr. Martin said the diagnosis row is based on the impairment approach from the 2008 edition, but it has now been designed to standardize and simplify the diagnosis impairment rating process. The physician no longer has to use multiple tables on multiple pages to find the impairment rating value. This standardized approach improves content validity, intra-rater and inter-rater reliability, and agreement to get the best impairment rating available for the patient based on a confirmed and clinically relevant diagnosis at the point of maximum medical improvement.

Dr. Martin said the physical evaluation component focuses on objectively verified anatomical or physiological findings. The process can include a direct examination, a review of findings recorded in the medical records, or both. The purpose of the physical evaluation is to evaluate the individual's physical state to detect those abnormalities or signs that may indicate an underlying condition or impairment.

Dr. Martin said the clinical studies must be relevant or pertinent and are pivotal in the diagnostic process for some conditions. This becomes important when dealing with joint injuries, fractures, or spinal conditions. It involves a

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comprehensive evaluation of the images and the reports from a variety of diagnostic tools, which may include laboratory tests or electrodiagnostic studies, and the evaluator needs to analyze these results again, obtaining the objective information from those tests that aid in supporting or refining the patient's diagnosis, ensuring a robust assessment of the clinical presentation.

Dr. Martin said the new 2024 version of the guidelines is web-based. Web-based processes have advantages, including portability, the frequency of updates, and ease of use. Additionally, he said there was no difference between the prior guides concerning the numerical values of impairment ratings between the two versions of the AMA Guides.

Dr. Martin said all system stakeholders, including injured parties, employers, medical professionals, legal representatives, insurers, state insurance regulators, legislators, and policymakers, benefit from the AMA Guides updates, which include consistent and accurate impairment evaluations. The AMA Guides updates provide increased reliability, reflecting the current medical best practices, methodologies, and technologies. The updates also offer enhancements that give a more structured approach to confirming a clinically relevant diagnosis.

Dr. Martin said evaluators can accurately assign the correct diagnostic row, class, grade, and impairment value in the diagnosis-based impairment table by thoroughly assessing the specific individual elements derived from the individual's clinical history, physical examination, and clinical studies. He said the updated systemic approach ensures reliable and meaningful assessments of an individual's condition and associated impairment ratings. Again, adopting and applying the AMA Guides is a jurisdictional matter.

Eichler said there is a specific difference between impairment and disability. Disability is one's ability to perform one's assigned work or any other work, while impairment is the physical measure of the function of a limb or body part. Eichler said an impairment is a snapshot in time. If it can be documented that an impairment rating is going down over time, the treatment is effective.

Information about AMA Guides Digital can be found at www.amaguidesdigital.com. The AMA Education Hub can be found at www.edhub.ama-assn.org/ama-guides-education.

A question in the chat asked how the numerical impairment values are maintained between the 2008 and 2024 versions while stating that the AMA has improved the rating reliability. Dr. Martin said the mean score when comparing the 2008 and 2024 guides is basically the same. He said the 2024 bell-shaped curve is much narrower than the 2008 curve, meaning you have more impairment ratings within the statistical standard deviation in the 2024 version than in the 2008 version.

Eichler said the National Council on Compensation Insurance (NCCI) is doing a study on the 2024 guide, and it is anticipated that the California Workers' Compensation Institute (CWCI) and a few other organizations will be conducting independent studies.

Grassel asked if the procedures for the AMA Guides were consistent and why some states were behind others in the adoption of the new guide. Eichler said the review process is relatively consistent. He said Tennessee is leading the charge, as it is forward-moving. Eichler said nearly all states using the most current version are engaging the objective review using staff internally with the agency as well as physicians in their community.

Commissioner McClain asked if pain was in the most current guidelines. Dr. Martin said the pain chapter was in the 2008 printed version. He said that, to date, the editorial panel has not received any requests for editorial changes. Dr. Martin said that some organizations are considering submitting changes to this in the future. He said that currently, the 2024 version remains the same for pain.

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Commissioner McClain said he remembered pain and range of motion being an issue at one time, as range of motion might change daily. Dr. Martin said the updates to the 2024 guides do not focus on range of motion as much. He said it is still a considered value but not a significant situation that drives the impairment rating number as it did in previous editions. Dr. Martin said there is a science that validates how the individual range of motion can vary from one day to another.

Commissioner McClain said that if anyone on the Task Force had suggestions for future meetings, let him or NAIC staff know.

Having no further business, the Workers' Compensation (C) Task Force adjourned.

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Workers' Compensation (C) Task Force
E-Vote
October 23, 2024

The Workers' Compensation (C) Task Force conducted an e-vote that concluded Oct. 23, 2024. The following Task Force members participated: Alan McClain, Chair (AR); John F. King, Vice Chair, represented by Steve Manders (GA); Lori K. Wing-Heier represented by Sian Ng-Ashcraft (AK); Mark Fowler represented by Erick Wright (AL); Ricardo Lara represented by Mitra Sanandajifar (CA); Andrew N. Mais represented by George Bradner (CT); Doug Ommen represented by Mathew Cunningham (IA); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark (KY); Kevin P. Beagan represented by Jackie Horigan (MA); Robert L. Carey represented by Sandra Darby (ME); Grace Arnold represented by Tammy Lohmann (MN); Chlora Lindley-Myers (MO); Scott Kipper (NV); Glen Mulready (OK); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Elizabeth Kelleher Dwyer represented by Beth Vollucci (RI); and Michael Wise represented by Will Davis (SC).

1. Adopted its 2025 Proposed Charges

The Task Force considered adoption of its 2025 proposed charges (*see NAIC Proceedings – Fall 2024, Property and Casualty Insurance (C) Committee, Attachment Four).* A majority of the Task Force members voted in favor of adopting its charges. The motion passed.

Having no further business, the Workers' Compensation (C) Task Force adjourned.

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