Initial Report of Rector & Associates, Inc.

to the

Principle-Based Reserving Implementation (EX) Task Force

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Introduction

Task Force's Charge

The NAIC's Principle-Based Reserving (PBR) Implementation (EX) Task Force serves as the coordinating body for all NAIC technical groups involved with projects related to the PBR initiative for life and health policies. The Task Force is also charged with further assessing the solvency implications of life insurer-owned captive insurers and alternative mechanisms. The following charge was given to the Task Force by the Executive Committee:

> *Upon completion of the Captives and Special Purpose Vehicle Use (E) Subgroup's Report and subsequent referral by the Financial Condition (E) Committee, consider the Report's recommendations in the context of the proposed PBR system and make further recommendations, if any, to the Executive (EX) Committee.*

This report is designed to assist the Task Force with its work relative to this charge.

What Led to the Charge

What led to the Task Force's charge can perhaps be most easily understood by considering the following hypothetical: Assume an Insurer has written a block of business consisting of term life and universal life with secondary guarantees (ULSG) that, in the aggregate, would require a XXX/AXXX statutory reserve of $1 Billion. Assume further that, although the Insurer agrees that the rules require a $1 Billion reserve, it believes there is a significant likelihood that the full $1 Billion will not be needed to pay policyholder claims. The Insurer knows there is a 100% probability that the first dollar in the reserve will be needed. However, assume the Insurer believes the probability is low that the last dollar in the $1 Billion reserve will be needed.

In response to this belief, the Insurer would like to fund the $1 Billion reserve using assets that correlate in some way to the probability they will be needed to pay claims. In other words, the Insurer would like to use high quality assets allowed by insurance statutory accounting (i.e., "admitted assets") to fund that portion of the reserve that has a high probability of being needed, plus what it views as a conservative cushion, and to use lower quality assets (including those typically not allowed by insurance statutory accounting, or "non-admitted assets") to fund the portion of the reserve that has a low probability of being needed. Continuing the example, assume that, based on an actuarial analysis, the Insurer concludes that $600 Million would be conservatively sufficient to pay all policyholder claims under the vast majority of realistic scenarios. In that case, the Insurer might want to fund the $1 Billion reserve by holding $600 Million in admitted assets and $400 Million in non-admitted assets. In the Insurer's view, using admitted assets to fund the full $1 Billion would significantly increase the Insurer's costs (since high quality admitted assets cost more than lower quality non-admitted assets) while providing little, if any, real additional protection to policyholders. Since these increased

costs would be passed on to consumers through increased premiums and/or decreased coverage, the Insurer believes funding the entire $1 Billion with admitted assets would actually harm, rather than help, the insurance consuming public.

The problem for the Insurer, of course, is that current insurance statutory accounting rules do not distinguish between the first and last dollar of the reserve requirement. Under current statutory accounting rules, the entire $1 Billion reserve must be funded with admitted assets. Those supporting this requirement say that the reserving rules were purposely established in a conservative fashion, that the Insurer's reserve is set at $1 Billion because that amount may be needed to pay policyholder claims, and that if reserving rules require a reserve to be established, then that reserve should be backed by admitted assets, which in most instances can be used more easily to pay claims than can non-admitted assets. Supporters of the requirement also state that the reserves of any particular insurer should be looked at in total, not just on a block of business by block of business basis, since reserving rules were designed with the understanding that very conservative reserves for some blocks of business might be needed to compensate for less conservative reserves for other blocks of business.

Transactions at Issue

The transactions at issue arose against this backdrop. In response to situations like those presented in the hypothetical, insurers have entered into various reinsurance transactions to "finance" different portions of the statutory reserve differently—i.e., to fund different portions of the reserve using different kinds of assets—based on what insurers believe is a better correlation between the kind of asset used and the probability that it will be needed. Using the hypothetical above, although the split between the $600 Million (in admitted assets) and $400 Million (in non-admitted assets) technically occurs at the reinsurance company level—at the "captive/SPV" level—the economic effect is to allow the Insurer to do through a reinsurance transaction what it could not do directly: to back the $1 Billion reserve using $600 Million in admitted assets and $400 Million in non-admitted assets.

There are strong opinions, at both ends of the spectrum, regarding the propriety of these types of transactions.

Insurers using these transactions state that the transactions are legal and within the legitimate bounds of captive reinsurance and regulatory discretion. In this regard, these insurers point out that the transactions usually are based on numerous actuarial studies and are approved by insurance regulators on behalf of both the ceding and assuming entities that are parties to the transaction. These insurers and regulators believe the actuarial studies incorporate conservative assumptions and lead to conservative determinations regarding the amount of high quality assets held. In their view, these transactions are safe, legal, and conservative, and they serve a proper role in more closely matching assets held to the likely need for those assets, thereby helping keep insurance available and cost-effective.

Those at the other end of the spectrum point out that these types of transactions allow an insurer to do indirectly what it could not do directly, thereby by-passing what they view as important safeguards in insurance statutory accounting and reserving rules. They also do not believe these transactions are in fact as safe, legal and conservative as their proponents claim. In this regard, some regulators believe the actuarial studies currently being performed are not sufficiently conservative and do not lead to appropriate levels of high quality assets being held. They also have concerns regarding the types of lower quality assets that have been allowed. Further, some regulators point out that the transactions involve third party risks (i.e., risks related to insurance provided by the ceding insurer to third party policyholders) rather than first party risks (i.e., insurance risks of the ceding insurer itself). These regulators therefore question whether the transactions truly involve "captive reinsurance" at all, or at least whether they involve "captive reinsurance" of the type intended to be exempt from the NAIC's Accreditation Program. Moreover, a number of regulators believe the lack of uniformity in the standards applied to these types of transactions has prompted insurers to seek out what the insurers view as favorable domiciles, thereby undermining a consistently appropriate regulatory approach.

Threshold Decision

The threshold decision the Task Force must make pertains to this divide. The Task Force needs to decide whether to accept the Insurer's general logic set out above—i.e., the logic that lower quality non-admitted assets should be allowed to back portions of the reserve that have a low probability of being needed to pay claims—or whether, instead, to seek to prohibit transactions that result in an economic effect different than the current statutory accounting requirement that admitted assets be used to back 100% of statutory reserves.

Most of those we interviewed appear to believe that insurers should be allowed to use lower quality non-admitted assets, at least to some extent, if the insurer can conservatively demonstrate that there is a low probability such assets will be needed to pay claims. Although this is the view of most of the regulators with whom we spoke (as well as that of most of the insurers interviewed), we only interviewed regulators representing approximately 15 states/jurisdictions, many of which have approved these types of transactions in some form or other. Accordingly, we do not know whether the views of those with whom we spoke are representative of the views of the broader regulatory community.

Further, even though most of those we interviewed appear to accept this logic in general terms, we also learned there is significant unease regarding how the logic is currently being implemented, and especially as to the lack of consistency from insurer to insurer and regulator to regulator regarding key aspects of transactions that have been approved. For example, even if two insurers were identical in all material ways, insurer and regulatory processes differ such that one of the insurers might be allowed to hold a lower level of high quality admitted assets than its identical twin. This unease is compounded by the fact that often there is minimal disclosure regarding key elements of approved transactions, even from one regulator to another.

Framework for Consideration

If the Task Force's response to the threshold decision is to reject the general logic that supports allowing lower quality non-admitted assets to back portions of the reserve, its task is fairly straightforward: it should work toward prohibiting these types of transactions. If the Task Force's response to the threshold decision is to accept the general logic supporting these types of transactions, but also to conclude that changes to the existing regulatory framework are needed to promote consistency and to ensure that approved transactions are appropriately conservative, the Task Force's job is more complex. For the purposes of our initial report, we have assumed the Task Force will want to at least explore the latter option. Accordingly, in this report we have set out a regulatory framework for consideration relative to these types of transactions, along with a corresponding list of "Issues to be Addressed."

The conceptual underpinnings of the framework are straightforward:

- XXX and AXXX reserves to pay policyholder claims should be established in full, using applicable reserving guidance (currently, the "formulaic" approach).

- To the extent there is a reasonable probability that they may be needed to pay policyholder claims, those reserves should be conservatively backed by high quality assets.

- Lower quality assets (including those not normally allowed as admitted assets under statutory accounting) should be allowed to support such reserves, to a limited extent, if an insurer receives regulatory approval to use them, if the assets meet certain criteria, and if the probability that they will be needed to pay policyholder claims is low.

- To provide consistency and a level playing field, all insurers and regulators should use the same actuarial standard to determine what portion of the reserves must be backed by high quality assets and what portion may be backed by lower quality assets.

- There should be appropriate disclosure so regulators and others (such as rating agencies) can verify that insurers are following the rules and can more effectively measure the levels of risk presented by approved transactions.

The framework sets out two alternatives as to how these concepts may be applied in practice. One alternative involves the use of reinsurance. The other involves keeping the assets and liabilities at the direct writing company level.

What the Framework Does Not Do; "Issues to be Addressed"

Of course, the framework leaves many of the key elements unanswered. For example, although the framework contemplates that all insurers and regulators will use the same actuarial standard to determine what portion of the reserves must be backed by high quality assets and what portion may be backed by lower quality assets, the framework does not propose any specific standard. Similarly, although the framework contemplates that lower quality assets would need to meet certain criteria, it does not propose any specific criteria or speak to whether any specific asset should or should not be allowed.

Following the framework is a list of "Issues to be Addressed" that covers these items, and many others. We have also included some comments and ideas for consideration regarding each of the issues. It is contemplated that decisions regarding the "Issues to be Addressed" will be made by regulators after duly considering input from all stakeholders. In this regard, please note that many of the issues are related, such that a decision made as to one issue may affect the decision made relative to another. For example, if the actuarial standard selected is sufficiently conservative so it results in high quality assets being held in an amount sufficient to cover policyholder claims under the vast majority of realistic possible scenarios, significant flexibility may be warranted as to the remaining assets because there will be a very low probability that such assets will be needed to pay claims. Conversely, if the actuarial standard selected provides a more moderate level of conservatism, there may be a need for greater regulation of the remaining assets because a greater probability exists that the insurer will need to use those assets to pay claims.

Applicability of Framework in Relation to Task Force's Threshold Decision

As noted above, the framework sets out a regulatory approach that could be used if the Task Force resolves the threshold question by deciding in favor of continuing to permit these types of financing arrangements in some form. The framework would not be appropriate if the Task Force decides to walk down the other path—the path of requiring the Insurer to back the full $1 Billion reserve with admitted assets. In presenting the framework, we hope that, at a minimum, it will allow the Task Force to see what the path of continuing to permit financing transactions might look like, so it can decide whether it wants to walk down that path or down a different one.

Conclusion

We hope the Task Force finds this Report helpful as it addresses the charge given to it by the NAIC's Executive Committee. We stand ready to answer any questions or to assist further regarding these matters, as requested by the Task Force.

Framework

Alternative A—via Reinsurance:

Any insurer that seeks to reduce the net retention of its XXX or AXXX reserves through a reinsurance ceding arrangement will be allowed to do so if, but only if, the following criteria are satisfied:

a. The ceding insurer's gross XXX and AXXX reserves are established, in full, using applicable reserving guidance (currently, the "formulaic" approach);

b. The transaction to reduce the net retention of those reserves is approved by the ceding insurer's domestic regulator and by the state/jurisdiction in which the assuming insurer is domiciled;

c. The ceding insurer satisfies the "Primary Asset Requirement" (i.e., the ceding insurer receives collateral consisting of "Primary Assets" in at least the amount determined pursuant to the "Actuarial Standard");

d. The ceding insurer receives collateral consisting of "Other Assets" with respect to any portion of the reserve credit that is not collateralized by "Primary Assets;" and

e. The "Disclosure Requirements" are met.

Alternative B—at the Direct Insurer Level:

In lieu of seeking to reduce its net retention of XXX or AXXX reserves through a reinsurance ceding arrangement, a direct writing insurer may choose to achieve substantially the same economic effect as the above by satisfying the following criteria:

a. The insurer's gross XXX and AXXX reserves are established, in full, using applicable reserving guidance (currently, the "formulaic" approach);

b. The arrangement is approved by the insurer's domestic regulator;

c. The insurer separately identifies on its statutory financial statement the gross reserve for the business at issue;

d. The insurer also separately identifies on its statutory financial statement the following two categories of assets supporting the gross reserve for that business: (1) "Primary Assets" in an amount at least equal to the "Primary Asset Requirement," and (2) "Other Assets" to the extent the insurer seeks to rely on such assets to support a portion of the gross reserve; and

e. The "Disclosure Requirements" are met.

Comment Regarding Alternative B: The intent of Alternative B is to allow an insurer to achieve substantially the same economic effect as what would be permitted under Alternative A, but without using reinsurance. Under Alternative B, the framework contemplates that the direct writing insurer would meet virtually the same requirements as it would if it were a ceding insurer under Alternative A. In other words, the direct insurer would be required to establish its gross reserves in full using applicable reserving guidance (currently, the "formulaic" approach) and to perform a review of those reserves using the "Actuarial Standard," just as it would if it were a ceding insurer under Alternative A. Additionally, the direct insurer would hold "Primary Assets" in the same amount as would be required if reinsurance were used and would be allowed to hold "Other Assets" in the same amount and subject to the same restrictions as if reinsurance were used. However, rather than holding these various assets pursuant to a reinsurance arrangement, the direct insurer would retain the assets and liabilities and would report them on its statutory financial statements. As discussed in Issue 8 of the Issues to be Addressed, it may be appropriate to use a separate account structure or a newly-developed accounting schedule to identify and report these assets and liabilities. Regardless of how reported, though, the intent of the framework is that, whether Alternative A or Alternative B is used, the net capital/surplus effect to the ceding/direct insurer would be the same.

Comment Regarding Choice Between Alternatives: As drafted, the framework assumes that both Alternative A and Alternative B would be adopted, so an insurer would have the ability to choose between them depending on whether the insurer wanted to use reinsurance as the vehicle for the financing arrangement or whether, instead, it wanted to hold the assets and liabilities directly. It is possible, of course, for the Task Force and NAIC to adopt only one of the two alternatives, thereby only permitting financing arrangements of the type described in the selected alternative. In this regard, it should be noted that some regulators and insurers we interviewed appeared to be of the view that any financing arrangements should be permitted only at the direct insurer level, due to a belief that those types of financing arrangements would be more transparent and could more easily be evaluated for compliance purposes than would arrangements conducted via reinsurance. If the Task Force agrees with that view, it should adopt Alternative B only.

Issues to be Addressed

1. Determine what constitutes the "Actuarial Standard" and how it is to be used to determine the "Primary Asset Requirement."

   Comment: By far the most important aspect of implementing the framework, and the most difficult to accomplish, is selecting the "Actuarial Standard."

   Two Goals

   The Actuarial Standard should meet two goals. The primary goal is to set criteria such that, if presented with the same fact pattern, all insurers/regulators would reach substantially the same result regarding what portion of an insurer's statutory reserve must be supported by Primary Assets and what portion may be supported by Other Assets. The Actuarial Standard need not be a rigid "one size fits all" approach to achieve the desired consistency. Rather, the goal is to select an Actuarial Standard that appropriately reflects differences in business mix and characteristics from one insurer to another, but one that also would lead to substantially the same result for any given insurer no matter who performs or oversees the actuarial analysis.

   A second goal is to select an Actuarial Standard that achieves consensus acceptance by all (or at least most) regulators and insurers. If regulators and insurers agree with the Actuarial Standard selected, all other aspects of the framework should fall into place and there should not be significant compliance issues in the years ahead. However, if either group is not comfortable with the standard selected—for example, if insurers believe the Actuarial Standard is unnecessarily conservative or if regulators believe it is not conservative enough—the group not comfortable with the standard will seek to achieve its objective through other aspects of the framework and/or may attempt to achieve its objective through other means while still remaining technically compliant.

   It will be difficult to develop consensus as to an Actuarial Standard, but it is worth the effort to try to do so. Not only would working toward a consensus Actuarial Standard be extremely important in successfully implementing the framework, it may also, more generally, help inform future discussions regarding PBR and might help bridge divides that may exist there.

   Starting point for discussion

   The starting point for discussion should probably be whether the Primary Reserve Methodology set out in AG 38, Section 8D.a.—either as adopted there or as modified—should be selected as the Actuarial Standard. This is the method that was agreed to on a compromise basis by regulators and insurers to be used to test certain AG 38 business that was "in force" as of December 31, 2012. This same method might be an appropriate Actuarial Standard, in part because it has the possibility of meeting both of the goals discussed above.

As to the first goal, the AG 38 method takes into account differences in business mix and characteristics, and yet it still leads to a reasonable level of consistency from one insurer to another.

As to the second goal, regulators and insurers ultimately agreed during the AG 38 deliberations that the method was an acceptable approach to determining whether the reserves held by insurers for in-force business are appropriate. As such, the AG 38 method might also ultimately find acceptance as the Actuarial Standard. We note that the New York Department of Financial Services (New York Department) recently issued a letter questioning how insurers were using AG 38 to establish reserves with respect to in-force business. In this regard, we wish to point out that, should it be selected as the Actuarial Standard, the method would be used for a different purpose here than for AG 38. Under AG 38, the method determines the amount of the reserve itself. In contrast, if selected as the Actuarial Standard, the method would not determine the reserve level; rather, it would determine the minimum amount of Primary Assets that must be held to support the reserve. The full statutory reserve—including any amounts exceeding the AG 38 number—would still need to be held and funded.

In addition to possibly meeting both of the goals discussed above, a supportive infrastructure has already been established relative to this AG 38 method, including that a group of regulatory actuaries has been created to answer questions as to how it should be applied. There also is a process in place whereby there is regulatory oversight through FAWG of how insurers are using the method. Further, the method incorporates significant elements of the Valuation Manual adopted by the NAIC pursuant to Model 820 (i.e., "VM 20"), thereby making it reasonably consistent with the reserving approach that would be required if PBR becomes effective.

It is likely that this method would not be anyone's first choice as to the Actuarial Standard. It should be anticipated that some insurers may want something less conservative, and some regulators may want something more conservative. However, the method would appear to meet the primary goal of providing consistency and a level playing field, and it may be something that insurers and regulators could ultimately find acceptable.

<u>Other approaches to be discussed</u>

Two other ways of arriving at a consensus Actuarial Standard present themselves. One way is to start with something that has consensus acceptance among regulators and then modifying it, as needed, so it also achieves consensus acceptance among insurers. A second way is somewhat the inverse of the first: to start with something that has consensus acceptance among insurers and then modifying it, as needed, so it also achieves consensus acceptance among regulators. Below are some comments regarding both of these possible approaches, as well as comments regarding a hybrid approach that may be worth exploring.

Starting with the regulator approach

As noted, one way to arrive at a consensus Actuarial Standard would be to start with something that has consensus acceptance among regulators and then modifying it, as needed, so it also achieves consensus acceptance among insurers. Although not all regulators have agreed to it, VM 20 is the most recent official determination by insurance regulators as to how much money insurance companies should set aside in reserves to pay policyholder claims. Using the same methodology to determine how much insurers should set aside in Primary Assets would be consistent with that regulatory determination. After all, insurers can only pay claims with cash, and Primary Assets would likely be more readily and easily convertible to cash than would Other Assets. Moreover, as discussed more fully in Issue 3 below, using VM 20 as the Actuarial Standard should obviate the need for extensive regulation of the "Other Asset" category. Further, if VM 20 is used as the Actuarial Standard, little or no incentive would exist for insurers to engage in these types of transactions in future years with respect to business covered by PBR since, for that business, the Primary Asset Requirement would be the same as the statutory reserve (both being determined using the same VM 20 methodology).

The primary argument against using VM 20 as the Actuarial Standard is that some insurers may believe it is too conservative, especially insurers that believe their experience will be significantly better than the assumptions prescribed in VM 20. In this regard, VM 20 may also be more conservative for some insurers than for others, due to differences in the business written, thereby unfairly impacting some insurers more than others and undermining incentives to develop products and underwriting practices designed to produce better than average experience. In contrast, there are at least some regulators who appear to believe VM 20 may not be conservative enough.

Other arguments against using VM 20 result from the fact that it is new. Accordingly, there are a number of questions as to how it should be applied. (In this regard, it should be noted that the existing group of regulatory actuaries referred to above that is answering questions pertaining to the application of VM 20 to AG 38 business could also be tasked with supporting use of VM 20 as the Actuarial Standard.) Further, because VM 20 is new, there has not been time or sufficient historical experience to vet the sufficiency/accuracy of the reserves that result from applying it.

Starting with the insurer approach

As noted above, a second way to arrive at a consensus would be to start with something that has consensus acceptance among insurers and then modifying it, as needed, so it also achieves consensus acceptance among regulators. Because each transaction is unique, and because each insurer approaches things in its own way, there is no one common "insurer approach" to these matters. However, it should not

be overly difficult to arrive at a "synthesized insurer approach," especially since most of the analyses relative to current transactions are performed by a handful of actuarial firms.

There are advantages to starting with a synthesized insurer approach. For example, insurers argue that due to the number of actuaries involved in most transactions—and to the fact that these actuaries approach the task from various perspectives and represent different interests—the insurer approach is more likely to arrive at the "right" answer regarding the need for primary assets than an approach developed in a more theoretical way. Further, insurers and third party financiers are already comfortable with the current insurer approach, thereby minimizing disruption in the marketplace that could result if a different approach is required.

The primary argument against using the current insurer approach is that some regulators may believe it is not conservative enough, especially in instances where insurers rely on their own actual or expected experience without having what regulators view as sufficiently credible historical experience to support that belief. Those questioning the insurer approach also point out that most of these transactions are relatively new, especially when compared to the longevity of the business underlying them, and that it is too early to tell whether the insurer approach is sufficiently conservative. Those regulators point to a long history of instances, involving all types of insurance, where insurers have been overly optimistic in their reserve projections. In this regard, it should be noted that analyses of various XXX and AXXX transactions currently being performed by the NAIC's Financial Analysis Working Group (FAWG) may be helpful to regulators as they evaluate the level of conservatism being incorporated into the current insurer approach and whether they are comfortable with that level of conservatism.

Additionally, at least some insurers also appear to believe that the current insurer approach may not be conservative enough. Those insurers point out that, due to the guaranty fund system, they might be left to pay claim liabilities incurred by other insurers if the assets supporting reserves are unavailable or of insufficient quality.

<u>Possible hybrid approach</u>

Rather than starting with either VM 20 or a synthesized insurer approach and making modifications to it in an attempt to achieve consensus, it may be worth considering a hybrid approach. Instead of using only one methodology and only one category of "Primary Assets," a hybrid approach might define the Actuarial Standard in such a way that it consists of two sets of calculations and two different tiers of "Primary Assets." For example, an insurer could be required to hold "Tier 1 Primary Assets" (e.g., high quality hard assets) to support reserves up to an amount determined pursuant to the synthesized insurer approach, and "Tier 2 Primary Assets" (e.g., assets that are of high quality, but of a type that are less expensive for insurers to finance) to support reserves above the level supported by Tier 1 assets up to an

amount determined pursuant to VM 20. "Other Assets" could then be used to support amounts exceeding VM 20.

At first blush, this hybrid approach might seem overly complicated, requiring duplicative and inappropriately expensive actuarial calculations. However, it may be easier and less expensive to develop such an approach than might be initially thought. For example, it appears that both the current insurer approach and VM 20 rely in significant part on stochastic testing. One of the most significant differences in how stochastic testing is used in the two approaches has to do with the level of conservatism selected—the "conditional tail expectation" ("CTE") used to define the upper level of the reserve. VM 20 requires that reserves be calculated to a "70 CTE" level. The current insurer approach may use a different CTE level. Accordingly, it may be worth exploring an Actuarial Standard that requires "Tier 1 Primary Assets" up to a particular CTE level and "Tier 2 Primary Assets" up to a higher CTE level. "Other Assets" could then be used to support portions of the reserve exceeding the higher CTE level. A variation of this hybrid would be to keep the same CTE level for the two calculations, but to allow differences in other assumptions, such as perhaps allowing insurers to have more flexibility in using their own expected experience for one calculation than for the other.

Other possible approaches

The approaches discussed above are certainly not the only possibilities. Other possible Actuarial Standards for consideration include: (1) the International Financial Reporting Standards (IFRS) (not yet adopted), (2) standards used to calculate reserves pursuant to Generally Accepted Accounting Principles (GAAP), and (3) cash flow testing approaches developed specifically for purposes of the framework.

2. Determine what constitutes "Primary Assets."

Comment: The starting point for discussion should probably be whether "Primary Assets" should consist solely of (1) cash and (2) securities listed by the NAIC's SVO. Another possibility for consideration would be assets that are considered to be "admitted assets" under the laws of the ceding/direct company. Clean, irrevocable, unconditional, "evergreen" letters of credit issued or confirmed by a qualified United States institution might also be considered for at least a portion of the Primary Asset Requirement (for example, as a permitted "Tier 2 Primary Asset" if the hybrid approach described above is used as the Actuarial Standard.)

3. Determine what constitutes "Other Assets."

Comment: The types of assets permitted as "Other Assets" should depend to a significant degree on what is selected as the Actuarial Standard. If the Actuarial Standard results in a high Primary Asset Requirement sufficient to cover the vast majority of realistic possible scenarios, significant flexibility may be warranted as to

Other Assets since there should be a very low probability that such assets will be needed to pay policyholder claims. In this regard, if VM 20 is selected as the Actuarial Standard, all insurers would be holding Primary Assets in an amount equal to 100% of what the full statutory reserve would be under PBR—and thus 100% of the most recent determination by insurance regulators as to how much money insurance companies need to set aside in reserves to pay claims. If VM 20 is selected as the Actuarial Standard, it would be inconsistent to impose significant regulation regarding Other Assets since such Other Assets would be collateralizing something that would not even need to be carried as a reserve if the business at issue were covered by PBR. In such a situation, the primary goal of regulation of Other Assets would be to minimize the chance that such assets do more harm than good by introducing additional levels of risk to the insurer and/or its holding company system.

Conversely, if the Actuarial Standard is set at a level below VM 20, then there would seem to be a need for more regulation of an insurer's Other Assets since such assets would be collateralizing amounts that regulators believe should be in reserves to pay claims (pursuant to their most recent official determination).

Accordingly, it probably makes sense to focus—first—on a decision regarding the Actuarial Standard. Once that decision is made, the extent to which Other Assets need to be regulated may become clearer. As to how those Other Assets could be defined, one possibility would be to set out a list of permitted assets, or a list of prohibited assets. However, because it would likely be impossible to come up with a comprehensive list in either instance, and because it is important to allow variation and innovation as part of a market economy, a better approach may be to list a number of permitted "safe harbor investments" coupled with a requirement that any assets not meeting one of the "safe harbors" must be specifically approved by the domiciliary regulator and disclosed in some manner to FAWG.

4. Determine how to ensure that an appropriate amount of capital/surplus exists in the event policyholder claims exceed the reserves established to pay them.

<u>Comment</u>: Insurance regulation contemplates that the primary source for payment of policyholder claims is money that the insurer has set aside in "reserves" for that purpose. For the reinsurance transactions at issue, although the ceding company holds a "net" reserve of $0 for the business ceded, it retains the ultimate legal obligation to pay policyholder claims, as reflected in its gross reserve. A secondary source for payment of policyholder claims is the insurer's capital/surplus. Insurance regulators require insurers to carry an appropriate level of capital/surplus that would allow it to pay claims in the event the monies held in the "reserves" are not sufficient to do so. It will be important to make sure there are appropriate capital/surplus cushions relative to these transactions to protect against the risk that policyholder claims exceed the Primary Assets and Other Assets held to pay them.

Several sub-issues present themselves. For example, although captive insurers are required to carry both "capital" and "reserves," should it matter for purposes of

evaluating the Primary Asset Requirement how such assets are designated so long as they are available to pay claims when due? Would it be better to focus on whether assets (and especially Primary Assets) exist in amounts sufficient to pay claims than on their characterization? Does/should Risk-Based Capital (RBC) reflect the fact that, pursuant to these transactions, typically only a portion of the current gross reserve is collateralized by Primary Assets? If a reinsurance transaction is involved, should any required capital/surplus cushion be held by the ceding insurer or by the assuming entity? Could it be held in some other way, such as unaffiliated reinsurance, affiliated party guarantees, "capital maintenance agreements," etc.? If affiliated entities are used in some way—for example, as a source of capital/surplus, or guaranteeing Other Assets or capital/surplus—should there be any restrictions/limitations on such arrangements, should the arrangement impact the valuation of the entity on the affiliate's books, etc.?

5. Determine the effective date of the new requirements.

   Comment: It will be important to determine the effective date of the new requirements. Possibilities include: (1) for contracts/transactions incepting after the date of the NAIC's adoption of the new requirements, (2) for cessions occurring after the date of the NAIC's adoption of the new requirements even if the contract/arrangement incepted prior to the date of adoption, (3) for any and all contracts/transactions/cessions, regardless of when incepted, and (4) for contracts/transactions/cessions incepting after some recent date (such as the date the NAIC adopted the Captive/SPV "white paper") to cover those instances where an insurer may have sought to implement a transaction/cession in advance of the new requirements.

   It should be noted that insurers believe category (3) (i.e., full retroactivity) is particularly inappropriate and would be extremely disruptive in the marketplace. It should also be noted that, in making decisions regarding the effective date, the Task Force should consider how such decisions may impact analyses currently being performed by FAWG regarding existing XXX and AXXX captive transactions.

6. Determine the "Disclosure Requirements" and appropriate levels of regulatory oversight of those disclosures; develop analysis and examination procedures.

   Comment: The framework responds to the fact that, frequently, minimal disclosure exists regarding key aspects of approved transactions, even from one regulator to another. It is important to respect the need for privacy of proprietary information and compliance with confidentiality laws. Nevertheless, appropriate disclosure is critical so all regulators and others will know that the rules are being followed and so they can more effectively measure the levels of risk presented by approved transactions. Further, appropriate disclosure can go a long way toward promoting the desired consistency from insurer to insurer and regulator to regulator. Disclosure, alone, will not address the issues raised, but appropriate disclosure is an important part of regulatory oversight.

In that regard, once decisions are made regarding key issues—especially decisions regarding the Actuarial Standard, Primary Assets, Other Assets and capital/surplus cushion issues—the NAIC statutory accounting pronouncements and annual statement reporting forms will need to be reviewed to determine to what extent amendments to those documents would be appropriate. The American Council of Life Insurance (ACLI) and the New York Department have already spent substantial amounts of time thinking about disclosure issues. It would be helpful to start by evaluating the work done by those parties—and any others.

There will also be a need to develop analysis and examination procedures to assist insurance regulators in their review of these transactions, both when the transactions are initially proposed and in monitoring them over time. Various groups have given a significant amount of thought to these issues, and, as with the issues mentioned above, it would be helpful to evaluate their work.

It may also make sense to consider developing something pertaining to XXX and AXXX transactions that is analogous to the NAIC's Form A database, thereby creating a more formal way that key information regarding these transactions could be shared confidentially between regulators.

7. Determine how the new framework will be "codified."

<u>Comment</u>: The framework pertaining to Alternative A focuses on the ability of the ceding insurer to take credit for reinsurance of XXX and AXXX reserves. This focus on the ceding insurer—rather than on the assuming entity—is deliberate because it would be difficult to effectively address the issues presented through regulation of the assuming entity. For example, if attempts were made to regulate "captives," an entity currently considered to be a "captive" could be renamed or reorganized, thereby avoiding the regulation. As another example, US insurance regulators have limited or no authority regarding non-US assuming entities, so focusing regulatory attention on US assuming entities (the ones over which US regulators have authority) could prompt these types of transactions to move off-shore, leading to even more regulatory opacity and concern than currently exists. The best way to create a level playing field, applicable to all types of transactions no matter the form, is to focus on the ability of the ceding insurer to reduce its net statutory reserve and to allow such reductions only if certain criteria are satisfied.

Because of this focus on the ceding insurer, the most appropriate place for new provisions relating to Alternative A is likely to be as an amendment to the NAIC Credit for Reinsurance Model Regulation. However, other approaches could be considered, such as amendments to the NAIC Holding Company System Model Regulation, the NAIC Life and Health Reinsurance Agreements Model Regulation, etc.

Additional thought needs to be given as to the most appropriate place to "codify" Alternative B, although the NAIC Accounting Practices and Procedures Manual may be the most logical place.

It will be extremely important that any amendments to laws and regulations be drafted carefully and correctly so all transactions of the type intended to be covered are in fact covered, and to minimize any unintended consequences.

To increase the likelihood that all states will adopt the provisions, the provisions could be made a part of the NAIC's Accreditation Standards in some form.

It will take time for each state to formally adopt the provisions, and for the Accreditation requirements to become effective. Nevertheless, once the new provisions are adopted by the NAIC, each state could immediately begin to use them pursuant to discretion allowed under current law. To provide comfort to other regulators that all states are complying with the new provisions even before formal state adoption, each state involved in an arrangement regarding XXX or AXXX reserves could be asked to report to FAWG regarding compliance with the new provisions, at least until that state has formally adopted the necessary amendments.

8. Determine the legal and statutory accounting treatment needed to implement Alternative B (at the Direct Insurer Level)

<u>Comment</u>: As noted above, the intent of Alternative B is to allow an insurer to achieve substantially the same economic effect as what would be permitted under Alternative A, but without using reinsurance. Under Alternative B, both the gross reserve and the Primary Assets and Other Assets used to support it would be held at the direct insurer level rather than at the assuming entity level.

Additional thought is needed as to the legal and statutory accounting treatment needed to implement this intent. For Alternative B to work, the block of business at issue, and the assets and liabilities supporting it, would need to be identified such that third party financiers will be able to limit their financing to the business at issue and not worry that they will be expected to cover claims arising from other blocks of business. Using a separate account structure, or something analogous to it, is one possibility. Another possibility is to develop a new accounting schedule on which the assets and liabilities involved would be reported. There may be other possibilities. A key decision that would need to be made is whether the direct insurer's statutory balance sheet should include the Primary Assets and Other Assets on the direct insurer's asset page, and the gross liability on its liability page, or whether those two items should be netted together in some fashion (on a separate schedule, for example) so that only the net of those two (i.e., gross reserve minus assets held) would be reported on the insurer's statutory balance sheet. Reporting the assets and the liabilities on the balance sheet would be consistent with reporting requirements pertaining to separate accounts. Reporting only the net on the balance sheet would be consistent with the way reinsurance financing transactions are reported at the

ceding company level. Under either approach, however, it is anticipated that the gross reserve liability, and the Primary Assets and Other Assets supporting it, would be reported somewhere in the direct insurer's statutory financial statements.

9. Determine framework applicability to reinsurance ceded to accredited/admitted, certified, and unaffiliated reinsurers.

   Comment: The question arises: to what extent should the new provisions be applied to instances where XXX or AXXX reserves are ceded to accredited/admitted entities, "certified" entities, or unaffiliated reinsurers? If the decision is made to exempt or limit the application of the new provisions in some instances, what should be done to ensure that the instances are bona fide and not merely a "front" whereby the substance of the transaction—or series of transactions—is of the type intended to be covered?

10. Determine requirements for periodically monitoring the sufficiency of the Primary Asset Requirement.

    Comment: Decisions will need to be made regarding how to monitor reserving and asset changes over time. Should there be re-evaluations of the reserve levels by periodically applying the Actuarial Standard to the business as it develops? If so, with what frequency and who should do the reviews? What should happen if the re-evaluation reveals that the new Primary Asset Requirement exceeds the Primary Assets actually held at the time? What should happen if the re-evaluation reveals that the Primary Assets held exceed the then-current Primary Asset Requirement?

11. Determine appropriate levels of examination coordination.

    Comment: If Alternative A (via Reinsurance) is used, should attempts be made to coordinate the statutory financial examinations of the ceding and assuming insurers so both sides of the transaction can be evaluated during the examination?

12. Determine guidelines for auditor and actuarial oversight.

    Comment: What should be done to prompt the insurer's independent auditor and/or opining actuary to evaluate whether insurers are complying with the new provisions and to make disclosures to regulators regarding compliance?

13. Determine tax impact.

    Comment: The potential tax impact of the framework should be evaluated and considered as the framework is implemented.

14. Determine whether separate solutions should be developed for XXX and AXXX.

Comment: As drafted, the framework applies to reserves arising from both term life (XXX) and ULSG (AXXX) business. However, some of the insurers and regulators we interviewed have suggested it may not be appropriate to treat both types of insurance the same way. In this regard, there appears to be more of a consensus that reserves pertaining to term (XXX) business are higher than necessary than there is that reserves pertaining to ULSG (AXXX) business are higher than necessary. As such, it may be appropriate to treat the two types of insurance differently. One possibility would be to apply the general conceptual framework to both types of business but to select a different Actuarial Standard—and/or a different Primary Asset Requirement—for XXX reserves than for AXXX reserves. Another possibility would be to permit financing arrangements with respect to XXX reserves but to prohibit them entirely, or to limit them in some way, with respect to AXXX reserves. There may also be other possibilities worth exploring.