The 2014 Summer National Meeting

Executive (EX) Committee and Plenary

Excerpt from the Proceedings of the NAIC

Louisville, KY
August 16 – 19, 2014
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EXECUTIVE (EX) COMMITTEE AND PLENARY

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The Executive (EX) Committee and Plenary met in joint session in Louisville, KY, Aug. 19, 2014. The following members participated: Adam Hamm, Chair (ND); Monica J. Lindeen, Vice Chair (MT); Michael F. Consedine, Vice President (PA); Sharon P. Clark, Secretary-Treasurer (KY); James J. Donelon, Immediate Past President (LA); Kevin M. McCarty, Past President, represented by Belinda Miller (FL); Sandy Praeger, Past President (KS); Roger A. Sevigny, Past President (NH); Lori K. Wing-Heier represented by Martin Hester (AK); Jim L. Ridling (AL); Jay Bradford represented by Lenita Blasingame (AR); Germaine L. Marks (AZ); Dave Jones (CA); Marguerite Salazar (CO); Thomas B. Leonardi (CT); Chester A. McPherson (DC); Karen Weldon Stewart (DE); Ralph T. Hudgens (GA); Artemio B. Ilagan (GU); Gordon I. Ito (HI); Nick Gerhart represented by Jim Mumford (IA); William W. Deal represented by Tom Donovan (ID); Andrew Boron (IL); Stephen W. Robertson (IN); Joseph G. Murphy represented by John Turchi (MA); Therese M. Goldsmith (MD); Eric A. Cioppa represented by Robert Wake (ME); Annette E. Flood (MI); Mike Rothman represented by Tim Vande Hey (MN); John M. Huff (MO); Mike Chaney (MS); Wayne Goodwin (NC); Bruce R. Ramge (NE); Kenneth E. Kobylowski represented by Peter Hart (NJ); John G. Franchini (NM); Scott J. Kipper (NV); Benjamin M. Lawsky represented by Robert Easton (NY); Mary Taylor represented by Mike Farley (OH); John D. Doak represented by James Mills (OK); Laura N. Cali (OR); Joseph Torti III (RI); Raymond G. Farmer (SC); Julie Mix McPeak (TN); Julia Rathgeber (TX); Todd E. Kiser (UT); Jacqueline K. Cunningham (VA); Gregory R. Francis (VI); Susan L. Donegan (VT); Mike Kreidler represented by James Odiorne (WA); Ted Nickel (WI); Michael D. Riley (WV); and Tom C. Hirsig (WY).

1. Adopted the Aug. 17 Report of the Executive (EX) Committee

Commissioner Hamm reported that the Executive (EX) Committee met Aug. 17 and adopted the Aug. 16 report from the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, which included adoption of: revisions to the NAIC long-term investment policy and to the defined benefit and defined contribution plan policies; the report of the Audit Committee, including a review of the June 30 financial statements, member grant funding, the 2014 audit process, the 2015 budget calendar and an update on the Statement of Standards for Attestation Engagements (SSAE) 16 Service Organization Control (SOC) 1 report; the report of the Information Systems (EX1) Task Force, including reports on 2013 and 2014 technology projects and updates on SBS, SERFF and the State-Producer Licensing project; and approved waiving registration fees for NAIC training courses for consumer representatives.

The Executive (EX) Committee adopted its interim meeting report, including approval of: retaining a consultant regarding the NAIC’s operating reserve policy; funding for retaining consulting actuaries to review current actuarial reporting to recommend a new format; Regulatory Treatment Analysis Service (RTAS) pricing for developing NAIC designations for new government-issued securities; a Governance Review (EX) Task Force recommendation to retain a consultant to review governance of the NAIC and adopted the related scope of work; funding for the September launch of “Protecting the Future,” the NAIC’s education outreach campaign; using the same selection process used in 2010 and 2012 to select a representative to the Financial Stability Oversight Council (FSOC); filing an amicus brief at the request of Commissioner Consedine in the case City of Sterling Heights General Employee’s Retirement System et al. v. Prudential Financial, Inc. et al. to address the confidentiality of state market-conduct examination materials; a recommendation of the NAIC’s independent investment advisor to liquidate the NAIC’s investments in a certain investment fund; the NAIC Audit Committee’s recommendation for the allocation of the 2014 Needs-Based Grant funding; and the allocation of existing NAIC resources to the Examination Tracking System Continuum Action Support Initiative.

The Executive (EX) Committee adopted the written reports of its task forces: Financial Stability (EX) Task Force; Government Relations (EX) Leadership Council; Governance Review (EX) Task Force; International Insurance Relations (EX) Leadership Group; Producer Licensing (EX) Task Force; and Speed to Market (EX) Task Force.

The Executive (EX) Committee also adopted the report of the Principle-Based Reserving Implementation (EX) Task Force, including adoption of the XXX/AXXX Reinsurance Framework in concept; the related charges for several other NAIC groups; and three related model law development requests for an XXX/AXXX reinsurance model regulation and amendments to the Credit for Reinsurance Model Law (#785) and the Actuarial Opinion and Memorandum Regulation (#822).
The Executive (EX) Committee also adopted two model law development requests for amendments to the Health Insurance Reserves Model Regulation (#10) referencing a new table in Appendix A for individual long-term disability liabilities and referencing new standards for the valuation of long-term care insurance liabilities.

The Executive (EX) Committee received written reports of model law development efforts for the following models: 1) amendments to the Annuity Disclosure Model Regulation (#245); amendments to the Suitability in Annuity Transactions Model Regulation (#275); amendments to the Advertisements of Life Insurance and Annuities Model Regulation (#570); amendments to the Life Insurance and Annuities Replacement Model Regulation (#613); amendments to the Insurance Holding Company System Regulatory Act (#440); amendments to the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450); the Individual Market Health Insurance Coverage Model Regulation; the Small Group Market Health Insurance Coverage Model Regulation; amendments to the Long-Term Care Insurance Model Act (#640) and the Long-Term Care Insurance Model Regulation (#641); amendments to the Creditor-Placed Insurance Model Act (#375); amendments to the Property and Casualty Actuarial Opinion Model Law (#745); amendments to the Actuarial Opinion and Memorandum Regulation (#822); amendments to the Mortgage Guaranty Insurance Model Act (#630); amendments to the Synthetic Guaranteed Investment Contracts Model Regulation (#695); amendments to the Annual Financial Reporting Model Regulation (#205); and the Corporate Governance Annual Disclosure Model Act and the Corporate Governance Annual Disclosure Model Regulation.

The Executive (EX) Committee also heard reports from the NIPR and the IIPRC.

Commissioner Nickel made a motion, seconded by Commissioner Lindeen, to adopt the Aug. 17 report of the Executive (EX) Committee. The motion passed.

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

Commissioner Donelon made a motion, seconded by Commissioner Stewart, to adopt by consent the Committee, Subcommittee and Task Force minutes of the Spring National Meeting, except for items #6, #8 and #11 (reported below), which were considered separately. The motion passed.

3. Adopted Amendments to the 2014 Committee Charges

Commissioner Lindeen made a motion, seconded by Commissioner Donelon, to adopt the 2014 Amended Committee Charges (Attachment One). The motion passed.

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

Commissioner McPeak reported that the Life Insurance and Annuities (A) Committee met Aug. 17 and took the following action: 1) heard a federal legislative update; 2) adopted its July 16 and June 5 minutes; 3) adopted the reports of the Contingent Deferred Annuity (A) Working Group, the Unclaimed Life Insurance Benefits (A) Working Group and the Life Actuarial (A) Task Force; and 4) discussed the Model Law Review (A) Subgroup membership and made a request for additional volunteers.

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

Commissioner Nickel reported that the Health Insurance and Managed Care (B) Committee met Aug. 17 and heard a presentation from the Georgetown Health Policy Institute, Center for Health Insurance Reform (CHIR), on several issue briefs it developed through the State Health Reform Assistance Network related to certain aspects of the federal Affordable Care Act (ACA) implementation.

The Committee adopted the reports of the Consumer Information (B) Subgroup; the Health Actuarial (B) Task Force; the Regulatory Framework (B) Task Force; and the Senior Issues (B) Task Force, which appointed a new subgroup to review long-term care consumer disclosures.

The Committee also: 1) heard an overview and key findings of a health insurance survey conducted by the National Association of Insurance and Financial Advisors (NAIFA); and 2) heard a status update on an NAIC consumer representative survey sent to all of the state insurance departments related to network adequacy issues.
6. **Adopted the Amendments to Model #641**

Commissioner Kipper presented amendments to the *Long-Term Care Insurance Model Regulation* (#641), intended to improve the rate stability standards contained in the model regulation, which was originally adopted by the NAIC in 2000.

In June 2013, the Senior Issues (B) Task Force began drafting these amendments at an interim meeting in Reston, VA, with more than 45 regulators in attendance. Over the past year, the Task Force worked to improve the draft, relying heavily upon the Health Actuarial (B) Task Force for its review and recommendations, as well as comments received from interested parties.

In December 2013, the NAIC adopted a model bulletin on long-term care premium increases that was intended to immediately address rate increases on existing policies, including the older pre-rate-stabilized blocks of business. The new model amendments would mostly be prospective and apply to rate increases on new policies. Some highlights of the amendments are: 1) the required actuarial certification is expanded from a one-time statement at the time of initial filing to an annual certification; 2) the concept of “moderately adverse conditions” is made more tangible by requiring that a new minimum margin be incorporated into the calculations for pricing; 3) additional improvements in oversight that would encourage more conservative pricing and a more consistent approach; 4) an improved consumer disclosure requirement to ensure that consumers understand the likelihood of a rate increase and are aware of their options when faced with a rate increase; 5) expansion of the contingent benefit upon lapse by requiring that consumers who have held the oldest policies (more than 20 years) will receive this benefit automatically.

Commissioner Kipper made a motion, seconded by Commissioner Stewart, to adopt the revisions to the *Long-Term Care Insurance Model Regulation* (#641) (Attachment Two). The motion passed, with Florida, Illinois and Minnesota voting against the motion. California and Vermont abstained.

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

Commissioner Chaney reported the Property and Casualty Insurance (C) Committee met Aug. 18 and took the following action: 1) adopted its May 5 minutes; 2) adopted revisions to the Casualty Actuarial and Statistical (C) Task Force’s 2014 charges; 3) adopted a recommendation to withdraw a request to revise the *Property and Casualty Actuarial Opinion Model Law* (#745); 4) adopted *Best Practices for Creating Consumer Online Insurance Policy Resources*; 5) adopted the *Data Collection Template* and referred it to the Financial Condition (E) Committee; 6) heard a report on the CIPR event, “Commercial Ride-sharing and Car-sharing Issues,” and appointed a working group to study related issues in more detail; 7) heard a presentation on the TransUnion/CARFAX rating model and agreed to ask the Auto Insurance (C/D) Study Group to research related issues; 8) heard an update on yellow corrugated stainless steel tubing (CSST) and carrier participation in the safety campaign; 9) adopted a motion that the NAIC join the National Association of State Fire Marshals in support of its public relations efforts; 10) heard an update on the Applied Insurance Research (AIR) inland flood model; 11) heard an update on the multipurpose vehicle proposal and appointed a working group to look into a broader NAIC catastrophe response effort; 12) agreed to examine issues related to cyber insurance, including possible data collection; 13) heard a report on the status of lender-placed insurance data collection; and 14) discussed a letter received from the National Association of Public Insurance Adjusters and agreed that a working group will look into issues related to the unauthorized practice of public adjusting.

The Property and Casualty Insurance (C) Committee also adopted its 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; Advisory Organization Examination Oversight (C) Working Group; Affordable Care Act Medical Professional Liability (C) Working Group; Auto Insurance (C/D) Study Group; Catastrophe Insurance (C) Working Group; Climate Change and Global Warming (C) Working Group; Crop Insurance (C) Working Group; Earthquake (C) Study Group; Risk Retention (C) Working Group; Terrorism Insurance Implementation (C) Working Group; and Transparency and Readability of Consumer Information (C) Working Group.

8. **Received an Update on the Compendium of Reports on the Pricing of Personal Automobile Insurance**

Commissioner Chaney reported that the Property and Casualty Insurance (C) Committee voted to send the *Compendium of Reports on the Pricing of Personal Automobile Insurance* back to the Auto Insurance (C/D) Study Group for additional work and reconsideration.
9. Received the Report of the Market Regulation and Consumer Affairs (D) Committee

Commissioner Robertson reported that the Market Regulation and Consumer Affairs (D) Committee met Aug. 18 and took the following action: 1) adopted its June 23 minutes; 2) adopted a recommendation to retain the Authorization for Criminal History Record Check Model Act (#222) and the Unauthorized Transaction of Insurance Criminal Model Act (#890) as part of the NAIC’s Model Law Review Initiative; 3) adopted ACA market conduct examination standards for rescissions, extension of dependent coverage to age 26, guaranteed availability of individual and small group market health insurance coverage, guaranteed renewability of individual and small group market health insurance coverage, and coverage of individuals participating in approved clinical trials; 4) appointed a Market Conduct Accreditation (D) Working Group; 5) adopted a process for choosing new Market Conduct Annual Statement (MCAS) lines of business and a revised attestation form for the submission of MCAS data; 6) received an update on action items from the 2015 Market Regulation Summit; 7) discussed ACA audits; and 8) heard a report on federal market regulation activities.

The Market Regulation and Consumer Affairs (D) Committee adopted the reports of its task forces and working groups: Antifraud (D) Task Force; Market Information Systems (D) Task Force; Market Conduct Examination Standards (D) Working Group; Market Actions (D) Working Group; and Auto Insurance (C/D) Study Group.

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

Superintendent Torti reported that the Financial Condition (E) Committee met Aug. 18 and took the following action: 1) adopted the Corporate Governance Annual Disclosure Model Act and the Corporate Governance Annual Disclosure Model Regulation, as adopted Aug. 17 by the Corporate Governance (E) Working Group; 2) adopted a charge to address regulatory redundancy concerns; 3) adopted the Model Guideline for Payment of Interest to Receivers on Overdue Reinsurance Recoverables, as adopted Aug. 17 by the Receivership and Insolvency (E) Task Force; 4) discussed a memorandum on recommendations regarding separate accounts from the Separate Account Risk (E) Working Group; 5) discussed a preliminary NAIC staff report on examiner salary recommendations; 6) received comments on the exposed draft NAIC Group Code Assignment process; and 7) exposed for a 30-day public comment period a proposed modification to Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation (AG 38) to delete the existing requirement for companies to file annual reports with the Financial Analysis (E) Working Group unless requested.


Note: Items adopted within the Financial Condition (E) Committee’s task force and working group reports that are considered technical, non-controversial 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 at the 2009 Fall National Meeting, a listing of the various technical changes will be sent to the NAIC members shortly after completion of this national meeting, and the members will have 10 days to comment with respect to those items. If no objections are received with respect to a particular item, the technical changes will be considered adopted by the NAIC membership and effective immediately.

11. Adopted the Amendments to Model #205

Superintendent Torti presented proposed revisions to the Annual Financial Reporting Model Regulation (#205) that are the result of work performed by the Corporate Governance (E) Working Group to compare existing U.S. corporate governance requirements to the regulatory needs, best practices and principles outlined in the Insurance Core Principles (ICPs) adopted by the International Association of Insurance Supervisors (IAIS).
The Working Group’s comparison identified the need for a requirement for large insurers to maintain an effective internal audit function capable of providing the insurer’s audit committee with independent assurance in regard to the insurer’s governance, risk management and internal controls.

The model law development request was approved by Executive (EX) Committee July 26, 2013. The Corporate Governance (E) Working Group developed the proposed revisions to Model #205 to require an internal audit function for large insurers. These were adopted by the Financial Condition (E) Committee March 31, 2014. The proposed effective date for these revisions is Jan. 1, 2016.

Superintendent Torti made a motion, seconded by Commissioner Stewart, to adopt the revisions to the Annual Financial Reporting Model Regulation (#205) (Attachment Three). The motion passed.

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

Director Huff reported that the Financial Regulation Standards and Accreditation (F) Committee met in regulator-to-regulator session Aug. 15 pursuant to paragraph 7 of the NAIC Policy Statement on Open Meetings (i.e., consideration of individual state insurance department’s compliance with the NAIC financial regulation standards). During this meeting, the Committee discussed state-specific accreditation issues and voted to award continued accreditation to the insurance departments of Delaware, Louisiana, Massachusetts and Rhode Island.

During its meeting held Aug. 16, the Committee took the following action: 1) adopted proposed revisions to the Review Team Guidelines to incorporate certain revisions to the 2014 Financial Condition Examiners Handbook related to critical risk categories and information technology general controls, effective Jan. 1, 2015; and 2) adopted the Model Risk Retention Act (#705) as a Part A accreditation standard for risk retention groups (RRGs), effective Jan. 1, 2017. Those states that charter domestic RRGs will be required to adopt the corporate governance standards included in Section 3D of Model #705, or something substantially similar.

The Committee also: 1) adopted the 2011 revisions to the Risk-Based Capital (RBC) for Insurers Model Act (#312) as an update to the Part A accreditation standards, effective Jan. 1, 2017. The 2011 revisions revise the trend test trigger point from 2.5 times the authorized control level RBC amount to 3.0 times the authorized control level amount; 2) adopted the Corporate Governance (E) Working Group’s referral related to the Part A Corrective Action accreditation standard, effective Jan. 1, 2017. This revision relates to the commissioner’s authority to require an insurer to correct corporate deficiencies; 3) adopted proposed revisions to the “Reinsurance Guidelines for Risk Retention Groups Licensed as Captive Insurers” (Reinsurance Guidelines), effective Jan. 1, 2015. The revisions clarify that the effective date provisions in the Reinsurance Guidelines are intended to apply to reinsurers, as opposed to reinsurance contracts; 4) adopted its 2015 Proposed Charges; and 5) discussed comments received related to a proposed definition of “multi-state reinsurer” for accreditation purposes. These revisions would subject certain reinsurers, including captive reinsurers, to the Part A and Part B accreditation standards.

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

Commissioner Consedine reported that the International Insurance Relations (G) Committee met Aug. 16 and took the following action: 1) heard an update on the Organisation for Economic Co-operation and Development; 2) adopted its Aug. 7, July 24 and April 23 minutes; 3) discussed the activities of the IAIS, the IAIS Financial Stability Committee and the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame); 4) adopted the report of the ComFrame Development and Analysis (G) Working Group; and 5) heard updates on international regulatory cooperation activities; the U.S./European Union (EU) Insurance Dialogue Project; the Joint Forum; and the International Monetary Fund’s Financial Sector Assessment Program.

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

Commissioner Hamm referred members to the written report for updates on the states’ implementation of NAIC-adopted model laws and regulations (Attachment Four).
15. Recognized the Contributions of William H.L. Woodyard, III

Commissioner Robertson made a motion, seconded by Director Ramge, to recognize the contributions to the regulation of insurance by former NAIC President (1981) and Arkansas Insurance Commissioner William H.L. Woodyard, III, recently deceased.

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

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Amendments for consideration are noted in revision marks.

Amendments adopted by the Life Insurance and Annuities (A) Committee on July 16, 2014.

LIFE ACTUARIAL (A) TASK FORCE

1. Address charges to the Life Actuarial (A) Task Force as provided in the Principle-Based Reserving (PBR) Implementation Plan adopted by the Principle-Based Reserving Implementation (EX) Task Force. These charges include Valuation Manual and PBR work expected by the parent Life Insurance and Annuities (A) Committee, including consideration of the VM-22 (A) Subgroup efforts to propose a PBR methodology for non-variable (fixed) annuities. Report progress to the Principle-Based Reserving Implementation (EX) Task Force and to the Life Insurance and Annuities (A) Committee.—Essential

2. Appoint the Experience Reporting (A) Subgroup to continue development of the experience reporting requirements within the Valuation Manual and provide input as appropriate for the process regarding the statistical agent, data collection and subsequent analysis and use of experience submitted.—Essential.

3. Work on appropriate revisions to the Standard Nonforfeiture Law for Life Insurance (#808) and the Valuation Manual to support continued tax qualification of life insurance policies under the Internal Revenue Code.—Essential

4. Respond to requests/referrals from the Life Insurance and Annuities (A) Committee regarding reserves or other requirements, including any relating to current or new product lines.—Essential

5. Monitor international developments regarding life and health insurance reserving. Compare and benchmark with PBR requirements.—Important

6. Work with the American Academy of Actuaries (AAA) and the Society of Actuaries (SOA) to develop new mortality tables for preneed, simplified issue and guaranteed issue forms of life insurance and minimum nonforfeiture requirements for life insurance. Provide periodic status reports on this project.—Important

7. Review Actuarial Guideline XLIII (AG43), CARVM for Variable Annuities, and recommend changes as appropriate to the requirements. Work with any recommendations from the C-3 Phase II/AG 43 (E/A) Subgroup, which is charged with evaluation of the overall effectiveness of the C-3 Phase II and AG43 methodologies used to evaluate the market risk component of risk-based capital. The Subgroup will conduct an in-depth analysis of the models, modeling assumptions, processes, supporting documentation and results of a sample of companies writing variable annuities with guarantees, and make recommendations to the Capital Adequacy (E) Task Force or Life Actuarial (A) Task Force on any changes to the methodologies to improve their overall effectiveness.—Important

8. Review Actuarial Guideline XXXIII (AG33), Determining CARVM Reserves for Annuity Contracts with Elective Benefits, and provide recommendations and changes as appropriate to address reserving issues.—Important

9. Study the feasibility of a new nonforfeiture law for life insurance and annuities to replace the existing nonforfeiture standards. Provide periodic status reports on this project.—Important

10. Work with the SOA to continue development of reporting channels of distribution information needed to better establish Generally Recognized Expense Table (GRET) factors.—Important

11. Provide recommendations and changes as appropriate to other reserve and nonforfeiture requirements to address issues and provide actuarial assistance and commentary to other NAIC committees relative to their work on actuarial matters.—Important
12. Provide appropriate recommendations in response to the work of the Joint Qualified Actuary (A/B/C) Subgroup whose charges are:

- Recommend a uniform definition of “qualified actuary” for life, health and P&C Appointed Actuaries signing prescribed Statements of Actuarial Opinion, identifying any differences that should remain between lines of business. Recommend a uniform definition of “qualified actuary” for other regulatory areas (e.g., rate filings, hearings). Consistency between uses is preferred, to the extent appropriate.—Important

- In performance of actuarial work upon which the regulators might rely, recommend a definition of “inappropriate or unprofessional actuarial work” and recommend a process (which could be an existing process) for regulatory and/or professional organizations’ action(s). If needed, recommend a means of implementation through a model act, regulation or other means.—Important

14. Address approvals from the Life Insurance and Annuities (A) Committee regarding Task Force requests to work on model requirements, including any approvals for modifications to the Actuarial Opinion and Memorandum Regulation (#822).—Important

15. Consider whether Model #808, or any provisions thereof, should be required for accreditation.—Important

16. Consider any revisions, as appropriate, for the Synthetic Guaranteed Investment Contracts Model Regulation (#695).—Important

17. Appoint the Contingent Deferred Annuity (A) Subgroup to:

- Evaluate AG43 to determine whether the reserve guidance as it applies to variable annuity guarantees would be deficient when applied to contingent deferred annuities (CDAs). Recommend changes, as appropriate, to address any deficiencies and determine whether clarifying guidance would be useful due to different nomenclature than variable annuities with guarantees.—Important

- Consider revisions to the Standard Nonforfeiture Law for Individual Deferred Annuities (#805) to specifically exclude CDAs from the scope of the model.—Essential

- Review and determine whether revisions to Model #695 are needed to clarify its relationship with CDAs.—Essential

- Review and consider changes, as necessary, to the appropriate Annual Statement Blank to address financial reporting requirements for CDAs.—Essential

18. Consider revisions to the Standard Nonforfeiture Law for Individual Deferred Annuities (#805) to specifically exclude CDAs from the scope of the model.—Important

16. Appoint the Index-Linked Variable Annuity (A) Subgroup to provide recommendations to the Task Force regarding the applicability of the NAIC variable annuity regulatory framework to non-unitized index-linked products filed as variable, including, but not limited to, product definition and nonforfeiture requirements.—Important

17. Appoint the Aggregate Margin (A) Subgroup to consider the appropriateness of an aggregate margin approach for quantifying a provision for uncertainty and risk in the underlying valuation assumptions.—Important
Amendments adopted by the Market Regulation and Consumer Affairs (D) Committee on March 31, 2014.

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

1. 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.—Essential

2. Monitor and assess the current process for multi-jurisdictional market conduct activities and provide appropriate recommendations for enhancement, as necessary.—Essential

3. Oversee the activities of the Market Information Systems (D) Task Force.—Essential

4. Oversee the activities of the Antifraud (D) Task Force.—Essential

5. Appoint a Market Actions (D) Working Group of 16 individuals to facilitate interstate communication and coordinate collaborative state regulatory actions.—Essential

6. Appoint a Market Analysis Procedures (D) Working Group to: 1) review MCAS data elements and the “Data Call and Definitions” for all lines of business collected in MCAS and update them, as necessary; 2) consider recommendations for new lines of business for MCAS and develop an MCAS blank to be used for the collection of data for additional lines of business, where appropriate; 3) 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; 4) develop a formalized process to add new lines of business to MCAS; and 5) discuss other market data—collection issues and make recommendations, as necessary.—Essential

7. Appoint a Market Conduct Examination Standards (D) Working Group to develop market conduct examination standards.—Essential

8. Monitor the underwriting and market practices of insurers and producers, as well as 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.—Important

9. In collaboration with other technical working groups, discuss and share best practices through public forums to address broad consumer concerns regarding personal insurance products.—Important

10. Coordinate with the International Insurance Relations (EX) Leadership Group 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.—Important

11. 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).—Essential

12. Appoint an Auto Insurance Study (C/D) Working Group, a joint working group of the Property and Casualty Insurance (C) Committee and the Market Regulation and Consumer Affairs (D) Committee, to review issues relating to low-income households and the auto insurance marketplace and to make recommendations as may be appropriate.—Essential

13. Oversee the activities of the Professional Health Insurance Advisors (D) Task Force, which is charged to monitor the impact of the ACA on health insurance brokers/agents, as well as the insurance consumers and the insurance markets they serve.—Important

14. Develop a formal market regulation accreditation proposal for consideration by the NAIC membership that provides recommendations for the following: 1) accreditation standards; 2) a process for the state implementation of the standards; 3) a process to measure the states’ compliance with the standards; and 4) a process for future revisions to the standards.—Essential
MARKET INFORMATION SYSTEMS (D) TASK FORCE

1. Complete implementation of the State Survey Project Action Plan to make changes to the market systems to be consistent with the strategic direction set forth by the Market Regulation and Consumer Affairs (D) Committee. The Market Information Systems include: 1) Complaint Database System (CDS); 2) Electronic Forums; 3) Examination Tracking System (ETS); 4) Market Analysis Prioritization Tool (MAPT); 5) Market Analysis Review System (MARS); 6) Market Conduct Annual Statement (MCAS); 7) Market Initiatives Tracking System (MITS); 8) Regulatory Information Retrieval System (RIRS); and 9) Special Activities Database (SAD) (in conjunction with the Antifraud (D) Task Force).—Essential

2. Appoint a Market Analysis Procedures (D) Working Group to: 1) review MCAS data elements and the “Data Call and Definitions” for all lines of business collected in MCAS and update where necessary; 2) consider recommendations for new lines of business for MCAS and develop an MCAS blank to be used for the collection of data for additional line of business where appropriate; 3) review the current set of Level 1 and Level 2 questions. Recommend changes based on results over the past five years; 4) develop a formalized process to add new lines of business to the Market Conduct Annual Statement.—Essential

3. Appoint a Regulatory Information Retrieval System (D) Subgroup to review the coding structure for the NAIC Regulatory Information Retrieval System (RIRS) and provide recommended changes to the coding structure.—Important

4. Appoint a Market Information Systems Research and Development (D) Working Group to serve as the business partner to review and prioritize submitted Uniform System Enhancement Request (USER) forms to ensure an efficient use of available NAIC staffing and resources.—Essential

5. Develop a plan for making more widely available the public data collected in the NAIC Market Information Systems.—Essential

6. Evaluate all data currently collected in the NAIC Market Information Systems and considered confidential to determine what, if any, can be made more widely available.—Essential
Amendments adopted by the Financial Condition (E) Committee on March 31, 2014.

FINANCIAL CONDITION (E) COMMITTEE

1. The Financial Condition (E) Committee will:
   - Coordinate the remaining activities with respect to the Solvency Modernization Initiative (SMI), including implementation, any remaining policy decisions and ongoing discussions with respect to new ideas to improve solvency regulation.—Essential
   - Review the Model Insurance Holding Company Act (#440) and Regulation (#450) (HCA Model Act) and consider amendments to address issues that have arisen subsequent to the adoption of the Act and Regulation by the NAIC in 2010.—Essential
   - Appoint and oversee the activities of the standing Task Forces: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Examination Oversight (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention Group (E) Task Force; and Valuation of Securities (E) Task Force.—Essential
   - Review and consider changes, as necessary, to the appropriate Annual Statement Blank to address financial reporting requirements for contingent deferred annuities (CDAs).
   - Consider the development of a template/checklist of questions that state insurance departments could use to facilitate the review of an insurer’s risk management program at the time of a policy form filing related to a contingent deferred annuity (CDA) consistent with the recommendations from the Contingent Deferred Annuity (A) Working Group.
   - Review and determine whether revisions to the Synthetic Guaranteed Investment Contracts Model Regulation (#695) are needed to clarify its relationship with contingent deferred annuities (CDAs).
   - Recommend salary rate adjustments for examiners.—Essential

2. The Corporate Governance (E) Working Group—no amendments

3. The Emerging Actuarial Issues (E) Working Group—no amendments

4. The Financial Analysis (E) Working Group—no amendments

5. The Group Solvency Issues (E) Working Group will:
   - Continue to develop potential enhancements to the current regulatory solvency system as it relates to group-solvency-related issues.—Essential
   - Critically review and provide input and drafting to the IAIS Insurance Groups and Cross-Sectoral Issues Subcommittee, the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) or on other IAIS papers dealing with group supervision issues.—Essential
   - Assist the International Insurance Relations (G) Committee in developing timely NAIC input into the IAIS Common Framework for the Supervision of Internationally Active Insurance Groups by providing a forum for technical (non-policy related) issues to be discussed with those states deemed to be most impacted by the project.—Essential
   - Review the Model Insurance Holding Company Act (#440) and Regulation (#450) (HCA Model Act) and consider amendments to address issues that have arisen subsequent to the adoption of the Act and Regulation by the NAIC in 2010.—Essential
   - Develop required procedures for state regulators to use when leading and participating in supervisory colleges. Encourage and facilitate communication among regulators participating in diverse supervisory colleges to ensure timely and relevant input toward continuing enhancements of required procedures for holding efficient and effective colleges. As necessary, gather data from states that can assist in answering questions policymakers have regarding U.S. supervisory colleges.—Essential
FINANCIAL CONDITION (E) COMMITTEE (Continued)

- In collaboration with the National Treatment and Coordination (E) Working Group, develop procedures to implement a consolidated public hearing for acquisitions involving multiple jurisdictions under the NAIC Model Holding Company Act and Regulation.—Important

6. The Health Reform Solvency Impact (E) Subgroup—no amendments

7. The International Solvency and Accounting Standards (E) Working Group will:
   - Assist the Committee with the Statutory Accounting and Financial Reporting focus area in the Solvency Modernization Initiative.—Important
   - Critically review and provide input and drafting to the IAIS Insurance Contracts Subcommittee, IAIS Solvency and Actuarial Issues Subcommittee, and on IAIS papers as assigned by the parent Committee. From this work, identify future initiatives to improve the U.S. regulatory solvency system.—Important
   - Analyze other financial supervisory modernization initiatives, to the extent appropriate. Analysis should include the International Accounting Standards Board (IASB) accounting standards development.—Important
   - Monitor and provide comments directly or to the IAIS on the IASB developments and on the IASB and Financial Accounting Standards Board (FASB) joint convergence projects related to insurance accounting issues. Coordinate with the Statutory Accounting Principles (E) Working Group to provide responses to the FASB on joint projects and report findings relative to these developing issues to the Accounting Practices and Procedures (E) Task Force.—Important
   - In consultation with the Statutory Accounting Principles (E) Working Group, monitor international and national accounting standards development and Securities and Exchange Commission (SEC) policy decisions and develop a recommendation to the NAIC membership regarding the future of U.S. statutory accounting.—Essential

8. The Mortgage Guaranty Insurance (E) Working Group—no amendments

9. The NAIC/AICPA (E) Working Group—no amendments

10. The National Treatment and Coordination (E) Working Group—no amendments

11. The Own Risk and Solvency Assessment (ORSA) (E) Subgroup—no amendments

12. The Private Equity Issues (E) Working Group—no amendments

12. The Risk Focused Surveillance (E) Working Group will:
   - Continually review the effectiveness of risk-focused surveillance and develop enhancements to the implementation process as necessary.—Essential
   - Review existing examination and analysis procedures to identify and eliminate redundant efforts in collecting and reviewing insurer information for solvency monitoring purposes.—Essential
   - Oversee and monitor the Supervisory Best Practices Program where regulators review and provide feedback on completed risk-focused examinations in a peer-review format.—Essential
   - Review the risk-focused examination process to determine the best way to increase the review of prospective risks and reduce unnecessary financial statement verification during an examination.—Essential
   - Review the financial analysis process and consider the development of enhancements to further incorporate a review of prospective solvency risks.—Essential
   - Develop more effective means for the financial analysis and examination functions to continually monitor and communicate the results of their review of significant solvency risks facing an insurer.—Essential
   - Monitor the work related to the Solvency Modernization Initiative (SMI) to determine which elements could impact risk-focused surveillance.—Essential
   - Identify and document the regulatory skillsets necessary to effectively monitor the solvency of insurers under an evolving risk-focused surveillance framework.—Essential
FINANCIAL CONDITION (E) COMMITTEE (Continued)

- Consider recommendations to the Financial Regulation Standards and Accreditation (F) Committee for the purpose of evaluating the suitability of insurance department staffing in relation to the necessary skillsets.—Essential
- Develop standardized job descriptions/requirements for common solvency monitoring positions to assist insurance departments in attracting and maintaining suitable staff.—Essential


EXAMINATION OVERSIGHT (E) TASK FORCE

1. The Examination Oversight (E) Task Force will:
   - Provide input and comments to the International Association of Insurance Supervisors (IAIS) or other related groups on issues regarding international risk-management concepts; coordinate such comments with the International Solvency and Accounting (E) Working Group.—Important
   - Recommend salary rate adjustments for examiners.—Essential
   - Provide ongoing maintenance and enhancements to the Form A Database and monitor its usage.—Important
   - Provide ongoing maintenance and enhancements to the NAIC Lead State Summary Report tool and encourage coordination with solvency matters.—Essential

3. The Contract Examination Oversight (E) Working Group will
   Develop additional guidance and best practices for state insurance departments to utilize in overseeing vendors providing contract examination services.—Essential
   Monitor and periodically evaluate and update the Financial Examination Contractor Listing for vendors offering contract examination services to state insurance departments.—Important

3. The Electronic Workpaper (E) Working Group will:
   - Develop a formal recommendation to fulfill the long-term needs of regulators in utilizing electronic workpapers to conduct and document solvency monitoring activities.—Essential

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

1. The Receivership and Insolvency (E) Task Force will:
   - Monitor and promote efficient operations of receiverships and guaranty funds.—Essential
   - Monitor and promote state adoption of receivership related Model Acts & Regulations.—Essential
   - Provide input and comments to the International Association of Insurance Supervisors (IAIS) or other related groups on issues regarding international resolution authority.—Essential
   - Monitor, review and provide input on federal rulemaking and studies related to insurance receivership.—Essential
   - Monitor the work of other NAIC Committees, Task Forces and Working Groups to identify and address any issues that impact receivership law or regulatory guidance.—Essential
   - Perform additional work as directed by the Financial Condition (E) Committee and/or received through referral by other groups.—Essential
   - Review the definition of contingent deferred annuity (CDA), as proposed by the Contingent Deferred Annuity (A) Working Group, and determine whether amendments to the Life and Health Insurance Guaranty Association Model Act (#520) are needed and warranted in light of that proposed definition.
   - Evaluate the benefits and cost associated with requiring resolution plans for large insurance groups. Develop guidance on resolution plans for states with large insurance groups and address related issues developing in the federal and international standards.—Essential
3. The Securitization Data Integrity (E) Working Group will:

- Develop, consistent with policies in the Purposes and Procedures Manual of the NAIC Securities Valuation Office (SVO), data quality and quantity standards for the purpose of assessing whether a new issue residential mortgage-backed security (RMBS) or commercial mortgage-backed security (CMBS) is eligible for analysis and modeling. Such data standards should address minimum requirements for eligibility, including, but not limited to: loan collateral data quality; trust structure and formation; representations and warranties; and risks other than mortgages (e.g., swaps, counterparty, funding).—Essential

- Recommend amendments to the Purposes and Procedures Manual to clarify when a private label RMBS or CMBS might be ineligible for analysis or modeling; and include general guidelines to the NAIC Structured Securities Group (SSG).—Essential

- Provide the Valuation of Securities (E) Task Force with a final report by June 15, 2014.—Essential
LONG-TERM CARE INSURANCE MODEL REGULATION

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Section 4. Definitions

For the purpose of this regulation, the terms “long-term care insurance,” “qualified long-term care insurance,” “group long-term care insurance,” “commissioner,” “applicant,” “policy” and “certificate” shall have the meanings set forth in section 4 of the NAIC Long-Term Care Insurance Model Act. In addition, the following definitions apply.

Drafting Note: Where the word “commissioner” appears in this regulation, the appropriate designation for the chief insurance supervisory official of the state should be substituted. To the extent that the model act is not adopted, the full definition of the above terms contained in that model act should be incorporated into this section.

A. “Benefit trigger”, for the purposes of independent review, means a contractual provision in the insured’s policy of long-term care insurance conditioning the payment of benefits on a determination of the insured’s ability to perform activities of daily living and on cognitive impairment. For purposes of a tax-qualified long-term care insurance contract, as defined in Section 7702B of the Internal Revenue Code of 1986, as amended, “benefit trigger” shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual.

Drafting Note: This definition is not intended to be a required definitional element of a long-term care insurance policy, but rather intended to clarify the scope and intent of Section 31. The requirement for a description of the benefit trigger in the policy or certificate is currently found in Section 8.

B. (1) “Exceptional increase” means only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified:

(a) Due to changes in laws or regulations applicable to long-term care coverage in this state; or
(b) Due to increased and unexpected utilization that affects the majority of insurers of similar products.

(2) Except as provided in Sections 20 and 20.1, exceptional increases are subject to the same requirements as other premium rate schedule increases.

(3) The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

(4) The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

Drafting Note: The commissioner may wish to review the request with other commissioners.

C. “Incidental,” as used in Sections 20J and 20.1J, means that the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

Drafting Note: The phrase “value of the benefits” is used in defining “incidental” to make the definition more generally applicable. In simple cases where the base policy and the long-term care benefits have separately identifiable premiums, the premiums can be directly compared. In other cases, annual cost of insurance charges might be available for comparison. Some cases may involve comparison of present value of benefits.

D. “Independent review organization” means an organization that conducts independent reviews of long-term care benefit trigger decisions.

E. “Licensed health care professional” means an individual qualified by education and experience in an appropriate field, to determine, by record review, an insured’s actual functional or cognitive impairment.

Drafting Note: For purposes of Section 31, it may be appropriate for certain licensed health care professionals, such as physical therapists, occupational therapists, neurologists, physical medicine specialists, and rehabilitation medicine specialists, to review a benefit trigger determination. However, some of these health care professionals may not meet the definition of a licensed health care practitioner under Section 7702B(c)(4) of the Internal Revenue Code. For tax-qualified long-term care insurance contracts, only a licensed health care professional who meets the definition of a licensed health care practitioner may certify that an individual is a chronically ill individual.

F. “Qualified actuary” means a member in good standing of the American Academy of Actuaries.

G. “Similar policy forms” means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in [insert reference to Section 4E(1) of the NAIC Long-Term Care Model Act] are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

Section 10. Initial Filing Requirements

A. This section applies to any long-term care policy issued in this state on or after [insert date that is 6 months after adoption of the amended regulation], except that Subsection B(2)(d) and Subsection B(3) apply to any long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation].
B. An insurer shall provide the information listed in this subsection to the commissioner [30 days] prior to making a long-term care insurance form available for sale.

Drafting Note: States should consider whether a time period other than 30 days is desirable. An alternative time period would be the time period required for policy form approval in the applicable state regulation or law.

1. A copy of the disclosure documents required in Section 9; and

2. An actuarial certification consisting of at least the following:

   a. A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

   b. A statement that the policy design and coverage provided have been reviewed and taken into consideration;

   c. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

   d. A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

      i. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; A composite margin shall not be less than 10% of lifetime claims.

      ii. A statement that the assumptions used for reserves contain reasonable margins for adverse experience; A composite margin that is less than 10% may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount and methods to monitor developing experience that would be the basis for withdrawal of approval for such lower margins must be submitted.

      iii. A statement that the net valuation premium for renewal years does not increase (except for attained age rating where permitted); and A composite margin lower than otherwise considered appropriate for the stand-alone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract. Such lower composite margin, if utilized, shall be justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product.

Drafting Note: For the justification required in (iii) above, examples of such considerations, if applicable to the product and company, might be found in Society of Actuaries research studies entitled “Quantification of the Natural Hedge Characteristics of Combination Life or Annuity Products Linked to Long-Term Care Insurance” (2012) and “Understanding the Volatility of Experience and Pricing Assumptions in Long-Term Care Insurance Programs” (2014).

   iv. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur.
A greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.

**Drafting Note:** Actual margins may be included in several actuarial assumptions (e.g. mortality, lapse, underwriting selection wear-off, etc.) in addition to some of the margin in the morbidity assumption. The composite margin is the total of such margins over best-estimate assumptions.

**Drafting Note:** When the difference between the gross premium and the renewal net valuation premiums is not sufficient to cover expected renewal expenses, the description provided could demonstrate the type and level of change in the reserve assumptions that would be necessary for the difference to be sufficient.

(I) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(II) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under Subsection C based on a standard age distribution; and

(e) (i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(ii) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

**Drafting Note:** In the event a series of increases is being applied to another policy form, intermediate premium levels are not to be used in this comparison.

**Drafting Note:** It is not expected that the insurer will need to provide a comparison of every age and set of benefits, period of payment or elimination period. A broad range of expected combinations is to be provided in a manner designed to provide a fair presentation for review by the commissioner.

(f) A statement that reserve requirements have been reviewed and considered. Support for this statement shall include:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and

(ii) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.

(3) An actuarial memorandum prepared, dated and signed by the member of the Academy of Actuaries shall be included and shall address and support each specific item required as part of the actuarial certification and provide at least the following information:

(a) An explanation of the review performed by the actuary prior to making the statements in Paragraph (2)(b) and (c),

(b) A complete description of pricing assumptions; and
(c) Sources and levels of margins incorporated into the gross premiums that are the basis for the statement in Paragraph (2)(a) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Deviations in margins between ages, sexes, plans or states shall be clearly described. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales.

(d) A demonstration that the gross premiums include the minimum composite margin specified in Paragraph (2)(d).

C. (1) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

In any review of the actuarial certification and actuarial memorandum, the commissioner may request review by an actuary with experience in long-term care pricing who is independent of the company. In the event the commissioner asks for additional information as a result of any review, the period in Subsection B does not include the period during which the insurer is preparing the requested information.

**Drafting Note:** The commissioner may accept a review done for another state or states if such review is for the same policy form or where any differences in benefits and premiums are not material and such review was completed within eighteen months of the date of the actuarial certification in Subsection B(2) above.

(2) In the event the commissioner asks for additional information under this provision, the period in Subsection B does not include the period during which the insurer is preparing the requested information.

**Drafting Note:** The commissioner may wish to have the actuarial demonstration reviewed by an independent actuary in those instances where the demonstration does not address fully the questions that triggered the request for the actuarial demonstration.

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**Section 15. Reporting Requirements**

A. Every insurer shall maintain records for each agent of that agent’s amount of replacement sales as a percent of the agent’s total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent’s total annual sales.

B. Every insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by Subsection A above. (Appendix G)

C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

D. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. (Appendix G)

E. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. (Appendix G)

F. Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix E)
For purposes of this section:

1. “Policy” means only long-term care insurance;

2. Subject to Paragraph (3), “claim” means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

3. “Denied” means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

4. “Report” means on a statewide basis.

H. Reports required under this section shall be filed with the commissioner.

I. Annual rate certification requirements.

1. This Subsection applies to any long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation].

2. The following annual submission requirements apply subsequent to initial rate filings for individual long-term care insurance policies made under this section.

   a. An actuarial certification prepared, dated and signed by a member of the American Academy of Actuaries who provides the information shall be included and shall provide at least the following information:

      i. A statement of the sufficiency of the current premium rate schedule including:

         a. The premium rate schedule continues to be sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated; or

         b. If the above statement cannot be made, a statement that margins for moderately adverse experience may no longer be sufficient. In this situation, the insurer shall provide to the commissioner, within sixty (60) days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience so that the ultimate premium rate schedule would be reasonably expected to be sustainable over the future life of the form with no future premium increases anticipated. Failure to submit a plan of action to the commissioner within sixty (60) days or to comply with the time frame stated in the plan of action constitutes grounds for the commissioner to withdraw or modify its approval of the form for future sales pursuant to [Reference State form approval authority and administrative procedures rules].
Drafting Note: In accordance with the anticipated changes to Section 10, in situations where the premium rates have been approved with less than the normal minimum margin for moderately adverse experience, any adverse experience should be reviewed to determine if the lower margins can be continued for new business.

(II) For the rate schedules that are no longer marketed,

a. That the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions; or

b. That the premium rate schedule may no longer be sufficient. In this situation, the insurer shall provide to the commissioner, within sixty (60) days of the date the actuarial certification is submitted to the commissioner, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience.

(ii) A description of the review performed that led to the statement.

(b) An actuarial memorandum dated and signed by a member of the American Academy of Actuaries who prepares the information shall be prepared to support the actuarial certification and provide at least the following information:

(i) A detailed explanation of the data sources and review performed by the actuary prior to making the statement in Paragraph (1)(a).

(ii) A complete description of experience assumptions and their relationship to the initial pricing assumptions.

Drafting Note: ASOP No. 18, the NAIC Guidance Manual for the Rating Aspects of the Long-Term Care Insurance Model Regulation and the Academy of Actuaries Practice Note “Long-Term Care Insurance, Compliance with the NAIC Long-Term Care Insurance Model Regulation Relating to Rate Stability” all provide details concerning the key pricing assumptions, underlying actuarial judgments and the manner in which experience should be monitored.

(iii) A description of the credibility of the experience data.

(iv) An explanation of the analysis and testing performed in determining the current presence of margins.

(c) The actuarial certification required pursuant to Paragraph (2)(a) must be based on calendar year data and submitted annually no later than May 1st of each year starting in the second year following the year in which the initial rate schedules are first used. The actuarial memorandum required pursuant to Paragraph (2)(b) must be submitted at least once every three (3) years with the certification.

Drafting Note: The commissioner may wish to have the actuarial demonstration reviewed by an independent actuary in those instances where the demonstration does not certify to the maintenance of margins.

Section 19. Loss Ratio

A. This section shall apply to all long-term care insurance policies or certificates except those covered under Sections 10, and 20 and 20.1.

B. Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a
manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

1. Statistical credibility of incurred claims experience and earned premiums;
2. The period for which rates are computed to provide coverage;
3. Experienced and projected trends;
4. Concentration of experience within early policy duration;
5. Expected claim fluctuation;
6. Experience refunds, adjustments or dividends;
7. Renewability features;
8. All appropriate expense factors;
9. Interest;
10. Experimental nature of the coverage;
11. Policy reserves;
12. Mix of business by risk classification; and
13. Product features such as long elimination periods, high deductibles and high maximum limits.

C. Subsection B shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
2. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of [cite to state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];
3. The policy meets the disclosure requirements of Sections 6I, 6J, and 6K of the NAIC Long-Term Care Insurance Model Act;
4. Any policy illustration that meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation; and
5. An actuarial memorandum is filed with the insurance department that includes:
   a. A description of the basis on which the long-term care rates were determined;
(b) A description of the basis for the reserves;

(c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(f) The estimated average annual premium per policy and the average issue age;

(g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

Drafting Note: The loss ratio reporting form for long-term care policies that was adopted in 1990 provides for reporting of loss ratios on group as well as individual policies. The amendment to Section 19 above which removes the word “individual”: (1) reflects the fact that loss ratios should be reported on all policies, and (2) establishes a 60% loss ratio for both group and individual policies. States may wish to apply a higher standard than 60% to group policies.

Section 20. Premium Rate Schedule Increases

Drafting Note: Section 20 applies to policies issued for effective dates prior to the date that is six (6) months after adoption of the amended regulation incorporating Section 20.1 (as adopted by the NAIC on [insert NAIC adoption date]). Policies issued on or after that date should adhere to the requirements of Section 20.1 instead of Section 20. Section 20 and Section 20.1 are identical with the exceptions of Subsections A, C and G.

A. This section shall apply as follows:

1. Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation] and prior to [insert date that is six (6) months after adoption of the amended regulation incorporating Section 20.1].

2. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is twelve months after adoption of the amended regulation].
B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least [30] days prior to the notice to the policyholders and shall include:

Drafting Note: In states where the commissioner is required to approve premium rate schedule increases, “shall provide notice” may be changed to “shall request approval.” States should consider whether a time period other than 30 days is desirable. An alternate time period would be the time period required for policy form approval in the applicable state regulation or law.

(1) Information required by Section 9;

(2) Certification by a qualified actuary that:

(a) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

(b) The premium rate filing is in compliance with the provisions of this section;

(c) The insurer may request a premium rate schedule increase less than what is required under this section and the commissioner may approve such premium rate schedule increase, without submission of the certification in Subparagraph (a) of this paragraph, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under Subparagraph (a) of this paragraph, the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the commissioner, in the best interest of policyholders.

Drafting Note: In any comparison of premiums under Section 10.B(2)(e) or Section 20.B(4), such lower premium or any subsequent higher premium based on a series of increases should not be used.

(3) An actuarial memorandum justifying the rate schedule change request that includes:

(a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(i) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;

(ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(iii) The projections shall demonstrate compliance with Subsection C; and

(iv) For exceptional increases,

(I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the commissioner determines as provided in Section 4A(4) that offsets may exist, the insurer shall use appropriate net projected experience;

(b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;
(c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates; and

(f) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in Section 10B(2)(d) is projected to be exhausted.

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(5) Sufficient information for review [and approval] of the premium rate schedule increase by the commissioner.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(a) The accumulated value of the initial earned premium times fifty-eight percent (58%);

(b) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;

(c) The present value of future projected initial earned premiums times fifty-eight percent (58%); and

(d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) on an earned basis;

(3) In the event that a policy form has both exceptional and other increases, the values in Paragraph (2)(b) and (d) will also include seventy percent (70%) for exceptional rate increase amounts; and

(4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the [insert reference to state equivalent to the Health Reserves Model Regulation Appendix A, Section IIA]. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for review [approval] by the commissioner updated projections, as defined in Subsection B(3)(a), annually for the next three (3) years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group
insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection B(3)(a), shall be filed for review [approval] by the commissioner every five (5) years following the end of the required period in Subsection D. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

F. (1) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Subsection C, the commissioner may require the insurer to implement any of the following:

   (a) Premium rate schedule adjustments; or
   (b) Other measures to reduce the difference between the projected and actual experience.

Drafting Note: The terms “adequately match the projected experience” include more than a comparison between actual and projected incurred claims. Other assumptions should also be taken into consideration, including lapse rates (including mortality), interest rates, margins for moderately adverse conditions, or any other assumptions used in the pricing of the product. It is to be expected that the actual experience will not exactly match the insurer’s projections. During the period that projections are monitored as described in Subsections D and E, the commissioner should determine that there is not an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

   (2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection B(3)(e), if applicable.

G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in Subsection H of this section; and

(2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection C had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subsection C(2)(a) and (c).

H. (1) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

   (a) The rate increase is not the first rate increase requested for the specific policy form or forms;
   (b) The rate increase is not an exceptional increase; and
   (c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse
In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(a) The offer shall:
   (i) Be subject to the approval of the commissioner;
   (ii) Be based on actuarially sound principles, but not be based on attained age; and
   (iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:
   (i) The maximum rate increase determined based on the combined experience; and
   (ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

I. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of Subsection H of this section, prohibit the insurer from either of the following:

**Drafting Note:** States may want to consider examining their statutes to determine whether a persistent practice of filing inadequate initial premium rates would be considered a violation of the state’s unfair trade practice act and subject to the penalties under that act.

(1) Filing and marketing comparable coverage for a period of up to five (5) years; or

(2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

J. Subsections A through I shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Section 4BC, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

   (a) [Cite state’s standard nonforfeiture law similar to the NAIC’s Standard Nonforfeiture Law for Life Insurance];

   (b) [Cite state’s standard nonforfeiture law similar to the NAIC’s Standard Nonforfeiture Law for Individual Deferred Annuities], and
(c) Cite state’s section of the variable annuity regulation similar to Section 7 of the NAIC’s Model Variable Annuity Regulation;

(3) The policy meets the disclosure requirements of [cite appropriate sections in the state’s long-term care insurance law similar to Section 6I, 6J, and 6K of the NAIC’s Long-Term Care Insurance Model Act];

(4) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(a) Policy illustrations as required by [cite state’s life insurance illustrations regulation similar to the NAIC’s Life Insurance Illustrations Model Regulation];

(b) Disclosure requirements in [cite state’s annuity disclosure regulation similar to the NAIC’s Annuity Disclosure Model Regulation]; and

(c) Disclosure requirements in [cite state’s variable annuity regulation similar to the NAIC’s Model Variable Annuity Regulation].

(5) An actuarial memorandum is filed with the insurance department that includes:

(a) A description of the basis on which the long-term care rates were determined;

(b) A description of the basis for the reserves;

(c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(f) The estimated average annual premium per policy and the average issue age;

(g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

K. Subsections F and H shall not apply to group insurance policies as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act] where:

(1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
(2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

Section 20.1 Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings.

Drafting Note: Section 20.1 applies to policies issued for effective dates on or after the date that is six (6) months after adoption of the amended regulation incorporating Section 20.1 (as adopted by the NAIC on [insert NAIC adoption date]). Policies issued prior to the date that is six (6) months after adoption of the amended regulation should adhere to the requirements of Section 20 instead of Section 20.1. Section 20 and Section 20.1 are identical with the exception of Subsections A, C and G.

A. This section shall apply as follows:

(1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation incorporating Section 20.1].

(2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is twelve (12) months after adoption of the amended regulation].

B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least [30] days prior to the notice to the policyholders and shall include:

Drafting Note: In states where the commissioner is required to approve premium rate schedule increases, “shall provide notice” may be changed to “shall request approval.” States should consider whether a time period other than 30 days is desirable. An alternate time period would be the time period required for policy form approval in the applicable state regulation or law.

(1) Information required by Section 9;

(2) Certification by a qualified actuary that:

   (a) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

   (b) The premium rate filing is in compliance with the provisions of this section;

   (c) The insurer may request a premium rate schedule increase less than what is required under this section and the commissioner may approve such premium rate schedule increase, without submission of the certification in Subparagraph (a) of this paragraph, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under Subparagraph (a) of this paragraph, the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the commissioner, in the best interest of policyholders.

Drafting Note: In any comparison of premiums under Section 10.B(2)(e) or Section 20.B(4), such lower premium or any subsequent higher premium based on a series of increases should not be used.

(3) An actuarial memorandum justifying the rate schedule change request that includes:
(a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(i) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;

(ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(iii) The projections shall demonstrate compliance with Subsection C; and

(iv) For exceptional increases,

(I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the commissioner determines as provided in Section 4A(4) that offsets may exist, the insurer shall use appropriate net projected experience;

(b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration;

(e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates; and

(f) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in Section 10B(2)(d) is projected to be exhausted.

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(5) Sufficient information for review [and approval] of the premium rate schedule increase by the commissioner.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated such that the sum of the lesser of (i) the accumulated value of actual incurred claims, without the inclusion of active life reserves, or (ii) the accumulated value of historic expected claims, without the inclusion of active life reserves,
plus the present value of the future expected incurred claims, projected without the inclusion of active life reserves, will not be less than the sum of the following:

(a) The accumulated value of the initial earned premium times the greater of (i) fifty-eight percent (58%) and (ii) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience;

(b) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;

(c) The present value of future projected initial earned premiums times the greater of (i) fifty-eight percent (58%) and (ii) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience; and

(d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) of this paragraph on an earned basis;

(3) Expected claims shall be calculated based on the original filing assumptions assumed until new assumptions are filed as part of a rate increase. New assumptions shall be used for all periods beyond each requested effective date of a rate increase. Expected claims are calculated for each calendar year based on the in-force at the beginning of the calendar year. Expected claims shall include margins for moderately adverse experience; either amounts included in the claims that were used to determine the lifetime loss ratio consistent with the original filing or as modified in any rate increase filing;

(4) In the event that a policy form has both exceptional and other increases, the values in Paragraph (2)(b) and (d) will also include seventy percent (70%) for exceptional rate increase amounts; and

(5) All present and accumulated values used to determine rate increases, including the lifetime loss ratio consistent with the original filing reflecting margins for moderately adverse experience, shall use the maximum valuation interest rate for contract reserves as specified in the [insert reference to state equivalent to the Health Reserves Model Regulation Appendix A, Section IIA]. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for review [approval] by the commissioner updated projections, as defined in Subsection B(3)(a), annually for the next three (3) years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection B(3)(a), shall be filed for review [approval] by the commissioner every five (5) years following the end of the required period in Subsection D. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

F. (1) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Subsection C, the commissioner may require the insurer to implement any of the following:

(a) Premium rate schedule adjustments; or

(b) Other measures to reduce the difference between the projected and actual experience.
Drafting Note: The terms “adequately match the projected experience” include more than a comparison between actual and projected incurred claims. Other assumptions should also be taken into consideration, including lapse rates (including mortality), interest rates, margins for moderately adverse conditions, or any other assumptions used in the pricing of the product. It is to be expected that the actual experience will not exactly match the insurer’s projections. During the period that projections are monitored as described in Subsections D and E, the commissioner should determine that there is not an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

(2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection B(3)(c), if applicable.

G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in Subsection H of this section.

H. (1) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(a) The rate increase is not the first rate increase requested for the specific policy form or forms;

(b) The rate increase is not an exceptional increase; and

(c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(2) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(a) The offer shall:

(i) Be subject to the approval of the commissioner;

(ii) Be based on actuarially sound principles, but not be based on attained age; and

(iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(i) The maximum rate increase determined based on the combined experience; and

(ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).
I. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of Subsection H of this section, prohibit the insurer from either of the following:

**Drafting Note:** States may want to consider examining their statutes to determine whether a persistent practice of filing inadequate initial premium rates would be considered a violation of the state’s unfair trade practice act and subject to the penalties under that act.

(1) Filing and marketing comparable coverage for a period of up to five (5) years; or

(2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

J. Subsections A through I shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Section 4C, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

   (a) [Cite state’s standard nonforfeiture law similar to the NAIC’s Standard Nonforfeiture Law for Life Insurance];

   (b) [Cite state’s standard nonforfeiture law similar to the NAIC’s Standard Nonforfeiture Law for Individual Deferred Annuities], and

   (c) [Cite state’s section of the variable annuity regulation similar to Section 7 of the NAIC’s Model Variable Annuity Regulation];

(3) The policy meets the disclosure requirements of [cite appropriate sections in the state’s long-term care insurance law similar to Section 6I, 6J, and 6K of the NAIC’s Long-Term Care Insurance Model Act];

(4) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

   (a) Policy illustrations as required by [cite state’s life insurance illustrations regulation similar to the NAIC’s Life Insurance Illustrations Model Regulation];

   (b) Disclosure requirements in [cite state’s annuity disclosure regulation similar to the NAIC’s Annuity Disclosure Model Regulation]; and

   (c) Disclosure requirements in [cite state’s variable annuity regulation similar to the NAIC’s Model Variable Annuity Regulation];

(5) An actuarial memorandum is filed with the insurance department that includes:

   (a) A description of the basis on which the long-term care rates were determined;

   (b) A description of the basis for the reserves;
(c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(f) The estimated average annual premium per policy and the average issue age;

(g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

K. Subsections F and H shall not apply to group insurance policies as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act] where:

(1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

(2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

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Section 27. Right to Reduce Coverage and Lower Premiums

A. (1) Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

(a) Reducing the maximum benefit; or

(b) Reducing the daily, weekly or monthly benefit amount.

(2) The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier’s administrative processes.

(3) In the event the reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholder to continue the benefit amount in effect at the time of the reduction.

B. The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.
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C. The age to determine the premium for the reduced coverage shall be based on the age used to determine the premium for the coverage currently in force.

The premium for the reduced coverage shall:

1. Be based on the same age and underwriting class used to determine the premium for the coverage currently in force; and

2. Be consistent with the approved rate table.

D. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

E. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by Section 7A(3) of this regulation.

F. This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

G. The requirements of Subsections A through F this Section shall apply to any long-term care policy issued in this state on or after [insert date that is twelve (12) months after adoption of the amended regulation].

H. A premium increase notice required by Section 9E of this regulation shall include:

1. An offer to reduce policy benefits provided by the current coverage consistent with the requirements of this section;

2. A disclosure stating that all options available to the policyholder may not be of equal value; and

3. In the case of a partnership policy, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder protections.

I. The requirements of Subsection H shall apply to any rate increase implemented in this state on or after [insert date that is twelve (12) months after adoption of the amended regulation].

Drafting Note: Compliance with this Section may be accomplished by policy replacement, exchange or by adding the required provision via amendment or endorsement to the policy.

Section 28. Nonforfeiture Benefit Requirement

A. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act]:

1. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection E; and

2. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

C. If the offer required to be made under [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act] is rejected, the insurer shall provide the contingent benefit upon lapse described in
this Section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in Subsection D(4) shall still apply.

D. (1) After rejection of the offer required under [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act], for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

(2) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(3) A contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured’s initial annual premium set forth below based on the insured’s issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

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<td>65</td>
<td>50%</td>
</tr>
<tr>
<td>66</td>
<td>48%</td>
</tr>
<tr>
<td>67</td>
<td>46%</td>
</tr>
<tr>
<td>68</td>
<td>44%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Percent Increase Over Initial Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>69</td>
<td>42%</td>
</tr>
<tr>
<td>70</td>
<td>40%</td>
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<tr>
<td>71</td>
<td>38%</td>
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<td>72</td>
<td>36%</td>
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<td>73</td>
<td>34%</td>
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<td>74</td>
<td>32%</td>
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<td>75</td>
<td>30%</td>
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<td>76</td>
<td>28%</td>
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<td>77</td>
<td>26%</td>
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<td>24%</td>
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<td>20%</td>
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<td>81</td>
<td>19%</td>
</tr>
<tr>
<td>82</td>
<td>18%</td>
</tr>
<tr>
<td>83</td>
<td>17%</td>
</tr>
</tbody>
</table>
A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured’s initial annual premium set forth below based on the insured’s issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in Paragraph (6)(b) is forty percent (40%) or more. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

### Triggers for a Substantial Premium Increase

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Percent Increase Over Initial Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>50%</td>
</tr>
<tr>
<td>65-80</td>
<td>30%</td>
</tr>
<tr>
<td>Over 80</td>
<td>10%</td>
</tr>
</tbody>
</table>

This provision shall be in addition to the contingent benefit provided by Paragraph (3) above and where both are triggered, the benefit provided shall be at the option of the insured.

On or before the effective date of a substantial premium increase as defined in Paragraph (3) above, the insurer shall:

(a) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting consistent with the requirements of Section 27 so that required premium payments are not increased;

**Drafting Note:** The insured’s right to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy.

(b) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection E. This option may be elected at any time during the 120-day period referenced in Subsection D(3); and

(c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection D(3) shall be deemed to be the election of the offer to convert in Subparagraph (b) above unless the automatic option in Paragraph (6)(c) applies.

On or before the effective date of a substantial premium increase as defined in Paragraph (4) above, the insurer shall:

(a) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting consistent with the requirements of Section 27 so that required premium payments are not increased;

**Drafting Note:** The insured’s right to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy.

(b) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse
times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in Subsection D(4); and

(c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection D(4) shall be deemed to be the election of the offer to convert in Subparagraph (b) above if the ratio is forth percent (40%) or more.

(7) For any long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation],

(a) In the event the policy or certificate was issued at least twenty (20) years prior to the effective date of the increase, a value of 0% shall be used in place of all values in the above table; and

(b) Values above 100% in the table in Paragraph (3) above shall be reduced to 100%.

E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with Subsection D(3) but not Subsection D(4), are described in this subsection:

(1) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).

(2) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (3).

(3) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection F.

(4) (a) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter.

(b) Notwithstanding Subparagraph (a), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

   (i) The end of the tenth year following the policy or certificate issue date; or

   (ii) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(5) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

F. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.
G. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

H. The requirements set forth in this section shall become effective twelve (12) months after adoption of this provision and shall apply as follows:

1. Except as provided in Paragraph (2) and (3) below, the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

2. For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

3. The last sentence in Subsection C and Subsections D(4) and D(6) shall apply to any long-term care insurance policy or certificate issued in this state after six (6) months after their adoption, except new certificates on a group policy as defined in Subsection 4E(1) one year after adoption.

I. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of Section 19, or Section 20 or Section 20.1, whichever is applicable, treating the policy as a whole.

J. To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection D(3) or D(4), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

K. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

1. The nonforfeiture provision shall be appropriately captioned;

2. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and

3. The nonforfeiture provision shall provide at least one of the following:

a. Reduced paid-up insurance;

b. Extended term insurance;

c. Shortened benefit period; or

d. Other similar offerings approved by the commissioner.
REQUEST FOR MODEL LAW DEVELOPMENT

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

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

1. Name of group to be responsible for drafting the model:
   Senior Issues (B) Task Force

2. NAIC staff support contact information:
   Jane Sung
   Health Policy Counsel
   National Association of Insurance Commissioners
   Executive Office, Washington DC
   202-471-3979 (direct)
   jsung@naic.org

3. Please provide a description and proposed title of the new model law. If an existing law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.
   Long Term Care Model Act (640) and Long Term Care Model Regulation (641)

4. Does the model law meet the Model Law Criteria? ☒ Yes or ☐ No (Check one)
   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).
   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? ☒ Yes or ☐ No (Check one)
      If yes, please explain why

Rate stability revisions (also known as rating practices amendments) to the long term care models were originally adopted by the NAIC in August 2000 to address significant problems in the pricing of long term care policies that were apparent in the market. While those revisions did address underpricing of long term care policies and improve pricing, challenges still exist in the market and it appears that additional changes are needed to the models. At least 37 states have adopted the original rate stabilization amendments. In recent year, the long term care market place has seen significantly large and/or multiple rate increases on policyholders, including on policies sold under rate stabilization standards. It appears that the current standards can and need to be improved.
b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?

☐ Yes or ☐ No (Check one)

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

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary:

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

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary:

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

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary:

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

No

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

No.
Project History

LONG-TERM CARE INSURANCE MODEL REGULATION (#641)

1. Description of the Project, Issues Addressed, etc.

These revisions make improvements to the “rate stability” standards contained in the Long-Term Care Insurance Model Regulation (#641). The improvements are intended to address the problem of rate increases on long-term care insurance policies, and apply primarily to new policies sold after the effective date of the revisions.

Among the changes, the model revisions include:

- Expansion of the actuarial certification currently required by the model from a one-time statement at the time of initial filing to a more robust annual certification. The annual certification requirement is similar to one adopted by the IIPRC.
- New requirement that a minimum margin be incorporated into pricing calculations to encourage more conservative pricing.
- Improvements to consumer disclosure requirements, including a new disclosure required when consumers consider actions to mitigate rate increases that may impact Long-Term Care Partnership Program protections and Medicaid eligibility.
- Expansion of the contingent benefit upon lapse by requiring that consumers who have held the oldest policies (i.e., more than 20 years) will receive this benefit automatically.

2. Name of Group Responsible for Drafting the Model and States Participating

The Senior Issues (B) Task Force was chaired by Commissioner Scott J. Kipper (NV) and vice chaired by Commissioner Wayne Goodwin (NC). The Long-Term Care Rate Stability (B) Subgroup of the Senior Issues (B) Task Force was chaired by John Rink (NE). The Task Force and Subgroup relied heavily upon the work of the Health Actuarial (B) Task Force (chaired by Steve Ostlund (AL)) to make recommendations on the actuarial aspects of the model revisions, including its Long-Term Care Actuarial (B) Working Group (chaired by Perry Kupferman (CA)) and the Long-Term Care Pricing (B) Subgroup (chaired by Jan Graeber (TX)). Other members of the Senior Issues (B) Task Force and the Health Actuarial (B) Task Force also participated.

3. Project Authorized by What Charge and Date First Given to the Group

At the 2012 Fall National Meeting, the Executive (EX) Committee approved a request by the Senior Issues (B) Task Force to amend the Long-Term Care Insurance Model Act (#640) and Model #641. At the 2013 Spring National Meeting, the Health Insurance and Managed Care (B) Committee granted the Task Force an extension to complete its work.

All changes are being proposed for Model #641 and no changes are required for Model #640.

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

A draft of the model revisions was developed by the chair of the Senior Issues (B) Task Force and the chair of the Long-Term Care Rate Stability (B) Subgroup and was distributed to Task Force members prior to a June 2013 interim meeting of the Task Force. This draft was developed following prior discussions by the Task Force and with interested parties. The Health Actuarial (B) Task Force was asked to provide comments on the draft. The Long-Term Care Pricing (B) Subgroup developed multiple sets of recommendations that were each adopted by the Health Actuarial (B) Task Force and then considered by the Senior Issues (b) Task Force on various conference calls.

At the 2013 Fall National Meeting, the Task Force granted a request by the Health Actuarial (B) Task Force for additional time to work on outstanding issues and recommendations. These additional recommendations were completed and presented to the Task Force on a March 14, 2014, conference call. The model revisions were adopted by the Senior Issues (B) Task Force March 29, 2014, at the Spring National Meeting and then by the Health Insurance and Managed Care (B) Committee on a June 10, 2014, conference call.
5. **A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)**

The Senior Issues (B) Task Force exposed the draft model for a public comment period in November 2013. The Health Actuarial (B) Task Force exposed the draft model for an additional public comment period in February 2014. The Health and Managed Care (B) Committee exposed the draft model for an additional public comment period prior to its adoption of the model on a June 10, 2014, conference call.

All drafts of the model were made available to interested parties by the Senior Issues (B) Task Force and the Health Actuarial (B) Task Force, as well as by their subgroups and working groups. All drafts considered by the Senior Issues (B) Task Force were posted on the Task Force’s Web page.

There were also opportunities for interested parties to provide comment on all conference calls, at each of the national meetings where the model was being discussed in 2013 and 2014, at the June 2013 interim meeting of the Senior Issues (B) Task Force and at the Senior Issues (B) Task Force’s Public Hearing on Long-Term Care Insurance Issues, which was held Nov. 28, 2012.

6. **A Discussion of the Significant Issues (items of some controversy raised during the due process and the group’s response)**

These model revisions would largely apply prospectively to rate increases on new policies. In order to quickly address the problem of rate increases on older policies (including older pre-rate-stabilized policies), the Task Force first worked to develop a model bulletin on long-term care premium increases that would apply to rate increases on existing policies. The Executive (EX) Committee and Plenary adopted this model bulletin in December 2013.

The model revisions do not make any changes to the dual loss-ratio structure currently contained in Model #641. When the rate stability amendments were first adopted in 2000, the previous 58% loss ratio requirement was replaced with a dual structure of 60% at the time of initial pricing and 85% if a rate increase is later required. When the Health Actuarial (B) Task Force considered its final recommendations, it adopted a provision to increase the 85% loss ratio requirement to 92%. The Senior Issues (B) Task Force rejected this proposal and, at the 2014 Spring National Meeting, adopted the model revisions without accepting this recommendation. A subsequent motion for the Task Force to amend the adopted model revisions, substituting 92% for the 85% loss ratio requirement, failed to win adoption. The Health Insurance and Managed Care (B) Committee discussed the 92% proposal during consideration of the model revisions on its March 29, 2014, conference call, but adopted the model revisions without any further changes. The Health Insurance and Managed Care (B) Committee and the Senior Issues (B) Task Force discussed that there may be opportunities to review the entire loss ratio structure at a future time.

7. **Any Other Important Information (e.g., amending an accreditation standard)**

The Senior Issues (B) Task Force and the Health Actuarial (B) Task Force are now working to update guidance to regulators contained in the *Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation* in order to help the states implement the model revisions.
ANNUAL FINANCIAL REPORTING MODEL REGULATION

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Section 1. Authority

This regulation is promulgated by the commissioner of insurance pursuant to Sections [insert applicable sections] of the [insert state] insurance law.

Section 2. Purpose and Scope

The purpose of this regulation is to improve the [insert state] Insurance Department’s surveillance of the financial condition of insurers by requiring (1) an annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants, (2) Communication of Internal Control Related Matters Noted in an Audit, and (3) Management’s Report of Internal Control over Financial Reporting.

Every insurer (as defined in Section 3) shall be subject to this regulation. Insurers having direct premiums written in this state of less than $1,000,000 in any calendar year and less than 1,000 policyholders or certificate holders of direct written policies nationwide at the end of the calendar year shall be exempt from this regulation for the year (unless the commissioner makes a specific finding that compliance is necessary for the commissioner to carry out statutory responsibilities) except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of $1,000,000 or more will not be so exempt.

Foreign or alien insurers filing the Audited financial report in another state, pursuant to that state’s requirement for filing of Audited financial reports, which has been found by the commissioner to be substantially similar to the requirements herein, are exempt from Sections 4 through 13 of this regulation if:

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Annual Financial Reporting Model Regulation

A. A copy of the Audited financial report, Communication of Internal Control Related Matters Noted in an Audit, and the Accountant’s Letter of Qualifications that are filed with the other state are filed with the commissioner in accordance with the filing dates specified in Sections 4, 11 and 12, respectively (Canadian insurers may submit accountants’ reports as filed with the Office of the Superintendent of Financial Institutions, Canada).

B. A copy of any Notification of Adverse Financial Condition Report filed with the other state is filed with the commissioner within the time specified in Section 10.

Foreign or alien insurers required to file Management’s Report of Internal Control over Financial Reporting in another state are exempt from filing the Report in this state provided the other state has substantially similar reporting requirements and the Report is filed with the commissioner of the other state within the time specified.

This regulation shall not prohibit, preclude or in any way limit the commissioner of insurance from ordering or conducting or performing examinations of insurers under the rules and regulations of the [insert state] Department of Insurance and the practices and procedures of the [insert state] Department of Insurance.

Section 3. Definitions

The terms and definitions contained herein are intended to provide definitional guidance as the terms are used within this regulation.

A. “Accountant” or “independent certified public accountant” means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants (AICPA) and in all states in which he or she is licensed to practice; for Canadian and British companies, it means a Canadian-chartered or British-chartered accountant.

B. An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

C. “Audit committee” means a committee (or equivalent body) established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or Group of insurers, the Internal audit function of an insurer or Group of insurers (if applicable), and external audits of financial statements of the insurer or Group of insurers. The Audit committee of any entity that controls a Group of insurers may be deemed to be the Audit committee for one or more of these controlled insurers solely for the purposes of this regulation at the election of the controlling person. Refer to Section 14E for exercising this election. If an Audit committee is not designated by the insurer, the insurer’s entire board of directors shall constitute the Audit committee.

D. “Audited financial report” means and includes those items specified in Section 5 of this regulation.

E. “Indemnification” means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing of other misrepresentations made by the insurer or its representatives.

F. “Independent board member” has the same meaning as described in Section 14C.

G. “Insurer” means a licensed insurer as defined in Sections [insert applicable sections] of the [insert state] insurance law or an authorized insurer as defined in Sections [insert applicable sections] of the [insert state] insurance law.
H. “Group of insurers” means those licensed insurers included in the reporting requirements of [insert state law equivalent of the model Insurance Holding Company System Regulatory Act], or a set of insurers as identified by management, for the purpose of assessing the effectiveness of Internal control over financial reporting.

I. “Internal audit function” means a person or persons that provide independent, objective and reasonable assurance designed to add value and improve an organization’s operations and accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

J. “Internal control over financial reporting” means a process effected by an entity’s board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements, i.e., those items specified in Section 5B through 5G of this regulation and includes those policies and procedures that:

1. Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;

2. Provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, i.e., those items specified in Section 5B through 5G of this regulation and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and

3. Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of assets that could have a material effect on the financial statements, i.e., those items specified in Section 5B through 5G of this regulation.

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

KL. “Section 404” means Section 404 of the Sarbanes-Oxley Act of 2002 and the SEC’s rules and regulations promulgated thereunder.

LM. “Section 404 Report” means management’s report on “internal control over financial reporting” as defined by the SEC and the related attestation report of the independent certified public accountant as described in Section 3A.

MN. “SOX Compliant Entity” means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002: (i) the preapproval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934); (ii) the Audit committee independence requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934); and (iii) the Internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K).

Section 4. General Requirements Related to Filing and Extensions for Filing of Annual Audited Financial Reports and Audit Committee Appointment

A. All insurers shall have an annual audit by an independent certified public accountant and shall file an Audited financial report with the commissioner on or before June 1 for the year ended December 31 immediately preceding. The commissioner may require an insurer to file an audited financial report earlier than June 1 with ninety (90) days advance notice to the insurer.

B. Extensions of the June 1 filing date may be granted by the commissioner for thirty-day periods upon a showing by the insurer and its independent certified public accountant of the reasons for requesting an
extension and determination by the commissioner of good cause for an extension. The request for extension must be submitted in writing not less than ten (10) days prior to the due date in sufficient detail to permit the commissioner to make an informed decision with respect to the requested extension.

C. If an extension is granted in accordance with the provisions in Section 4B, a similar extension of thirty (30) days is granted to the filing of Management’s Report of Internal Control over Financial Reporting.

D. Every insurer required to file an annual Audited financial report pursuant to this regulation shall designate a group of individuals as constituting its Audit committee, as defined in Section 3. The Audit committee of an entity that controls an insurer may be deemed to be the insurer’s Audit committee for purposes of this regulation at the election of the controlling person.

Section 5. Contents of Annual Audited Financial Report

The annual Audited financial report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the Department of Insurance of the state of domicile.

The annual Audited financial report shall include the following:

A. Report of independent certified public accountant.

B. Balance sheet reporting admitted assets, liabilities, capital and surplus.

C. Statement of operations.

D. Statement of cash flow.

E. Statement of changes in capital and surplus.

F. Notes to financial statements. These notes shall be those required by the appropriate NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to Section [insert applicable section] of the [insert state] insurance law with a written description of the nature of these differences.

G. The financial statements included in the Audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the commissioner, and the financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. (However, in the first year in which an insurer is required to file an Audited financial report, the comparative data may be omitted).

Section 6. Designation of Independent Certified Public Accountant

A. Each insurer required by this regulation to file an annual Audited financial report must within sixty (60) days after becoming subject to the requirement, register with the commissioner in writing the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit set forth in this regulation. Insurers not retaining an independent certified public accountant on the effective date of this regulation shall register the name and address of their retained independent certified public accountant not less than six (6) months before the date when the first Audited financial report is to be filed.
B. The insurer shall obtain a letter from the accountant, and file a copy with the commissioner stating that the accountant is aware of the provisions of the insurance code and the regulations of the insurance department of the state of domicile that relate to accounting and financial matters and affirming that the accountant will express his or her opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that insurance department, specifying such exceptions as he or she may believe appropriate.

C. If an accountant who was the accountant for the immediately preceding filed Audited financial report is dismissed or resigns, the insurer shall within five (5) business days notify the commissioner of this event. The insurer shall also furnish the commissioner with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) months preceding such event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure; which disagreements, if not resolved to the satisfaction of the former accountant, would have caused him or her to make reference to the subject matter of the disagreement in connection with his or her opinion. The disagreements required to be reported in response to this section include both those resolved to the former accountant’s satisfaction and those not resolved to the former accountant’s satisfaction. Disagreements contemplated by this section are those that occur at the decision-making level, i.e., between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer shall also in writing request the former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer’s letter and, if not, stating the reasons for which he or she does not agree; and the insurer shall furnish the responsive letter from the former accountant to the commissioner together with its own.

Section 7. Qualifications of Independent Certified Public Accountant

A. The commissioner shall not recognize a person or firm as a qualified independent certified public accountant if the person or firm:

(1) Is not in good standing with the AICPA and in all states in which the accountant is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant; or

(2) Has either directly or indirectly entered into an agreement of indemnity or release from liability (collectively referred to as *indemnification*) with respect to the audit of the insurer.

B. Except as otherwise provided in this regulation, the commissioner shall recognize an independent certified public accountant as qualified as long as he or she conforms to the standards of his or her profession, as contained in the Code of Professional Ethics of the AICPA and Rules and Regulations and Code of Ethics and Rules of Professional Conduct of the [insert state] Board of Public Accountancy, or similar code.

C. A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under [cite applicable receivership statute], the mediation or arbitration provisions shall operate at the option of the statutory successor.

D. (1) The lead (or coordinating) audit partner (having primary responsibility for the audit) may not act in that capacity for more than five (5) consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of five (5) consecutive years. An insurer may make application to the commissioner for relief from the above rotation requirement on the basis of unusual circumstances. This application should be made at least thirty (30) days before the end of the calendar year. The commissioner may consider the following factors in determining if the relief should be granted:

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(a) Number of partners, expertise of the partners or the number of insurance clients in the currently registered firm;

(b) Premium volume of the insurer; or

(c) Number of jurisdictions in which the insurer transacts business.

(2) The insurer shall file, with its annual statement filing, the approval for relief from Subsection D(1) with the states that it is licensed in or doing business in and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

E. The commissioner shall neither recognize as a qualified independent certified public accountant, nor accept an annual Audited financial report, prepared in whole or in part by, a natural person who:

(1) Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. Sections 1961 to 1968, or any dishonest conduct or practices under federal or state law;

(2) Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this regulation; or

(3) Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this regulation.

F. The commissioner of insurance, as provided in Section [insert applicable section] of the insurance code, may, as provided in [insert applicable citation], hold a hearing to determine whether an independent certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing his or her opinion on the financial statements in the annual Audited financial report made pursuant to this regulation and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this regulation.

G. (1) The commissioner shall not recognize as a qualified independent certified public accountant, nor accept an annual Audited financial report, prepared in whole or in part by an accountant who provides to an insurer, contemporaneously with the audit, the following non-audit services:

(a) Bookkeeping or other services related to the accounting records or financial statements of the insurer;

(b) Financial information systems design and implementation;

(c) Appraisal or valuation services, fairness opinions, or contribution-in-kind reports;

(d) Actuarially-oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer’s financial statements. An accountant’s actuary may also issue an actuarial opinion or certification (“opinion”) on an insurer’s reserves if the following conditions have been met:
Model Regulation Service

(i) Neither the accountant nor the accountant’s actuary has performed any management functions or made any management decisions;

(ii) The insurer has competent personnel (or engages a third party actuary) to estimate the reserves for which management takes responsibility; and

(iii) The accountant’s actuary tests the reasonableness of the reserves after the insurer’s management has determined the amount of the reserves;

(e) Internal audit outsourcing services;

(f) Management functions or human resources;

(g) Broker or dealer, investment adviser, or investment banking services;

(h) Legal services or expert services unrelated to the audit; or

(i) Any other services that the commissioner determines, by regulation, are impermissible.

Drafting Note: Any additions or deletions from the list of prohibited services by a state must be carefully considered as uniformity among states is essential in this section. In determining whether other services are impermissible, the commissioner shall consider utilizing the guidance provided in the SEC’s Final Rule No. 33-8183, Strengthening the Commission’s Requirements Regarding Auditor Independence adopted January 28, 2003, in order to evaluate whether the provision of such services impairs the independence of the accountant.

(2) In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three basic principles, violations of which would impair the accountant’s independence. The principles are that the accountant cannot function in the role of management, cannot audit his or her own work, and cannot serve in an advocacy role for the insurer.

H. Insurers having direct written and assumed premiums of less than $100,000,000 in any calendar year may request an exemption from Subsection G(1). The insurer shall file with the commissioner a written statement discussing the reasons why the insurer should be exempt from these provisions. If the commissioner finds, upon review of this statement, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer, an exemption may be granted.

I. A qualified independent certified public accountant who performs the audit may engage in other non-audit services, including tax services, that are not described in Subsection G(1) or that do not conflict with Subsection G(2), only if the activity is approved in advance by the Audit committee, in accordance with Subsection J.

Drafting Note: A qualified independent certified public accountant who performs the audit may also engage in other non-audit services for an insurer, including tax services, that are not described in Subsection G(1) or that do not conflict with Subsection G(2) if the Audit committee is in compliance with the SEC’s Final Rule No. 33-8183, Strengthening the Commission’s Requirements Regarding Auditor Independence adopted January 28, 2003 and has approved such activity.

J. All auditing services and non-audit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be preapproved by the Audit committee. The preapproval requirement is waived with respect to non-audit services if the insurer is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity or:

(1) The aggregate amount of all such non-audit services provided to the insurer constitutes not more than five percent (5%) of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the non-audit services are provided;
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(2) The services were not recognized by the insurer at the time of the engagement to be non-audit services; and

(3) The services are promptly brought to the attention of the Audit committee and approved prior to the completion of the audit by the Audit committee or by one or more members of the Audit committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the Audit committee.

K. The Audit committee may delegate to one or more designated members of the Audit committee the authority to grant the preapprovals required by Subsection J. The decisions of any member to whom this authority is delegated shall be presented to the full Audit committee at each of its scheduled meetings.

L. (1) The commissioner shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer, was employed by the independent certified public accountant and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due. This section shall only apply to partners and senior managers involved in the audit. An insurer may make application to the commissioner for relief from the above requirement on the basis of unusual circumstances.

(2) The insurer shall file, with its annual statement filing, the approval for relief from Subsection L(1) with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

Section 8. Consolidated or Combined Audits

An insurer may make written application to the commissioner for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies that utilizes a pooling or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer’s reserves and the insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet shall be filed with the report, as follows:

A. Amounts shown on the consolidated or combined Audited financial report shall be shown on the worksheet;

B. Amounts for each insurer subject to this section shall be stated separately;

C. Noninsurance operations may be shown on the worksheet on a combined or individual basis;

D. Explanations of consolidating and eliminating entries shall be included; and

E. A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual statements of the insurers.

Section 9. Scope of Audit and Report of Independent Certified Public Accountant

Financial statements furnished pursuant to Section 5 shall be examined by the independent certified public accountant. The audit of the insurer’s financial statements shall be conducted in accordance with generally accepted auditing standards. In accordance with AU Section 319 of the Professional Standards of the AICPA, Consideration of Internal Control in a Financial Statement Audit, the independent certified public accountant should obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU 319, for those insurers required to file a Management’s Report of Internal Control over Financial Reporting pursuant to Section 1617, the independent certified public accountant should
consider (as that term is defined in Statement on Auditing Standards (SAS) No. 102, Defining Professional Requirements in Statements on Auditing Standards or its replacement) the most recently available report in planning and performing the audit of the statutory financial statements. Consideration shall be given to the procedures illustrated in the Financial Condition Examiners Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

Section 10. Notification of Adverse Financial Condition

A. The insurer required to furnish the annual Audited financial report shall require the independent certified public accountant to report, in writing, within five (5) business days to the board of directors or its Audit committee any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the commissioner as of the balance sheet date currently under audit or that the insurer does not meet the minimum capital and surplus requirement of the [insert state] insurance code as of that date. An insurer that has received a report pursuant to this paragraph shall forward a copy of the report to the commissioner within five (5) business days of receipt of the report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the commissioner. If the independent certified public accountant fails to receive the evidence within the required five (5) business day period, the independent certified public accountant shall furnish to the commissioner a copy of its report within the next five (5) business days.

B. No independent certified public accountant shall be liable in any manner to any person for any statement made in connection with the above paragraph if the statement is made in good faith in compliance with Subsection A.

C. If the accountant, subsequent to the date of the Audited financial report filed pursuant to this regulation, becomes aware of facts that might have affected his or her report, the commissioner notes the obligation of the accountant to take such action as prescribed in Volume 1, Section AU 561 of the Professional Standards of the AICPA.

Section 11. Communication of Internal Control Related Matters Noted in an Audit

A. In addition to the annual Audited financial report, each insurer shall furnish the commissioner with a written communication as to any unremediated material weaknesses in its Internal control over financial reporting noted during the audit. Such communication shall be prepared by the accountant within sixty (60) days after the filing of the annual Audited financial report, and shall contain a description of any unremediated material weakness (as the term material weakness is defined by Statement on Auditing Standard 60, Communication of Internal Control Related Matters Noted in an Audit, or its replacement) as of December 31 immediately preceding (so as to coincide with the Audited financial report discussed in Section 4(A)) in the insurer’s Internal control over financial reporting noted by the accountant during the course of their audit of the financial statements. If no unremediated material weaknesses were noted, the communication should so state.

Drafting Note: The insurer is expected to maintain information about significant deficiencies communicated by the independent certified public accountant. Such information should be made available to the examiner conducting a financial condition examination for review and kept in such a manner as to remain confidential.

B. The insurer is required to provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if the actions are not described in the accountant’s communication.
Section 12. Accountant’s Letter of Qualifications

The accountant shall furnish the insurer in connection with, and for inclusion in, the filing of the annual Audited financial report, a letter stating:

A. That the accountant is independent with respect to the insurer and conforms to the standards of his or her profession as contained in the Code of Professional Ethics and pronouncements of the AICPA and the Rules of Professional Conduct of the [insert state] Board of Public Accountancy, or similar code;

B. The background and experience in general, and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within this regulation shall be construed as prohibiting the accountant from utilizing such staff as he or she deems appropriate where use is consistent with the standards prescribed by generally accepted auditing standards;

C. That the accountant understands the annual Audited financial report and his opinion thereon will be filed in compliance with this regulation and that the commissioner will be relying on this information in the monitoring and regulation of the financial position of insurers;

D. That the accountant consents to the requirements of Section 13 of this regulation and that the accountant consents and agrees to make available for review by the commissioner, or the commissioner’s designee or appointed agent, the workpapers, as defined in Section 13;

E. A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the AICPA; and

F. A representation that the accountant is in compliance with the requirements of Section 7 of this regulation.

Section 13. Definition, Availability and Maintenance of Independent Certified Public Accountants Work Papers

A. Work papers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the accountant’s audit of the financial statements of an insurer. Work papers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of his or her audit of the financial statements of an insurer and which support the accountant’s opinion.

B. Every insurer required to file an Audited financial report pursuant to this regulation, shall require the accountant to make available for review by insurance department examiners, all work papers prepared in the conduct of the accountant’s audit and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the insurance department or at any other reasonable place designated by the commissioner. The insurer shall require that the accountant retain the audit work papers and communications until the insurance department has filed a report on examination covering the period of the audit but no longer than seven (7) years from the date of the audit report.

C. In the conduct of the aforementioned periodic review by the insurance department examiners, it shall be agreed that photocopies of pertinent audit work papers may be made and retained by the department. Such reviews by the department examiners shall be considered investigations and all working papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination work papers generated by the department.
Section 14. Requirements for Audit Committees

This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity.

A. The Audit committee shall be directly responsible for the appointment, compensation and oversight of the work of any accountant (including resolution of disagreements between management and the accountant regarding financial reporting) for the purpose of preparing or issuing the Audited financial report or related work pursuant to this regulation. Each accountant shall report directly to the Audit committee.

B. The Audit committee of an insurer or Group of insurers shall be responsible for overseeing the insurer’s Internal audit function and granting the person or persons performing the function suitable authority and resources to fulfill their responsibilities if required by Section 15 of this Regulation.

C. Each member of the Audit committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to Subsection E-F and Section 3C.

D. In order to be considered independent for purposes of this section, a member of the Audit committee may not, other than in his or her capacity as a member of the Audit committee, the board of directors, or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof. However, if law requires board participation by otherwise non-independent members, that law shall prevail and such members may participate in the Audit committee and be designated as independent for Audit committee purposes, unless they are an officer or employee of the insurer or one of its affiliates.

E. If a member of the Audit committee ceases to be independent for reasons outside the member’s reasonable control, that person, with notice by the responsible entity to the state, may remain an Audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

Drafting Note: In determining independence, the commissioner shall consider utilizing guidance provided in the SEC’s Final Rule No. 33-8220, Standards Relating to Listed Company Audit Committees adopted April 9, 2003.

F. To exercise the election of the controlling person to designate the Audit committee for purposes of this regulation, the ultimate controlling person shall provide written notice to the commissioners of the affected insurers. Notification shall be made timely prior to the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the commissioner by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

G. (1) The Audit committee shall require the accountant that performs for an insurer any audit required by this regulation to timely report to the Audit committee in accordance with the requirements of SAS 61, Communication with Audit Committees, or its replacement, including:

(a) All significant accounting policies and material permitted practices;

(b) All material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant; and

(c) Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.
(2) If an insurer is a member of an insurance holding company system, the reports required by
Subsection FG(1) may be provided to the Audit committee on an aggregate basis for insurers in the
holding company system, provided that any substantial differences among insurers in the system
are identified to the Audit committee.

GH. The proportion of independent Audit committee members shall meet or exceed the following criteria:

<table>
<thead>
<tr>
<th>Prior Calendar Year Direct Written and Assumed Premiums</th>
<th>$0 - $300,000,000</th>
<th>Over $300,000,000 - $500,000,000</th>
<th>Over $500,000,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>No minimum requirements. See also Note A and B.</td>
<td>Majority (50% or more) of members shall be independent. See also Note A and B.</td>
<td>Supermajority of members (75% or more) shall be independent. See also Note A.</td>
<td></td>
</tr>
</tbody>
</table>

Note A: The commissioner has authority afforded by state law to require the entity’s board to enact improvements to the independence of the Audit committee membership if the insurer is in a RBC action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer.

Note B: All insurers with less than $500,000,000 in prior year direct written and assumed premiums are encouraged to structure their Audit committees with at least a supermajority of independent Audit committee members.

Note C: Prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities.

HI. An insurer with direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000 may make application to the commissioner for a waiver from the Section 14 requirements based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from Section 14 with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

Section 15. Internal Audit Function Requirements

A. Exemption – An insurer is exempt from the requirements of this section if:

1. The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000; or,

2. If the insurer is a member of a Group of insurers that has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1,000,000,000.

Note: An insurer or Group of insurers exempt from the requirements of this section is encouraged, but not required, to conduct a review of the insurer business type, sources of capital, and other risk factors to determine whether an Internal audit function is warranted. The potential benefits of an Internal audit function should be assessed and compared against the estimated costs.

B. Function – The insurer or Group of insurers shall establish an Internal audit function providing independent, objective and reasonable assurance to the Audit committee and insurer management regarding the insurer’s governance, risk management and internal controls. This assurance shall be provided by performing general
and specific audits, reviews and tests and by employing other techniques deemed necessary to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regulations.

C. Independence – In order to ensure that internal auditors remain objective, the Internal audit function must be organizationally independent. Specifically, the Internal audit function will not defer ultimate judgment on audit matters to others, and shall appoint an individual to head the Internal audit function who will have direct and unrestricted access to the board of directors. Organizational independence does not preclude dual-reporting relationships.

D. Reporting – The head of the Internal audit function shall report to the Audit committee regularly, but no less than annually, on the periodic audit plan, factors that may adversely impact the Internal audit function’s independence or effectiveness, material findings from completed audits and the appropriateness of corrective actions implemented by management as a result of audit findings.

E. Additional Requirements – If an insurer is a member of an insurance holding company system or included in a Group of insurers, the insurer may satisfy the Internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level.

Section 16. Conduct of Insurer in Connection with the Preparation of Required Reports and Documents

A. No director or officer of an insurer shall, directly or indirectly:

(1) Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication required under this regulation; or

(2) Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review or communication required under this regulation.

B. No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any accountant engaged in the performance of an audit pursuant to this regulation if that person knew or should have known that the action, if successful, could result in rendering the insurer’s financial statements materially misleading.

C. For purposes of Subsection B of this section, actions that, “if successful, could result in rendering the insurer’s financial statements materially misleading” include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead or fraudulently influence an accountant:

(1) To issue or reissue a report on an insurer’s financial statements that is not warranted in the circumstances (due to material violations of statutory accounting principles prescribed by the commissioner, generally accepted auditing standards, or other professional or regulatory standards);

(2) Not to perform audit, review or other procedures required by generally accepted auditing standards or other professional standards;

(3) Not to withdraw an issued report; or

(4) Not to communicate matters to an insurer’s Audit committee.

Drafting Note: In determining what types of sanctions or penalties could be assessed for violations of items included in Subsections A through C, each state should refer to its individual authority provided by state statutes.

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**Section 1617. Management’s Report of Internal Control over Financial Reporting**

A. Every insurer required to file an Audited financial report pursuant to this regulation that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of $500,000,000 or more shall prepare a report of the insurer’s or Group of insurers’ Internal control over financial reporting, as these terms are defined in Section 3. The report shall be filed with the commissioner along with the Communication of Internal Control Related Matters Noted in an Audit described under Section 11. Management’s Report of Internal Control over Financial Reporting shall be as of December 31 immediately preceding.

B. Notwithstanding the premium threshold in Subsection A, the commissioner may require an insurer to file Management’s Report of Internal Control over Financial Reporting if the insurer is in any RBC level event, or meets any one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in (include reference to Corrective Action statute).

C. An insurer or a Group of insurers that is

(1) directly subject to Section 404;

(2) part of a holding company system whose parent is directly subject to Section 404;

(3) not directly subject to Section 404 but is a SOX Compliant Entity; or

(4) a member of a holding company system whose parent is not directly subject to Section 404 but is a SOX Compliant Entity;

may file its or its parent’s Section 404 Report and an addendum in satisfaction of this Section 1617 requirement provided that those internal controls of the insurer or Group of insurers having a material impact on the preparation of the insurer’s or Group of insurers’ audited statutory financial statements (those items included in Section 5B through 5G of this regulation) were included in the scope of the Section 404 Report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer’s or Group of insurers’ audited statutory financial statements (those items included in Section 5B through 5G of this regulation) excluded from the Section 404 Report. If there are internal controls of the insurer or Group of insurers that have a material impact on the preparation of the insurer’s or Group of insurers’ audited statutory financial statements and those internal controls were not included in the scope of the Section 404 Report, the insurer or Group of insurers may either file (i) a Section 1617 report, or (ii) the Section 404 Report and a Section 1617 report for those internal controls that have a material impact on the preparation of the insurer’s or Group of insurers’ audited statutory financial statements not covered by the Section 404 Report.

D. Management’s Report of Internal Control over Financial Reporting shall include:

(1) A statement that management is responsible for establishing and maintaining adequate Internal control over financial reporting;

(2) A statement that management has established Internal control over financial reporting and an assertion, to the best of management’s knowledge and belief, after diligent inquiry, as to whether its Internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

(3) A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its Internal control over financial reporting; and
(4) A statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

(5) Disclosure of any unremediated material weaknesses in the Internal control over financial reporting identified by management as of December 31 immediately preceding. Management is not permitted to conclude that the Internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is one or more unremediated material weaknesses in its Internal control over financial reporting;

(6) A statement regarding the inherent limitations of internal control systems; and

(7) Signatures of the chief executive officer and the chief financial officer (or equivalent position/title).

E. Management shall document and make available upon financial condition examination the basis upon which its assertions, required in Subsection D above, are made. Management may base its assertions, in part, upon its review, monitoring and testing of internal controls undertaken in the normal course of its activities.

(1) Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost effective manner and, as such, may include assembly of or reference to existing documentation.

(2) Management’s Report on Internal Control over Financial Reporting, required by Subsection A above, and any documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the state insurance department.

Drafting Note: It is the recommendation that the company officer responsible for financial reporting would not be a member of the Audit committee and that the independent committee members would meet periodically, with no management present, with the independent certified public accountant to discuss the strengths and weaknesses of the insurer’s or Group of insurers’ internal control environments.

Section 4718. Exemptions and Effective Dates

A. Upon written application of any insurer, the commissioner may grant an exemption from compliance with any and all provisions of this regulation if the commissioner finds, upon review of the application, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten (10) days from a denial of an insurer’s written request for an exemption from this regulation, the insurer may request in writing a hearing on its application for an exemption. The hearing shall be held in accordance with the regulations of the [insert state] Department of Insurance pertaining to administrative hearing procedures.

B. Domestic insurers retaining a certified public accountant on the effective date of this regulation who qualify as independent shall comply with this regulation for the year ending December 31, 20[ ] and each year thereafter unless the commissioner permits otherwise.

C. Domestic insurers not retaining a certified public accountant on the effective date of this regulation who qualifies as independent may meet the following schedule for compliance unless the commissioner permits otherwise.

(1) As of December 31, 20[ ], file with the commissioner an Audited financial report
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(2) For the year ending December 31, 20[ ] and each year thereafter, such insurers shall file with the commissioner all reports and communication required by this regulation.

D. Foreign insurers shall comply with this regulation for the year ending December 31, 20[ ] and each year thereafter, unless the commissioner permits otherwise.

E. The requirements of Section 7D shall be in effect for audits of the year beginning January 1, 2010 and thereafter.

F. The requirements of Section 14 are to be in effect January 1, 2010. An insurer or Group of insurers that is not required to have independent Audit committee members or only a majority of independent Audit committee members (as opposed to a supermajority) because the total written and assumed premium is below the threshold and subsequently becomes subject to one of the independence requirements due to changes in premium shall have one (1) year following the year the threshold is exceeded (but not earlier than January 1, 2010) to comply with the independence requirements. Likewise, an insurer that becomes subject to one of the independence requirements as a result of a business combination shall have one (1) calendar year following the date of acquisition or combination to comply with the independence requirements.

Drafting Note: Adoption of Section 14 is assumed to occur one year prior to the effective date of Section 14.

G. The requirements of Section 14 and other modified sections [identify modified sections], except for Section 14 covered above, are effective beginning with the reporting period ending December 31, 2010 and each year thereafter. An insurer or Group of insurers that is not required to file a report because the total written premium is below the threshold and subsequently becomes subject to the reporting requirements shall have two (2) years following the year the threshold is exceeded (but not earlier than December 31, 2010) to file a report. Likewise, an insurer acquired in a business combination shall have two (2) calendar years following the date of acquisition or combination to comply with the reporting requirements.

H. The requirements of Section 15 are to be in effect January 1, 2016. If an insurer or Group of insurers that is exempt from the Section 15 requirements no longer qualifies for that exemption, it shall have one year after the year the threshold is exceeded to comply with the requirements of this article.

Section 4819. Canadian and British Companies

A. In the case of Canadian and British insurers, the annual Audited financial report shall be defined as the annual statement of total business on the form filed by such companies with their supervision authority duly audited by an independent chartered accountant.

B. For such insurers, the letter required in Section 6B shall state that the accountant is aware of the requirements relating to the annual Audited financial report filed with the commissioner pursuant to Section 4 and shall affirm that the opinion expressed is in conformity with those requirements.

Section 4920. Severability Provision

If any section or portion of a section of this regulation or its applicability to any person or circumstance is held invalid by a court, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.
Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2003 Proc. 2nd Quarter 473, 489, 491 (amended and adopted by parent committee).
REQUEST FOR MODEL LAW DEVELOPMENT

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

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

1. Name of group to be responsible for drafting the model:
   Corporate Governance (E) Working Group

2. NAIC staff support contact information:
   Bruce Jenson - bjenson@naic.org

3. Please provide a description and proposed title of the new model law. If an existing law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.
   Annual Financial Reporting Model Regulation - Propose adding a new section between existing sections 16 and 17.

4. Does the model law meet the Model Law Criteria? ☒ Yes or □ No (Check one)
   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).
   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? ☒ Yes or □ No (Check one)
      If yes, please explain why
      This model regulation currently includes a requirement for insurers to receive an annual financial statement audit as well as requirements related to the establishment of audit committees and maintenance of effective internal controls over financial reporting. The addition proposed by the Corporate Governance (E) Working Group would require large insurers (exceeding $500 million in annual premiums) to maintain an effective internal audit function capable of providing the Audit Committee independent assurance in respect of the insurer’s governance, risk management, and internal controls. The requirement for insurers to maintain an internal audit function is a significant element of the IAIS Insurance Core Principles and development of a U.S. requirement in this area was a direct recommendation of the 2009 FSAP and the 2012 EU/US Dialog.
   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?
      ☒ Yes or □ No (Check one)
5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

- ☒ 1  - ☐ 2  - ☐ 3  - ☐ 4  - ☐ 5  (Check one)

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Explanation, if necessary: The development of an internal audit requirement for this model should be straightforward and does not appear to be controversial.

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

- ☒ 1  - ☐ 2  - ☐ 3  - ☐ 4  - ☐ 5  (Check one)

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Explanation, if necessary: The proposed addition was recommended through the 2009 FSAP results and the 2012 EU/US dialog. These recommendations and the non-controversial nature of the addition should ensure a two-thirds majority vote to adopt the model revisions.

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

- ☒ 1  - ☐ 2  - ☐ 3  - ☐ 4  - ☐ 5  (Check one)

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Explanation, if necessary: This model is currently required for accreditation and this revision would likely be viewed as a significant element that would be required of states to maintain their accredited status. In addition, the significance given to this recommendation through the 2009 FSAP and 2012 EU/US Dialog process should support the uniform adoption of this revision.

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

Yes.

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

No.
PROJECT HISTORY

Internal Audit Revisions to Model #205: Annual Financial Reporting Model Regulation

1. Project Description

U.S. insurance regulators concluded that a greater regulatory focus on corporate governance is required, and formed the Corporate Governance (E) Working Group in September 2009. The Working Group received a charge to outline high-level corporate governance principles for use in U.S. insurance regulation. To do so, regulators analyzed the statutory and regulatory requirements and initiatives and best practices of the states, other countries, other regulators and the insurance industry. The Working Group was also asked to determine the appropriate method to ensure adherence with such principles, giving due consideration to development of a model law and to development of additional regulatory guidance, including detailed best practices for the corporate governance of insurers.

In completing work on this charge, regulators developed a summary of existing corporate governance requirements found within NAIC/insurance-specific sources—as well as more general, broadly based sources—to identify potential changes in the existing insurance regulatory structure that could be affected through the NAIC Solvency Modernization Initiative (SMI). The Working Group then compared those existing U.S. requirements to regulatory needs, best practices and principles outlined in the Insurance Core Principles adopted by the International Association of Insurance Supervisors (IAIS). The results of this comparative analysis indicated the need to require large insurers to maintain an effective internal audit function capable of providing the insurer’s audit committee with independent assurance in regard to the insurer’s governance, risk management and internal controls.

The Working Group determined that the best way to implement an internal audit requirement would be to place the requirement within the NAIC’s existing Annual Financial Reporting Model Regulation (#205). This model regulation currently includes a requirement for insurers to receive an annual financial statement audit, as well as requirements related to the establishment of audit committees and maintenance of effective internal controls over financial reporting.

2. Group Responsible for Drafting the Revisions

The project to review and produce revisions to Model #205 to incorporate an internal audit function requirement was given to the Corporate Governance (E) Working Group. The Working Group created an Internal Audit (E) Subgroup to develop an initial draft of the proposed revisions for the Working Group to consider. Members of the Subgroup included Virginia (chair), Connecticut, New York, Ohio and Oklahoma. After the initial draft was developed by the Subgroup, it was reviewed and revised by the Working Group, whose members included Vermont (chair), New York (vice chair), Alabama, California, Connecticut, Florida, Iowa, Indiana, Louisiana, New Hampshire, Ohio, Oklahoma, Pennsylvania, Virginia and Washington.

3. Charge Authorizing the Project

On April 8, 2013, the Financial Condition (E) Committee adopted a request for model law development to develop an internal audit function requirement as an addition to the existing Model #205. The Executive (EX) Committee and Plenary adopted this request July 26, 2013. The Financial Condition (E) Committee delegated the assignment of developing revisions to Model #205 to the Corporate Governance (E) Working Group, and drafting work began soon after the 2013 Summer National Meeting.

4. General Description of the Drafting Process and Due Process

- During September and October 2013, the Internal Audit (E) Subgroup held regulator-to-regulator conference calls to develop the initial draft of proposed revisions to Model #205.
- After finalizing an initial draft of revisions, the Subgroup referred the draft to the Corporate Governance (E) Working Group for review on a Nov. 8, 2013, conference call.
- The Working Group voted to expose the draft for a 30-day public comment period ending Dec. 6, 2013. Several comment letters were received during the exposure period suggesting a number of changes to the draft.
- The comment letters were reviewed and discussed during a meeting of the Corporate Governance (E) Working Group held Dec. 16, 2013. As a result of its discussions, the Working Group agreed to make a number of
amendments to the proposed draft and voted to re-expose the updated draft for a 45-day public comment period ending Jan. 31, 2014.

- One comment letter was received from the Pennsylvania Insurance Department during the second exposure period. Members of the Working Group discussed and agreed to accept the amendments proposed by Pennsylvania before adopting the proposed revisions as final at its March 30, 2014, meeting.

5. **Discussion of Key Issues**

Revisions were made to several sections of the existing model regulation to incorporate an internal audit function requirement for large insurers. A summary of the revisions is provided below.

i. A definition of “internal audit function” was added to the model as follows:

   **Section 3 – Definitions**

   I. “Internal audit function” means a person or persons that provide independent, objective and reasonable assurance designed to add value and improve an organization’s operations and accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

ii. Responsibilities and instructions for audit committees to follow in overseeing the internal audit function were added as follows:

   **Section 14 – Requirements for Audit Committees**

   B. The Audit committee of an insurer or group of insurers shall be responsible for overseeing the insurer’s Internal audit function and granting the person or persons performing the function suitable authority and resources to fulfill their responsibilities if required by Section 15 of this Regulation.

iii. A new section was added to the model regulation to outline the specific requirements and expectations related to the internal audit function employed by large insurers as follows:

   **Section 15 – Internal Audit Function Requirements**

   A. Exemption – An insurer is exempt from the requirements of this section if:

   (1) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000; or,

   (2) If the insurer is a member of a group of insurers that has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1,000,000,000.

   (3) An insurer or Group of insurers exempt from the requirements of this section is encouraged, but not required, to conduct a review of the insurer business type, sources of capital, and other risk factors to determine whether an Internal audit function is warranted. The potential benefits of an Internal audit function should be assessed and compared against the estimated costs.

   B. Function – The insurer or Group of insurers shall establish an Internal audit function providing independent, objective and reasonable assurance to the Audit committee and insurer management regarding the insurer’s governance, risk management and internal controls. This assurance shall be provided by performing general and specific audits, reviews and tests and by employing other techniques deemed necessary to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regulations.
C. Independence – In order to ensure that internal auditors remain objective, the Internal audit function must be organizationally independent. Specifically, the Internal audit function will not subordinate ultimate judgment on audit matters to others, and shall appoint an individual to head the Internal audit function who will have direct and unrestricted access to the board of directors. Organizational independence does not preclude dual-reporting relationships.

D. Reporting – The head of the Internal audit function shall report to the Audit committee regularly, but no less than annually, on the periodic audit plan, factors that may adversely impact the Internal audit function’s independence or effectiveness, material findings from completed audits and the appropriateness of corrective actions implemented by management as a result of audit findings.

E. Additional Requirements – If an insurer is a member of an insurance holding company system or included in a Group of insurers, the insurer may satisfy the Internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level.

iv. An effective date for the new internal audit function requirement was added to the model as follows:

Section 18 – Exemptions and Effective Dates

H. The requirements of Section 15 are to be in effect January 1, 2016. If an insurer or Group of insurers that is exempt from the Section 15 requirements no longer qualifies for that exemption, it shall have one year after the year the threshold is exceeded to comply with the requirements of this article.

6. Any Other Important Information

No other items identified at this time.
Date: 8/18/14

State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

Amendments to the Annuity Disclosure Model Regulation (#245)—Revisions were adopted by the Executive (EX) Committee and Plenary during a joint conference call held Oct. 11, 2011. At this time, approximately five states have adopted the revised model. NAIC staff will continue tracking state legislative and regulatory activities in 2014.

Amendments to the Health Insurance Reserves Model Regulation (#10) and adopted the new Actuarial Guideline—The Application of Company Experience in the Calculation of Claim Reserves under the 2012 Group Long-Term Disability Valuation Table—Revisions were adopted by the Executive (EX) Committee and Plenary during the 2014 Spring National Meeting.

Amendments to the Business Transacted with Producer Controlled Property/Casualty Insurer Act (#325)—Revisions were adopted at the 2012 Fall National Meeting to remove the exemption for risk retention groups (RRGs) from this model. The removal of the exemption from the model will allow the Part A Standards of the NAIC Financial Regulation Standards and Accreditation Program to become effective for captive RRGs, including a requirement that state enactments of a regulatory framework similar to Model #325 apply to RRGs. As the amendments affect an accreditation standard, it is expected that the states will make the necessary revisions.

Amendments to the Standard Nonforfeiture Law for Life Insurance (#808)—Through July 17, 2014, 19 states have adopted the model revisions. Eighteen of those states have also adopted the Standard Valuation Law (#820).

Amendments to the NAIC Model Rule (Regulation) for Recognizing a New Annuity Mortality Table for Use in Determining Reserve Liabilities for Annuities (#821)—Revisions were adopted by the Executive (EX) Committee and Plenary during the 2012 Fall National Meeting. This model has been adopted in nine states. Thirteen states have indicated their intention to adopt Model #821 in 2014, with a Jan. 1, 2015, effective date.

Individual Market Health Insurance Coverage Model Act (#36)—(falls under the September 2008 federal law exemption to the Executive (EX) Committee approval requirement)—This model was adopted by the Executive (EX) Committee and Plenary at the 2013 Spring National Meeting. At this time, it appears that approximately 14 states have enacted laws consistent with the provisions of the model. NAIC staff will continue to track state adoption for the remainder of 2014.

Amendments to the Health Carrier Grievance Procedure Model Act (#72)—(falls under the September 2008 federal law exemption to the Executive (EX) Committee approval requirement)—This model was revised for consistency with Section 2719 of the Public Health Service Act (PHSA) of the federal Affordable Care Act (ACA) and the interim final regulations published in the Federal Register July 23, 2010, implementing that section. Section 2719 of the PHSA sets out requirements that health carriers must follow for the internal review of adverse benefit determinations. Section 2719 was effective Sept. 23, 2010. NAIC staff are not actively tracking state adoption because, in order for a state to have the authority to enforce this provision of federal law against health insurance issuers in the state, the state must include this provision or something substantially similar in its law or regulations. As such, it is anticipated that most of the states will be enacting legislation or revising existing regulations for consistency with the federal law. The Regulatory Framework (B) Task Force revised this model to reflect the amendments made to the July 23, 2010, interim final rules, as published in the Federal Register June 24, 2011. Those revisions were adopted by the Health Insurance and Managed Care (B) Committee at the 2011 Fall National Meeting and adopted by the Executive (EX) Committee and Plenary at the 2012 Spring National Meeting.

Amendments to the Utilization Review and Benefit Determination Model Act (#73)—(falls under the September 2008 federal law exemption to the Executive (EX) Committee approval requirement)—This model was revised for consistency with Section 2719 of the PHSA of the ACA and the interim final regulations published in the Federal Register July 23, 2010, implementing that section. Section 2719 sets out requirements that health carriers must follow for the internal review of adverse benefit determinations. Section 2719 was effective Sept. 23, 2010. NAIC staff are not actively tracking state adoption because, in order for a state to have the authority to enforce this provision of federal law against health insurance issuers in the state, the state must include this provision or something substantially similar in its law or regulations. As such, it is anticipated that most states will be enacting legislation or revising existing regulations for consistency with the federal law. The Regulatory Framework (B) Task Force revised this model to reflect the amendments made to the July 23, 2010, interim final rules, as published in the Federal Register June 24, 2011. Those revisions were adopted by the Health Insurance and
Managed Care (B) Committee at the 2011 Fall National Meeting and adopted by the Executive (EX) Committee and Plenary at the 2012 Spring National Meeting.

**Small Group Market Health Insurance Coverage Model Act (#106)—** (falls under the September 2008 federal law exemption to the Executive (EX) Committee approval requirement)—This model was adopted by the Executive (EX) Committee and Plenary at the 2013 Spring National Meeting. At this time, it appears that approximately 14 states have enacted laws consistent with the provisions of this model. NAIC staff will continue to track state adoption for the remainder of 2014.

**Amendments to the Coordination of Benefits Model Regulation (#120)—** The revisions to Section 3 and Section 6 of this model were adopted by the Executive (EX) Committee and Plenary at the 2013 Summer National Meeting. At this time, it appears that no states have adopted the revisions. NAIC staff will continue to track state adoption for the remainder of 2014.

**Amendments to the Risk-Based Capital (RBC) for Insurers Model Act (#312)—** NAIC staff surveyed member jurisdictions in summer 2014 to gather information regarding plans to adopt the model revisions. Forty-four jurisdictions responded to the survey. Based on the survey results, 32 jurisdictions have already adopted the revisions and six jurisdictions intend to adopt the revisions, one of which intends to adopt the revisions with changes. Five jurisdictions are undecided and one jurisdiction does not intend to adopt the revisions.

**Risk Management and Own Risk and Solvency Assessment (ORSA) Model Act (#505)—** NAIC staff surveyed member jurisdictions in summer 2014 to gather information regarding plans to adopt this model. Forty-four jurisdictions responded to the survey. Based on the survey results, 15 jurisdictions have already adopted the model, 15 jurisdictions intend to adopt the model and one jurisdiction intends to adopt the model with revisions. Thirteen jurisdictions are undecided.

**Amendments to the Model Risk Retention Act (#705)—** Amendments to this model were adopted at the 2011 Fall National Meeting. The revisions were made in order to incorporate corporate governance standards into this model, with the expectation that they will be accreditation standards. The Financial Regulation Standards and Accreditation (F) Committee is currently considering the corporate governance standards that were added to this model as accreditation standards. It is expected that the Financial Regulation Standards and Accreditation (F) Committee will vote on these standards in 2014. In order to give the states time to enact the law, the standard becomes effective two years after the final determination (i.e., Jan. 1, 2017). To date, it is not believed that many of the states have amended this model. It is expected that the adoption of these amendments will pick up as the movement toward becoming accreditation standards progresses.

**Amendments to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786)—** NAIC staff surveyed member jurisdictions in summer 2014 to gather information regarding plans to adopt the model revisions. Based on the survey results, 19 jurisdictions have already adopted the model revisions and nine jurisdictions intend to adopt the revisions, three of which intend to adopt the revisions with changes. Fifteen jurisdictions are undecided and three jurisdictions do not intend to adopt the revisions.