The Executive (EX) Committee and Plenary met in Laguna Beach, CA, Feb. 8, 2015. The following members participated: Monica J. Lindeen, Chair (MT); Sharon P. Clark, Vice President (KY); Ted Nickel, Secretary-Treasurer (WI); Adam Hamm, Immediate Past President (ND); James J. Donelon, Past President (LA); Kevin M. McCarty, Past President (FL); Roger A. Sevigny, Past President represented by Barbara Richardson (NH); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Allen W. Kerr (AR); Tau Tanuvasa (AS); Germaine L. Marks (AZ); Dave Jones (CA); Marguerite Salazar (CO); Anne Melissa Dowling (CT); Chester A. McPherson (DC); Karen Weldin Stewart (DE); Ralph T. Hudgens (GA); Artemio B. Ilagan (GU); Gordon I. Ito (HI); Nick Gerhart (IA); Tom Donovan represented by Gina McBride (ID); Stephen W. Robertson (IN); Ken Selzer (KS); Gary Anderson (MA); Al Redmer Jr. represented by Nancy Grodin (MD); Eric A. Cioppa (ME); Annette E. Flood (MI); Mike Rothman (MN); John M. Huff (MO); Mark O. Rabauliman (MP); Mike Chaney represented by Mark Haire (MS); Wayne Goodwin (NC); Bruce R. Ramge represented by Christy Neighbors (NE); Kenneth E. Kobylowski represented by Peter L. Hartt (NJ); John G. Franchini (NM); Scott J. Kipper (NV); Benjamin M. Lawsky represented by Robert Easton (NY); Mary Taylor (OH); John D. Doak (OK); Laura N. Cali (OR); Teresa D. Miller (PA); Angela Weyne (PR); Joseph Torti III (RI); Raymond G. Farmer (SC); Larry Deiter (SD); Julie Mix McPeak (TN); David Mattax represented by Danny Saenz (TX); Todd E. Kiser (UT); Jacqueline K. Cunningham (VA); Osbert Potter (VI); Susan L. Donegan (VT); Mike Kreidler (WA); Michael D. Riley (WV); and Tom Glause (WY).

1. **Elected NAIC President-Elect**

Michael F. Consedine resigned effective Jan. 20 as NAIC President-Elect and Pennsylvania Insurance Commissioner. An interim election was held Feb. 8, in which Director Huff (MO) was elected President-Elect to serve from Feb. 8 – Dec. 31.

Having no further business, the Executive (EX) Committee and Plenary adjourned.
Draft Pending Adoption
Attachment Two
Executive (EX) Committee and Plenary
3/31/15

Executive (EX) Committee and Plenary
Conference Call
December 16, 2014

The Executive (EX) Committee and Plenary met in joint session via conference call, Dec. 16, 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 (FL); Sandy Praeger, Past President (KS); Roger A. Sevigny, Past President (NH); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Jay Bradford represented by Mel Anderson (AR); Germaine L. Marks represented by Darren Ellingson (AZ); Dave Jones (CA); Anne Melissa Dowling (CT); Chester A. McPherson (DC); Karen Weldin Stewart (DE); Ralph T. Hudgens (GA); Gordon I. Ito (HI); Nick Gerhart represented by Jim Mumford (IA); William W. Deal represented by Tom Donovan (ID); Stephen W. Robertson (IN); Gary Anderson (MA); Therese M. Goldsmith represented by Michele Oshman (MD); Eric A. Cioppa (ME); Annette F. Flood (MI); Mike Rothman (MN); John M. Huff (MO); Mike Shaney (MS); Bruce R. Ramge (NE); Kenneth E. Kobylowski represented by Christopher Hughes (NJ); Scott J. Kimper (NV); Benjamin M. Lawsky represented by Robert Easton (NY); Mary Taylor (OH); John D. Doak (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 represented by John McDonald (VI); Susan L. Donegan (VT); Mike Kreidler (WA); Ted Nickel (WI); and Michael D. Riley (WV).

2. **Adopted the Individual Market Health Insurance Coverage Model Regulation**

Commissioner Praeger reported that the Regulatory Framework (B) Task Force began drafting the Individual Market Health Insurance Model Regulation in 2013 as a companion model regulation to the Individual Market Health Insurance Coverage Model Act (#36). This model regulation is based on the provisions of various federal regulations implementing the federal Affordable Care Act’s (ACA) 2014 market reforms such as: guaranteed availability; guaranteed renewability; rating restrictions; prohibition on preexisting condition exclusion provisions; and summary of benefits and coverage information requirements.

The Task Force adopted the model regulation Nov. 16 and presented it to the Health Insurance and Managed Care (B) Committee for its consideration Nov. 17, where it was adopted.

Commissioner Praeger made a motion, seconded by Commissioner Stewart, to adopt the Individual Market Health Insurance Coverage Model Regulation (Attachment A). The motion passed.

3. **Adopted the Small Group Market Health Insurance Coverage Model Regulation**

Commissioner Praeger reported that the Small Group Market Health Insurance Coverage Model Regulation was also adopted by the Regulatory Framework (B) Task Force Nov. 16. The Health Insurance and Managed Care (B) Committee adopted this model Nov. 17.

The Small Group Market Health Insurance Coverage Model Regulation was developed as a companion to the Small Group Market Health Insurance Coverage Model Act (#106). This model regulation is derived from federal regulations implementing the ACA’s 2014 market reform provisions.

Commissioner Praeger made a motion, seconded by Commissioner Stewart, to adopt the Small Group Market Health Insurance Coverage Model Regulation (Attachment B). The motion passed.

4. **Adopted Revisions to Model #440**

Superintendent Torti presented the revised Insurance Holding Company System Regulatory Act (#440), which is the result of the work performed by the Group Solvency Issues (E) Working Group in response to a charge of the Financial Condition (E) Committee to “… consider amendments to address issues that have arisen subsequent to the adoption of the [Insurance
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Holding Company System Regulatory Act (#440) and [Holding Company System Model] Regulation (#450) by the NAIC in 2010."

One recommended amendment to the model was the need for a clear legal authority to act as the group-wide supervisor for an internationally active insurance group (IAIG). The Group Solvency Issues (E) Working Group then directed NAIC staff to incorporate relevant language from the Pennsylvania holding company statute into the draft revised model act. This draft was exposed for comment, and the Working Group held a series of four conference calls to consider comments. During the 2014 Fall National Meeting, the Working Group received and discussed additional comments that narrowed the scope of outstanding issues. Each of those outstanding issues was resolved during the Working Group’s Dec. 3 conference call, when the proposed changes to the model act were approved.

These changes include: 1) authorizing the commissioner to determine if he or she should act as group-wide supervisor or acknowledge another regulator as group-wide supervisor for a defined class of IAIGs and other groups that request the commissioner to make such a determination or acknowledgement; 2) providing factors for determining a single group-wide supervisor based on concepts used in determining the lead state for domestic insurance groups; 3) setting out the activities the commissioner may engage in as group-wide supervisor; and 4) extending existing confidentiality protections to cover information received in the course of group-wide supervision.

Superintendent Torti made a motion, seconded by Commissioner Stewart, to adopt revisions to Model #440 (Attachment C). The motion passed.

5. Adopted AG 48

Superintendent Torti presented for consideration a proposed new Actuarial Guideline (AG) 48 – Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation, which is the result of the work of the Life Actuarial (A) Task Force and the NAIC’s consultant, Rector & Associates. AG 48, along with two previously adopted components of the XXX/AXXX Reinsurance Framework, would become effective in 2015. As a reminder, the two components already adopted are the new reporting supplement to the annual statement to provide greater transparency pertaining to XXX/AXXX reinsurance transactions, and revised financial analysis procedures to allow states to improve their regulatory review of these transactions.

Superintendent Torti stated that AG 48 does not prohibit XXX/AXXX captive reinsurance transactions but instead establishes consistent, national standards regarding those transactions, including securing a portion of the insurer’s statutory reserve, approximately equal to principle-based reserving, with high-quality, “traditional” assets. The remaining portion of the insurer’s statutory reserve may be backed by other forms of security, but only as approved by the ceding insurer’s domiciliary regulator. AG 48 does not apply to XXX/AXXX policies issued prior to Jan. 1, 2015, if those policies are part of a captive reserve financing arrangement when AG 48 takes effect.

AG 48 uses the ceding insurer’s opinining actuary to analyze whether the insurer has complied with the standards. A remediation period is provided to allow the company to correct any noncompliance issues. Any remaining noncompliance will result in the opinining actuary issuing a qualified actuarial opinion reflecting, in part, the risk posed by the noncompliant transaction. Although outside of AG 48’s scope, another response to noncompliance will be provided in the ceding insurer’s RBC.

Additional work related to the Framework anticipated to be completed in 2015 are a new note in the financial statement and new charges in RBC. The longer term work is the development of a new Credit for Reinsurance model regulation pertaining specifically to XXX/AXXX reinsurance transactions and an amendment to the Credit for Reinsurance Model Act (#785) to recognize the new regulation.

Superintendent Torti made a motion, seconded by Commissioner Rathgeber, to adopt AG 48 (Attachment D). The motion passed, with Delaware and New York voting against the motion. Minnesota abstained.
6. **Adopted SSAP No. 107**

Superintendent Torti reported the proposed new *Statement of Statutory Accounting Principles (SSAP) 107—Accounting for the Risk-Sharing Provisions of the Affordable Care Act (ACA)* was developed by the Statutory Accounting Principles (E) Working Group to establish appropriate regulatory accounting for the 3Rs: risk adjustment, risk corridors and reinsurance. The 3Rs are risk transfer and spreading mechanisms from the ACA to help insurers provide price stabilization due to the potential for adverse selection. Risk adjustment is currently the only permanent mechanism, as risk corridors and reinsurance will not be assessed after 2016. The SSAP would be effective for Q4 2014 and beyond.

The proposed accounting is not significantly different from interpretation (INT) 13-04, which was adopted early in 2014 as a transitional measure and which treats amounts that are solely assessments as taxes, licenses and fees.

Superintendent Torti made a motion, seconded by Commissioner Stewart, to adopt SSAP No. 107 (Attachment E). The motion passed.

7. **Approved as Qualified Jurisdictions Seven Non-U.S. Reinsurance Supervisory Authorities under the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions**

Director Huff reported that in order for a non-U.S. reinsurer to be eligible as a certified reinsurer under the 2011 revisions to the *Credit for Reinsurance Model Act (#785)* and *Credit for Reinsurance Model Regulation (#786)*, it must be licensed and domiciled in a qualified jurisdiction." On Dec. 11, the Reinsurance (E) Task Force recommended that the NAIC approve seven reinsurance supervisory authorities as qualified jurisdictions and add them to the *NAIC List of Qualified Jurisdictions* for a 5-year period beginning Jan. 1, 2015. They are: 1) Bermuda (BMA); 2) Central Bank of Ireland; 3) France (ACPR); 4) Germany (BaFin); 5) Japan (FSA); 6) Switzerland (FINMA); and 7) the United Kingdom (PRA).

Director Huff briefly summarized the process by which the Qualified Jurisdiction (E) Working Group evaluated each jurisdiction. The Working Group performed an initial evaluation of each jurisdiction’s regulatory system by using the information identified in Sections A through G of the Evaluation Methodology of the Qualified Jurisdiction Process. This included a review of each jurisdiction’s most recent International Monetary Fund (IMF)/World Bank Financial Sector (FSAP) report, the Report on Observance for Standards and Codes (ROSC), and the European Insurance and Occupational Pensions Authority (EIOPA) Solvency II Equivalency Assessment, where applicable, as well as other publicly available information regarding the reinsurance laws, regulations, practices and procedures applicable for each jurisdiction. The Working Group invited each jurisdiction to provide information to update the publicly available information, and also notified both the Federal Insurance Office (FIO) and the United States Trade Representative (USTR) of these reviews.

The NAIC staff’s initial review and findings with respect to each jurisdiction were reviewed by the Working Group in a series of eight meetings between September and November 2014. Following these meetings, the Working Group issued a *Preliminary Evaluation Report* to each jurisdiction containing its initial findings and preliminary recommendation. After giving each jurisdiction an opportunity to respond to this report, the Working Group issued its *Final Evaluation Report* and a *Summary of Findings and Determination* related to each jurisdiction and released it for public comment. One comment letter was received recommending approval of each of the seven as qualified jurisdictions.

Each *Summary of Findings and Determination* outlines the procedural history of the evaluation, along with the materials that were reviewed. Each report provides a recommendation with respect to each jurisdiction reviewed, along with any specific issues or limitations that were noted. For example, with respect to Bermuda, the Working Group is recommending that its approval be limited to reinsurers of Class 3A, Class 3B and Class 4, and long-term insurers of Class C, Class D and Class E.

The Qualified Jurisdiction Process allows this matter to be sent directly to the Executive (EX) Committee and Plenary for approval. This approval would be valid for five years (absent a material change in circumstances), after which each jurisdiction would be subject to re-evaluation under the provisions of the Qualified Jurisdiction Process.

Director Huff made a motion, seconded by Commissioner Stewart, to approve the *Summary of Findings and Determinations* with respect to each of the seven jurisdictions and place them on the *NAIC List of Qualified Jurisdictions* effective Jan. 1, 2015 (Attachment F). The motion passed.
Having no further business, the Executive (EX) Committee and Plenary adjourned.

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Amendments as adopted by the Financial Condition (E) Committee, except where noted.

FINANCIAL CONDITION (E) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

1. The **Financial Condition (E) Committee** will:
   - 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
   - Appoint and oversee the activities of the following: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Examination Oversight (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention Group (E) Task Force; and Valuation of Securities (E) Task Force.—Essential
   - 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.—Important
   - 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
   - Utilize the Risk-Focused Surveillance (E) Working Group to address specific industry concerns regarding regulatory redundancy, and review any issues industry subsequently escalates to the Committee.—Essential

2. The **Emerging Actuarial Issues (E) Working Group** will:
   - Work expeditiously to provide timely guidance for companies seeking to comply with the revisions to Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation (AG 38).—Essential
   - Consider questions presented by state regulators and companies with respect to requirements under AG 38, and provide timely guidance after an appropriate public process permitting an abbreviated review and comment period. Such guidance will become effective upon its adoption by the Financial Condition (E) Committee.—Essential
FINANCIAL CONDITION (E) COMMITTEE (Continued)

3. The Financial Analysis (E) Working Group will:
   • Analyze nationally significant insurers and groups that exhibit characteristics of trending toward or being financially troubled; determine if appropriate action is being taken.—Essential
   • Interact with domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods and action(s).—Essential
   • Support, encourage, promote and coordinate multi-state efforts in addressing solvency problems, including identifying adverse industry trends, including coordination and consultation with the International Association of Insurance Supervisors (IAIS) Supervisory Forum.—Essential
   • Increase information-sharing and coordination between state regulators and federal authorities, including through representation of state regulators in national bodies with responsibilities for system-wide oversight.—Essential
   • Contribute the perspective and expertise of the Working Group via the chair, or his/her representative, to the development of NAIC regulatory guidance for any security under review by the Invested Assets (E) Working Group of the Valuation of Securities (E) Task Force. (Upon notice that a class of securities has been placed under regulatory review, the chair of Financial Analysis (E) Working Group, or his/her representative, will be deemed a member of the Invested Assets (E) Working Group.)—Essential

4. 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 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 (ComFrame) 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 Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation (#450) and consider amendments to address issues that have arisen subsequent to the adoption of Model #440 and Model #450 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
   • 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 Model #440 and Model #450.—Important
   • Begin to develop an enterprise risk management (ERM) education program for regulators that is designed to maximize the benefit of such training for the ORSA 2015 effective date.—Essential
   • Finalize the ORSA Pilot Project that began in 2014 and complete applicable outputs from the project, including a report to Financial Condition (E) Committee.—Essential
Amendments as adopted by the Financial Condition (E) Committee, except where noted.

FINANCIAL CONDITION (E) COMMITTEE (Continued)

5. The **Health Reform Solvency Impact (E) Subgroup** will:
   - Monitor and assess the solvency impacts/concerns for health insurers as a result of the federal Affordable Care Act (ACA) and recommend charges for the appropriate Financial Condition (E) Committee groups to address these impacts/concerns.—**Essential**

6. The **Health Reform Exam (E) Technical Group** of the Health Reform Solvency Impact (E) Subgroup will:
   - Monitor and update the examiners role in reviewing the medical loss ratio reported by insurers to the U.S. Department of Health and Human Services (HHS). Also work with HHS to update standard examination procedures surrounding the review and reporting of the medical loss ratio.—**Essential**

7. The **Mortgage Guaranty Insurance (E) Working Group** will:
   - Develop changes to the *Mortgage Guaranty Insurers Model Act* (#630) and other areas of solvency regulation of mortgage guaranty insurers.—**Essential**

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

*The following charge is pending adoption by the Financial Condition (E) Committee at Spring National Meeting.*

9. The **Variable Annuities Issues (E) Working Group** will:
   - Oversee the NAIC’s efforts to study and address, as appropriate, regulatory issues resulting in variable annuity captive reinsurance transactions.
FINANCIAL CONDITION (E) COMMITTEE (Continued)

9.10. The National Treatment and Coordination (E) Working Group will:

- Increase utilization and implementation of the Company Licensing Best Practices Handbook.—Essential
- In collaboration with the Speed to Market (EX) Task Force, encourage synergies between corporate changes/amendments and rate and form filing review and approval to improve efficiency.—Important
- Analyze federal law development and the NAIC Solvency Modernization Initiative (SMI) for any needed modifications or revisions to the work of the Working Group.—Essential
- Address the future work items identified in the completion of the Company Licensing Best Practices Handbook project.—Important
- In collaboration with the Corporate Governance (E) Working Group, encourage uniformity of requirements in relation to individuals’ fitness and propriety and the company’s responsibility in notifying state insurance departments of concerns or changes to key individuals. Define “key individuals.”—Essential
- In collaboration with the Group Solvency Issues (E) Working Group, develop procedures to implement a consolidated public hearing for acquisitions involving multiple jurisdictions under the Insurance Holding Company System Regulatory Act (#440) and update the Form A Database.—Essential

10.11. The Biographical Third-Party Review (E) Subgroup of the National Treatment and Coordination (E) Working Group will:

- Increase the uniformity of the third-party vendors that prepare background investigative reports to those state insurance departments that require them. Reduce the inefficiency of applications by developing procedures and approval processes.—Essential
- Monitor the ongoing adherence of background investigation reports and third-party vendors.—Essential
- Encourage uniformity of requirements in relation to individuals’ fitness and propriety and the company’s responsibility in notifying state insurance departments of concerns or changes to key individuals.—Essential

11.12. The Company Licensing Transactions (E) Subgroup of the National Treatment and Coordination (E) Working Group will:

- Continue to reduce state-specific requirements, including the need for hardcopies and the forms and supplemental information involved in Uniform Certificate of Authority Application (UCAA), and to streamline the application process.—Essential
- Continue to enhance all electronic tools relating to UCAA to increase user-friendliness, accuracy and utility, and to increase its usage by the industry and regulators.—Essential

12.13. The Private Equity Issues (E) Working Group will:

- Consider development of procedures that regulators can use when considering ways to mitigate or monitor risks associated with private equity/hedge fund ownership or control of insurance company assets, including the development of best practices and consideration of possible changes in NAIC policy positions as deemed appropriate.—Essential
Amendments as adopted by the Financial Condition (E) Committee, except where noted.

FINANCIAL CONDITION (E) COMMITTEE (Continued)

14.14. 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
   - Consider specific regulatory redundancy issues provided by interested parties and provide recommendations to other NAIC committee groups as needed.—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 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
   - Identify and document the regulatory skillsets necessary to effectively monitor the solvency of insurers under an evolving risk-focused surveillance framework.—Essential
   - 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

15. The Risk-Limiting Contracts (E) Working Group will:
   - Develop regulatory guidance on how to evaluate risk transfer as it pertains to reinsurance contracts with risk limiting features and also evaluate how current actuarial/accounting practices used to monitor a company’s financial strength need to be enhanced due to distortions from these contracts.

14.16. The Separate Account Risk (E) Working Group will:
   - Study the need to modify existing regulatory guidance related to separate accounts where in recent years various products and contract benefits have increased the risk to the general account. At the conclusion of such study, provide a recommendation to the Financial Condition (E) Committee, including a request for model law development/change if the recommendation is for the NAIC to devote its resources to such an effort.—Important

15.17. The Surplus Lines Financial Analysis (E) Working Group will:
   - Provide NAIC/International Insurers Department (IID) financial staff guidance and expertise relative to regulatory policy and practices with respect to individual companies and Lloyd’s syndicates that are either listed on or seeking admission to the Quarterly Listing of Alien Insurers.—Essential and Ongoing
   - Refer suggestions to the IID Plan of Operation (C) Review Group regarding the IID Plan of Operation and its requirements relating to standards for inclusion on the Quarterly Listing of Alien Insurers. Additionally, refer suggestions for improvements for the IID annual reporting standards and forms. —Essential

NAIC Support Staff: Todd Sells
ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Accounting Practices and Procedures (E) Task Force will:
   • Oversee the activities of the Blanks (E) Working Group, the Emerging Accounting Issues (E) Working Group and the Statutory Accounting Principles (E) Working Group.—Essential

2. The Blanks (E) Working Group will:
   • Consider improvements and revisions to the various annual/quarterly statement blanks to: 1) conform these blanks to changes made in other areas of the NAIC to promote uniformity in reporting of financial information by insurers; 2) develop reporting formats for other entities subject to the jurisdiction of state insurance departments; 3) conform the various NAIC blanks and instructions to adopted NAIC policy; and 4) oversee the development of additional reporting formats within the existing annual financial statements as needs are identified.—Essential and Ongoing
   • Continue to monitor state filing checklists to maintain current filing requirements.—Essential and Ongoing
   • Continue to monitor and improve the quality of financial data filed by insurance companies by recommending improved or additional language for the Annual Statement Instructions.—Essential and Ongoing
   • Continue to monitor and review all proposals necessary for the implementation of statutory accounting guidance to ensure proper implementation of any action taken by the Accounting Practices and Procedures (E) Task Force affecting annual financial statements and/or instructions.—Essential and Ongoing
   • Continue to coordinate with other task forces of the NAIC to ensure proper implementation of reporting and instructions changes as proposed by these task forces.—Essential and Ongoing
   • When a class of securities is being reviewed by the Invested Assets (E) Working Group, the chair of Blanks (E) Working Group, or his/her representative, will be deemed a member of the Invested Assets (E) Working Group of the Valuation of Securities (E) Task Force. The chair, or his/her representative, is charged with contributing the applicable perspective and expertise of the regulatory group to the development of NAIC regulatory guidance for the security under review by the Invested Assets (E) Working Group.—Essential and Ongoing
   • Adjust blanks and instructions to develop principle-based reserving (PBR) reporting under the framework developed by the PBR Review (EX) Working Group.—Essential
   • Coordinate with the Life Actuarial (A) Task Force to utilize any special reports developed and avoid duplication of reporting.—Essential
ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE (Continued)

3. The **Investment Reporting (E) Subgroup** of the Blanks (E) Working Group will:
   - Review requests for investment schedule blanks and instructions changes in connection with the work being performed by the Investment Risk-Based Capital (E) Working Group. The Subgroup will review for technical changes and/or clarifications to the blanks and instructions.—**Essential and Ongoing**
   - Review changes requested by other NAIC groups, including, but not limited to, the Valuation of Securities (E) Task Force, the Statutory Accounting Principles (E) Working Group and the Invested Asset (E) Working Group as it relates to their work on other invested assets reporting for technical consistency within the investment reporting schedules and instructions. **This includes requests by interested parties for reporting instruction clarifications.**—**Essential and Ongoing**

4. The **Emerging Accounting Issues (E) Working Group** will:
   - Provide authoritative guidance on current statutory accounting issues, generally relating to application, interpretation and clarification of existing statutory accounting principles, by conducting meetings at NAIC national meeting sites and other meetings and conference calls when necessary.—**Essential and Ongoing**
   - Evaluate individual statutory accounting issues based on its established timeline and report its findings to the Accounting Practices and Procedures (E) Task Force.—**Essential and Ongoing**

5. The **Statutory Accounting Principles (E) Working Group** will:
   - Maintain codified statutory accounting principles by providing periodic updates to the guidance that address new statutory issues and new GAAP pronouncements as they develop.—**Essential and Ongoing**
   - At the discretion of the chair, comment on exposed GAAP pronouncements affecting financial accounting and reporting.—**Essential**
   - Report its findings relative to these developing issues to the Accounting Practices and Procedures (E) Task Force.—**Essential**
   - When a class of securities is being reviewed by the Invested Assets (E) Working Group, the chair of Statutory Accounting Principles Working Group, or his or her representative, will be deemed a member of the Invested Assets (E) Working Group of the Valuation of Securities (E) Task Force. The chair, or his or her representative, is charged with contributing the applicable perspective and expertise of the regulatory group to the development of NAIC regulatory guidance for the security under review by the Invested Assets (E) Working Group.—**Essential**
   - Provide comments on issues related to evaluating and or implementing to International Financial Reporting Standards (IFRS) for possible U.S. statutory accounting use and provide input on the solvency modernization project as it relates to accounting and reporting issues.—**Essential and Ongoing**
   - Coordinate with the Life Actuarial (A) Task Force on changes to the Accounting Practices and Procedures Manual related to the Valuation Manual VM-A, Requirements, and VM-C, Actuarial Guidelines, and other valuation manual requirements. This process will include the receipt of periodic reports on changes to the valuation manual on items that require coordination as well as the development of an accounting mechanism to address reserve volatility.—**Essential and Ongoing**
   - Develop the proposed definition for “Primary Security” for use in the Principle-Based Reserving Implementation (EX) Task Force’s future consideration of a proposed XXX/AXXX Reinsurance Model Regulation.—**Essential**
   - Develop a Note to the Audited Financial Statements regarding compliance with the XXX/AXXX Reinsurance Model Regulation—**Essential**

Amendments as adopted by the Financial Condition (E) Committee, except where noted.
6. The **Restricted Asset (E) Subgroup** of the Statutory Accounting Principles (E) Working Group will:
   - Address issues related to assets that are pledged or restricted, which include, but are not limited to: repurchase/reverse repurchase agreements and tri-party repurchase agreements, qualified financial contracts, Federal Home Loan Bank (FHLB) transactions and assets held under reinsurance trusts.

   —*Essential*

NAIC Support Staff: Robin Marcotte
EXAMINATION OVERSIGHT (E) TASK FORCE

The mission of the Examination Oversight (E) Task Force is to monitor all aspects of the financial examination process and to identify, investigate and develop solutions to problems related to financial examinations; to monitor and refine the IRIS ratios and the Financial Analysis Solvency Tools, including Company Profiles, FAST ratio scoring system and the Financial Analysis Handbook; to oversee the Analyst Team Project; to review details of examination surveillance process; to monitor the development of tests for determining when a financial examination of an insurer is necessary; to establish procedures for flow of information between states about troubled companies; to enhance the quality and timeliness of financial examinations and monitor additions to the Financial Condition Examiners Handbook covering this area; and to monitor the examination schedules in various states and assist the states in developing methods to maintain current schedules.

Ongoing Support of NAIC Programs, Products or Services

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
   - 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

2. The Analyst Team System Oversight (E) Working Group will:
   - Monitor the work performed by the Analyst Team and the progress of any changes made to the Analyst Team Project.—Essential

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

4. The Financial Analysis Handbook (E) Working Group will:
   - Provide ongoing maintenance and enhancements to the Financial Analysis Handbook and related applications for changes to the NAIC annual/quarterly financial statement blanks, as well as coordinate and analyze input received from other state regulators.—Essential
   - Continue to incorporate the assessment of risk and risk management into the financial analysis oversight role and incorporate guidance into the Financial Analysis Handbooks to assist analysts in reviewing Own Risk and Solvency Assessment (ORSA) Summary Reports.—Essential
   - In compliance with the framework developed by the PBR Review (EX) Working Group:
     - Provide advice to regulators, identifying and judging risk, establishing Level 1 and Level 2 procedures, identifying frequency of model reviews, and documenting some best practices. Address all risks, financial and non-financial (e.g., ERM, board, corporate governance and ORSA).—Important
     - Adjust the Financial Analysis Handbook to develop principle-based reserving (PBR) changes.—Important
   - Continue incorporating enhancements that encourage coordination of analysis activities within holding company groups.—Essential
EXAMINATION OVERSIGHT (E) TASK FORCE (Continued)

5. The Financial Analysis Research and Development (E) Working Group will:
   • Provide ongoing maintenance and enhancements to the automated financial solvency tools developed to assist in monitoring the financial condition of insurance companies. Prioritize analysis and examination efforts to help ensure that the tools remain reliable and accurate.—Essential
   • Review current financial analysis solvency tools for life insurance companies for consideration of risk with reserve liabilities as affected by principle-based reserving standards; make appropriate enhancements as necessary.—Important

6. The Financial Examiners Coordination (E) Working Group will:
   • Develop enhancements that encourage coordination of examination activities with regard to holding company groups.—Essential
   • Promote coordination by assisting and advising domiciliary regulators and exam coordinating states as to what might be the most appropriate regulatory strategies, methods and actions regarding financial examinations of holding company groups.—Essential
   • Provide ongoing maintenance and enhancements to the Financial Examination Electronic Tracking System (FEETS). The Working Group also will provide reports to the Examination Oversight (E) Task Force regarding usage of ETS, including examination and coordination statistics.—Essential

7. The Financial Examiners Handbook (E) Technical Group will:
   • Continue incorporating the assessment of risk and risk management into the financial solvency oversight role and maintain guidance in the Financial Condition Examiners Handbook to assist examiners in reviewing Own Risk and Solvency Assessment (ORSA) Summary Reports.—Essential
   • Continually review the Financial Condition Examiners Handbook and revise, as appropriate.—Essential
   • Review annually the examination procedures included within the Financial Condition Examiners Handbook for updates in response to revisions to the Accounting Practices and Procedures Manual. —Essential
   • Continually review the Annual Financial Reporting Model Regulation (#205) and its related Implementation Guide and revise the Financial Condition Examiners Handbook, as appropriate. —Essential
   • Coordinate with the Risk-Focused Surveillance (E) Working Group to monitor the implementation of the risk-assessment process by developing additional guidance and exhibits within the Financial Condition Examiners Handbook, including the use of interim examination procedures, development of the branded risk classifications as a communication tool between examiners and analysts, and other guidance as needed to assist examiners in completing financial condition examinations.—Important
   • Coordinate with the Financial Analysis Handbook (E) Working Group to develop and maintain guidance for reviewing ORSA Summary Reports, corporate governance and other projects as necessary in order to provide effective solvency monitoring.—Important
   • In compliance with the framework developed by the PBR Review (EX) Working Group:
     o Provide advice to regulators, identifying and judging risk, building repositories, evaluating controls, determining the extent of data quality testing (by actuaries and examiners), identifying frequency of model reviews, and documenting some best practices. Address all risks, financial and non-financial (e.g., ERM, board, corporate governance and ORSA).—Important
     o Adjust the Financial Condition Examiners Handbook to develop PBR changes.—Important
EXAMINATION OVERSIGHT (E) TASK FORCE (Continued)

- Upon notice that a class of securities has been placed under regulatory review, the chair of the Financial Examiners Handbook (E) Working Group or his/her representative will be deemed a member of the Invested Asset (E) Working Group of the Valuation of Securities (E) Task Force. The chair or his/her representative is charged with contributing the perspective and expertise of the regulatory group to the development of NAIC regulatory guidance for the security under review.—Important

8. The Financial Examination Report (E) Subgroup of the Financial Examiners Handbook (E) Technical Group will:
   - Review existing requirements for examination reports and consider revisions to align with examination objectives. The Subgroup will provide its recommendations to the Financial Examiners Handbook (E) Technical Group.—Essential

9. The IT Examination (E) Working Group will:
   - Monitor state usage of automated examination tools, technology changes and emerging issues in order to re-evaluate examination processes and keep states abreast of the latest tools, techniques and training.—Essential
   - Enhance current training opportunities for auditing tools and techniques: Continue offering on-site training programs that are available to the states upon request.—Essential
   - Continually review and revise, as needed, the “General Information Technology Review” and “Exhibit C—Evaluation of Controls in Information Systems” sections of the Financial Condition Examiners Handbook.—Essential
   - Develop and maintain tools that will be part of a more complete information technology (IT) examination process.—Essential

NAIC Support Staff: Becky Meyer
Amendments as adopted by the Financial Condition (E) Committee, except where noted.

REINSURANCE (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Reinsurance (E) Task Force will:
   - Provide a forum for the consideration of reinsurance-related issues of public policy.—Essential
   - Oversee the activities of the Reinsurance Financial Analysis (E) Working Group.—Essential
   - Oversee the activities of the Qualified Jurisdiction (E) Working Group.—Essential
   - Monitor the implementation of the revised Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) by NAIC-member jurisdictions.—Essential
   - Communicate and coordinate with the Federal Insurance Office and other federal authorities on matters pertaining to reinsurance.—Essential
   - Consider recommendations referred to the Task Force with respect to the Captives and Special Purpose Vehicles (SPV) white paper.—Essential
   - Consider the referral from the Valuation of Securities (E) Task Force regarding the planned modification of credit rating standards in the NAIC Bank List and advice about the definition of “qualified U.S. financial institution” and other issues.—Essential
   - Consider any other issues related to the revised Model #785 and Model #786.—Important
   - Monitor the development of international principles, standards and guidance with respect to reinsurance. This includes, but is not limited to, monitoring the activities of various groups within the International Association of Insurance Supervisors (IAIS), including the Reinsurance and Other Forms of Risk Transfer Subcommittee, Reinsurance Mutual Recognition Subgroup and Reinsurance Transparency Group.—Important
   - Consider the impact of reinsurance-related federal legislation, including, but not limited to, the federal Nonadmitted and Reinsurance Reform Act and the Federal Insurance Office Act, and coordinate any appropriate NAIC action.—Important
   - Consider referrals with respect to the XXX/AXXX Reinsurance Framework.—Essential

2. The Reinsurance Financial Analysis (E) Working Group will:
   - Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.—Essential
   - Provide a forum for discussion among NAIC jurisdictions of reinsurance issues related to specific companies, entities or individuals.—Essential
   - Support, encourage, promote and coordinate multi-state efforts in addressing issues related to certified reinsurers, including but not limited to multi-state recognition of certified reinsurers.—Essential
   - Provide analytical expertise and support to the states with respect to certified reinsurers and applicants for certification.—Essential
   - Interact with domiciliary regulators of ceding insurers and certifying states to assist and advise on the most appropriate regulatory strategies, methods and actions with respect to certified reinsurers.—Essential
   - Provide guidance and expertise on regulatory policy and practices with respect to certified reinsurers.—Essential
   - Provide advisory support with respect to issues related to the determination of qualified jurisdictions.—Important
Amendments as adopted by the Financial Condition (E) Committee, except where noted.

REINSURANCE (E) TASK FORCE (Continued)

3. The **Qualified Jurisdiction (E) Working Group** will:
   • Develop and maintain the NAIC List of Qualified Jurisdictions in accordance with the *Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions.*—Essential

4. The **XXX/AXXX Reinsurance Regulation Drafting (E) Subgroup** will:
   • Consider referrals with respect to the XXX/AXXX Reinsurance Framework.—Essential

NAIC Support Staff: Dan Schelp
ACTUARIAL GUIDELINE XXXVIII
THE APPLICATION OF THE VALUATION OF LIFE INSURANCE POLICIES
MODEL REGULATION (“MODEL 830”)

Introduction

The revised version of Model 830 was adopted by the NAIC in March 1999. Since that date, some questions have been raised regarding whether and how Model 830 applies to various product designs. The purpose of this guideline is to provide direction as to the application of Model 830 to such products. Specifically, this guideline provides examples of various policy features that constitute “guarantees” and gives directions on how to reserve for these guarantees in accordance with Model 830.

Obviously, new policy designs will emerge subsequent to the development of this document. No statute, regulation, or guideline can anticipate every future product design, and common sense and professional responsibility are needed to assure compliance with both the letter and the spirit of the law. While Model 830 is a complex regulation, its intent is clear: reserves need to be established for the guarantees provided by a policy. Policy designs which are created to simply disguise those guarantees or exploit a perceived loophole must be reserved in a manner similar to more typical designs with similar guarantees.

Text

The following product designs have been brought to the attention of the NAIC’s Life Actuarial Task Force. The list below specifies reserving approaches which the Task Force regards as being most consistent with the letter and spirit of Model 830. However, the specified reserving approaches should be modified as needed to comply with the intent of this guideline that similar reserves be established for policy designs that contain similar guarantees.

1. An initial level premium rate is guaranteed for 10 years followed by increased guaranteed premiums for an additional 20 years. However, the company cannot increase premiums after year 10 (i.e., the initial premium continues to be charged) unless some specified event occurs.

   The initial reserve segment is 30 years. Since the contract contains provisions that limit the company’s ability to increase premiums, then the initial premium should be treated as guaranteed for the entire 30 year period. It would be contrary to the conservative nature of statutory accounting to treat this policy the same as one in which the ability to raise premiums is unrestricted.

2. A term policy has an illustrated level premium for 30 years, the first 10 of which are guaranteed. Additionally, there is a refund option which provides that a specified refund will be paid if the premium ever increases. The refund must be requested within a limited time (e.g., 30 days) of receiving notice of the increase. Coverage terminates if the option is exercised.

   This example differs from the one above in that there is no specified event that has to occur in order for the company to impose a premium increase; however, the company must provide an additional benefit to the policyholder if it exercises this right. Thus the company does not have an unrestricted right to impose an increase after 10 years. If the contract contains provisions that require that additional benefits be provided to the policyholder in the event of a premium increase, even if these benefits are lost if not claimed within a stated time frame, then the initial premiums should be treated as guaranteed for the entire 30 year period. It would be contrary to the conservative nature of statutory accounting to treat this policy the same as one in which the ability to raise premiums does not require that additional benefits be provided. Therefore, the initial segment for this policy is 30 years.
3. An initial level premium rate is guaranteed for 10 years followed by increased guaranteed premiums for an additional 20 years. However, after year 10 the policyholder is protected against premiums being increased above the initial level, with the protection provided by a second company through either reinsurance, a second policy issued to the consumer, or an agreement between the companies.

The combined reserves of the direct writer and the second company should be no less than the amount which the direct writer would hold if a) there were no second company and b) the initial reserve segment were 30 years. If this condition is not met, reserve credits for the direct writer should be disallowed. The reserve held by the direct writer should be based on the initial level premium being guaranteed for 30 years.

4. A product has relatively high gross premiums but with a guaranteed dividend or guaranteed refund schedule, or by some other means guarantees a low net cost to the policyholder.

The net amount of premium (i.e., gross premium less dividends or refunds) should be used in the reserve calculation. That represents the amount the insured actually pays for coverage.

For products reinsured on either a coinsurance or modified coinsurance basis, the reinsurer’s reserve calculation should also be based on the net premium (i.e., gross premiums less dividends or refunds guaranteed to be paid to the policyholder).

5. a) A re-entry term product has an initial rate guarantee for 10 years, with loose or non-existent re-entry underwriting, allowing the policyholder to re-enter for an additional 20 years at specified favorable rates. b) A universal life policy has provisions such that, if the UL policy lapses prior to the 10th policy anniversary because the actual accumulation value (or cash value, depending on design) falls below zero but stipulated premiums have been paid, a substitute policy is guaranteed to be issued providing the same amount of insurance coverage at the same stipulated premium for the remainder of the 10-year period plus an additional 20 years.

The reentry periods and premiums should be treated as a continuation of the initial guarantees for reserve calculation purposes. The initial reserve segment applicable to the original policy should be 30 years if the stipulated premium for the substitute policy is not high enough to trigger a new reserve segment. When the substitute policy is issued, reserves should be determined as if the coverage had been issued at the issue age and issue date of the original policy. Effectively, the company has guaranteed coverage for 30 years at the time the initial policy is issued, and the reserves established should reflect that guarantee.

6. A reinsurance treaty provides for 30 years of level premiums on a current scale but directly guarantees those premiums for only the first 10 years. However, if the reinsurer increases the premiums after 10 years, the reinsurer agrees to increase the expense allowance such that the net payments (premium minus allowance) by the direct writer remains unchanged.

Relative to the reinsurer’s reserve calculation, the initial reserve segment should be 30 years and the valuation premium should be level over that period. In this instance, the additional “expense allowance” has no relationship to the expenses actually incurred by the direct writer in administering the reinsured policies. Although a bona fide expense allowance would typically not be considered in determining the valuation premiums and reserve segments, in this instance the additional “expense allowance” has no relationship to the expenses actually incurred by the direct writer in administering the reinsured policies.”

7. A universal life policy has a cumulative “premium catch-up provision” in which the coverage is guaranteed to remain in force as long as a stipulated premium is paid each year, and if the insured is paying less than is required to maintain the guarantee, there is an unlimited right to make up past premium deficiencies.

Model 830 requires that “when a policy contains more than one secondary guarantee, the minimum reserve shall be the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees.” Since secondary guarantees with “catch-up” provisions are capable of being reinstated up to the end of the secondary guarantee period, they constitute “unexpired secondary guarantees” which must be
incorporated into the calculation of “the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees.”

The basic and deficiency reserves for a secondary guarantee with a catch-up provision should be computed as if the stipulated premium requirement had been met. The basic reserve shall be reduced by the product of a) the “catch-up amount,” if any, which would be required on the valuation date and b) the ratio of the “initial” (i.e., before adjustment) basic reserve to the sum of the “initial” basic and deficiency reserves. In no event shall the “reduced” basic reserve be reduced below zero. The deficiency reserve shall be reduced by the product of a) the “catch-up amount,” if any, which would be required on the valuation date and b) the ratio of the “initial” deficiency reserve to the sum of the “initial” basic and deficiency reserves. In no event shall the “reduced” deficiency reserve be reduced below zero.

If a universal life policy with a “premium catch up provision” has a shadow account below the level necessary to maintain the secondary guarantee, then the reserve for the secondary guarantee shall be valued according to this example. The basic and deficiency reserves, before deduction for the catch-up amount, shall be calculated as specified in Sections 8A, 8B, 8C, or 8E, as applicable.

8A. For policies and certificates issued prior to July 1, 2005: A universal life policy guarantees the coverage to remain in force as long as the accumulation of premiums paid satisfies the secondary guarantee requirement.

First, the minimum gross premiums (determined at issue) that will satisfy the secondary guarantee requirement must be derived.

Second, for purposes of applying Sections 7B and 7C of Model 830, the “specified premiums” are the minimum gross premiums derived in “Step One.”

Third, a determination should be made of the amount of actual premium payments in excess of the minimum gross premiums. For policies utilizing shadow accounts, this will be the amount of the shadow account. For policies with no shadow accounts but which specify cumulative premium requirements, this excess will be the amount of the cumulative premiums paid in excess of the cumulative premium requirements; the cumulative premium payments and requirements should include any interest credited under the secondary guarantee (with interest credited at the rate specified under the secondary guarantee).

Fourth, a determination should be made of the single payment necessary at the valuation date to fully fund the remaining secondary guarantee assuming that the minimum gross premiums have been paid, up through the valuation date, during the secondary guarantee period. The result from “Step Three” should be divided by this number.

Fifth, compute the net single premium on the valuation date for the coverage provided by the secondary guarantee for the remainder of the secondary guarantee period, using any valuation table and select factors authorized in Section 5A of Model 830.

Sixth, the “net amount of additional premiums” is determined by multiplying the ratio from “Step Four” by the difference between the net single premium from “Step Five” and the basic and deficiency reserve, if any, computed in “Step Two.”

Seventh, a “reduced deficiency reserve” should be computed by multiplying the deficiency reserve, if any, by the one minus the ratio from “Step Four,” but not less than zero. This “reduced deficiency reserve” is the deficiency reserve to be used for purposes of Section 7D(1) of Model 830.

Eighth, the actual reserve used for purposes of Section 7D(1) of Model 830 is the lesser of: (1) the net single premium from “Step Five,” and (2) the amount of the excess from “Step Six” plus the basic reserve and the deficiency reserve, if any, computed in “Step Two.” Reduce this result by the applicable policy surrender charges, i.e., the account value less the cash surrender value. If the resulting amount is less than the sum of the basic and
deficiency reserve from Step #2, then the basic and deficiency reserves to be used for the purposes of Section 7D(1) are those calculated in Step #2, and no further calculation is required.

Ninth, an “increased basic reserve” should be computed by subtracting the “reduced deficiency reserve” in “Step Seven” from the reserve computed in “Step Eight.” This “increased basic reserve” is the basic reserve to be used for purposes of Section 7D(1) of Model 830.

8B. For policies and certificates issued on or after July 1, 2005 and on or prior to December 31, 2006: A universal life policy guarantees the coverage to remain in force as long as the accumulation of premiums paid satisfies the secondary guarantee requirement.

First, the minimum gross premiums (determined at issue) that will satisfy the secondary guarantee requirement must be derived.

Second, for purposes of applying Sections 7B and 7C of Model 830, the “specified premiums” are the minimum gross premiums derived in “Step One.” Consistent with Model 830, the remaining steps in this guideline should be calculated on a segmented basis, using the segments that Model 830 defines for the product. Therefore, in the remaining steps, the term “fully fund the guarantee” should be interpreted to mean fully funding the guarantee to the end of each possible segment. The term “remainder of the secondary guarantee period” should be interpreted to mean the remainder of each possible segment. The total reserve should equal the greatest of all possible segmented reserves.

Third, a determination should be made of the amount of actual premium payments in excess of the minimum gross premiums. For policies utilizing shadow accounts, this will be the amount of the shadow account. For policies with no shadow accounts but which specify cumulative premium requirements, this excess will be the amount of the cumulative premiums paid in excess of the cumulative premium requirements; the cumulative premium payments and requirements should include any interest credited under the secondary guarantee (with interest credited at the rate specified under the secondary guarantee).

Fourth, as of the valuation date for the policy being valued, for policies utilizing shadow accounts, determine the minimum amount of shadow account required to fully fund the guarantee. For policies with no shadow accounts but which specify cumulative premium requirements, determine the amount of the cumulative premiums paid in excess of the cumulative premium requirements that would result in no future premium requirements to fully fund the guarantee; the cumulative premium payments and requirements should include any interest credited under the secondary guarantee (with interest credited at the rate specified under the secondary guarantee). For any policy for which the secondary guarantee can not be fully funded in advance, solve for the minimum sum of any possible excess funding (either the amount in the shadow account or excess cumulative premium payments depending on the product design) and the present value of future premiums (using the maximum allowable valuation interest rate and the minimum mortality standards allowable for calculating basic reserves) that would fully fund the guarantee. The amount determined above for this step is to then be divided by one minus a seven percent premium load allowance (0.93). The result from “Step Three” should be divided by this number, with the resulting ratio capped at 1. The ratio is intended to measure the level of prefunding for a secondary guarantee which is used to establish reserves. Assumptions within the numerator and denominator of the ratio therefore must be consistent in order to appropriately reflect the level of prefunding. The denominator is allowed to be inconsistent only by the amount of the premium load allowance as defined in this step. As used here, “assumptions” include any factor or value, whether assumed or known, which is used to calculate the numerator or denominator of the ratio.

[DRAFTING NOTE: The 7% premium load allowance approximates an average premium load level as evidenced by policies currently sold in the market. Rather than have the funding ratio vary according to the actual policy loads (which can fluctuate greatly by company and product), all companies will use an identical premium load allowance at a level approximately equal to the current industry average.]
Fifth, compute the net single premium on the valuation date for the coverage provided by the secondary guarantee for the remainder of the secondary guarantee period, using any valuation table and select factors authorized in Section 5A of Model 830.

Sixth, the “net amount of additional premiums” is determined by multiplying the ratio from “Step Four” by the difference between the net single premium from “Step Five” and the basic and deficiency reserve, if any, computed in “Step Two.”

Seventh, a “reduced deficiency reserve” should be computed by multiplying the deficiency reserve, if any, by the one minus the ratio from “Step Four,” but not less than zero. This “reduced deficiency reserve” is the deficiency reserve to be used for purposes of Section 7D(1) of Model 830.

Eighth, the actual reserve used for purposes of Section 7D(1) of Model 830 is the lesser of: (1) the net single premium from “Step Five,” and (2) the amount of the excess from “Step Six” plus the basic reserve and the deficiency reserve, if any, computed in “Step Two.” Reduce this result by the applicable policy surrender charges, i.e., the account value less the cash surrender value. Multiply this surrender charge by the ratio of the net level premium for the secondary guarantee period divided by the net level premium for whole life insurance. Calculate both net premiums using the maximum allowable valuation interest rate and the minimum mortality standards allowable for calculating basic reserves. However, if no future premiums are required to support the guarantee period being valued, there is no reduction for surrender charges. If the resulting amount is less than the sum of the basic and deficiency reserve from Step #2, then the basic and deficiency reserves to be used for the purposes of Section 7D(1) of Model 830 are those calculated in Step #2, and no further calculation is required.

Ninth, an “increased basic reserve” should be computed by subtracting the “reduced deficiency reserve” in “Step Seven” from the reserve computed in “Step Eight.” This “increased basic reserve” is the basic reserve to be used for purposes of Section 7D(1) of Model 830.

8C. For all policies and certificates issued on or after January 1, 2007 and on or prior to December 31, 2012: A universal life policy guarantees the coverage to remain in force as long as the accumulation of premiums paid satisfies the secondary guarantee requirement.

First, the minimum gross premiums (determined at issue) that will satisfy the secondary guarantee requirement must be derived.

Second, for purposes of applying Sections 7B and 7C of Model 830, the “specified premiums” are the minimum gross premiums derived in “Step One.” Consistent with Model 830, the remaining steps in this guideline should be calculated on a segmented basis, using the segments that the Model defines for the product. Therefore, in the remaining steps, the term “fully fund the guarantee” should be interpreted to mean fully funding the guarantee to the end of each possible segment. The term “remainder of the secondary guarantee period” should be interpreted to mean the remainder of each possible segment. The total reserve should equal the greatest of all possible segmented reserves. Additionally, for purposes of applying Sections 7B and 7C of Model 830, a lapse rate of no more than 2% per year for the first 5 years, followed by no more than 1% per year to the policy anniversary specified in the following table based on issue age, and 0% per year thereafter may be used. If the duration in the table is less than 5, then a lapse rate of no more than 2% per year may be used through that duration, and 0% per year thereafter.

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-50</td>
<td>30th policy anniversary</td>
</tr>
<tr>
<td>51 - 60</td>
<td>Policy Anniversary age 80</td>
</tr>
<tr>
<td>61 - 70</td>
<td>20th policy anniversary</td>
</tr>
<tr>
<td>71 - 89</td>
<td>Policy anniversary age 90</td>
</tr>
<tr>
<td>90 and over</td>
<td>no lapse</td>
</tr>
</tbody>
</table>

Third, a determination should be made of the amount of actual premium payments in excess of the minimum gross premiums. For policies utilizing shadow accounts, this will be the amount of the shadow account. For policies with
no shadow accounts but which specify cumulative premium requirements, this excess will be the amount of the cumulative premiums paid in excess of the cumulative premium requirements; the cumulative premium payments and requirements should include any interest credited under the secondary guarantee (with interest credited at the rate specified under the secondary guarantee).

Fourth, as of the valuation date for the policy being valued, for policies utilizing shadow accounts, determine the minimum amount of shadow account required to fully fund the guarantee. For policies with no shadow accounts but which specify cumulative premium requirements, determine the amount of the cumulative premiums paid in excess of the cumulative premium requirements that would result in no future premium requirements to fully fund the guarantee; the cumulative premium payments and requirements should include any interest credited under the secondary guarantee (with interest credited at the rate specified under the secondary guarantee). For any policy for which the secondary guarantee can not be fully funded in advance, solve for the minimum sum of any possible excess funding (either the amount in the shadow account or excess cumulative premium payments depending on the product design) and the present value of future premiums (using the maximum allowable valuation interest rate and the minimum mortality standards allowable for calculating basic reserves) that would fully fund the guarantee. The amount determined above for this step is to then be divided by one minus a seven percent premium load allowance (0.93). The result from “Step Three” should be divided by this number, with the resulting ratio capped at 1. The ratio is intended to measure the level of prefunding for a secondary guarantee which is used to establish reserves. Assumptions within the numerator and denominator of the ratio therefore must be consistent in order to appropriately reflect the level of prefunding. The denominator is allowed to be inconsistent only by the amount of the premium load allowance as defined in this step. As used here, “assumptions” include any factor or value, whether assumed or known, which is used to calculate the numerator or denominator of the ratio.

[F DRAFTING NOTE: The 7% premium load allowance approximates an average premium load level as evidenced by policies currently sold in the market. Rather than have the funding ratio vary according to the actual policy loads (which can fluctuate greatly by company and product), all companies will use an identical premium load allowance at a level approximately equal to the current industry average.]

Fifth, compute the net single premium on the valuation date for the coverage provided by the secondary guarantee for the remainder of the secondary guarantee period, using any valuation table and select factors authorized in Section 5A of Model 830. For purposes of calculating the net single premium, a lapse rate subject to the same criteria as the lapse rate used in applying Step 2 of 8C above may be used.

Sixth, the “net amount of additional premiums” is determined by multiplying the ratio from “Step Four” by the difference between the net single premium from “Step Five” and the basic and deficiency reserve, if any, computed in “Step Two.”

Seventh, a “reduced deficiency reserve” should be computed by multiplying the deficiency reserve, if any, by the one minus the ratio from “Step Four,” but not less than zero. This “reduced deficiency reserve” is the deficiency reserve to be used for purposes of Section 7D(1) of Model 830.

Eighth, the actual reserve used for purposes of Section 7D(1) of Model 830 is the lesser of: (1) the net single premium from “Step Five,” and (2) the amount of the excess from “Step Six” plus the basic reserve and the deficiency reserve, if any, computed in “Step Two.” Reduce this result by the applicable policy surrender charges, i.e., the account value less the cash surrender value. Multiply this surrender charge by the ratio of the net level premium for the secondary guarantee period divided by the net level premium for whole life insurance. Calculate both net premiums using the maximum allowable valuation interest rate and the minimum mortality standards allowable for calculating basic reserves. If the resulting amount is less than the sum of the basic and deficiency reserve from Step #2, then the basic and deficiency reserves to be used for the purposes of Section 7D(1) of Model 830 are those calculated in Step #2, and no further calculation is required.

Ninth, an “increased basic reserve” should be computed by subtracting the “reduced deficiency reserve” in “Step Seven” from the reserve computed in “Step Eight.” This “increased basic reserve” is the basic reserve to be used for purposes of Section 7D(1) of Model 830.
Business reserved pursuant to Section 8C must be supported by an asset adequacy analysis specific to this business. This asset adequacy analysis must be performed pursuant to the requirements of Section 3 of the Standard Valuation Law. Reserves required by Section 8C shall be increased by any additional reserves required by the asset adequacy analysis.

8D. This Section 8D applies to policies and certificates (1) issued on and after July 1, 2005, (2) issued prior to January 1, 2013, and (3) in force on December 31, 2012, or on any valuation date thereafter: Under a universal life policy with a secondary guarantee, the coverage is guaranteed to remain in force as long as the accumulation of premiums paid satisfies the secondary guarantee requirement.

Notwithstanding the requirements of any of the other sections of this Actuarial Guideline (and in addition to any testing that may be required under Section 8C), this Section 8D describes the reserving requirements with respect to universal life with secondary guarantee products, with or without a shadow account, with multiple sets of interest rate or other credits, or multiple sets of cost of insurance, expense, or other charges that may become applicable to the calculation of the secondary guarantee measures in any one policy year. This Section 8D does not apply if the minimum gross premiums for the policies are determined by applying the set of charges and credits that produces the lowest premiums, regardless of the imposition of constraints, contingencies, or conditions that would otherwise limit the application of those credits and charges. The requirements of this Section 8D apply to a company on December 31, 2012, and on any subsequent valuation date if (1) on the applicable date, the in force face amount (direct plus assumed) of universal life insurance to which this Section 8D would otherwise apply exceeds 2% of the company’s face amount of individual permanent life insurance in force, or (2) on the applicable date, the company’s face amount of insurance in force subject to this Section 8D exceeds $1,000,000,000 (One Billion Dollars). Any company otherwise meeting these criteria may seek an exemption to the requirements under this Section 8D by filing an exemption request with its state of domicile, which will provide a copy of the request to the NAIC Financial Analysis (E) Working Group (“FAWG”). If the state of domicile agrees with the exemption request, then the requirements of this Section 8D do not apply to such company, provided FAWG does not conclude that the exemption would allow the company to use a reserving methodology that is not appropriate in relation to the benefits and the pattern of premiums for the plans covered.

a. Primary Reserve Methodology

The company’s aggregate gross reserve before reinsurance for the business subject to this Section 8D to be reported in the December 31, 2012, and subsequent annual statutory financial statements of the company will be the aggregate reserve under 1 below, plus any excess of the aggregate reserve determined as defined in 2 below, over 1:

1. The basic and deficiency reserve as of the valuation date determined by the company according to the reserve methodology and assumptions used by the company for the statutorily-reported reserve for the business subject to this Section 8D as of December 31, 2011.

2. The reserve amount as of the valuation date determined according to the same requirements for determining the deterministic reserve in the version of the valuation manual specified under Section 11 of the Standard Valuation Law (“Model 820”) and adopted by NAIC Life Insurance and Annuities (A) Committee on August 17, 2012, or in any version subsequently adopted by the NAIC as of the July 1 preceding the valuation date (“Valuation Manual”), but with the two modifications identified below, determined as follows:

a) First, future year-by-year cash flows for the block of business subject to this Section 8D are projected as of the valuation date. In making this projection:

(I) the projected net investment earnings from the starting assets shall be the lesser of (i) the actual portfolio net investment returns and (ii) net investment returns based on a portfolio of A-rated corporate bonds purchased in the year of issue of the policies based on yields available in the year of issue for those bonds.
II. the projected net investment rate for the reinvestment assets shall be the lesser of (i) the average over a period of 12 months, ending on the June 30 prior to the valuation date, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody’s Investor Services, Inc. and (ii) 7% per annum.

b) Second, future year-by-year net investment returns are determined from the cash flows generated in a).

c) Third, the reserve for the policies is computed using the year-by-year net investment returns determined in b) to discount the cash flows applicable to those policies.

The company may calculate the reserves as of any December 31 as of a date no earlier than three months before that December 31 valuation date, using relevant company data, provided an appropriate method is used to adjust those reserves to the valuation date.

If the aggregate reserve determined pursuant to the second calculation above exceeds the aggregate reserve determined pursuant to the first calculation, the additional reserve to be held is deemed to be required pursuant to Model 820, Sections 3 and 6, which provide for an analysis of reserves pursuant to an asset adequacy analysis with margins for moderately adverse assumptions. Any such excess shall be allocated to each policy in proportion to the step 1 reserve for that policy.

b. Alternative Reserve Methodology

The requirements of subsection a. above shall not apply to a company that holds a total gross reserve amount, before reinsurance, for the business subject to this Section 8D at least equal to the total reserve determined in accordance with the November 1, 2011 Life Actuarial (A) Task Force Statement on Actuarial Guideline XXXVIII, except that for purposes of determining any deficiency reserves under Model 830, using mortality and lapse assumptions according to the same requirements for determining the deterministic reserve in the Valuation Manual.

c. Documentation and Reporting

Under the direction of one or more qualified actuaries, the company shall prepare a stand-alone Actuarial Memorandum covering the reserve analysis performed on the business described in this Section 8D in compliance with Section 7 of the Actuarial Opinion and Memorandum Regulation (“Model 822”) to document the assumptions, analyses and results of the reserve calculations described above. The Actuarial Memorandum shall be prepared regardless of whether the company used the Primary Reserve Methodology described in Section 8D.a or the Alternative Reserve Methodology described in Section 8D.b. Documentation in the submitted Actuarial Memorandum must be sufficient for another actuary qualified in the same practice area to evaluate the assumptions, analyses and results, and to enable regulatory review and verification that the assumptions, analyses and results satisfy the requirements described above, as they relate to the company. In the event that the Valuation Manual is incomplete or unclear as to any matter, the actuary preparing the Actuarial Memorandum shall use his or her best judgment in applying the requirements of the Valuation Manual and shall document his or her decisions in the Actuarial Memorandum. For any business subject to this Section 8D that has been ceded by the company, the Actuarial Memorandum shall provide a listing of the assuming companies with face amount, reserve credit taken, and form of reinsurance for such business. The Actuarial Memorandum shall be submitted to the state of domicile of the company by the April 30 following the valuation date.

For reporting years prior to 2015: The state of domicile shall provide a copy of the Actuarial Memorandum to FAWG and, upon request, to any other state in which the company is licensed.

For reporting years 2015 and after: The state of domicile shall provide a copy of the Actuarial Memorandum to FAWG upon request and, upon request, to any other state in which the company is licensed.

For those companies that used the Primary Reserve Methodology described above, the Actuarial Memorandum shall also provide with respect to the business subject to this Section 8D a description of the simplifications, approximations and modeling efficiency (aggregation) techniques used to calculate the reserve amount set forth in...
Subsection 2 of the Primary Reserve Methodology (i.e., Section 8D.a.2) and a clear indication that, upon request, information may be obtained that is adequate to permit the audit of any subgroup of the aggregated reserve amounts to ensure that the total of the seriatim (policy-by-policy) reserve calculations produces a reserve not materially different than the aggregated reserve amount determined pursuant to Subsection 2 of the Primary Reserve Methodology (i.e., Section 8D.a.2).

Along with the filing of the Actuarial Memorandum pertaining to the December 31, 2012 valuation date, those companies using the Primary Reserve Methodology above shall also submit a report to its state of domicile indicating what the gross reserve before reinsurance for the business subject to this Section 8D would be as of December 31, 2012 if the reserve had been determined pursuant to the methodology and experience assumptions used to determine the reserve set forth in Subsection 2 of the Primary Reserve Methodology (i.e., Section 8D.a.2), except using a net reinvestment return rate assumption not greater than the maximum valuation interest rate for the year of issue of each policy set forth in Model 820. The company shall include in this report what its (i) total adjusted capital and (ii) company action level risk based capital would be if the company held the reserve calculated pursuant to this methodology rather than the reserve actually reported for the applicable business in the annual statement submitted by the company to the NAIC. The report described in this paragraph will be provided by the company to the state of domicile, which will forward a copy to FAWG. Upon request, the state of domicile will also forward a copy of this report to any other state in which the company is licensed. The state of domicile, FAWG, and any other state receiving the report will treat it as containing confidential information. The report is to be provided for informational purposes only, and it is to be considered and used as one additional piece of information to be evaluated in the context of the company’s overall financial position.

For reporting years prior to 2015: The domestic state will perform a review of the Actuarial Memorandum in consultation with FAWG to ensure the company’s reserve calculations have been performed according to the requirements of this Section 8D.

If:

- the company reports in its financial statements the reserve level required above, adjusted for any phase-in period approved by the company’s state of domicile, and
- the company complies with any applicable phase-in period made by the state of domicile with respect to such additional reserves, and
- FAWG agrees with the state of domicile’s decisions,

FAWG shall issue a confidential report to non-domiciliary states indicating that the company’s reserving methodology is appropriate in relation to the benefits and the pattern of premiums for the plans covered. If FAWG does not agree with the state of domicile’s decisions, FAWG shall issue a confidential report to non-domiciliary states indicating that the company’s reserving methodology is not appropriate in relation to the benefits and the pattern of premiums for the plans covered.

For reporting years 2015 and after: The domestic state will perform a review of the Actuarial Memorandum in consultation with FAWG to ensure the company’s reserve calculations have been performed according to the requirements of this Section 8D and may consult with FAWG regarding this review.

If:

- the company reports in its financial statements the reserve level required above, adjusted for any phase-in period approved by the company’s state of domicile, and
- the company complies with any applicable phase-in period made by the state of domicile with respect to such additional reserves, and
- FAWG agrees with the state of domicile’s decisions,

FAWG shall issue a confidential report to non-domiciliary states indicating that the company’s reserving methodology is appropriate in relation to the benefits and the pattern of premiums for the plans covered. If FAWG
does not agree with the state of domicile’s decisions, FAWG shall issue a confidential report to non-domiciliary states indicating that the company’s reserving methodology is not appropriate in relation to the benefits and the pattern of premiums for the plans covered.

8E. For policies and certificates issued on or after January 1, 2013: For a universal life policy that guarantees the coverage to remain in force as long as the accumulation of premiums paid satisfies the secondary guarantee requirement.

Step 1: The first step is to derive the minimum gross premiums for the policy or certificate (to be determined at issue). Except as indicated for policies and certificates described in Method I Policy Design #3 (described below), the minimum premiums so derived must satisfy the secondary guarantee requirement. Model 830, Section 7A4, does not apply in determining the minimum gross premiums for policies and certificates described in this Section 8E.

I) Methodology for determining the minimum gross premiums for certain designs (“Method I”):

1. **Policy Design #1**: For a policy containing a secondary guarantee that uses a shadow account with a single set of charges and credits, the minimum gross premium for any policy year is the premium that, when paid into a policy with a zero shadow account value at the beginning of the policy year, produces a zero shadow account value at the end of the policy year, using the guaranteed shadow account charges and credits (e.g., interest credited rate, mortality charges, premium loads and expense charges) specified under the secondary guarantee.

2. **Policy Design #2**: For a policy that compares paid accumulated premiums to minimum required accumulated premiums (cumulative premium policy), with both accumulations based on a single set of charges and credits specified under the secondary guarantee, the minimum gross premium for any policy year is the premium that, when paid into a policy for which the accumulated premiums equals the minimum required accumulated premiums at the beginning of the policy year, results in the paid accumulated premiums being equal to the minimum required accumulated premiums at the end of the policy year.

3. **Policy Design #3**: If, for any policy year, a shadow account secondary guarantee, a cumulative premium secondary guarantee design, or other secondary guarantee design, provides for multiple sets of charges and/or credits, then the minimum gross premiums shall be determined by applying the set of charges and credits in that policy year that produces the lowest premiums, ignoring the constraint that such minimum premiums satisfy the secondary guarantee requirement and ignoring any contingencies or conditions that would otherwise limit the application of those charges and credits.

Notwithstanding the language in the approaches described above, the guaranteed (including conditionally guaranteed) policy credits for each year shall be limited as to magnitude in order for minimum gross premiums to be determined consistent with any of the policy designs above. The limitations must be met at the time of each product filing and also when guaranteed credits or charges for each such product are revised. For this purpose, policy credits based on the interest or accumulation rates in the policy shall not exceed the “Index” (defined in the next sentence) plus 3% per annum. The Index used to establish the limitation as to magnitude shall be either (i) the monthly average of the composite yield on seasoned corporate bonds as published by Moody’s Investors Service, Inc. for the month immediately preceding the date of the Actuarial Opinion required under this Section 8E and described below, or (ii) the monthly average over a period of twelve months, ending on the June 30 preceding the date of the Actuarial Opinion required below, of the composite yield on seasoned corporate bonds, as published by Moody’s Investors Service, Inc. The averaging period chosen by the company must be elected at time of product filing and consistently used for that product thereafter even if guaranteed credits or charges are subsequently revised for that product.

II) Methodology for determining the minimum gross premiums for other designs (“Method II”):

Unless otherwise provided in this Section 8E, the minimum gross premiums shall be the lowest schedule of premiums that keep the policy in force over the life of the secondary guarantee period and that produce the greatest
deficiency reserve at issue. If deficiency reserves produced at issue are all zero, then the smallest absolute value of
the difference between “quantity A” set forth in Model 830, Section 5B, over the basic reserve shall be considered
the greatest deficiency reserve. For purposes of this Step 1, in deriving the deficiency reserve associated with a
particular schedule of gross premiums, the X factors used shall be set equal to 1 for all durations, issue ages, and risk
classes.

For policies that use a shadow account, and for cumulative premium policies, the schedule of premiums that keep
the policy in force over the life of the secondary guarantee period and that produce the greatest deficiency reserve at
issue shall be determined assuming the following premium-paying patterns for premiums actually paid under the
policy:

- Level premiums for the life of the secondary guarantee but not beyond the duration that premiums may be
  paid under the policy, and
- Increasing premiums over the life of the secondary guarantee (including any resulting reserve segments
  created), but not beyond the durations that premiums may be paid under the policy and,
- Combinations of the above premium patterns including higher initial premiums for funding levels to have
  access to better charges and credits with combinations of level and increasing premium patterns thereafter.

For all policies and certificates subject to this Step 1 of Method II of this Section 8E, the company shall also perform
a good faith high-level analytical review of the product design with respect to the premium payment patterns to be
expected with respect to that design. The review should consider whether there are situations whereby the product
design is likely to elicit a pattern of premium payments that, if paid, would provide the insured with access to lower
charges and/or higher credits than those that would apply assuming the premium paying patterns required to be
tested under this Section 8E and thereby result in the need for a deficiency reserve significantly in excess of that
determined using the schedules of minimum gross premiums determined pursuant to the premium payment patterns
required to be tested under this Section 8E. To the extent identified, the company shall use such other premium
payment patterns it determines are likely to result in the need for a greater deficiency reserve than implied by the
premium payment patterns required to be tested under this Section 8E in determining the schedule of minimum
gross premiums and related deficiency reserve. In performing this analytic review, the company shall consider
payment patterns which keep the policy in force over the lifetime of the secondary guarantee.

Step 2: For purposes of applying Sections 7B and 7C of Model 830, the “specified premiums” are the minimum
gross premiums derived in Step 1. Consistent with Model 830, the remaining steps in this guideline should be
calculated on a segmented basis, using the segments that Model 830 defines for the product. Therefore, in the
remaining steps, the term “fully fund the guarantee” should be interpreted to mean fully funding the guarantee to the
end of each possible segment. The term “remainder of the secondary guarantee period” should be interpreted to
mean the remainder of each possible segment. The total reserve should equal the greatest of all possible segmented
reserves. Additionally, for purposes of applying Sections 7B and 7C of Model 830, the lapse rate used shall be no
more than 2% per year for the first 5 years, followed by no more than 1% per year to the policy anniversary
specified in the following table based on issue age, and 0% per year thereafter. If the duration in the table is less
than 5, than a lapse rate of no more than 2% per year may be used through that duration, and 0% per year thereafter.

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-50</td>
<td>30th policy anniversary</td>
</tr>
<tr>
<td>51-60</td>
<td>Policy Anniversary age 80</td>
</tr>
<tr>
<td>61-70</td>
<td>20th policy anniversary</td>
</tr>
<tr>
<td>71-89</td>
<td>Policy anniversary age 90</td>
</tr>
<tr>
<td>90 and over</td>
<td>no lapse</td>
</tr>
</tbody>
</table>

Step 3: A determination should be made of the amount of actual premium payments greater than or less than the
minimum gross premiums. For policies using shadow accounts and qualifying under one of the Policy Designs of
Method I, this will be the amount of the shadow account. For policies using shadow accounts whose minimum
gross premium is determined under Method II, this will be the amount of the shadow account minus the amount that would be in the shadow account if the minimum gross premiums used to calculate basic and deficiency reserves in Step 2 were paid. This result may be negative. For cumulative premium policies whose minimum gross premiums are determined under Method I, this excess will be the amount of cumulative premiums paid over the cumulative premium requirements. For cumulative premium policies whose minimum gross premiums are determined under Method II, this excess will be the amount of the cumulative premiums paid minus the cumulative premium using the minimum gross premiums used to calculate basic and deficiency reserves in Step 2. This result may be negative. The cumulative premium payments and requirements should include any interest credited under the secondary guarantee (with interest credited at the rate specified under the secondary guarantee).

Step 4: As of the valuation date for the policy being valued, for policies using shadow accounts, determine the minimum amount of shadow account required to fully fund the guarantee. For cumulative premium policies, determine the minimum amount of the cumulative premiums required to fully fund the guarantee less the cumulative premium requirements. For any policy for which the secondary guarantee cannot be fully funded in advance, solve for the minimum sum of any possible excess funding (either the amount in the shadow account or excess cumulative premium payments depending on the product design) and the present value of future premiums (using the maximum allowable valuation interest rate and the minimum mortality standards allowable for calculating basic reserves) that would fully fund the guarantee. For shadow account policies, if the minimum gross premium is determined according to Method II and the Step 3 amount is positive then the amount determined above for this step is reduced by any positive shadow account based on minimum gross premiums. For cumulative premium policies, if the minimum gross premium is determined according to Method II and the Step 3 amount is positive then the amount determined above for this step is reduced by the excess of cumulative premiums, assuming minimum gross premiums are paid, over the cumulative premium requirements. For shadow account policies, if the minimum gross premium is determined according to Method II and the Step 3 amount is negative then the amount determined above for this step is replaced by the amount of the shadow account based on the minimum gross premiums. For cumulative premium policies, if the minimum gross premiums are determined by Method II and the Step 3 amount is negative then the amount determined above for this step is replaced by the excess of cumulative premiums, assuming minimum gross premiums are paid, over the cumulative premium requirements.

The amount determined above for this step is then divided by one minus a seven percent premium load allowance (0.93).

The result from Step 3 should be divided by the number above, with the resulting ratio capped at 1 and no less than (-1). The ratio is intended to measure the level of prefunding for a secondary guarantee and is used to establish reserves. Assumptions within the numerator and denominator of the ratio therefore must be consistent in order to appropriately reflect the level of prefunding. The denominator is allowed to be inconsistent only by the amount of the premium load allowance as defined in this step. As used here, “assumptions” include any factor or value, whether assumed or known, that is used to calculate the numerator or denominator of the ratio.

[DRAFTING NOTE: The 7% premium load allowance approximates an average premium load level as evidenced by policies currently sold in the market. Rather than have the funding ratio vary according to the actual policy loads (which can fluctuate greatly by company and product), all companies will use an identical premium load allowance at this 7% level, which is approximately equal to the current industry average.]

Step 5: Compute the net single premium on the valuation date for the coverage provided by the secondary guarantee for the remainder of the secondary guarantee period, using any valuation table and select factors authorized in Section 5A of Model 830. For purposes of calculating the net single premium, a lapse rate subject to the same criteria as the lapse rate used in applying Step 2 may be used.

Step 6: If the amount in Step 3 is positive the “net amount of additional premiums” is determined by multiplying the ratio from Step 4 by the difference between the net single premium from Step 5 and the basic and deficiency reserve, if any, computed in Step 2.
If the amount in Step 3 is negative, the “net amount of additional premiums” is determined by multiplying the ratio from Step 4 by the basic reserves, if any, computed in Step 2. This result will be negative or zero. Subtract the deficiency reserve calculated in Step 2 from this result and then add the following amount, depending on whether the policy is a shadow account policy or a cumulative premium policy:

a) If a shadow account policy add the following:
   The deficiency reserve at issue calculated using X factors associated with the premium paying pattern used in determining the greatest deficiency reserve in Method II, Step 1, multiplied by one minus the ratio of the amount of the shadow account divided by minimum amount in the shadow account that would fully fund the guarantee. This amount in a) is not to be less than zero.

b) If a cumulative premium policy add the following:
   The deficiency reserve at issue calculated using X factors associated with the premium paying pattern used in determining the greatest deficiency reserve in Method II, Step 1, multiplied by one minus the ratio of the amount of cumulative premiums paid divided by the minimum amount of cumulative premiums required to fully fund the guarantee. This amount in b) is not to be less than zero.

Step 7: A “reduced deficiency reserve” shall be computed by multiplying the deficiency reserve, if any, by one minus the ratio (such ratio not to be set less than zero) from Step 4; this final amount also not to be set less than zero. This “reduced deficiency reserve” is the deficiency reserve to be used for purposes of Section 7D(1) of Model 830.

Step 8: The reserve used for purposes of Model 830, Section 7D(1) is as follows:

a) Take the lesser of:
   1) the “net amount of additional premiums” from Step 6 plus the basic reserve and the deficiency reserve, if any, computed in Step 2, and
   2) the net single premium from Step 5.

b) Reduce the result in a) by the applicable policy surrender charges (i.e., the account value less the cash surrender value). Multiply this surrender charge by the ratio of the net level premium for the secondary guarantee period divided by the net level premium for whole life insurance. Calculate both net premiums using the maximum allowable valuation interest rate and the minimum mortality standards allowable for calculating basic reserves.

c) Calculate the reserve floor:
   1) If the result in Step 3 is negative, then the reserve floor shall equal the sum of the Step 2 basic and deficiency reserves and the amount from Step 6.
   2) If the result in Step 3 is not negative, then the reserve floor shall equal the sum of the Step 2 basic and deficiency reserves without any adjustment.

The reserve to be used for purposes of Model 830, Section 7D(1) is the greater of the resulting amount from b) above and reserve floor.

Step 9: An “increased basic reserve” shall be computed by subtracting the “reduced deficiency reserve” in Step 7 from the reserve computed in Step 8. This “increased basic reserve” is the basic reserve to be used for purposes of Model 830, Section 7D(1).

Actuarial Opinion and Company Representation Requirements

If a company uses one of the Policy Design methodologies described above in Method I of this Section 8E to determine the minimum gross premiums in Step 1, the company shall submit to its state of domicile at the time of filing/approval of a new product, or by December 31, 2012, for current products that will be issued in 2013 or thereafter, and at any time when rates and/or charges are changed, an Actuarial Opinion signed by the Appointed
Actuary and a Representation of the Company signed by a Senior Officer of the company regarding the applicable policy form(s) that states:

**Actuarial Opinion**

“I, (name and professional designation), am the appointed actuary for (company name). I have examined the actuarial assumptions and actuarial methods used in determining the reserves described herein, and, in my opinion: (1) the product referenced herein meets the definition of Policy Design # ___ described in Method I in Section 8E of Actuarial Guideline XXXVIII ("AG38"), (2) notwithstanding the language in Policy Design # ___, the guaranteed (including conditionally guaranteed) policy credits in the product available for any year do not exceed the “Index” defined in Method I in Section 8E of AG38 plus 3% per annum, and (3) the minimum gross premiums determined under Policy Design # ___ are not inconsistent with the minimum premiums, charges and credits that are expected to apply under the policy.”

(Name of actuary, printed or typed)
(Signature of actuary)
(date signed)

**Company Representation**

“(company name) hereby represents: (1) that the product referenced herein meets the definition of Policy Design # ___ described in Method I in Section 8E of Actuarial Guideline XXXVIII ("AG38"), (2) notwithstanding the language in Policy Design # ___, the guaranteed (including conditionally guaranteed) policy credits in the product available for any year do not exceed the “Index” defined in Method I in Section 8E of AG38 plus 3% per annum, and (3) the minimum gross premiums determined under Policy Design # ___ are not inconsistent with the minimum premiums, charges and credits that are expected to apply under the policy.”

(Name of company Officer, printed or typed)
(Signature of company Officer)
(date signed)

For reporting years prior to 2015: The state of domicile shall provide a copy of the Actuarial Opinion and the Company Representation to FAWG and, upon request, to any state in which the company plans to issue the policy that is the subject of the Actuarial Opinion and Company Representation.

For reporting years 2015 and after: The state of domicile shall provide a copy of the Actuarial Opinion and the Company Representation to FAWG, upon request, and, upon request, to any state in which the company plans to issue the policy that is the subject of the Actuarial Opinion and Company Representation.

**Policy Design**

For reporting years prior to 2015: If a company develops reserves based on Method II of this Section 8E, the company shall submit a report from its Appointed Actuary prior to issuing policies on that form to its state of domicile, which will provide a copy to FAWG and (upon request) to any state in which the company plans to issue the product, that briefly describes the analytical review performed, the company’s conclusions following the analytical review, and whether any additional premium payment patterns other than those required by this Section 8E were tested as a result of the review. If FAWG agrees with the state of domicile’s decisions with respect to the company’s Method II reserving methodology, FAWG shall issue a confidential report to non-domiciliary states indicating that the company’s reserving methodology is appropriate in relation to the benefits and the pattern of premiums for the plans covered. If FAWG does not agree with the state of domicile’s decisions with respect to the company’s Method II reserving methodology, FAWG shall issue a confidential report to non-domiciliary states indicating that the company’s reserving methodology is not appropriate in relation to the benefits and the pattern of premiums for the plans covered.
**For reporting years 2015 and after:** If a company develops reserves based on Method II of this Section 8E, the company shall submit a report from its Appointed Actuary prior to issuing policies on that form to its state of domicile, which will provide a copy to FAWG, upon request, and (upon request) to any state in which the company plans to issue the product, that briefly describes the analytical review performed, the company's conclusions following the analytical review, and whether any additional premium payment patterns other than those required by this Section 8E were tested as a result of the review. If FAWG agrees with the state of domicile’s decisions with respect to the company’s Method II reserving methodology, FAWG shall issue a confidential report to non-domiciliary states indicating that the company’s reserving methodology is appropriate in relation to the benefits and the pattern of premiums for the plans covered. If FAWG does not agree with the state of domicile’s decisions with respect to the company’s Method II reserving methodology, FAWG shall issue a confidential report to non-domiciliary states indicating that the company’s reserving methodology is not appropriate in relation to the benefits and the pattern of premiums for the plans covered.

**Effective Date**

With the exception of Steps 3 through Step 9 of Section 8A and all of Sections 8B, 8C, 8D and 8E, the scope of this guideline shall be inclusive of policies issued on and after the earlier of a state’s adoption of the revised Model 830 (adopted by the NAIC in March 1999) or the statutory accounting practices and procedures as set forth in the NAIC Accounting Practices and Procedures Manual. All of Sections 8A, 8B, 8C, 8D and 8E shall be applicable to policies and certificates issued on or after the later of the date of a state’s adoption of the revised Model 830 and January 1, 2003, subject to the dates and/or applicable scope specified in Sections 8A, 8B, 8C, 8D and 8E.
ANNUIY DISCLOSURE MODEL REGULATION

The NAIC amended this model during the 2013 Fall National Meeting. These amendments were adopted as guidelines under the NAIC’s model laws process. The December 2013 Guideline Amendments are highlighted in grey.

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Appendix A. Annuity Illustration Example

Section 1. Purpose

The purpose of this regulation is to provide standards for the disclosure of certain minimum information about annuity contracts to protect consumers and foster consumer education. The regulation specifies the minimum information which must be disclosed, the method for disclosing it and the use and content of illustrations, if used, in connection with the sale of annuity contracts. The goal of this regulation is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts.

Section 2. Authority

This regulation is issued based upon the authority granted the commissioner under Section [cite any enabling legislation and state law corresponding to Section 4 of the NAIC Unfair Trade Practices Act].

Section 3. Applicability and Scope

This regulation applies to all group and individual annuity contracts and certificates except:

A. Immediate and deferred annuities that contain no non-guaranteed elements;

B. (1) Annuities used to fund:

   (a) An employee pension plan which is covered by the Employee Retirement Income Security Act (ERISA);

   (b) A plan described by Sections 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer,

   (c) A governmental or church plan defined in Section 414 or a deferred compensation plan of a state or local government or a tax exempt organization under Section 457 of the Internal Revenue Code; or
(d) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(2) Notwithstanding Paragraph (1), the regulation shall apply to annuities used to fund a plan or arrangement that is funded solely by contributions an employee elects to make whether on a pre-tax or after-tax basis, and where the insurance company has been notified that plan participants may choose from among two (2) or more fixed annuity providers and there is a direct solicitation of an individual employee by a producer for the purchase of an annuity contract. As used in this subsection, direct solicitation shall not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement;

C. Non-registered variable annuities issued exclusively to an accredited investor or qualified purchaser as those terms are defined by the Securities Act of 1933 (15 U.S.C. Section 77a et seq.), the Investment Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.), or the regulations promulgated under either of those acts, and offered for sale and sold in a transaction that is exempt from registration under the Securities Act of 1933 (15 U.S.C. Section 77a et seq.).

D. (1) Transactions involving variable annuities and other registered products in compliance with Securities and Exchange Commission (SEC) rules and Financial Industry Regulatory Authority (FINRA) rules relating to disclosures and illustrations, provided that compliance with Section 5 shall be required after January 1, 2014, unless, or until such time as, the SEC has adopted a summary prospectus rule or FINRA has approved for use a simplified disclosure form applicable to variable annuities or other registered products.

Drafting Note: States should be aware that the provision in paragraph (1) above requiring transactions involving variable annuities and other registered products to comply with the requirements of Section 5 of the regulation after Jan. 1, 2014 unless the U.S. Securities and Exchange Commission (SEC) adopts a summary prospectus rule or the Financial Industry Regulatory Authority (FINRA) approves for use a simplified disclosure form applicable to variable annuities or other registered products could be preempted by the National Securities Markets Improvement Act of 1996 (NSMIA). NSMIA prohibits the States from making laws establishing record-making or record-keeping requirements for broker-dealers. Given this, in adopting this regulation, States may want to omit the language in paragraph (1) above that eliminates the exemption for these transactions after Jan. 1, 2014 and, as a consequence, would require broker-dealers to comply with Section 5 of this regulation unless or until the SEC or FINRA takes the delineated action. States should consider only adopting the language from paragraph (1) above that exempts transactions involving variable annuities and other registered products in compliance with the SEC and FINRA rules relating to disclosures and illustrations from having to comply with the regulation.

(2) Notwithstanding Subsection D(1), the delivery of the Buyer’s Guide is required in sales of variable annuities, and when appropriate, in sales of other registered products.

Drafting Note: The requirement to provide a Buyer’s Guide would not be appropriate for contingent deferred annuities unless, or until such time as, the NAIC adopts a Buyer’s Guide that specifically addresses contingent deferred annuities.

(3) Nothing in this subsection shall limit the commissioner’s ability to enforce the provisions of this regulation or to require additional disclosure.

E. Structured settlement annuities;

F. [Charitable gift annuities; and]

G. [Funding agreements].

Drafting Note: States that regulate charitable gift annuities should exempt them from the requirements of this regulation. States that recognize or regulate funding agreements as annuities should exempt them from the requirements of this regulation.
Section 4. Definitions

For the purposes of this regulation:

A. “Buyer’s Guide” means the National Association of Insurance Commissioner’s approved Annuity Buyer’s Guide.

B. “[“Charitable gift annuity” means a transfer of cash or other property by a donor to a charitable organization in return for an annuity payable over one or two lives, under which the actuarial value of the annuity is less than the value of the cash or other property transferred and the difference in value constitutes a charitable deduction for federal tax purposes, but does not include a charitable remainder trust or a charitable lead trust or other similar arrangement where the charitable organization does not issue an annuity and incur a financial obligation to guarantee annuity payments.]

C. “Contract owner” means the owner named in the annuity contract or certificate holder in the case of a group annuity contract.

D. “Determinable elements” means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion, but where the values or amounts cannot be determined until some point after issue. These elements include the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable elements only, or from both determinable and guaranteed elements.

E. [“Funding agreement” means an agreement for an insurer to accept and accumulate funds and to make one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies.]

F. “Generic name” means a short title descriptive of the annuity contract being applied for or illustrated such as “single premium deferred annuity.”

G. “Guaranteed elements” means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are guaranteed or have determinable elements at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

H. “Illustration” means a personalized presentation or depiction prepared for and provided to an individual consumer that includes non-guaranteed elements of an annuity contract over a period of years.

I. “Market Value Adjustment” or “MVA” feature is a positive or negative adjustment that may be applied to the account value and/or cash value of the annuity upon withdrawal, surrender, contract annuitization or death benefit payment based on either the movement of an external index or on the company’s current guaranteed interest rate being offered on new premiums or new rates for renewal periods, if that withdrawal, surrender, contract annuitization or death benefit payment occurs at a time other than on a specified guaranteed benefit date.

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

K. “Registered product” means an annuity contract or life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

Drafting Note: Registered products include, but are not limited to, contingent deferred annuities.
"Structured settlement annuity" means a “qualified funding asset” as defined in section 130(d) of the Internal Revenue Code or an annuity that would be a qualified funding asset under section 130(d) but for the fact that it is not owned by an assignee under a qualified assignment.

Section 5. Standards for the Disclosure Document and Buyer’s Guide

A.  (1) Where the application for an annuity contract is taken in a face-to-face meeting, the applicant shall at or before the time of application be given both the disclosure document described in Subsection B and the Buyer’s Guide, if any.

(2) Where the application for an annuity contract is taken by means other than in a face-to-face meeting, the applicant shall be sent both the disclosure document and the Buyer’s Guide no later than five (5) business days after the completed application is received by the insurer.

(a) With respect to an application received as a result of a direct solicitation through the mail:

(i) Providing a Buyer’s Guide in a mailing inviting prospective applicants to apply for an annuity contract shall be deemed to satisfy the requirement that the Buyer’s Guide be provided no later than five (5) business days after receipt of the application.

(ii) Providing a disclosure document in a mailing inviting a prospective applicant to apply for an annuity contract shall be deemed to satisfy the requirement that the disclosure document be provided no later than five (5) business days after receipt of the application.

(b) With respect to an application received via the Internet:

(i) Taking reasonable steps to make the Buyer’s Guide available for viewing and printing on the insurer’s website shall be deemed to satisfy the requirement that the Buyer’s Guide be provided no later than five (5) business day of receipt of the application.

(ii) Taking reasonable steps to make the disclosure document available for viewing and printing on the insurer’s website shall be deemed to satisfy the requirement that the disclosure document be provided no later than five (5) business days after receipt of the application.

(c) A solicitation for an annuity contract provided in other than a face-to-face meeting shall include a statement that the proposed applicant may contact the insurance department of the state for a free annuity Buyer’s Guide. In lieu of the foregoing statement, an insurer may include a statement that the prospective applicant may contact the insurer for a free annuity Buyer’s Guide.

(d) Where the Buyer’s Guide and disclosure document are not provided at or before the time of application, a free look period of no less than fifteen (15) days shall be provided for the applicant to return the annuity contract without penalty. This free look shall run concurrently with any other free look provided under state law or regulation.

B.  At a minimum, the following information shall be included in the disclosure document required to be provided under this regulation:

(1) The generic name of the contract, the company product name, if different, and form number, and the fact that it is an annuity;

(2) The insurer’s legal name, physical address, website address and telephone number;
(3) A description of the contract and its benefits, emphasizing its long-term nature, including examples where appropriate:

(a) The guaranteed and non-guaranteed elements of the contract, and their limitations, if any, including for fixed indexed annuities, the elements used to determine the index-based interest, such as the participation rates, caps or spread, and an explanation of how they operate;

(b) An explanation of the initial crediting rate, or for fixed indexed annuities, an explanation of how the index-based interest is determined, specifying any bonus or introductory portion, the duration of the rate and the fact that rates may change from time to time and are not guaranteed;

(c) Periodic income options both on a guaranteed and non-guaranteed basis;

(d) Any value reductions caused by withdrawals from or surrender of the contract;

(e) How values in the contract can be accessed;

(f) The death benefit, if available and how it will be calculated;

(g) A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

(h) Impact of any rider, including, but not limited to, a guaranteed living benefit or long-term care rider;

(4) Specific dollar amount or percentage charges and fees shall be listed with an explanation of how they apply; and

(5) Information about the current guaranteed rate or indexed crediting rate formula, if applicable, for new contracts that contains a clear notice that the rate is subject to change.

C. Insurers shall define terms used in the disclosure statement in language that facilitates the understanding by a typical person within the segment of the public to which the disclosure statement is directed.

* * * * * * * * * *
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:
   Contingent Deferred Annuity (A) Working Group

2. NAIC staff support contact information:
   Jennifer R. Cook, jcook@naic.org, Phone: 202-471-3986

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.

   Annuity Disclosure Model Regulation (#245)

   Revise model to exempt SEC registered contingent deferred annuities (CDAs) and CDAs offered through ERISA retirement plans from the requirement that the buyer’s guide be provided at the time of sale.

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

   Due to increasing interest at state and federal levels in mitigating longevity risk, CDAs are likely to become increasingly prevalent. Therefore, state laws should be clear as to the applicability of their laws.

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: As CDAs become more prevalent in the marketplace, states will want to make sure their state laws explicitly apply to CDAs.

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.

The SEC prospectus preempts all other state disclosures, with the exception of the buyer’s guide. The requirement that buyer’s guides be provided at the time of sale shouldn’t apply to CDAs because the buyer’s guide doesn’t contain any information about CDAs and would be confusing.
PROJECT HISTORY

ANNUITY DISCLOSURE MODEL REGULATION (#245)

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

The Annuity Disclosure Model Regulation (#245) was revised to clarify its application to contingent deferred annuities (CDAs) by:

- Adding a drafting note to clarify that the requirement to provide a Buyers Guide would not be appropriate for CDAs unless, or until such time as, the NAIC adopts a Buyers Guide that specifically addresses CDAs.

- Adding to Section 4. Definitions: Registered product means an annuity contract or life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933, with a drafting note stating that registered products include, but are not limited to, CDAs.

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

The Contingent Deferred Annuity (A) Working Group of the Life Insurance and Annuities (A) Committee was responsible for drafting the revisions.

States Participating:

- Ted Nickel, Chair, Wisconsin
- Robert Chester, Connecticut
- Jim Mumford, Iowa
- Jason Lapham, Kansas
- Bruce R. Ramge, Nebraska
- Roger A. Sevigny/Keith Nyhan, New Hampshire
- Joseph Torti III/Elizabeth Dwyer, Rhode Island
- Michael Humphreys, Tennessee
- Tomasz Serbinowski, Utah
- Jim Mumford, Iowa
- Michael Humphreys, Tennessee
- Tomasz Serbinowski, Utah

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

The project was authorized in 2012 by the following charge: Appoint a Contingent Deferred Annuity (A) Working Group to develop NAIC guidelines and/or model bulletin that can serve as a reference for states interested in modifying their annuity laws to clarify their applicability to contingent deferred annuities (CDAs) and, as part of this work, review existing NAIC model laws and regulations applicable to consumer protection issues associated with CDAs.

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.

The revisions to the Annuity Disclosure Model Regulation (#245) were drafted by the Contingent Deferred Annuity (A) Working Group. The revisions, and comments received on them, were reviewed and discussed by the Working Group. All comments were posted on the NAIC website. The Working Group adopted a draft of proposed revisions at the 2014 Fall National Meeting, which was then forwarded to the Life Insurance and Annuities (A) Committee. The Life Insurance and Annuities (A) Committee also adopted the revisions at the 2014 Fall National Meeting.

All drafts were distributed to more than 100 interested parties and posted on the NAIC website. Numerous interested parties participated, including: the American Council of Life Insurers (ACLI); the National Association for Fixed Annuities (NAFA); the Insured Retirement Institute (IRI); the National Association of Insurance and Financial Advisors (NAIFA); Birny Birnbaum (Center for Economic Justice—CEJ); and the American Academy of Actuaries (Academy).
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 Contingent Deferred Annuity (A) Working Group met at each national meeting and held interim meetings and interim conference calls beginning in June 2012 until adopting the revisions at the 2014 Fall National Meeting.

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

There were concerns that using the term “CDAs” when revising the model would be too limiting and that subsequent model revisions would be necessary to address every innovation in the industry. The language adopted seeks to address this concern by using broader language and using drafting notes to clarify that the terms are intended to include CDAs.

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

None
SUITABILITY IN ANNUITY TRANSACTIONS
MODEL REGULATION

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Section 1. Purpose

A. The purpose of this regulation is to require insurers to establish a system to supervise recommendations and to set forth standards and procedures for recommendations to consumers that result in transactions involving annuity products so that the insurance needs and financial objectives of consumers at the time of the transaction are appropriately addressed.

B. Nothing herein shall be construed to create or imply a private cause of action for a violation of this regulation.

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

Section 2. Scope

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

Section 3. Authority

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

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

Section 4. Exemptions

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

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

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

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

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

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

(5) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(6) Formal prepaid funeral contracts.

Section 5. Definitions

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

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

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

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

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

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

G. “Recommendation” means advice provided by an insurance producer, or an insurer where no producer is involved, to an individual consumer that results in a purchase, exchange or replacement of an annuity in accordance with that advice.

H. “Replacement” means a transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer, that by reason of the transaction, an existing policy or contract has been or is to be:

(1) Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;

(2) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(3) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
(4) Reissued with any reduction in cash value; or

(5) Used in a financed purchase.

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

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

(1) Age;

(2) Annual income;

(3) Financial situation and needs, including the financial resources used for the funding of the annuity;

(4) Financial experience;

(5) Financial objectives;

(6) Intended use of the annuity;

(7) Financial time horizon;

(8) Existing assets, including investment and life insurance holdings;

(9) Liquidity needs;

(10) Liquid net worth;

(11) Risk tolerance; and

(12) Tax status.

* * * * * * * * * *

**Section 6. Duties of Insurers and of Insurance Producers**

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

(1) The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk;

**Drafting Note:** If a State has adopted the NAIC Annuity Disclosure Model Regulation, the State should insert an additional phrase in paragraph (1) above to explain that the requirements of this section are intended to supplement and not replace the disclosure requirements of the NAIC Annuity Disclosure Model Regulation.
(2) The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;

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

(4) In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:

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

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

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

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

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

D. (1) Except as provided under paragraph (2) of this subsection, neither an insurance producer, nor an insurer, shall have any obligation to a consumer under subsection A or C related to any annuity transaction if:

   (a) No recommendation is made;

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

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

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

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

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

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

   (2) Obtain a customer signed statement documenting a customer’s refusal to provide suitability information, if any; and
(3) Obtain a customer signed statement acknowledging that an annuity transaction is not
recommended if a customer decides to enter into an annuity transaction that is not based on the
insurance producer’s or insurer’s recommendation.

F. (1) An insurer shall establish a supervision system that is reasonably designed to achieve the insurer’s
and its insurance producers’ compliance with this regulation, including, but not limited to, the
following:

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

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

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

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

(e) The insurer shall maintain reasonable procedures to detect recommendations that are not
suitable. This may include, but is not limited to, confirmation of consumer suitability
information, systematic customer surveys, interviews, confirmation letters and programs
of internal monitoring. Nothing in this subparagraph prevents an insurer from complying
with this subparagraph by applying sampling procedures, or by confirming suitability
information after issuance or delivery of the annuity; and

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

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

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

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

(ii) Annually obtaining a certification from a senior manager who has responsibility
for the contracted function that the manager has a reasonable basis to represent,
and does represent, that the function is properly performed.
(3) An insurer is not required to include in its system of supervision an insurance producer’s recommendations to consumers of products other than the annuities offered by the insurer.

G. An insurance producer shall not dissuade, or attempt to dissuade, a consumer from:

(1) Truthfully responding to an insurer’s request for confirmation of suitability information;
(2) Filing a complaint; or
(3) Cooperating with the investigation of a complaint.

H. (1) Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. This subsection applies to FINRA broker-dealer sales of variable annuities and fixed annuities if the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the insurance commissioner’s ability to enforce (including investigate) the provisions of this regulation.

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

(2) For paragraph (1) to apply, an insurer shall:

(a) Monitor the FINRA member broker-dealer using information collected in the normal course of an insurer’s business; and
(b) Provide to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

Section 7. Insurance Producer Training

A. An insurance producer shall not solicit the sale of an annuity product unless the insurance producer has adequate knowledge of the product to recommend the annuity and the insurance producer is in compliance with the insurer’s standards for product training. An insurance producer may rely on insurer-provided product-specific training standards and materials to comply with this subsection.

B. (1) An insurance producer who engages in the sale of annuity products shall complete a one-time four (4) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider.

(b) Insurance producers who hold a life insurance line of authority on the effective date of this regulation and who desire to sell annuities shall complete the requirements of this subsection within six (6) months after the effective date of this regulation. Individuals who obtain a life insurance line of authority on or after the effective date of this regulation may not engage in the sale of annuities until the annuity training course required under this subsection has been completed.

(2) The minimum length of the training required under this subsection shall be sufficient to qualify for at least four (4) CE credits, but may be longer.

(3) The training required under this subsection shall include information on the following topics:

(a) The types of annuities and various classifications of annuities;
(b) Identification of the parties to an annuity;
(c) How fixed, variable, and indexed specific annuity contract provisions affect consumers;

(d) The application of income taxation of qualified and non-qualified annuities;

(e) The primary uses of annuities; and

(f) Appropriate sales practices, replacement and disclosure requirements.

(4) Providers of courses intended to comply with this subsection shall cover all topics listed in the prescribed outline and shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer’s products. Additional topics may be offered in conjunction with and in addition to the required outline.

(5) A provider of an annuity training course intended to comply with this subsection shall register as a CE provider in this State and comply with the rules and guidelines applicable to insurance producer continuing education courses as set forth in [insert reference to State law or regulations governing producer continuing education course approval].

(6) Annuity training courses may be conducted and completed by classroom or self-study methods in accordance with [insert reference to State law or regulations governing producer continuing education course approval].

(7) Providers of annuity training shall comply with the reporting requirements and shall issue certificates of completion in accordance with [insert reference to State law or regulations governing to producer continuing education course approval].

(8) The satisfaction of the training requirements of another State that are substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection in this State.

(9) An insurer shall verify that an insurance producer has completed the annuity training course required under this subsection before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports provided by commissioner-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.
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:
   Contingent Deferred Annuity (A) Working Group

2. NAIC staff support contact information:
   Jennifer R. Cook, jcook@naic.org, Phone: 202-471-3986

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.
   Suitability in Annuity Transactions Model Regulation (#275)
   Revise to specifically reference its applicability to the sale of contingent deferred annuities (CDAs), including the one-time, four hour training and the product-specific training requirements.

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
      Due to increasing interest at state and federal levels in both suitability and mitigating longevity risk, state laws should be clear as to the applicability of their laws to CDAs.

   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: States will want to include this clarification, especially since the federal government continues to scrutinize state's ability to protect consumers, including the adequacy of state suitability laws.

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

SUITABILITY IN ANNUITY TRANSACTIONS MODEL REGULATION (#275)

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

The Suitability in Annuity Transactions Model Regulation (#275) was revised to clarify its application to contingent deferred annuities (CDAs) by:

- Deleting references to variable and fixed and leaving the broader reference to “annuities” in Section 6H, which states that sales made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation.

- Adding to Section 7. Producer Training the clarification that training include how product-specific annuity contract features affect consumers.

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

The Contingent Deferred Annuity (A) Working Group of the Life Insurance and Annuities (A) Committee was responsible for drafting the revisions.

States Participating:

Ted Nickel, Chair
Robert Chester
Jim Mumford
Jason Lapham
Bruce R. Ramge
Wisconsin
Connecticut
Iowa
Kansas
Nebraska
Roger A. Sevigny/Keith Nyhan
Joseph Torti III/Elizabeth Dwyer
Michael Humphreys
Tomasz Serbinowski
New Hampshire
Rhode Island
Tennessee
Utah

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

The project was authorized in 2012 by the following charge: Appoint a Contingent Deferred Annuity (A) Working Group to develop NAIC guidelines and/or model bulletin that can serve as a reference for states interested in modifying their annuity laws to clarify their applicability to contingent deferred annuities (CDAs) and, as part of this work, review existing NAIC model laws and regulations applicable to consumer protection issues associated with CDAs.

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.

The revisions to the Suitability in Annuity Transactions Model Regulation (#275) were drafted by the Contingent Deferred Annuity (A) Working Group. The revisions, and comments received on them, were reviewed and discussed by the Working Group. All comments were posted on the NAIC website. The Working Group adopted a draft of proposed revisions at the 2014 Fall National Meeting, which was then forwarded to the Life Insurance and Annuities (A) Committee. The Life Insurance and Annuities (A) Committee also adopted the revisions at the 2014 Fall National Meeting.

All drafts were distributed to more than 100 interested parties and posted on the NAIC website. Numerous interested parties participated, including: the American Council of Life Insurers (ACLI); the National Association for Fixed Annuities (NAFA); the Insured Retirement Institute (IRI); the National Association for Insurance and Financial Advisors (NAIFA); Birny Birnbaum (Center for Economic Justice—CEJ); and the American Academy of Actuaries (Academy).
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 Contingent Deferred Annuity (A) Working Group met at each national meeting and held interim meetings and interim conference calls beginning in June 2012 until adopting the revisions at the 2014 Fall National Meeting.

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

There were concerns that using the term “CDAs” when revising the model would be too limiting and that subsequent model revisions would be necessary to address every innovation in the industry. The language adopted seeks to address this concern by using broader language.

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

None
ADVERTISEMENTS OF LIFE INSURANCE AND ANNUITIES MODEL REGULATION

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Section 10. Penalties
Section 11. Conflict With Other Regulations
Section 12. Severability

Section 1. Purpose

The purpose of this regulation is to set forth minimum standards and guidelines to assure a full and truthful disclosure to the public of all material and relevant information in the advertising of life insurance policies and annuity contracts.

Section 2. Definitions

For the purpose of this regulation:

A. (1) “Advertisement” means material designed to create public interest in life insurance or annuities or in an insurer, or in an insurance producer; or to induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy including:

Comment: See drafting note caveat immediately following the definition of “insurance producer” in this section.

(a) Printed and published material, audiovisual material and descriptive literature of an insurer or insurance producer used in direct mail, newspapers, magazines, radio and television scripts, telemarketing scripts, billboards and similar displays, and the Internet or any other mass communication media.

(b) Descriptive literature and sales aids of all kinds, authored by the insurer, its insurance producers, or third parties, issued, distributed or used by the insurer or insurance producer; including but not limited to circulars, leaflets, booklets, web pages, depictions, illustrations and form letters;

(c) Material used for the recruitment, training and education of an insurer’s insurance producers which is designed to be used or is used to induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy;

(d) Prepared sales talks, presentations and materials for use by insurance producers.

(2) “Advertisement” for the purpose of this regulation shall not include:
(a) Communications or materials used within an insurer’s own organization and not intended for dissemination to the public;

(b) Communications with policyholders other than material urging policyholders to purchase, increase, modify, reinstate or retain a policy; and

(c) A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged; provided the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage.

B. “Determinable policy elements” means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion, but where the values or amounts cannot be determined until some point after issue. These elements include the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable policy elements only, or from both determinable and guaranteed policy elements.

C. “Guaranteed policy elements” means the premiums, benefits, values, credits or charges under a policy, or elements of formulas used to determine any of these that are guaranteed and determined at issue.

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

Drafting Note: Each jurisdiction may wish to revise the definition of “insurance producer” to reference the definition in that jurisdiction’s licensing law. This definition from the NAIC Producer Licensing Model Act, which also defines the terms “sell,” “solicit,” and “negotiate,” should be used. This term and words related thereto should not be included in life advertising regulations unless “insurance producer” also is statutorily defined and the definitions are identical.

E. “Insurer” means any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd’s, fraternal benefit society, and any other legal entity which is defined as an “insurer” in the insurance code of this state or issues life insurance or annuities in this state and is engaged in the advertisement of a policy.

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

G. “Policy” means any policy, plan, certificate, including a fraternal benefit certificate, contract, agreement, statement of coverage, rider or endorsement which provides for life insurance or annuity benefits.

H. “Preneed funeral contract or prearrangement” means an arrangement by or for an individual before the individual’s death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

I. “Registered product” means an annuity contract or life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

Drafting Note: Registered product includes, but is not limited to, contingent deferred annuities.

Section 3. Applicability

A. This regulation shall apply to any life insurance or annuity advertisement intended for dissemination in this state. In variable contracts and other registered products where disclosure requirements are established...
pursuant to federal regulation, this regulation shall be interpreted so as to eliminate conflict with federal regulation.

B. All advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer, as well as the producer who created or presented the advertisement. Insurers shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. A system of control shall include regular and routine notification, at least once a year, to agents, brokers and others authorized by the insurer to disseminate advertisements of the requirement and procedures for company approval prior to the use of any advertisements that is not furnished by the insurer and that clearly sets forth within the notice the most serious consequence of not obtaining the required prior approval.

*****
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:
   Contingent Deferred Annuity (A) Working Group

2. NAIC staff support contact information:
   Jennifer R. Cook, jcook@naic.org, Phone: 202-471-3986

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.
   Advertisements of Life Insurance and Annuities Model Regulation (#570)
   Revise to specifically reference applicability to contingent deferred annuities (CDAs).

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
      Due to increasing interest at state and federal levels in mitigating longevity risk, CDAs are likely to become increasingly prevalent. Therefore, state laws should be clear as to the applicability of their laws.
   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: As CDA become more prevalent in the marketplace, states will want to make sure their state laws explicitly apply to CDAs.

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

ADVERTISEMENTS OF LIFE INSURANCE AND ANNUITIES MODEL REGULATION (#570)

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

The Advertisements of Life Insurance and Annuities Model Regulation (#570) was revised to clarify its application to contingent deferred annuities (CDAs) by:

- Adding to Section 2. Definitions: Registered product means an annuity contract or life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933, with a drafting note stating that registered products include, but are not limited to, CDAs.

- Adding a reference to “registered products” in Section 3. Applicability.

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

The Contingent Deferred Annuity (A) Working Group of the Life Insurance and Annuities (A) Committee was responsible for drafting the revisions.

States Participating:

- Ted Nickel, Chair
  - Wisconsin
- Robert Chester
  - Connecticut
- Jim Mumford
  - Iowa
- Jason Lapham
  - Kansas
- Bruce R. Ramge
  - Nebraska
- Roger A. Sevigny/Keith Nyhan
  - New Hampshire
- Joseph Torti III/Elizabeth Dwyer
  - Rhode Island
- Michael Humphreys
  - Tennessee
- Tomasz Serbinowski
  - Utah

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

The project was authorized in 2012 by the following charge: Appoint a Contingent Deferred Annuity (A) Working Group to develop NAIC guidelines and/or model bulletin that can serve as a reference for states interested in modifying their annuity laws to clarify their applicability to contingent deferred annuities (CDAs) and, as part of this work, review existing NAIC model laws and regulations applicable to consumer protection issues associated with CDAs.

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.

The revisions to the Advertisements of Life Insurance and Annuities Model Regulation (#570) were drafted by the Contingent Deferred Annuity (A) Working Group. The revisions, and comments received on them, were reviewed and discussed by the Working Group. All comments were posted on the NAIC website. The Working Group adopted a draft of proposed revisions at the 2014 Fall National Meeting, which was then forwarded to the Life Insurance and Annuities (A) Committee. The Life Insurance and Annuities (A) Committee also adopted the revisions at the 2014 Fall National Meeting.

All drafts were distributed to more than 100 interested parties and posted on the NAIC website. Numerous interested parties participated, including: the American Council of Life Insurers (ACLI); the National Association for Fixed Annuities (NAFA); the Insured Retirement Institute (IRI); the National Association for Insurance and Financial Advisors (NAIFA); Birny Birnbaum (Center for Economic Justice—CEJ); and the American Academy of Actuaries (Academy).

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 Contingent Deferred Annuity (A) Working Group met at each national meeting and held interim meetings and interim conference calls beginning in June 2012 until adopting the revisions at the 2014 Fall National Meeting.

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

There were concerns that using the term “CDAs” when revising the model would be too limiting and that subsequent model revisions would be necessary to address every innovation in the industry. The language adopted seeks to address this concern by using broader language and a drafting note to clarify that the terms are intended to include CDAs.

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

None
LIFE INSURANCE AND ANNUITIES REPLACEMENT MODEL REGULATION

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Section 4. Duties of Insurers that Use Producers
Section 5. Duties of Replacing Insurers that Use Producers
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Appendix A. Important Notice Regarding Replacements
Appendix B. Notice Regarding Replacements for Direct Response Insurers
Appendix C. Important Notice Regarding Replacements for Direct Response Insurers

Section 1. Purpose and Scope

A. The purpose of this regulation is:

(1) To regulate the activities of insurers and producers with respect to the replacement of existing life insurance and annuities.

(2) To protect the interests of life insurance and annuity purchasers by establishing minimum standards of conduct to be observed in replacement or financed purchase transactions. It will:

(a) Assure that purchasers receive information with which a decision can be made in his or her own best interest;

(b) Reduce the opportunity for misrepresentation and incomplete disclosure; and

(c) Establish penalties for failure to comply with requirements of this regulation.

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

(1) Credit life insurance;

(2) Group life insurance or group annuities where there is no direct solicitation of individuals by an insurance producer. Direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating or enrolling individuals or, when initiated by an individual member of the group, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual. Group life insurance or group annuity certificates marketed through direct response solicitation shall be subject to the provisions of Section 7;

(3) Group life insurance and annuities used to fund prearranged funeral contracts;

(4) An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is
being replaced by the same insurer pursuant to a program filed with and approved by the commissioner; or, when a term conversion privilege is exercised among corporate affiliates;

(5) Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company;

(6) (a) Policies or contracts used to fund (i) an employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA); (ii) a plan described by Sections 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer; (iii) a governmental or church plan defined in Section 414, a governmental or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the Internal Revenue Code; or (iv) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(b) Notwithstanding Subparagraph (a), this regulation shall apply to policies or contracts used to fund any plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, and where the insurer has been notified that plan participants may choose from among two (2) or more insurers and there is a direct solicitation of an individual employee by an insurance producer for the purchase of a contract or policy. As used in this subsection, direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating individuals about the plan or arrangement or enrolling individuals in the plan or arrangement or, when initiated by an individual employee, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual employee;

(7) Where new coverage is provided under a life insurance policy or contract and the cost is borne wholly by the insured’s employer or by an association of which the insured is a member;

(8) Existing life insurance that is a non-convertible term life insurance policy that will expire in five (5) years or less and cannot be renewed;

(9) Immediate annuities that are purchased with proceeds from an existing contract. Immediate annuities purchased with proceeds from an existing policy are not exempted from the requirements of this regulation; or

(10) Structured settlements.

C. Registered contracts shall be exempt from the requirements of Sections 5A(2) and 6B with respect to the provision of illustrations or policy summaries; however, premium or contract contribution amounts and identification of the appropriate prospectus or offering circular shall be required instead.

Section 2. Definitions

A. “Direct-response solicitation” means a solicitation through a sponsoring or endorsing entity or individually solely through mails, telephone, the Internet or other mass communication media.

B. “Existing insurer” means the insurance company whose policy or contract is or will be changed or affected in a manner described within the definition of “replacement.”

C. “Existing policy or contract” means an individual life insurance policy (policy) or annuity contract (contract) in force, including a policy under a binding or conditional receipt or a policy or contract that is within an unconditional refund period.
D. “Financed purchase” means the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from values of an existing policy to pay all or part of any premium due on the new policy. For purposes of a regulatory review of an individual transaction only, if a withdrawal, surrender or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy owned by the same policyholder and issued by the same company within four (4) months before or thirteen (13) months after the effective date of the new policy, it will be deemed prima facie evidence of the policyholder’s intent to finance the purchase of the new policy with existing policy values. This prima facie standard is not intended to increase or decrease the monitoring obligations contained in Section 4A(5) of this regulation.

E. “Illustration” means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years as defined in [insert reference to state law equivalent to the NAIC Life Insurance Illustrations Model Regulation].

F. “Policy summary,” for the purposes of this regulation;

(1) For policies or contracts other than universal life policies, means a written statement regarding a policy or contract which shall contain to the extent applicable, but need not be limited to, the following information: current death benefit; annual contract premium; current cash surrender value; current dividend; application of current dividend; and amount of outstanding loan.

(2) For universal life policies, means a written statement that shall contain at least the following information: the beginning and end date of the current report period; the policy value at the end of the previous report period and at the end of the current report period; the total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders); the current death benefit at the end of the current report period on each life covered by the policy; the net cash surrender value of the policy as of the end of the current report period; and the amount of outstanding loans, if any, as of the end of the current report period.

G. “Producer,” for the purpose of this regulation, shall be defined to include agents, brokers and producers.

H. “Replacing insurer” means the insurance company that issues or proposes to issue a new policy or contract that replaces an existing policy or contract or is a financed purchase.

I. “Registered contract” means an variable annuity contract or variable life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

Drafting Note: Registered contracts include, but are not limited to, contingent deferred annuities.

J. “Replacement” means a transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer, that by reason of the transaction, an existing policy or contract has been or is to be:

(1) Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;

(2) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(3) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(4) Reissued with any reduction in cash value; or

(5) Used in a financed purchase.
K. “Sales material” means a sales illustration and any other written, printed or electronically presented information created, or completed or provided by the company or producer and used in the presentation to the policy or contract owner related to the policy or contract purchased.

* * * * *
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:
   Contingent Deferred Annuity (A) Working Group

2. NAIC staff support contact information:
   Jennifer R. Cook, jcook@naic.org, Phone: 202-471-3986

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.

   Life Insurance and Annuities Replacement Model Regulation (#613)
   Revise to specifically reference applicability to contingent deferred annuities (CDAs).

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
      Due to increasing interest at state and federal levels in mitigating longevity risk, CDAs are likely to become increasingly prevalent. Therefore, state laws should be clear as to the applicability of their laws.
   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: As CDAs become more prevalent in the marketplace, states will want to make sure their state laws explicitly apply to CDAs.

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

LIFE INSURANCE AND
ANNUITIES REPLACEMENT MODEL REGULATION (#613)

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

The Life Insurance and Annuities Replacement Model Regulation (#613) was revised to clarify its application to contingent deferred annuities (CDAs) by:

- Deleting the reference to “variable” in the definition of “registered contract” so that it reads “an annuity contract or life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933” and adding a drafting note stating that registered contracts include, but are not limited to, CDAs.

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

The Contingent Deferred Annuity (A) Working Group of the Life Insurance and Annuities (A) Committee was responsible for drafting the revisions.

States Participating:

<table>
<thead>
<tr>
<th>Name</th>
<th>State</th>
<th>Name</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ted Nickel</td>
<td>Wisconsin</td>
<td>Roger A. Sevigny/Keith Nyhan</td>
<td>New Hampshire</td>
</tr>
<tr>
<td>Robert Chester</td>
<td>Connecticut</td>
<td>Joseph Torti III/Elizabeth Dwyer</td>
<td>Rhode Island</td>
</tr>
<tr>
<td>Jim Mumford</td>
<td>Iowa</td>
<td>Michael Humphreys</td>
<td>Tennessee</td>
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<tr>
<td>Jason Lapham</td>
<td>Kansas</td>
<td>Tomasz Serbinowski</td>
<td>Utah</td>
</tr>
<tr>
<td>Bruce R. Ramge</td>
<td>Nebraska</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

The project was authorized in 2012 by the following charge: Appoint a Contingent Deferred Annuity (A) Working Group to develop NAIC guidelines and/or model bulletin that can serve as a reference for states interested in modifying their annuity laws to clarify their applicability to contingent deferred annuities (CDAs) and, as part of this work, review existing NAIC model laws and regulations applicable to consumer protection issues associated with CDAs.

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.

The revisions to the Life Insurance and Annuities Replacement Model Regulation (#613) were drafted by the Contingent Deferred Annuity (A) Working Group. The revisions, and comments received on them, were reviewed and discussed by the Working Group. All comments were posted on the NAIC website. The Working Group adopted a draft of proposed revisions at the 2014 Fall National Meeting, which was then forwarded to the Life Insurance and Annuities (A) Committee. The Life Insurance and Annuities (A) Committee also adopted the revisions at the 2014 Fall National Meeting.

All drafts were distributed to more than 100 interested parties and posted on the NAIC website. Numerous interested parties participated, including: the American Council of Life Insurers (ACLI); the National Association for Fixed Annuities (NAFA); the Insured Retirement Institute (IRI); the National Association for Insurance and Financial Advisors (NAIFA); Birny Birnbaum (Center for Economic Justice—CEJ); and the American Academy of Actuaries (Academy).

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 Contingent Deferred Annuity (A) Working Group met at each national meeting and held interim meetings and interim conference calls beginning in June 2012 Spring National Meeting until adopting the revisions at the 2014 Fall National Meeting.
6. **A Discussion of the Significant Issues (e.g., items of some controversy raised during the due process and the group’s response)**

There were concerns that using the term “CDAs” when revising the model would be too limiting and that subsequent model revisions would be necessary to address every innovation in the industry. The language adopted seeks to address this concern by using broader language and using a drafting note to clarify that the terms are intended to include CDAs.

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

None
Compendium of Reports on the Pricing of Personal Automobile Insurance

Report of the Auto Insurance (C/D) Study Group
Adopted by the Property and Casualty Insurance (C) Committee
and the Market Regulation and Consumer Affairs (D) Committee, Nov. 16, 2014

Introduction

This document, created by the Auto Insurance (C/D) Study Group, is meant to serve as a resource for state insurance regulators seeking to know more about issues concerning the availability and affordability of automobile insurance. The document contains background information that provides: prior work done by the NAIC; summaries of materials relevant to the issue; and a list of studies and surveys examining the use of credit, occupation or education. The document also includes potential policy options, consisting of an array of state laws and initiatives that may impact the availability and/or affordability of automobile insurance.

The information contained in this document was collected by the Study Group, which was created in 2012. The Study Group created a work plan in August 2012 that called for the collection of research related to its charge to “review issues relating to low-income households and the auto insurance marketplace and to make recommendations as may be appropriate.” In addition to research collected by the Study Group, two separate surveys of state insurance regulators were conducted in order to obtain information concerning laws and various initiatives that states have undertaken to address issues related to the availability and affordability of automobile insurance. These results are summarized in Section E – Policy Options.

State insurance regulators are frequently called upon to research the issue of auto insurance availability and affordability. The Study Group hopes that regulators find this document useful when conducting such research for their state.

A. Prior NAIC Work


B. Summaries Drafted by the Auto Insurance (C/D) Study Group

Uninsured Motorist Issues


Competitiveness of Auto Markets

C. Studies, Reports and Surveys Examining the Use of Credit Scoring, Occupation or Education in Insurance

1. List of studies collected by the Auto Insurance (C/D) Study Group, March 2013.

D. Insurer Initiatives Related to Availability and Affordability Issues


E. Consumer Groups’ Perspectives

1. “Summary of Consumer Groups’ Comments Related to the Availability and Affordability of Auto Insurance for Low Income Drivers” November 2014

F. Policy Options


   Includes state laws related to:
   - Rate Filing
   - Form Filing
   - Fault System
   - Tort Threshold
   - Compulsory Liability
   - Compulsory Personal Injury Protection (PIP)
   - Compulsory Uninsured Motorists
   - Minimum Liability Limits
   - No Pay, No Play
   - Negligent Systems


   Includes information related to:
   a) State studies, hearings or inquiries regarding the availability or affordability of auto insurance for low-income households.
   b) Changes to state residual auto insurance markets.
   c) State identification of uninsured motorists.
   d) State data collection that can be used to examine the impact of underwriting or rating practices on low-income consumers.
   e) State initiatives.
   f) States requiring insurers to provide a disclosure notice to automobile insurance applicants or policyholders that includes underwriting guidelines, rating factors or discounts.
   g) States with publicly available auto insurance underwriting guidelines.
   h) Laws or regulations that specify or limit the factors auto insurers can use in underwriting or rating including, but not limited to, credit, education or occupation.
   i) States with Market Assistance Programs for automobile insurance.
   j) States with auto insurance rate comparison guides.
   k) Other initiatives.

Note: The Auto Insurance (C/D) Study Group has agreed to maintain an active listing of documents related to auto insurance availability and affordability issues on its website. This document can be found at http://www.naic.org/documents/committees_c_d_auto_insurance_study_group_related_to_availability_affordability_of_auto_mobile_insurance.pdf.
MODEL BULLETIN


TO: ALL PROPERTY AND CASUALTY INSURERS WRITING COMMERCIAL LINES INSURANCE PRODUCTS
ALL INSURERS ON THE NAIC QUARTERLY LISTING OF ALIEN INSURERS

RE: FILING PROCEDURES FOR COMPLIANCE WITH THE PROVISIONS OF THE TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT OF 2015

FROM: [Insert name and title]

DRAFTING NOTE: This bulletin was drafted to expedite the delivery of a common message to insurers related to implementation issues that have developed as a result of the extension of the Terrorism Risk Insurance Act. The basic bulletin recognizes that most jurisdictions have allowed some coverage limitations related to non-certified acts of terrorism that are affected by the reauthorization of the Act. A few jurisdictions have not generally allowed coverage limitations related to other acts of terrorism. Each state needs to review the provisions of the bulletin as they relate to the Act and to existing state regulatory requirements and determine which of its provisions relate to their specific situation. Please note that states might wish to distinguish between filing requirements that apply to admitted insurers and those applicable to surplus lines insurers.

The purpose of this bulletin is to advise you of certain provisions of the Terrorism Risk Insurance Program Reauthorization Act of 2015 amending and extending the Terrorism Risk Insurance Act of 2002 (the Act) by reauthorization, which may require insurers to submit a filing in this state of disclosure notices, policy language, and applicable rates as a result of the Act. For further details related to the Act, please consult the Act itself.

Background

Uncertainty in the markets for commercial lines property and casualty insurance coverage arose following the substantial loss of lives and property experienced on September 11, 2001. Soon after these tragic events, many reinsurers announced that they would no longer provide coverage for acts of terrorism in future reinsurance contracts. This led to a concerted effort on behalf of all interested parties to seek a federal backstop to facilitate the ability of the insurance industry to continue to provide coverage for these unpredictable and potentially catastrophic events. As a result, Congress enacted and the President signed into law in November 2002, the Terrorism Risk Insurance Act of 2002. This federal law provided a federal backstop for defined acts of terrorism and imposed certain obligations on insurers. The Act was extended for a two-year period covering Program Years 2006 and 2007, and for an additional seven years through December 31, 2014 with the enactment of the Terrorism Risk Insurance Program Reauthorization Act of 2007. The Act has now been extended again with the enactment of the Terrorism Risk Insurance Program Reauthorization Act of 2015.

The reauthorized Act, as amended and extended, included several changes including:

- Extending the program through December 31, 2020.
- Fixing the Insurer Deductible at 20% of an insurer’s direct earned premium of the preceding calendar year and the federal share of compensation at 85% of insured losses that exceed insurer deductibles until January 1, 2016, at which time the federal share shall decrease by 1 percentage point per calendar year until equal to 80%.
- Requiring the Secretary of the Treasury certify acts of terrorism in consultation with the Secretary of Homeland Security.
- Amending the program trigger to apply to certified acts with insured losses exceeding $100 million for calendar year 2015, $120 million for calendar year 2016, $140 million for calendar year 2017, $160 million for calendar year 2018, $180 million for calendar year 2019, and $200 million for calendar year 2020 and any calendar year thereafter.
• The mandatory recoupment of the federal share through policyholder surcharges increasing to 140 percent (from 133 percent).
• The insurance marketplace aggregate retention amount being the lesser of $27.5 billion, increasing annually by $2 billion until it equals $37.5 billion, and the aggregate amount of insured losses for the calendar year for all insurers. In the calendar year following the calendar year in which the marketplace retention amount equals $37.5 billion, and beginning in calendar year 2020 it is revised to be the lesser of the annual average of the sum of insurer deductibles for all insurers participating in the Program for the prior three calendar years as such sum is determined by the Secretary of the Treasury by regulation.
• Requiring the Secretary of the Treasury, not later than nine months after the date of enactment of the Act, to conduct and complete a study on the certification process, including the establishment of a reasonable timetable by which the Secretary must make an accurate determination on whether to certify an act as an act of terrorism.
• Requiring insurers participating in the Program to submit to the Secretary of the Treasury for a Congressional report to be submitted on June 30, 2016 and every June 30 thereafter, information regarding insurance coverage for terrorism losses in order to evaluate the effectiveness of the Program. The information to be provided includes: lines of insurance with exposure to terrorism losses, premiums earned on coverage, geographical location of exposures, pricing of coverage, the take-up rate for coverage, the amount of private reinsurance for acts of terrorism purchased and such other matters as the Secretary considers appropriate. This information may be collected by a statistical aggregator and in coordination with State insurance regulatory authorities.
• Requiring the Comptroller General of the United States to complete a study on the viability and effects of the Federal Government assessing and collecting upfront premiums and creating a capital reserve fund.
• Requiring the Secretary of the Treasury to conduct a study not later than June 30, 2017 and every June 30 thereafter to identify competitive challenges small insurers face in the terrorism risk insurance marketplace.
• Requiring the Secretary of the Treasury to appoint an Advisory Committee on Risk-Sharing Mechanisms to provide advice, recommendations and encouragement with respect to the creation and development of nongovernmental risk-sharing mechanisms. The Advisory Committee will be composed of nine members who are directors, officers, or other employees of insurers, reinsurers or capital market participants.
• Changing the terms “program year” and “transition period” to “calendar year” throughout.

Definition of Act of Terrorism

Section 102(1) defines an act of terrorism for purposes of the Act. Please note that the unmodified reference to “the Secretary” refers to the Secretary of the Treasury. The revised Section 102(1)(A) states, “The term 'act of terrorism' means any act that is certified by the Secretary, in consultation with the Secretary of Homeland Security, and the Attorney General of the United States—(i) to be an act of terrorism; (ii) to be a violent act or an act that is dangerous to—(I) human life: (II) property: or (III) infrastructure: (iii) to have resulted in damage within the United States, or outside the United States in the case of—(I) an air carrier or vessel described in paragraph (5)(B); or (II) the premises of a United States mission; and (iv) to have been committed by an individual or individuals, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.” Section 102(1)(B) states, “No act shall be certified by the Secretary as an act of terrorism if—(i) the act is committed as part of the course of a war declared by the Congress, except that this clause shall not apply with respect to any coverage for workers’ compensation; or (ii) property and casualty insurance losses resulting from the act, in the aggregate, do not exceed $5,000,000.” Section 102(1)(C) and (E) specify that the determinations are final and not subject to judicial review and that the Secretary of the Treasury cannot delegate the determination to anyone.

Submission of Rates, Policy Form Language and Disclosure Notices

If an insurer relies on an advisory organization to file loss costs and related rating systems on its behalf, no rate filing is required unless an insurer plans to use a different loss cost multiplier than is currently on file for coverage for certified losses. Insurers that develop and file rates independently may choose to maintain their currently filed rates or submit a new filing. The rate filing should provide sufficient information for the reviewer to determine what price would be charged to a business seeking to cover certified losses. This state will accept filings that contain a specified percentage of premium to provide for coverage for certified losses. Insurers may also choose to use rating plans that take into account other factors such as geography, building profile, proximity to target risks, and other reasonable rating factors. The insurer should state in the filing the basis that it has for selection of the rates and rating systems that it chooses to apply. The supporting documentation should be sufficient for the reviewer to determine whether the rates are excessive, inadequate or unfairly discriminatory. For the convenience of insurers, this state will waive its requirements for supporting documentation for rates for certified losses for filings that apply an increased premium charge of between 0% and [insert percentage of premium]% and do not vary by application of other rating factors.
This state will not allow exclusions of coverage for acts of terrorism that fail to be *certified losses* solely because they fall below the $5,000,000 threshold in Section 102(1)(B) on any policy that provides coverage for acts of terrorism that fail to be *certified*. Insurers required to file policy forms may submit language containing coverage limitations for *certified losses* that exceed $100 billion in the aggregate.

Insurers subject to policy form regulation must submit the policy language that they intend to use in this state. The policy should define *acts of terrorism* in ways that are consistent with the Act, as amended, state law and the guidance provided in this bulletin. The definitions, terms and conditions should be complete and accurately describe the coverage that will be provided in the policy. Insurers may conclude that current filings are in compliance with the Act, as amended, state law and the requirements of this bulletin.

**DRAFTING NOTE:** Additional filings may be necessary under state law.

A change introduced in the Terrorism Risk Insurance Program Reauthorization Act of 2007 was a disclosure requirement for any policy issued after the enactment of the Act. Specifically, in addition to other disclosure requirements previously contained in TRIA, insurers since 2007 have had to provide clear and conspicuous disclosure to the policyholder of the existence of the $100 billion cap under Section 103(e)(2), at the time of offer, purchase, and renewal of the policy.

The [insert applicable term—commissioner, director, superintendent, insurance administrator] requests that the disclosure notices be filed for informational purposes, along with the policy forms, rates and rating systems as they are an integral part of the process for notification of policyholders in this state and should be clear and not misleading to business owners in this state. The disclosures should comply with the requirements of the Act, as amended, and should be consistent with the policy language and rates filed by the insurer.

**DRAFTING NOTE:** Your state may require disclosure notices be filed as a policy form, and not for informational purposes. If so, the second to the last sentence should be modified to eliminate the reference to informational purposes.

Given that the provisions of the Terrorism Risk Insurance Program Reauthorization Act of 2015 are already in effect, and insurers and advisory organizations must accelerate filing activity in order to achieve compliance with the revised provisions of TRIA, this state will permit insurers and advisory organizations to place new rates, policy forms and disclosure notices into immediate use without receiving prior approval from the [insert applicable term—commissioner, director, superintendent, insurance administrator] [NOTE: if state law requires a waiting period for filings, that can also be waived by using the following phrase: “…into immediate use without waiting for the tolling of the statutory waiting period.”]

**DRAFTING NOTE:** Waiving this requirement will enhance the revised products’ speed to market and minimize insurers’ operational costs and delays.

If an insurer wants to take advantage of this voluntary speed to market initiative for revised terrorism products, it should complete the attached Expedited SERFF Filing Transmittal Document for Terrorism Risk Insurance Forms and Pricing, and certify on the form that it is in compliance with the terms of the Terrorism Risk Insurance Program Reauthorization Act of 2015 and the laws of this state. Completion of the Expedited SERFF Filing Transmittal will also relieve an insurer from having to complete any other filing form or supplementary exhibit that is normally required to accompany filings.

**DRAFTING NOTE:** Some states may not require the Expedited SERFF Filing Transmittal Document and some states may require additional information.

[If needed, state-specific requirements should be inserted here.]

**DRAFTING NOTE:** A state should choose one of the following paragraphs depending on whether or not the state mandates the use of SERFF.
For states mandating SERFF:
Filers should use the SERFF system for submitting such filings. Filers should use the term “TRIA2015” in the product name field in SERFF to indicate a filing related to terrorism made in connection with the Terrorism Risk Insurance Program Reauthorization Act of 2015. The SERFF system alleviates the need to provide additional information in support of a request for expedited review, although some states may have additional requirements.

For other states:
We encourage filers to take advantage of the SERFF system for submitting such filings. Filers should use the term “TRIA2015” in the product name field in SERFF to indicate a filing related to terrorism made in connection with the Terrorism Risk Insurance Program Reauthorization Act of 2015. The SERFF system alleviates the need to provide additional information in support of a request for expedited review, although some states may have additional requirements.

Optional Provision for Standard Fire Policy States

DRAFTING NOTE: This is an optional section for those states that have a statutory Standard Fire Policy that does not permit terrorism exclusions. States should also consider whether their Standard Fire Policy includes or excludes commercial inland marine coverages and inform insurers concerning this subject.

In this state, the requirements for fire coverage are established by law and where applicable, must meet or exceed the provisions of the Standard Fire Policy. These legal requirements cannot be waived. Thus, a business cannot voluntarily waive this statutorily mandated coverage.

 Provision for Workers’ Compensation Policies

Workers’ compensation insurance coverage is statutorily mandated for nearly all U.S. employers and exemptions are barred in all states. Thus, a business cannot voluntarily waive workers’ compensation insurance (or terrorism coverage provided by a workers’ compensation insurance policy), nor can an insurer exempt terrorism risk from a workers’ compensation policy.

Effective Date

This bulletin shall take immediate effect and shall expire on December 31, 2020, unless Congress extends the duration of the Act.
POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM
INSURANCE COVERAGE

You are hereby notified that under the Terrorism Risk Insurance Act, as amended, you have a right to purchase insurance coverage for losses resulting from acts of terrorism. As defined in Section 102(1) of the Act: The term “act of terrorism” means any act or acts that are certified by the Secretary of the Treasury—in consultation with the Secretary of Homeland Security, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

YOU SHOULD KNOW THAT WHERE COVERAGE IS PROVIDED BY THIS POLICY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM, SUCH LOSSES MAY BE PARTIALLY REIMBURSED BY THE UNITED STATES GOVERNMENT UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THE FORMULA, THE UNITED STATES GOVERNMENT GENERALLY REIMBURSES 85% THROUGH 2015; 84% BEGINNING ON JANUARY 1, 2016; 83% BEGINNING ON JANUARY 1, 2017; 82% BEGINNING ON JANUARY 1, 2018; 81% BEGINNING ON JANUARY 1, 2019 and 80% BEGINNING ON JANUARY 1, 2020, OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURANCE COMPANY PROVIDING THE COVERAGE. THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS THAT MAY BE COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A $100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS’ LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS $100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED $100 BILLION, YOUR COVERAGE MAY BE REDUCED.

Acceptance or Rejection of Terrorism Insurance Coverage

| I hereby elect to purchase terrorism coverage for a prospective premium of $________. |
| I hereby decline to purchase terrorism coverage for certified acts of terrorism. I understand that I will have no coverage for losses resulting from certified acts of terrorism. |

Policyholder/Applicant’s Signature

Insurance Company

Print Name

Policy Number

Date

© 2015 National Association of Insurance Commissioners
Coverage for acts of terrorism is included in your policy. You are hereby notified that under the Terrorism Risk Insurance Act, as amended in 2015, the definition of act of terrorism has changed. As defined in Section 102(1) of the Act: The term “act of terrorism” means any act or acts that are certified by the Secretary of the Treasury—in consultation with the Secretary of Homeland Security, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Under your coverage, any losses resulting from certified acts of terrorism may be partially reimbursed by the United States Government under a formula established by the Terrorism Risk Insurance Act, as amended. However, your policy may contain other exclusions which might affect your coverage, such as an exclusion for nuclear events. Under the formula, the United States Government generally reimburses 85% through 2015; 84% beginning on January 1, 2016; 83% beginning on January 1, 2017; 82% beginning on January 1, 2018; 81% beginning on January 1, 2019 and 80% beginning on January 1, 2020, of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The Terrorism Risk Insurance Act, as amended, contains a $100 billion cap that limits U.S. Government reimbursement as well as insurers’ liability for losses resulting from certified acts of terrorism when the amount of such losses exceeds $100 billion in any one calendar year. If the aggregate insured losses for all insurers exceed $100 billion, your coverage may be reduced.

The portion of your annual premium that is attributable to coverage for acts of terrorism is _________, and does not include any charges for the portion of losses covered by the United States government under the Act.

I ACKNOWLEDGE THAT I HAVE BEEN NOTIFIED THAT UNDER THE TERRORISM RISK INSURANCE ACT, AS AMENDED, ANY LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM UNDER MY POLICY COVERAGE MAY BE PARTIALLY REIMBURSED BY THE UNITED STATES GOVERNMENT AND MAY BE SUBJECT TO A $100 BILLION CAP THAT MAY REDUCE MY COVERAGE, AND I HAVE BEEN NOTIFIED OF THE PORTION OF MY PREMIUM ATTRIBUTABLE TO SUCH COVERAGE.

_________________________
Policyholder/Applicant’s Signature

_________________________
Print Name

_________________________
Date

Name of Insurer: ___________________
Policy Number: ___________________

DRAFTING NOTE: An insurer may choose not to use the acknowledgement section for workers’ compensation.
EXPEDITED SERFF FILING TRANSMITTAL DOCUMENT
FOR TERRORISM RISK INSURANCE FORMS AND PRICING

<table>
<thead>
<tr>
<th>Indicate Type of Filing</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Filing Related to Certified Losses</td>
</tr>
<tr>
<td>☐ Filing Related to Non-Certified Losses</td>
</tr>
<tr>
<td>☐ Filing Applicable to Both Certified and Non-Certified Losses</td>
</tr>
</tbody>
</table>

This abbreviated filing transmittal document should be used in conjunction with a SERFF filing only.

To be complete, a filing must include the following:
- A completed Expedited SERFF Filing Transmittal Document.
- One copy of each endorsement, disclosure form and/or other policy language, unless the insurer has given an advisory organization authorization to file them on its behalf.
- A copy of the rates, rating systems and supporting documentation, if applicable.
- The appropriate filing fees, if applicable

The insurer(s) submitting this filing certifies that it:
- ☐ Is in compliance with the terms of the Terrorism Risk Insurance Act, as amended, and/or the laws of this state; and
- ☐ Is in compliance with the requirements of the bulletin containing the voluntary expedited filing procedures.

Electronic Signature: [This would be replaced with a prompt for an Adobe electronic signature.]
EXPEDITED SERFF FILING TRANSMITTAL DOCUMENT FOR TERRORISM RISK INSURANCE FORMS AND PRICING

Indicate Type of Filing

☐ Filing Related to Certified Losses  ☑ Filing Related to Non-Certified Losses
☐ Filing Applicable to Both Certified and Non-Certified Losses

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- The appropriate filing fees, if applicable

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☑ Is in compliance with the terms of the Terrorism Risk Insurance Act, as amended, and/or the laws of this state; and
☑ Is in compliance with the requirements of the bulletin containing the voluntary expedited filing procedures.

Electronic Signature: [This would be replaced with an actual Adobe electronic signature.]

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HEALTH REFORM DATA CALL DEFINITIONS

Adopted by the Market Analysis Procedures (D) Working Group – December 11, 2014

Adopted by the Market Regulation and Consumer Affairs (D) Committee – December 19, 2014
<table>
<thead>
<tr>
<th>Line #</th>
<th>Terms and Data Elements</th>
<th>Definition</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health Insurance Coverage</td>
<td>Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. This is not intended to include excepted benefits as defined in 42 U.S.C. § 300gg-91(c). This is also not intended to include closed blocks not subject to Medical Loss Ratio (MLR) reporting under Centers for Medicare &amp; Medicaid Services (CMS) guidance nor is it intended to include self-funded plans.</td>
<td>42 U.S.C. § 300gg-91 (c) CCIIO Technical Guidance (CCIIO 2013-0001)</td>
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<td>Exchange (Marketplace)</td>
<td>The Affordable Care Act (ACA) creates new “American Health Benefit Exchanges” in each state to assist individuals and small businesses in comparing and purchasing qualified health insurance plans. An exchange may be a governmental agency or non-profit entity that meets the applicable standards of the ACA and makes Qualified Health Plans (QHPs) available on the marketplace to qualified individuals and/or qualified employers. Unless otherwise identified, this term includes an Exchange serving the individual market for qualified individuals and a Small Business Health Options Program (SHOP) serving the small group market for qualified employers, regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by Health and Human Services (HHS). The individual Exchange will determine who qualifies for subsidies and make subsidy payments to insurers on behalf of individuals receiving them.</td>
<td>Part 155.20-- Exchange Establishment Standards and Other Related Standards under the Affordable Care Act</td>
</tr>
<tr>
<td>Line #</td>
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<td>Definition</td>
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<td></td>
<td><strong>In Exchange</strong></td>
<td><strong>Health insurance coverage</strong> acquired through the <strong>Exchange</strong> (marketplace) as described above.</td>
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<tr>
<td></td>
<td><strong>Out of Exchange</strong></td>
<td><strong>Health insurance coverage</strong> acquired outside the <strong>Exchange</strong> (marketplace) as described above.</td>
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<td><strong>Bronze (Metal Level)</strong></td>
<td><strong>Health insurance coverage</strong> in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value (with allowable de minimus variations as described in 45 CFD 156.140(c)) of the benefits provided under the plan.</td>
<td>42 U.S.C. § 18022 (d)(1)(A)</td>
</tr>
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<td><strong>Silver (Metal Level)</strong></td>
<td><strong>Health insurance coverage</strong> in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value (with allowable de minimus variations as described in 45 CFD 156.140(c)) of the benefits provided under the plan.</td>
<td>42 U.S.C. § 18022 (d)(1)(B)</td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
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<td></td>
<td>Gold (Metal Level)</td>
<td>Health insurance coverage in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value (with allowable de minimus variations as described in 45 CFD 156.140(c)) of the benefits provided under the plan.</td>
<td>42 U.S.C. § 18022 (d)(1)(C)</td>
</tr>
<tr>
<td></td>
<td>Platinum (Metal Level)</td>
<td>Health insurance coverage in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value (with allowable de minimus variations as described in 45 CFD 156.140(c)) of the benefits provided under the plan.</td>
<td>42 U.S.C. § 18022 (d)(1)(D)</td>
</tr>
<tr>
<td></td>
<td>Catastrophic</td>
<td>Health insurance coverage that does not provide a metal level of coverage. Catastrophic coverage plans pay less than 60% of the total average cost of care and are available only to people who are under 30 years of age before the beginning of the plan year or who have received an exemption from the requirement to maintain minimum essential coverage by reason of hardship or lack of affordability.</td>
<td>42 U.S.C. § 18022 (E)</td>
</tr>
<tr>
<td></td>
<td>Individual Health Insurance Coverage</td>
<td>Health insurance coverage offered in the individual market, but does not include short-term limited duration insurance.</td>
<td>42 U.S.C. § 300gg-91 (b) (5)</td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
<td>Definition</td>
<td>Reference</td>
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<td></td>
<td>Grandfathered</td>
<td>Health insurance coverage that an individual was enrolled in prior to March 23, 2010 either through an individual health insurance coverage or group health insurance coverage plan. Grandfathered plans are exempted from most changes required by the ACA. New employees may be added to group plans that are grandfathered, and new family members may be added to all grandfathered plans. The plan may lose grandfathered status if significant changes are made to the plan...</td>
<td>29 CFR § 2590.715-1251</td>
</tr>
<tr>
<td></td>
<td>Multi-State</td>
<td>Health insurance coverage created by ACA operated under contract with The U.S. Office of Personnel Management (OPM) and available in multiple states.</td>
<td>ACA 1334</td>
</tr>
<tr>
<td></td>
<td>Short-Term</td>
<td>Health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract.</td>
<td>45 CFR § 144.103</td>
</tr>
<tr>
<td></td>
<td>Small Group Health Insurance Coverage</td>
<td>Health insurance coverage offered in the small group market.</td>
<td>45 CFR § 144.103</td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
<td>Definition</td>
<td>Reference</td>
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</tr>
<tr>
<td></td>
<td>Student</td>
<td>Individual <strong>health insurance coverage</strong> that is provided pursuant to a written agreement between an institution of higher education and a health insurance issuer, and provided to students enrolled in that institution of higher education and their dependents, that meets the following conditions: (1) Does not make <strong>health insurance coverage</strong> available other than in connection with enrollment as a student (or as a dependent of a student) in the institution of higher education. (2) Does not condition eligibility for the <strong>health insurance coverage</strong> on any health status-related factor relating to a student (or a dependent of a student). (3) Meets any additional requirement that may be imposed under State law.</td>
<td>45 CFR § 147.145</td>
</tr>
<tr>
<td></td>
<td>Transitional Plan</td>
<td>Plans that are issued pursuant to the policy promulgated by the Centers for Medicare &amp; Medicaid Services (CMS) in a letter dated November 14, 2013 to the State Insurance Commissioners. If permitted by applicable State authorities, health insurance issuers may choose to continue certain coverage that would otherwise be <strong>cancelled</strong> or modified to comply with the ACA, and affected individuals and small businesses may choose to re-enroll in such coverage. CMS has further stated that, under the transitional policy, non-<strong>grandfathered health insurance coverage</strong> in the individual or small group market that is renewed for a policy year starting between January 1, 2014 and October 1, 2016 will not be considered to be out of compliance with certain market reforms if certain specific conditions are met including the approval of state authorities.</td>
<td></td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
<td>Definition</td>
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</tr>
<tr>
<td></td>
<td>Policy Administration</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Rescission</td>
<td>A rescission is a cancellation or discontinuance of coverage that has retroactive effect. (Does not include cancellations for non-payment.)</td>
<td>29 CFR § 2590.715-2712 A (2) NAIC Model Act 36 - Individual Market Health Insurance Coverage Model Act</td>
</tr>
<tr>
<td>PA1</td>
<td>Earned Premium</td>
<td>Total premium earned from all policies written by the insurer during the specified period.</td>
<td></td>
</tr>
<tr>
<td>PA2</td>
<td>Number of policies issued</td>
<td>Number of policies (contracts) for <strong>health insurance coverage</strong> issued during the specified period.</td>
<td></td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
<td>Definition</td>
<td>Reference</td>
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</tr>
<tr>
<td>PA3</td>
<td>Applications received by carrier that did not result in a policy</td>
<td>Number of applications (questionnaires and forms required by the insurer to determine eligibility) which were received by the carrier during the period but which did not result in a policy being issued.</td>
<td></td>
</tr>
<tr>
<td>PA4</td>
<td>Number of lives on policies issued</td>
<td>Total number of persons covered under all the insurance contracts during the period. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.</td>
<td></td>
</tr>
<tr>
<td>PA5</td>
<td>Member months for policies issued</td>
<td>The sum of total number of lives insured on a pre-specified day of each month of the reported year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.</td>
<td>Accident &amp; Health Policy Experience Exhibit of the Financial Annual Statement</td>
</tr>
<tr>
<td>PA6</td>
<td>Number of policy terminations and cancellations initiated by the consumer</td>
<td>Number of policies terminated at the insured's request.</td>
<td></td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
<td>Definition</td>
<td>Reference</td>
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</tr>
<tr>
<td>PA7</td>
<td>Number of policy terminations and cancellations due to non-payment of premium</td>
<td>Number of policies terminated because the insured never paid, or stopped paying, the required premium for coverage.</td>
<td></td>
</tr>
<tr>
<td>PA8</td>
<td>Number of lives impacted on terminations and cancellations initiated by the consumer</td>
<td>Total number of lives which were no longer covered as a result of policies terminated at the insured's request. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.</td>
<td></td>
</tr>
<tr>
<td>PA9</td>
<td>Number of lives impacted on policies terminated and cancelled due to non-payment</td>
<td>Total number of lives which were no longer covered as a result of policies terminated because the insured never paid, or stopped paying, the required premium for coverage. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.</td>
<td></td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
<td>Definition</td>
<td>Reference</td>
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</tr>
<tr>
<td>PA10</td>
<td>Number of rescissions</td>
<td>Number of policies cancelled as a result of a <em>rescission</em>.</td>
<td></td>
</tr>
<tr>
<td>PA11</td>
<td>Number of lives impacted by rescissions</td>
<td>Total number of lives which were no longer covered as a result of <em>rescissions</em>. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Claims Administration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Claim</td>
<td>For the purposes of this data call a claim means any individual line of service within a bill for services.</td>
<td>42 CFR § 447.45 (b)</td>
</tr>
<tr>
<td>CA1</td>
<td>Number of claims received</td>
<td>Number of <em>claims</em> received by a carrier during the period requesting payment or reimbursement based on the terms of the insurance policy. Note: For the purposes of this data call a <em>claim</em> means any individual line of service.</td>
<td></td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
<td>Definition</td>
<td>Reference</td>
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</tr>
<tr>
<td>CA2</td>
<td>Number of claims submitted by in-network providers</td>
<td>Number of claims received by a carrier asking for a payment or reimbursement by or on behalf of an in-network health care provider (such as a hospital or doctor) that is contracted to be part of the network for a carrier (such as a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO)). The provider agrees to the carriers' rules and fee schedules in order to be part of the network and usually agrees not to balance bill patients for amounts beyond the agreed upon fee. Note: For the purposes of this data call a claim means any individual line of service.</td>
<td></td>
</tr>
<tr>
<td>CA3</td>
<td>Number of claims submitted by out-of-network Providers</td>
<td>Number of claims received by a carrier asking for a payment or reimbursement by or on behalf of an out-of-network health care provider (such as a hospital or doctor) that is not contracted to be part of a carrier's network (such as an HMO or PPO). Note: For the purposes of this data call a claim means any individual line of service.</td>
<td></td>
</tr>
<tr>
<td>CA4</td>
<td>Number of claim denials for in-network claims</td>
<td>Number of claims received by a carrier asking for a payment or reimbursement by or on behalf of an in-network health care provider (such as a hospital or doctor) that is contracted to be part of the network for a carrier (such as an HMO or PPO) and were subsequently denied by the carrier. Note: For the purposes of this data call a claim means any individual line of service. Do not include claims that were pended for additional information and subsequently paid.</td>
<td></td>
</tr>
<tr>
<td>CA5</td>
<td>Stratification of days (tied to CA4)</td>
<td>A grouping of number of days that it has taken to deny in-network claims. (0-15, 16-30, 31 to 45, 46 to 90, 91 to 180, 181 to 360, 360+).</td>
<td></td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
<td>Definition</td>
<td>Reference</td>
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</tr>
<tr>
<td>CA6</td>
<td>Number of claims denials for out-of-network claims</td>
<td>Total number of <em>claims</em> received by a carrier asking for a payment or reimbursement by or on behalf of an out-of-network health care provider (such as a hospital or doctor) that is not contracted to be part of a carrier's network (such as an HMO or PPO) and subsequently denied by the carrier. Note: For the purposes of this data call a claim means any individual line of service. Do not include <em>claims</em> that were pended for additional information and subsequently paid.</td>
<td></td>
</tr>
<tr>
<td>CA7</td>
<td>Stratification of days (tied to CA6)</td>
<td>A grouping of number of days that it has taken to deny out-of-network <em>claims</em>. (0-15, 16-30, 31 to 45, 46 to 90, 91 to 180, 181 to 360, 360+).</td>
<td></td>
</tr>
<tr>
<td>CA8</td>
<td>Number of paid claims for in-network services</td>
<td>Total number of <em>claims</em> received by a carrier asking for a payment or reimbursement by or on behalf of an in-network health care provider (such as a hospital or doctor) that is contracted to be part of the network for a carrier (such as an HMO or PPO) and were subsequently paid by the carrier. Note: For the purposes of this data call a claim means any individual line of service. Include <em>claims</em> that were pended for additional information and subsequently paid.</td>
<td></td>
</tr>
<tr>
<td>CA9</td>
<td>Stratification of days (tied to CA8)</td>
<td>A grouping of number of days that it has taken to pay in-network <em>claims</em>. (0-15, 16-30, 31 to 45, 46 to 90, 91 to 180, 181 to 360, 360+).</td>
<td></td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
<td>Definition</td>
<td>Reference</td>
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</tr>
<tr>
<td>CA10</td>
<td>Number of paid claims for out-of-network services</td>
<td>Total number of claims received by a carrier asking for a payment or reimbursement by or on behalf of an out-of-network health care provider (such as a hospital or doctor) that is not contracted to be part of a carrier's network (such as an HMO or PPO) and subsequently paid by the carrier. Note: For the purposes of this data call a claim means any individual line of service. Include claims that were pended for additional information and subsequently paid.</td>
<td></td>
</tr>
<tr>
<td>CA11</td>
<td>Stratification of days (tied to CA10)</td>
<td>A grouping of number of days that it has taken to pay out-of-network claims. (0-15, 16-30, 31 to 45, 46 to 90, 91 to 180, 181 to 360, 360+).</td>
<td></td>
</tr>
<tr>
<td>CA12</td>
<td>Claims Paid</td>
<td>Total dollar value of payments by the carrier for benefits reflected in claimants’ Explanations of Benefits (EOBs) for the requested period.</td>
<td></td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
<td>Definition</td>
<td>Reference</td>
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</tr>
<tr>
<td>CA13</td>
<td>Insured/beneficiary co-payment responsibility</td>
<td>Total dollar value of co-payments reflected in claimants' EOBs for the requested period. A co-payment is a fixed amount (for example, $15) paid by a covered life for a covered health care service, usually paid when the service is provided. The amount can vary by the type of covered health care service.</td>
<td></td>
</tr>
<tr>
<td>CA14</td>
<td>Insured coinsurance responsibility</td>
<td>Total dollar value of co-insurance applied on benefits reflected in claimants' EOBs for the requested period. Co-insurance is the percentage amount, if any, of a covered benefit which the insured pays as share of the payment made against a claim.</td>
<td></td>
</tr>
<tr>
<td>CA15</td>
<td>Insured deductible responsibility</td>
<td>Total dollar value of deductibles applied by the carrier for the requested period. A deductible is the amount owed for health care services the plan covers before the health insurance or plan begins to pay.</td>
<td></td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
<td>Definition</td>
<td>Reference</td>
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<td></td>
<td><strong>Adverse Determination</strong></td>
<td>A <em>rescission</em>, or a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a member’s, or eligible dependent’s, eligibility to participate in a plan, and including a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>External Review</strong></td>
<td>An independent review of an <em>adverse determination</em> or final adverse determination.</td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
<td>Definition</td>
<td>Reference</td>
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</tr>
<tr>
<td>1</td>
<td>External (Independent) Review Organization</td>
<td>An entity that conducts independent external review of adverse determinations or final adverse determination.</td>
<td>NAIC Model Act 76 - Uniform Health Carrier External Review Model Act</td>
</tr>
<tr>
<td>2</td>
<td>Grievance</td>
<td>A written complaint, or oral complaint if the complaint involves an urgent care request, submitted by or on behalf of a covered person regarding: (1) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (2) Claims payment, handling or reimbursement for health care services; or (3) Matters pertaining to the contractual relationship between a covered person and a health carrier.</td>
<td>NAIC Model Act 72 - Health Carrier Grievance Procedure Model Act</td>
</tr>
<tr>
<td>3</td>
<td>Grievance for Non-Adverse Determination</td>
<td>A grievance arising from any issue other than an adverse determination.</td>
<td>NAIC Model Act 72 - Health Carrier Grievance Procedure Model Act</td>
</tr>
<tr>
<td>4</td>
<td>Internal Review</td>
<td>A process by which the insured may have an adverse determination reviewed by the carrier with respect to a denial of an admission, availability of care, continued stay or health care services for a covered person.</td>
<td>NAIC Model Act 72 - Health Carrier Grievance Procedure Model Act</td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
<td>Definition</td>
<td>Reference</td>
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</tr>
<tr>
<td></td>
<td>Overtuned Decision</td>
<td>A reversal of a denial of an adverse determination by a health carrier or its designee utilization review organization.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Upheld Decision</td>
<td>A denial of an adverse determination that has been found to be supported by a health carrier or its designee utilization review organization.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Voluntary Review Level</td>
<td>A level of review beyond the normal internal appeals process.</td>
<td>NAIC Model Act 72 - Health Carrier Grievance Procedure Model Act - Section 9</td>
</tr>
<tr>
<td>IR1</td>
<td>Number of customer requests for internal reviews of grievances involving adverse determinations (Do not include additional voluntary levels of reviews.)</td>
<td>See definition of internal review above.</td>
<td></td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
<td>Definition</td>
<td>Reference</td>
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</tr>
<tr>
<td>IR2</td>
<td>Number of adverse determinations upheld upon request for internal review (Do not include additional voluntary levels of reviews.)</td>
<td>See definition of <strong>upheld decision</strong> above.</td>
<td></td>
</tr>
<tr>
<td>IR3</td>
<td>Number of final adverse determinations overturned upon request for external review (Do not include additional voluntary levels of reviews.)</td>
<td>See definition of <strong>overturned decision</strong> above.</td>
<td></td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
<td>Definition</td>
<td>Reference</td>
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</tr>
<tr>
<td>IR4</td>
<td>Does the company have an additional voluntary level of review for grievances? Y/N (Applies to all plans and all metal levels)</td>
<td>See definition of <strong>voluntary review level</strong> above.</td>
<td></td>
</tr>
<tr>
<td>IR5</td>
<td>Number of customer requests for internal reviews of grievances not involving adverse determinations</td>
<td>See definition of <strong>grievance for non-adverse determination</strong>.</td>
<td></td>
</tr>
<tr>
<td>ER1</td>
<td>Number of customer requested appeals on final adverse determinations to an external review organization</td>
<td>See definition of <strong>external review</strong> above.</td>
<td></td>
</tr>
<tr>
<td>Line #</td>
<td>Terms and Data Elements</td>
<td>Definition</td>
<td>Reference</td>
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</tr>
<tr>
<td>ER2</td>
<td>Number of final adverse determinations upheld upon request for external review</td>
<td>See definition of <em>upheld decision</em> above.</td>
<td></td>
</tr>
<tr>
<td>ER3</td>
<td>Number of final adverse determinations overturned upon request for external review</td>
<td>See definition of <em>overturned decision</em> above.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Policy Administration</td>
<td>Claims Administration</td>
<td></td>
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<tr>
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<td></td>
</tr>
<tr>
<td>1</td>
<td>Health insurance coverage other than transitional, grandfathered, multi-state, or student</td>
<td>For all Small Group Health Insurance Coverage other than transitional, grandfathered, or multi-state policies</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Multi-State (Individual)</td>
<td>Multi-State (Small Group)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Bronze</td>
<td>Silver</td>
<td>Gold</td>
</tr>
<tr>
<td>4</td>
<td>Number of claims submitted by network providers</td>
<td>Number of claims submitted for by out of network providers</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Number of claim denials for out-of-network claims</td>
<td>Stratification by number of days: 0-15, 16-30, 31 to 45, 46 to 90, 91 to 180, 181 to 360, 360+</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Number of claim denials for out-of-network claims</td>
<td>Number of paid claims for in-network services</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Stratification by number of days: 0-15, 16-30, 31 to 45, 46 to 90, 91 to 180, 181 to 360, 360+</td>
<td>Stratification by number of days: 0-15, 16-30, 31 to 45, 46 to 90, 91 to 180, 181 to 360, 360+</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Number of paid claims for out-of-network services</td>
<td>Number of paid claims for out-of-network services</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Stratification by number of days: 0-15, 16-30, 31 to 45, 46 to 90, 91 to 180, 181 to 360, 360+</td>
<td>Stratification by number of days: 0-15, 16-30, 31 to 45, 46 to 90, 91 to 180, 181 to 360, 360+</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Number of days -- 0-15, 16-30, 31 to 45, 46 to 90, 91 to 180, 181 to 360, 360+</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>Number of days -- 0-15, 16-30, 31 to 45, 46 to 90, 91 to 180, 181 to 360, 360+</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>Number of days -- 0-15, 16-30, 31 to 45, 46 to 90, 91 to 180, 181 to 360, 360+</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td>Number of days -- 0-15, 16-30, 31 to 45, 46 to 90, 91 to 180, 181 to 360, 360+</td>
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</tr>
<tr>
<td>14</td>
<td></td>
<td>Number of days -- 0-15, 16-30, 31 to 45, 46 to 90, 91 to 180, 181 to 360, 360+</td>
<td></td>
</tr>
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<td>15</td>
<td></td>
<td>Number of days -- 0-15, 16-30, 31 to 45, 46 to 90, 91 to 180, 181 to 360, 360+</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td>Number of days -- 0-15, 16-30, 31 to 45, 46 to 90, 91 to 180, 181 to 360, 360+</td>
<td></td>
</tr>
</tbody>
</table>

In Exchange (Note: there are two sections with the same questions. In Exchange would not include large group or student coverage. Out of Exchange would not include Multi-State)
In Exchange (Note: there are two sections with the same questions. In Exchange would not include large group or student coverage. Out of Exchange would not include Multi-State)

<table>
<thead>
<tr>
<th></th>
<th>Health insurance coverage other than transitional, grandfathered, multi-state, or student</th>
<th>For all Small Group Health Insurance Coverage other than transitional, grandfathered or multi-state policies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Catastrophic</td>
<td>Multi-State (Individual)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

1. Number of customer requests for internal reviews of grievances involving adverse determinations. (Do not include additional voluntary levels of reviews.)
2. Number of adverse determinations upheld upon request for internal review. (Do not include additional voluntary levels of reviews.)
3. Number of adverse determinations overturned upon request for internal review. (Do not include additional voluntary levels of reviews.)
4. Does the company have an additional voluntary level of review for grievances? (N/A Applies to all plans and all metal levels)
5. Number of customer requests for internal reviews of grievances not involving adverse determinations.

1. Number of customer requests for appeals on final adverse determinations to an external review organization.
2. Number of final adverse determinations upheld upon request for external review.
3. Number of final adverse determinations overturned upon request for external review.
### Out of Exchange

(Note: there are two sections with the same questions. In Exchange does not include large group or student coverage. Out of Exchange does not include Multi-State)

<table>
<thead>
<tr>
<th>Policy Administration</th>
<th>Claims Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bronze</strong></td>
<td><strong>Bronze</strong></td>
</tr>
<tr>
<td><strong>Silver</strong></td>
<td><strong>Silver</strong></td>
</tr>
<tr>
<td><strong>Gold</strong></td>
<td><strong>Gold</strong></td>
</tr>
<tr>
<td><strong>Platinum</strong></td>
<td><strong>Platinum</strong></td>
</tr>
</tbody>
</table>

#### For all Large Group comprehensive major medical and managed care (Minimum Essential Coverage) policies

- Earned premiums for Reporting Year
- Number of policies issued
- Number of Applications received by the carrier that did not result in an issued policy
- Number of applications approved
- Number of claims denied
- Number of claims submitted by network providers
- Number of claims submitted by out of network providers
- Number of claims denied for out-of-network claims
- Number of claim denials for out-of-network claims
- Number of paid claims for in-network services
- Number of paid claims for in-network services
- Number of paid claims for out-of-network services
- Number of paid claims for out-of-network services
- **Insured/beneficiary co-payment responsibility**
<table>
<thead>
<tr>
<th>#</th>
<th><strong>Out of Exchange</strong> (Note: there are two sections with the same questions. In Exchange does not include large group or student coverage. Out of Exchange does not include Multi-State)</th>
<th><strong>Grandfathered</strong></th>
<th><strong>Catastrophic</strong></th>
<th><strong>For all Large Group comprehensive major medical and managed care (Minimum Essential Coverage) policies</strong></th>
<th><strong>For Student Coverage</strong></th>
<th><strong>Transitional Plans</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Health insurance coverage other than transitional, grandfathered, multi-state, or student</td>
<td>For Small Group health insurance Coverage other than transitional, grandfathered, or multi-state policies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Bronze Silver Gold Platinum</td>
<td>Bronze Silver Gold Platinum</td>
<td>Large Group Small Group Individual</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Consumer Requested Internal Reviews

1. Number of customer requests for internal review of grievances involving adverse determinations (Do not include additional voluntary levels of reviews.)
2. Number of adverse determinations upheld upon request for internal review (Do not include additional voluntary levels of reviews.)
3. Number of adverse determinations overturned upon request for internal review. (Do not include additional voluntary levels of reviews.)
4. Does the company have an additional voluntary level of review for grievances? 
   - Yes
   - No (Applies to all plans and all mental levels)
5. Number of customer requests for internal reviews of grievances not involving adverse determinations

### Consumer Requested External Reviews

6. Number of customer requested appeals of final adverse determinations to an internal review organization
7. Number of final adverse determinations upheld upon request for internal review.
8. Number of final adverse determinations overturned upon request for internal review.
To: weave.commissioner@nai.org
Subject: 2011 Revisions to the Model Risk Retention Act

In December 2011, the NAIC membership adopted revisions, consisting of the addition of corporate governance standards, to the Model Risk Retention Act. The revisions first arose from a request based upon the Risk Retention (C) Working Group’s consideration of developing corporate governance standards to respond to accreditation and corporate governance issues. The corporate governance standards were adopted by the Property and Casualty (C) Committee in June 2007 and referred to the Financial Condition (E) Committee for consideration to include the standards in the Property/Casualty Annual Statement Instructions. The Risk Retention (E) Task Force found that the Annual Statement Instructions were not the proper place for this guidance, but instead, should be incorporated into a model law or regulation so that a state insurance department could compel the RRG to comply with these requirements.

A statement and explanation of how the potential standard is directly related to solvency surveillance and why the proposal should be included in the standards:

Corporate Governance is a framework of systems, policies and procedures through which an insurer effectively and efficiently: provides for sound and prudent management and oversight of the insurer’s business; creates security and long-term value for policyholders, beneficiaries, and other stakeholders; exercises its corporate authority; and holds its Board members, Senior Management, and Key Persons in Control Functions accountable. Good corporate governance may include board membership, control, independent members, and audit committee make-up.

The purpose of the corporate governance standards within the Act is to ensure that insurers implement and operate within effective risk management and internal controls systems, including determining the level of internal economic capital that should be held for solvency purpose.

A statement as to why ultimate adoption by every jurisdiction may be desirable:

The purpose of the amendment to the Model Act is to incorporate corporate governance provisions for domestic regulators of risk retention groups. It is part of the accreditation review enhancement of the regulation of risk retention groups. Some domestic risk retention group regulators do not have any regulatory standards for corporate governance, for example whether independent board members should be required. This issue was addressed in a 2005 GAO Report, Risk Retention Groups: Common Regulatory Standards and Greater Member Protections Are Needed, GAO-05-536, which found that some risk retention group insureds were vulnerable to misgovernance. The Report called for uniform corporate governance standards that would establish the insureds’ authority over management.
Adoption of corporate governance standards related to risk retention groups will ensure uniform and effective regulation throughout the marketplace. The incorporation of corporate governance standards will allow a state insurance department to compel a risk retention group to comply with these requirements.

A statement as to the number of jurisdictions that have adopted and implemented the proposal or a similar proposal and their experience to date:

No states have been identified as adopting the proposed corporate governance standards for risk retention groups.

A statement as to the provisions needed to meet the minimum requirements of the standard. That is, whether a state would be required to have “substantially similar” language or rather a regulatory framework. If it is being proposed that “substantially similar” language be required, the referring committee, task force or working group shall recommend those items that should be considered significant elements:

States should have a regulatory framework such as the corporate governance standards contained within the NAIC’s Model Risk Retention Act or similar provisions.

An estimate of the cost for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it, if reasonably quantifiable:

There will be some initial costs to implement changes at the company and state insurance departments of states that have domestic RRGs, however the compliance and implementation costs should not be overly burdensome, since the Working Group considered the size of the companies and allows for alternative compliance as appropriate. The Model Act permits states to use their existing enforcement tools, but would expand the actions that may be taken given the new items that need to be complied with.

Additional information: None.
State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

NOTE: In order to provide readers with the most current status of each adopted model, an update of this report will be available on March 30, with the posting of final materials for the Executive (EX) Committee and Plenary joint meeting.

**Life Insurance and Annuities (A) Committee**
- Amendments to the *Annuity Disclosure Model Regulation* (#245)
- Amendments to the *Standard Nonforfeiture Law for Life Insurance* (#808)
- Amendments to the *NAIC Model Rule for Recognizing a New Annuity Mortality Table for Use in Determining Reserve Liabilities for Annuities* (# 821)

**Health Insurance and Managed Care (B) Committee**
- Amendments to the *Health Insurance Reserves Model Regulation* (#10)
- *Individual Market Health Insurance Coverage Model Regulation* (#26)—(falls under the September 2008 federal law exemption to the Executive (EX) Committee approval requirement).
- *Individual Market Health Insurance Coverage Model Act* (#36)—(falls under the September 2008 federal law exemption to the Executive (EX) Committee approval requirement).
- 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).
- 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).
- *Small Group Market Health Insurance Coverage Model Act* (#106)
- *Coordination of Benefits Model Regulation* (#120)
- *Small Group Market Health Insurance Coverage Model Regulation* (#126)
- Amendments to the *Long-Term Care Insurance Model Regulation* (#641)

**Property and Casualty Insurance (C) Committee**
- Amendments to the *Business Transacted with Producer Controlled Property/Casualty Insurer Act* (#325)

**Financial Condition (E) Committee**
- *Corporate Governance Annual Disclosure Model Act* (#305)
- *Corporate Governance Annual Disclosure Model Regulation* (#306)
- *Insurance Holding Company System Regulatory Act* (#440)
- *Risk Management and Own Risk and Solvency Assessment Model Act* (#505)