Report of the Executive (EX) Committee

The Executive (EX) Committee met Aug. 7, 2017. During this meeting the Committee:

1. Adopted the Aug. 6 report from the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, which included the following action:
   a. Adopted its Spring National Meeting minutes.
   b. Adopted the Executive (EX) Committee minutes of July 13, June 19 and May 8.
   c. Adopted the Aug. 5 Audit Committee report, which included the following action:
      1. Received an overview of the June 30 financials.
      3. Received an update on past-due database filing fees.
      4. Requested a proposal for potential zone funding changes.
      5. Adopted the proposed 2018 Audit Committee charter.
   d. Adopted the Aug. 5 Information Systems (EX1) Task Force report, which included the following action:
      1. Received an operational report on NAIC information technology activities.
      2. Received updates on technical projects closed from March through June.
      3. Received an update on four 2017 approved fiscals with a technology component.
   e. Approved funding for an application performance monitoring tool to monitor and analyze near real-time data.
   f. Approved the Principle-Based Reserving (PBR) Experience Data Collection Agent recommendation which includes:
      1. Authorizing the NAIC to serve as a data collection agent for states in support of PBR.
      2. Requesting the Life Actuarial (A) Task Force to prepare amendments to the Valuation Manual to account for the NAIC specifically as a data collection agent for states.
   g. Approved the selection of a financial advisor.
   h. Approved the fiscal for the next phase of the Actuarial Credentialing Project.
   i. Approved filing an amicus brief regarding Moda Health Plan v. United States.
   j. Selected Indianapolis, IN as the meeting location for the 2020 Fall National Meeting.

2. Adopted its interim meeting report from July 13, June 19 and May 8, which included the following action:
   a. Heard a mid-year financial and operational update.
   b. Approved a recommendation for a cloud computer vendor for the NAIC and NIPR.
   c. Approved funding for: Transition to the Cloud–Phase 1; the Tableau Business Intelligence Tool; the Market Conduct Annual Statement Application; and the Insurance Data Application.
   d. Adopted the recommendation of the ad hoc group regarding actuarial credentialing.
   e. Received a corporate governance briefing and education on the duties of the board members.
   f. Received an update on NAIC internal cybersecurity activities.
   g. Adopted the report of the Investment (EX1) Committee.
   h. Adopted the report of the Audit Committee.
   i. Appointed Commissioner Katharine L. Wade (CT) to the International Association of Insurance Supervisors (IAIS) Executive Committee.
   j. Approved funding for the Voluntary Market Regulation Certification Program pilot.

3. Adopted its June 19 minutes, which included the following action:
   a. Adopted Requests for Model Law Development for the: Life Insurance Disclosure Model Regulation (#580); Life Insurance Illustrations Model Regulation (#582); Annuity Disclosure Model Regulation (#245); and the new Travel Insurance Model Law.
   b. Adopted revised charges of the Innovation and Technology (EX) Task Force.

4. Adopted the reports of its task forces: the Financial Stability (EX) Task Force; the Government Relations (EX) Leadership Council; the Innovation and Technology (EX) Task Force; and the Principle-Based Reserving Implementation (EX) Task Force.

5. Approved the model law development request to revise the Life and Health Insurance Guaranty Association Model Act (#520).
6. Approved the model law development request for the Creditor-Placed Real Property Insurance Model Act.

7. Approved the request for an extension for development of the Insurance Data Security Model Law.

8. Received a status report of model law development efforts for amendments to the: Health Insurance Reserves Model Regulation (#10); Health Carrier Prescription Drug Benefit Management Model Act (#22); Accident and Sickness Insurance Minimum Standards Model Act (#170); Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171); Annuity Disclosure Model Regulation (#245); Creditor-Placed Insurance Model Act (#375); Life Insurance Disclosure Model Regulation (#580) Buyer’s Guide; Life Insurance Disclosure Model Regulation (#580); Life Insurance Illustrations Model Regulation (#582) Policy Overview Document; Mortgage Guaranty Insurance Model Act (#630); Standard Nonforfeiture Law for Individual Deferred Annuities (#805); and for development of the new Unclaimed Life Insurance and Annuities Model Law; Insurance Data Security Model Law; Short Duration Long-Term Care Policies Model Law; and Travel Insurance Model Law.

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

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The Plenary met via conference call May 12, 2017. The following members participated: Ted Nickel, Chair (WI); Julie Mix McPeak, Vice Chair (TN); Eric A. Cioppa, Vice President (ME); James J. Donelon, Most Recent Past President (LA); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Allen W. Kerr (AR); Leslie R. Hess represented by Kurt Regner (AZ); Dave Jones represented by Geoffrey Margolis (CA); Marguerite Salazar represented by Peg Brown (CO); Katharine L. Wade (CT); Stephen C. Taylor (DC); Trinidad Navarro represented by Mitch Crane (DE); David Altmaier (FL); Ralph T. Hudgens (GA); Artemio B. Ilagan (GU); Gordon I. Ito (HI); Doug Ommen (IA); Dean L. Cameron represented by Tom Donovan (ID); Jennifer Hammer (IL); Stephen W. Robertson (IN); Ken Selzer represented by Clark Shultz (KS); Nancy G. Atkins (KY); Gary Anderson (MA); Al Redmer Jr. (MD); Patrick M. McPharlin (MI); Mike Rothman (MN); Chlora Lindley-Myers (MO); Mark O. Rabauliman (MP); Mike Chaney (MS); Matthew Rosendale represented by Nancy Butler (MT); Mike Causey represented by Jacqueline R. Obusek (NC); Jon Godfread (ND); Bruce R. Ramge (NE); Roger A. Sevigny (NH); Richard J. Badolato (NJ); John G. Franchini represented by Robert Doucette (NM); Barbara D. Richardson (NV); Maria T. Vullo represented by Scott Fischer (NY); Jillian Froment (OH); John D. Doak (OK); Laura Cali Robison (OR); Teresa D. Miller (PA); Javier Rivera Rios represented by Rafael Cestero Lopategui (PR); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer (SC); Larry Deiter (SD); Todd E. Kiser represented by Tanji Northrup (UT); Jacqueline K. Cunningham (VA); Michael S. Pieciak (VT); Mike Kreidler represented by Jim Odiorne (WA); Allan L. McVey (WV); and Tom Glause (WY).

1. **Conducted NAIC Secretary-Treasurer Interim Election**

The Plenary conducted an interim election May 12, in which Director Farmer was elected NAIC secretary-treasurer to serve from May 12 to Dec. 31.

Having no further business, the Plenary adjourned.
AMENDMENTS TO 2017 COMMITTEE CHARGES

FINANCIAL STABILITY (EX) TASK FORCE

The mission of the Financial Stability (EX) Task Force is to consider issues concerning domestic or global financial stability as they pertain to the role of state insurance regulators.

Ongoing Support of NAIC Program, Products or Services

1. The Financial Stability (EX) Task Force will:
   A. Consider issues concerning domestic or global financial stability as they pertain to the role of state insurance regulators and make recommendations to the International Insurance Relations (G) Committee, the Government Relations (EX) Leadership Council and/or the Executive (EX) Committee, as appropriate.
   1. Analyze existing post-financial crisis regulatory reforms for their application in identifying macro-economic trends, including identifying possible areas of improvement or gaps, and propose to the Financial Condition (E) Committee or other relevant committee enhancements and/or additions to further improve the ability of state insurance regulators and industry to address macro-prudential impacts; consult with such committees on implementation as needed.
   B. Consider state insurance regulators' input to national and international discussions on macro-financial vulnerabilities affecting the insurance sector.
   C. Serve as a forum to coordinate state insurance regulators' perspectives on a wide variety of issues arising from the designation of a U.S. insurance group as “systemically important,” both pre- and post-designation, including:
      1. Where appropriate, develop policy recommendations and/or guidance regarding the role, responsibilities and activities of state insurance regulators in the context of consolidated supervision resulting from designation.
      2. Analyze proposed rules by the federal agencies that relate to financial stability.
      3. Analyze proposed policy measures regarding supervisory standards for global systemically important insurers.
      4. Develop comment letters on such analysis for further consideration by the International Insurance Relations (G) Committee, the Government Relations (EX) Leadership Council and/or the Executive (EX) Committee, as appropriate.

2. The Liquidity Assessment Subgroup will:
   A. Review existing public and regulator only data related to liquidity risk, identify any gaps based upon regulatory needs, and propose the universe of companies to which any recommendations may apply.
   B. Construct a liquidity stress testing framework proposal for consideration by the Financial Condition (E) Committee, including the proposed universe of companies to which the framework will apply, (e.g. large life insurers).

NAIC Support Staff: Elise Liebers/John Hopman/Mark Sagat/Todd Sells
INNOVATION AND TECHNOLOGY (EX) TASK FORCE

The mission of the Innovation and Technology (EX) Task Force is to provide a forum for regulator education and discussion of innovation and technology in the insurance sector, to monitor technology developments that impact the state insurance regulatory framework, and to develop regulatory guidance as appropriate.

Ongoing Support of NAIC Programs, Products or Services

1. The Innovation and Technology (EX) Task Force will:
   A. Provide a forum for the discussion of innovation and technology developments in the insurance sector, including the collection and use of data by insurers and state insurance regulators—as well as new products, services and distribution platforms—in order to educate state insurance regulators on how these developments impact consumer protection, insurer and producer oversight, marketplace dynamics, and the state-based insurance regulatory framework.
   B. Develop regulatory guidance, white papers, model laws and/or regulations, or make other recommendations to the Executive (EX) Committee, as appropriate.
   C. Discuss regulatory issues that arise with the development of autonomous vehicles; study and, if necessary, develop recommendations for changes needed to the state-based insurance regulatory framework; consider development of a white paper or model legislation, if necessary.
   D. Discuss emerging issues related to on-demand insurance applications—in addition to potential implications on the state-based insurance regulatory structure—including, but not limited to, cancellations, nonrenewals, coverage issues, notice provisions and policy-delivery requirements.
   E. Coordinate with other NAIC committees and task forces, as appropriate, on technology and innovation issues.

2. The Big Data (EX) Working Group will:
   A. Review current regulatory frameworks used to oversee insurers’ use of consumer and non-insurance data. If appropriate, recommend modifications to model laws/regulations regarding marketing, rating, underwriting and claims, regulation of data vendors and brokers, regulatory reporting requirements, and consumer disclosure requirements.
   B. Propose a mechanism to provide resources and allow states to share resources to facilitate states’ ability to conduct technical analysis of and data collection related to states’ review of complex models used by insurers for underwriting, rating and claims. Such a mechanism shall respect and in no way limit states’ regulatory authority.
   C. Assess data needs and required tools for state insurance regulators to appropriately monitor the marketplace and evaluate underwriting, rating, claims and marketing practices. This assessment shall include gaining a better understanding of currently available data and tools, as well as recommendations for additional data and tools as appropriate. Based upon this assessment, propose a means to collect, house and analyze needed data.

3. The Cybersecurity (EX) Working Group will:
   A. Monitor developments in the area of cybersecurity.
   B.Advise, report and make recommendations to the Innovation and Technology (EX) Task Force on cybersecurity issues.
   C. Coordinate activities with NAIC standing committees and their task forces and working groups regarding cybersecurity issues.
   D. Continue development of the Insurance Data Security Model Law. This model law is specific to insurers, brokers, and other state-regulated entities regarding cybersecurity standards.
   E. Represent the NAIC and communicate with other entities/groups, including the sharing of information as may be appropriate, on cybersecurity issues.
   F. Perform such other tasks as may be assigned by the Innovation and Technology (EX) Committee relating to the area of cybersecurity.
4. The **Speed to Market (EX) Working Group** will:
   
   A. Provide a forum for discussion and recommendations related to product filing needs, efficiencies and effective consumer protection.
   
   B. Provide a forum for the review, discussion and recommendation regarding rate and form filing needs as impacted by the federal Affordable Care Act (ACA).
      1. Provide policy support and guidance regarding System for Electronic Rate and Form Filing (SERFF) enhancements necessary for the states to comply with state law, federal law and/or contractual obligations.
      2. Provide a forum for discussing product filing issues related to the activity of the U.S. Department of Health and Human Services (HHS) and the federal Center for Consumer Information and Insurance Oversight (CCIIO).
      3. Provide input and guidance to other NAIC committees related to the ACA.
   
   C. Provide direction to, receive input from and hear reports concerning the SERFF Advisory Board activity related to SERFF.
   
   D. Provide direction to NAIC staff regarding SERFF functionality, development and enhancements.
   
   E. In collaboration with the National Treatment and Coordination (E) Working Group, evaluate synergies between corporate changes/amendments, as well as rate and form filing review and approval, to improve efficiency.
   
   F. Conduct the following activities as desired by the Interstate Insurance Product Regulation Commission (IIPRC):
      1. Provide support to the IIPRC as the speed to market vehicle for asset-based insurance products, encouraging state participation in, and industry usage of, the IIPRC, as requested.
      2. Receive a report from the IIPRC at each national meeting.
   
   G. Oversee the work of the **Operational Efficiencies (EX) Subgroup** to include:
      1. Oversee the implementation and ongoing maintenance/enhancement of speed to market operational efficiencies that have been adopted. Report the results of this ongoing charge at each national meeting.
      2. Maintain the speed to market assessment tool, which includes a nationwide summary and individual state summaries of speed to market compliance; report at each national meeting.
      3. Facilitate proposed changes to the Product Coding Matrices (PCMs) on an annual basis, including the review, approval and notification of changes. Monitor, assist with and report on state implementation of any PCM changes.
      4. Facilitate proposed changes to the Uniform Transmittal Document (UTD) on an annual basis, including the review, approval and notification of changes. Collaborate with the SERFF Advisory Board to ensure incorporation of UTD changes in SERFF.
      5. Use SERFF data to develop, refine, implement, collect and distribute common filing metrics that provide a tool to measure the success of the speed to market modernization efforts, with an emphasis on data that monitors state regulatory and insurer responsibilities for speed to market for insurance products; ensure full and complete communication of any change in filing requirements.
      6. Facilitate the review and revision of the **Product Filing Review Handbook**, which contains an overview of all of the operational efficiency tools and describes best practices for industry filers and state reviewers with regard to the rate and form filing and review process.

NAIC Support Staff: Scott Morris/Denise Matthews
PRINCIPLE-BASED RESERVING IMPLEMENTATION (EX) TASK FORCE

The mission of the Principle-Based Reserving Implementation (EX) Task Force is to serve as the coordinating body with all NAIC technical groups (e.g., Life Actuarial (A) Task Force) involved with projects related to the principle-based reserving (PBR) initiative for life and health policies.

**Ongoing Support of NAIC Programs, Products or Services**

1. **The Principle-Based Reserving Implementation (EX) Task Force** will:
   
   A. Maintain and oversee the Principle-Based Reserving (PBR) Implementation Plan. Coordinate actions related to the following: enhancing the PBR methodology and updating the *Valuation Manual*; creating and improving reporting and regulatory review processes; creating the company experience reporting framework; evaluating risk-based capital (RBC); preparing accreditation-related recommendations for PBR; and continuing to promote creation of state and company PBR education.
   
   B. Coordinate activities to finalize and implement the XXX/AXXX Reinsurance Framework.

2. **The PBR Review (EX) Working Group** will:
   
   A. Develop risk-focused examination and risk-focused analysis (analysis/examination/actuarial) procedures for PBR. Considerations include support for reviews, PBR preparedness, communication between domestic states and market states (or non-domestic states where the company has significant market share), safeguards and controls already incorporated in requirements (e.g., documentation requirements, internal controls, linkage to risk management, corporate governance, and audited financials), coordination and consistency of all such activities, and coordination with other groups as appropriate concerning these efforts and procedures.
   
   B. Develop review tools and propose means to obtain information to support the review. Test the tools and information for usefulness and accuracy. Considerations include automated tools or identify software that can be used for both financial analysis and actuarial review, housing of automated tools and software, especially to create cost savings for the states, what reporting should be required via electronic data submission (e.g., in the PBR Report) to populate automated tools, tools that might be given to, or purchased by, the NAIC, central repository of information, and consultation with Information Systems (EX1) Task Force regarding tools, databases and storage needs.
   
   C. Identify the data and other reporting needs for actuarial review, financial analysis and public transparency. Recommend changes to other NAIC groups to modify the financial statement blanks, financial statement instructions and the *Valuation Manual* to obtain such needed data and disclosure. Utilize confidentiality where needed, maintaining an ability to share data appropriate for valuation improvements.
   
   D. Identify the ideal staffing resources for PBR reviews, including ideal NAIC assistance, as well as any new financial modeling or software reviewers. After review processes are better defined, conduct another PBR state resource survey.
   
   E. Inform the Principle-Based Reserving Implementation (EX) Task Force of needs of responsive PBR training to inform and support PBR education for regulators and companies. Specifically, evaluate training and/or resource needs for modeling.
   
   F. Respond to requests from the Principle-Based Reserving Implementation (EX) Task Force.
   
   G. **The PBR Review Procedures (EX) Subgroup** will:
      
      1. Provide recommendations to the PBR Review (EX) Working Group regarding Working Group charges A and B, including drafting PBR review procedures and changes to the *Financial Condition Examiners Handbook* and the *Financial Analysis Handbook* and working with NAIC support staff to develop review tools or recommendations for development and testing.
      
      2. Respond to requests by the PBR Review (EX) Working Group to carry out its charges.

NAIC Support Staff: Kris DeFrain/Dan Daveline
PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Property and Casualty Insurance (C) Committee will:
   A. Discuss issues arising and make recommendations with respect to advisory organization and insurer filings for personal and commercial lines, as needed. Report yearly.
   B. Monitor the activities of the Workers’ Compensation (C) Task Force.
   C. Monitor the activities of the Casualty Actuarial and Statistical (C) Task Force.
   D. Monitor the activities of the Surplus Lines (C) Task Force.
   E. Monitor the activities of the Title Insurance (C) Task Force.
   F. Provide an impartial forum for considering appeals of adverse decisions involving alien insurers delisted or rejected for listing to the Quarterly Listing of Alien Insurers. Appeal procedures are described in the International Insurers Department (IID) Plan of Operation.
   G. Monitor and review developments in case law and rehabilitation proceedings related to risk retention groups (RRGs); if warranted, make appropriate changes to the Risk Retention and Purchasing Group Handbook.
   H. Monitor the activities of the Federal Crop Insurance Corporation (FCIC) that affect state insurance regulators. Serve as a forum for discussing issues related to the interaction of federal crop insurance programs with state insurance regulation. Review law changes and court decisions and, if warranted, make appropriate changes to the Federal Crop Insurance Program Handbook: A Guide for Insurance Regulators. Monitor the regulatory information exchanges between the FCIC and state insurance regulators, as well as the FCIC and the NAIC, and make recommendations for improvement or revisions, as needed.

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

3. The Affordable Care Act Medical Professional Liability (C) Working Group will:
   A. Study the potential impact of the federal Affordable Care Act (ACA) on the professional liability exposures of medical providers by continuing to gather data and information on medical malpractice claims. Explore the possibility of data-sharing in regard to medical malpractice claims in general to better inform state insurance regulators on trends and activities. Where gaps in the data exist, propose solutions for resolving those issues. Report on progress at each national meeting.

4. The Auto Insurance (C/D) Working Group of the Property and Casualty Insurance (C) Committee and the Market Regulation and Consumer Affairs (D) Committee will:
   A. Review issues relating to low-income households and the auto insurance marketplace; make recommendations, as appropriate
   B. Consider collection of data to evaluate the availability and affordability of auto insurance.
5. The **Catastrophe Insurance (C) Working Group** will:
   A. Report progress at each national meeting on the following catastrophe insurance issues:
      1. Monitor and recommend measures to improve the availability and affordability of insurance and reinsurance related to catastrophe perils for personal and commercial lines.
      2. Evaluate potential state, regional and national programs to increase capacity for insurance and reinsurance related to catastrophe perils.
      3. Monitor and assess proposals that address disaster insurance issues at the federal and state levels; assess concentration-of-risk issues and whether a regulatory solution is needed.
      4. Provide a forum for discussing issues and recommending solutions related to insuring for catastrophe risk, including terrorism, war and natural disasters.
      5. Provide a forum for discussing various issues related to catastrophe modeling and monitor issues that will result in changes to the *Catastrophe Computer Modeling Handbook*.
      6. Develop a model law, regulation and/or guideline to standardize insurer premium collection procedures, underwriting limitations, claims-handling processes and claims data reporting requirements that a state could adopt in advance of a catastrophe and activate after a catastrophe. Following a catastrophe, diverse regulatory mandates increase insurer uncertainty and could divert insurer resources that are needed to respond to claims. To provide added certainty for insurers and regulators in advance of a major disaster, procedures need to be in place so that regulators and insurers know what to expect and insurers are prepared to comply.
      7. Review findings from the fall 2012 public hearing on catastrophe issues and consider developing a model guideline, white paper and/or compilation of best practices to reduce post-disaster insurance recovery obstacles for insurance consumers. Issues could include, but are not limited to: the appropriate duration for payment of additional living expenses; the appropriate duration for consumers to recover the full replacement cost of personal and real property; streamlined inventory requirements in the event of a total loss; enhanced training requirements regarding calculation of accurate dwelling replacement values; requiring insurers to provide a complete copy of a policy upon request as part of the claim settlement process; and providing claimants access to copies of all claim-related documents in a claim file.
      8. Collect and analyze NFIP data to facilitate the private market writing flood insurance.
      9. Investigate and recommend ways the NAIC can assist the states in responding to disasters, and discuss issues surrounding loss mitigation.
      10. Update the *State Disaster Response Plan*, as needed, so that it provides a blueprint for action by the states to respond to catastrophic events.
      11. Study, in coordination with other NAIC task forces and working groups, earthquake matters of concern to state insurance regulators; consider various innovative earthquake insurance coverage options aimed at improving take-up rates.
      12. Investigate and recommend ways the **Catastrophe Response (C) Working Group** can assist the states in responding to disasters, and discuss issues surrounding loss mitigation.
   B. Update the *State Disaster Response Plan*, as needed, so that it provides a blueprint for action by the states to respond to catastrophic events.

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6. The **Catastrophe Response (C) Working Group** will:
   A. Investigate and recommend ways the NAIC can assist the states in responding to disasters, and discuss issues surrounding loss mitigation.
   B. Update the *State Disaster Response Plan*, as needed, so that it provides a blueprint for action by the states to respond to catastrophic events.

7. The **Climate Change and Global Warming (C) Working Group** will:
   A. Review the enterprise risk management efforts by carriers and how they may be affected by climate change and global warming.
   B. Investigate and receive information regarding the use of modeling by carriers and their reinsurers concerning climate change and global warming.
   C. Review the impact of climate change and global warming on insurers through presentations by interested parties.
   D. Investigate sustainability issues and solutions related to the insurance industry.
PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE (continued)

E. Review innovative insurer solutions to climate change, including new insurance products through presentations by interested parties.

87. The Creditor-Placed Insurance Model Act Review (C) Working Group will:
A. Review information from the public hearing on lender-placed insurance and determine if changes to the Creditor-Placed Insurance Model Act (#375) are warranted. Make recommendations for changes, if warranted. Complete work on the model by the 2017 Summer National Meeting.

9. The Crop Insurance (C) Working Group will:
A. Monitor the activities of the Federal Crop Insurance Corporation (FCIC) that affect state insurance regulators. Report at each national meeting.
B. Serve as a forum for discussing issues related to the interaction of federal crop insurance programs with state insurance regulation.
D. Monitor the regulatory information exchanges between the FCIC and state insurance regulators, as well as the FCIC and the NAIC, and make recommendations for improvement or revisions, as needed. Report at each national meeting.

10. The Earthquake (C) Study Group will:
A. Study, in coordination with other NAIC task forces and working groups, earthquake matters of concern to state insurance regulators. Report at each national meeting.
B. Consider various innovative earthquake insurance coverage options aimed at improving take-up rates.
C. Increase knowledge and awareness of the earthquake risk nationally and in each state. This includes working with earth scientists, first responders, emergency managers, consumer groups, public and private modelers, and other experts.
D. Work with engineers, the Federal Emergency Management Agency (FEMA) and other seismic and actuarial experts to determine effective techniques for retrofitting and mitigating against earthquake risk. This includes identifying which building types are most seismically at risk and exploring methods of collecting post-earthquake loss damage information to improve loss-modeling and loss-mitigation capabilities.
E. Identify strategies to communicate earthquake risk awareness, preparation, loss-mitigation and recovery measures to insurers, producers and consumers. This includes continued development of an earthquake consumer brochure and working with social scientists to understand the latest research on promoting public preparedness.
F. Stay abreast of federal and state legislation affecting the earthquake insurance industry. This includes receiving presentations from speakers on pending federal and/or state legislation involving mitigation initiatives and alternative financing methodologies.
G. Assist state insurance regulators in determining the availability and affordability of earthquake coverage in their respective states.

811. The Public Adjuster (C/D) Working Group of the Property and Casualty Insurance (C) Committee and the Market Regulation and Consumer Affairs (D) Committee will:
A. Review issues related to the unauthorized practice of public adjusting and make recommendations as may be appropriate.

912. The Risk Retention (C) Working Group will:
A. Monitor and review developments in case law and rehabilitation proceedings related to risk-retention groups (RRGs); if warranted, make appropriate changes to the Risk Retention and Purchasing Group Handbook. Report at each national meeting.

13. The Sharing Economy (C) Working Group will:
A. Study and make recommendations about regulatory issues related to the sharing economy, such as transportation sharing, house-sharing and any emerging sharing products marketed to consumers.

B. Track consumer reports and bulletins published by the states and develop documentation on best practices for the states to address insurance coverage issues related to the sharing economy.

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

115. The **Transparency and Readability of Consumer Information (C) Working Group** will:
   
   A. Study and evaluate actions that will improve the capacity of consumers to comparison shop on the basis of differences in coverage provided by different insurance carriers offering personal lines products.
   
   B. Systematize and improve presale disclosures of coverage.
   
   C. Increase consumer accessibility to different carriers’ policy forms on a presale basis. The Working Group should consider all possible avenues of accessibility, including state insurance department websites, the NAIC, insurance companies and the possibility of pre-sale provision of complete policy language.
   
   D. Facilitate consumers’ capacity to understand the content of insurance policies and assess differences in insurers’ policy forms. The Working Group should consider: 1) implementing new readability rules as suggested by the Market Regulation and Consumer Affairs (D) Committee; 2) promoting consistent, clear and logical formatting and organization of all policies; and 3) any other measures that would improve the intellectual accessibility of policy forms.
   
   E. Develop a shopping tool for homeowners, renters and business owners on flood insurance coverage; work with state insurance regulators to develop a standardized website and flood bulletin to assist consumers who have questions about flood insurance.

126. The **Travel Insurance (C) Working Group** will:

   A. Consider development of a model law or guideline to establish appropriate regulatory standards for the travel and tourism insurance industry.
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

14. The Valuation Analysis (E) Working Group will:
   
   A. Respond to states in a confidential forum regarding questions and issues arising during the course of annual PBR reviews or PBR examination and which also may include consideration of asset adequacy analysis questions and issues.
   
   B. Work with NAIC resources to assist in prioritizing and responding to issues and questions regarding PBR and asset adequacy analysis including actuarial guidelines or other requirements making use of or relating to PBR such as AG38, AG48, and the Term and Universal Life Insurance Reserve Financing Model Regulation (Model #787).
   
   C. Respond to questions from states regarding how to properly reserve under PBR for new product types or unique product designs.
   
   D. Develop and implement a plan with the NAIC Resources to identify outliers/concerns regarding PBR/asset adequacy analysis.
   
   E. Refer questions/issues as appropriate to the Life Actuarial (A) Task Force which may require consideration of changes/interpretations to be provided in the Valuation Manual.
   
   F. Make referrals as appropriate to the Financial Analysis (E) Working Group (FAWG).
   
   G. Perform other work to carry out the VAWG procedures.

NAIC Support Staff: Dan Daveline
CAPITAL ADEQUACY (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Capital Adequacy (E) Task Force will:
   A. Evaluate emerging “risk” issues for referral to the risk-based capital (RBC) working groups/subgroups for certain issues involving more than one RBC formula. Monitor emerging and existing risks relative to their consistent or divergent treatment in the three RBC formulas.
   B. Review and evaluate company submissions for the schedule and corresponding adjustment to total adjusted capital (TAC). Determine whether asset charges for the forms of “other security” used by insurers, as required by the proposed Term and Universal Life Insurance Reserve Financing Model Regulation, should be developed or otherwise accounted for in the shortfall calculation and address deferred issues with consolidation presentation.
   C. Review and evaluate company submissions for the Primary Security Shortfall schedule and corresponding adjustment to Authorized Control Level.

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

3. The Investment Risk-Based Capital (E) Working Group will:
   A. Evaluate relevant historical data and apply defined statistical safety levels over appropriate time horizons in developing recommendations for revisions to the current asset risk structure and factors in each of the RBC formulas and delivering those recommendations to the Capital Adequacy (E) Task Force.

4. The Life Risk-Based Capital (E) Working Group will:
   A. Evaluate RBC in light of principle-based reserving (PBR). Consider changes to RBC needed because of the changes in reserve values, including the “right-sizing” of reserves, margins in the reserves, any expected increase in reserve volatility, the overall desired level of solvency measurement and other issues.
   B. Consider a total balance sheet approach (e.g., total asset requirement (TAR) type calculation and then subtracting out the PBR reserves) and application of stress scenarios. These charges should include appropriate consideration of International Association of Insurance Supervisors’ (IAIS) Insurance Core Principles.

5. The Operational Risk (E) Subgroup will:
   A. Evaluate options for developing an operational risk charge in each of the RBC formulas and provide a recommendation to the Capital Adequacy (E) Task Force as to treatment of operational risk in the RBC formulas.
CAPITAL ADEQUACY (E) TASK FORCE (continued)

56. The **C-3 Phase II/AG 43 (E/A) Subgroup**, a joint subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force, will:
   A. Evaluate the overall effectiveness of the C-3 Phase II and *Actuarial Guideline XLIII—CARVM for Variable Annuities* (AG 43) methodologies used to evaluate the market risk component of RBC by conducting an in-depth analysis of the models, modeling assumptions, processes, supporting documentation and results of a sample of companies writing variable annuities with guarantees, and to make recommendations to the Capital Adequacy (E) Task Force or the Life Actuarial (A) Task Force on any changes to the methodologies to improve their overall effectiveness.
   B. Develop and recommend changes to C-3 Phase II and AG 43 that implement, for 2017 adoption, the Variable Annuities Framework for Change.

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

7. The **Stress Testing (E) Subgroup** of the Life Risk-Based Capital (E) Working Group will:
   A. Evaluate RBC in light of principle-based reserving (PBR). Consider changes to RBC needed because of the changes in reserve values, including the “right-sizing” of reserves, margins in the reserves, any expected increase in reserve volatility, the overall desired level of solvency measurement and other issues.
   B. Consider a total balance sheet approach (e.g., total asset requirement (TAR) type calculation and then subtracting out the PBR reserves) and application of stress scenarios. These charges should include appropriate consideration of International Association of Insurance Supervisors’ (IAIS) Insurance Core Principles.

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

NAIC Support Staff: Jane Barr
JOINT LONG TERM CARE INSURANCE (B/E) TASK FORCE

1. Coordinate all aspects of the NAIC’s work regarding the long term care insurance (LTCI) market. In addition to coordinating all current B and E Committee projects, The task force should pursue the following general objectives:

A. To more rigorously assess the financial solvency of LTCI writers;
B. To evaluate the sufficiency of current financial reporting and actuarial valuation standards;
C. To assess state activities regarding the regulatory considerations on rate increase requests on blocks and to identify common elements for achieving greater transparency and predictability;
D. To coordinate state actions aimed at revising state guaranty fund laws;
E. To monitor the development of regulatory policy regarding short duration LTCI policies; and
F. To consider product innovations and the development of potential state and federal solutions for stabilizing the LTCI market.
G. Provide periodic reports to the B and E Committees, and the Executive Committee, regarding key issues and progress toward the general objectives set forth above. Conduct meetings in regulator-only session, as appropriate.

NAIC Support Staff: Dan Daveline/Jolie Matthews
The Life Insurance and Annuities (A) Committee met Aug. 7, 2017. During this meeting, the Committee:

1. Adopted its July 17 minutes, which included the following action:
   a. Adopted its May 19 minutes, which included the following action:
      i. Adopted its Spring National Meeting minutes.
      ii. Adopted nine Valuation Manual (VM) amendments.
      iii. Adopted an NAIC model law development request to revise Section 6 of the Annuity Disclosure Model Regulation (#245) to address issues identified by the Working Group related to innovations of annuity products that are not addressed, or addressed adequately, in the current standards.
   b. Adopted 13 VM amendments.
   c. Adopted an amendment to Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48).

2. Heard an update on the NAIC Life Insurance Policy Locator service. Between Nov. 4, 2016, and June 30, 2017, 26,333 queries have been made and 4,144 matches found, totaling $41,712,670. Additional modifications are being considered. Contact NAIC staff for additional information.

3. Adopted the Annuity Disclosure (A) Working Group report, which included the following action:
   a. Adopted its April 13 minutes, during which the Working Group voted to refer to the Life Insurance and Annuities (A) Committee a request for model law development to revise Section 6 of Model #245 to address issues identified by the Working Group related to innovations of annuity products that are not addressed, or addressed adequately, in the current standards.

4. Adopted the Annuity Suitability (A) Working Group report, which included the following action:
   a. Adopted its Spring National Meeting minutes.
   b. Adopted its July 26 minutes, during which the Working Group heard an overview from the U.S. Department of Labor (DOL) on its fiduciary rule, heard an overview of the American Council of Life Insurers’ (ACLI) “Uniform Standard of Care” proposal, and received an update on the July 24 conference call of Director Dean L. Cameron (ID) and Commissioner Doug Ommen (IA) with representatives of the U.S. Securities and Exchange Commission (SEC) to discuss the DOL fiduciary rule and the NAIC’s work to potentially revise the Suitability in Annuity Transactions Model Regulation (#275).
   c. Heard an update on NAIC activities related to the DOL fiduciary rule.
   d. Continued its discussions regarding potential revisions to Model #275 to incorporate a best interest standard and heard from stakeholders—consumer representatives, insurers, and agents and brokers—on the issue. The Working Group intends to continue stakeholder discussions via conference calls before the Fall National Meeting.

5. Adopted the Life Insurance Buyer’s Guide (A) Working Group report, which included the following action:
   i. Summarized its July 31 meeting, during which the Working Group agreed to work on a short buyer’s guide in a question and answer format, as well as an electronic tool where more comprehensive information could be accessed in manageable sections.
   ii. Adopted its July 11 minutes, during which the Working Group discussed potential formats, structure and content for the revised buyer’s guide.

6. Adopted the Life Insurance Illustration Issues (A) Working Group report, which included the following action:
   a. Summarized its July 31 meeting, during which it adopted it June 28 minutes, during which it adopted its June 14 minutes.
   b. Discussed draft revisions to the Life Insurance Illustrations Model Regulation (#582) and the Life Insurance Disclosure Model Regulation (#580) to include a requirement for a policy overview document, as well as a draft policy overview template, that will serve as an example of a policy overview document that meets the requirements of the model.
7. Adopted the Model Law Review (A) Subgroup report, which included the following action:
   a. Adopted its June 19 conference call minutes, during which the Subgroup agreed to: 1) ask the American Council of Life Insurers (ACLI) to survey its membership to determine the extent to which modified guaranteed annuities (MGAs) are being sold in the states and whether they are sold as general or separate account products; and 2) ask insurance department actuaries how the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805) is being implemented in states that have not adopted the *Annuity Nonforfeiture Model Regulation* (#806).

8. Adopted the Promoting Appropriate Sales Practices in Life Insurance and Annuities (A) Working Group report, which included the following action:
   a. Adopted its June 26, June 1 and May 11 minutes, during which the Working Group continued to discuss draft revisions to the NAIC Consumer Alert “Preventing Abusive Practices: The Misuse of Senior Designations and ‘Free Lunch’ Seminars” and sent a survey to NAIC membership to assist the Working Group in determining whether the *Model Regulation on the Use of Senior-Specific Certifications and Professional Designations in the Sale of Life Insurance and Annuities* (#278) should be revised.

9. Adopted the Unclaimed Life Insurance Benefits (A) Working Group report, which included the following action:
   i. Adopted its June 8 minutes, during which the Working Group identified the top three issues about which it cannot reach consensus and, as a result, could threaten the Committee’s and the full NAIC membership’s ability to obtain the two-thirds vote of their respective members necessary to adopt the proposed Unclaimed Life Insurance and Annuities Model Act as an NAIC model law in accordance with the NAIC Model Law Development Procedures.
   ii. Voted to disband the Working Group based on the number of states that have already taken action on the issue and the lack of consensus necessary to adopt the model.

10. Adopted the Life Actuarial (A) Task Force report, which included the following action:
    a. Adopted its July 13, June 29, June 22, June 15, June 8, June 1, May 18, May 11 and May 4 minutes, during which it adopted:
       i. Revisions to the VM companywide exemption.
       ii. Revisions to the timing for calculation of quarterly VM-20, Requirements for Principle-Based Reserves for Life Products.
       iii. Requirements for VM-20 investment spread tables.
       iv. The proposal for the VM-22, Maximum Valuation Interest Rates for Income Annuities, method for determining the valuation interest rate for income annuities more responsive to the economic environment.
       v. The proposal requiring the 2017 Commissioners’ Standard Ordinary (CSO) when calculating the net premium reserve (NPR) in the actuarial method.
       vi. Revisions to VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Reserve Valuation.
    b. Adopted the 2017-6 amendment to VM Section II to reflect that the minimum requirements for fixed annuity contract valuation interest rates are defined in VM-22.
    c. Adopted the VM-20 default cost tables updated using data through December 2016.
    d. Exposed the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Joint Committee 2017 Guaranteed Issue Mortality Tables Report, the guaranteed issue mortality tables and an accompanying amendment proposal for incorporating the mortality tables into the VM.
    e. Exposed the Academy and SOA Joint Committee 2017 Simplified Issue Mortality Tables Report, the simplified issue mortality tables and an accompanying definition for simplified issue.
    f. Exposed the 2018 Generally Recognized Expense Tables (GRET).
    g. Adopted the reports of its subgroups and working groups, and heard various reports and updates.

11. Heard a report on an ambiguity identified in *Life Insurance and Annuities Replacement Model Regulation* (#613) and agreed to revisit the issue on a future conference call.

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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 Example #8.

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).

Eighth, the actual reserve used for purposes of Section 7D(1) 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).

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).

Eighth, the actual reserve used for purposes of Section 7D(1) 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) 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).
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, 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>

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. 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).

Eighth, the actual reserve used for purposes of Section 7D(1) 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) 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).

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’s Life Insurance and Annuities (A) Committee to govern the principle-based valuation on the valuation date 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. 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 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.

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.

8E. For policies and certificates issued on or after January 1, 2013 except for ULSG policies and certificates for which the company elects or is required to apply VM-20 as the reserve standard, per Valuation Manual requirements: For a universal life policy or certificate 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.

1) Methodology for determining the minimum gross premiums for certain designs (“Method 1”).

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 segment), 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.

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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).

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)

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.

Policy Design

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.

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.
PROJECT HISTORY

REVISIONS TO ACTUARIAL GUIDELINE XXXVIII

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

On Nov. 1, 2011, the NAIC Life Actuarial (A) Task Force adopted the Statement on Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation (AG 38), which addressed certain reserving practices for universal life insurance products with shadow account secondary guarantees (ULSG) that do not fully reflect the benefits of the secondary guarantees as required pursuant to the NAIC model laws, regulations and actuarial guidelines. Specifically, the Task Force Statement found that the lowest schedule of premiums is required to be used in calculating reserves to reflect the key benefit of the secondary guarantee of paying lower premiums to keep the policy in force. It was determined at that time that not all states accepted the reserving methodology required by the Task Force Statement, and that there was a lack of consistency and uniformity among the states and industry in setting reserves for these products.

As a result, the NAIC Executive (EX) Committee believed that further work was necessary to address the issues surrounding statutory reserve requirements for companies offering ULSG products, and it formed the Joint Working Group of the Life Insurance and Annuities (A) Committee and the Financial Condition (E) Committee (Joint Working Group) to address these issues. The Joint Working Group was authorized to engage resources as necessary to assist with analysis and preparation of necessary guidelines and/or regulatory tools to assist state insurance regulators in evaluating reserves for these products.

On Aug. 28, 2012, the Joint Working Group adopted revisions to AG 38, which also were adopted by the Life Insurance and Annuities (A) Committee and Financial Condition (E) Committee on a joint conference call on Sept. 6, 2012. The proposed revisions to AG 38 take a bifurcated approach to address policies issued before a specified date (in force) and policies issued on and after a specified date (prospective). With respect to in force business, revised AG 38 applies a principle-based reserving (PBR)-type gross premium approach to the determination of a minimum reserve for that business with certain additional safeguards to make sure the reserves are sufficiently conservative. With respect to prospective business, new rules will be effective for policies written on or after Jan. 1, 2013. Consistent with these new requirements, most policies will follow a safe-harbor reserving methodology that will result in reserves closely approximating the reserves required under the Life Actuarial (A) Task Force Statement.

Finally, the revisions to AG 38 for both in-force and prospective business also provide that the Financial Analysis (E) Working Group will review the reserving methodology used by a company and approved by the domiciliary state. Work still remains for the Joint Working Group and the NAIC in implementing the new Financial Analysis (E) Working Group process under AG 38.

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

The Joint Working Group of the Life Insurance and Annuities (A) Committee and the Financial Condition (E) Committee was charged by the Executive (EX) Committee to address this issue. The 2012 members of the Joint Working Group that drafted and adopted the revisions to AG 38 on Aug. 28, 2012, were: Texas (Chair), Alaska, California, Florida, Iowa, New Jersey, New York, Tennessee and Virginia.

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

The Joint Working Group was created to address the issues surrounding AG 38 and statutory reserve requirements for insurers offering ULSG and term universal life (UL) products. The following charge was given to the Joint Working Group by the Executive (EX) Committee on Nov. 6, 2011:

"The Joint Working Group shall work expeditiously to determine whether it is prudent and necessary to develop interim guidelines and/or tools to be utilized by regulators in evaluating reserves for ULSG and term UL products and, if so, to promptly develop such interim guidelines and/or tools. As part of this effort, the Joint Working Group shall make recommendations regarding whether these interim guidelines and/or tools should be applied to in force and/or prospective ULSG and term UL products until such time as the final Valuation Manual is adopted. The Joint Working Group shall use as guidance the work completed by the Life Actuarial (A) Task Force with respect to this..."
4. A General Description of the Drafting Process and Due Process

- The Joint Working Group retained Neil Rector (Rector & Associates) and John MacBain (Actuarial Resources Corporation of Georgia—ARC-GA) as outside consultants to work on the project. Mr. Rector and Mr. MacBain worked extensively with state insurance regulators, NAIC staff and members of the life insurance industry in crafting the revisions to AG 38.

- On Jan. 12, 2012, the Joint Working Group issued a draft framework for how to evaluate In-Force business, as well as prospective business. Policies issued after the effective date of the NAIC’s adoption of PBR would be reserved using PBR methodology.

- On March 6, 2012, the NAIC adopted a motion to (1) adopt a bifurcated approach to in force and prospective business in concept; and (2) retain one or more independent, consulting actuaries to advise the Joint Working Group with respect to the issues identified in the draft framework.

- On July 17, 2012, the Joint Working Group released proposed revisions to AG 38 for a public comment period ending Aug. 3, 2012. The Joint Working Group released two alternative versions of new Section 8D of AG 38 with respect to in force business. Under Option 1 (PBR Base), the reserving methodology historically used by the company is compared to a gross premium reserve determined according to a PBR methodology. Alternatively, under Option 2 (Valuation Interest Rate Reserve Base), the reserving methodology historically used by the company is compared to a gross premium reserve that incorporates as the reinvestment return rate assumption the maximum valuation interest rate under the Standard Valuation Law (#820) for the year of issue of each policy (expected to be 4% for most policies within the scope of the reviews). In addition, the Joint Working Group released a new Section 8E relating to prospective business, which would be effective for policies issued after Jan. 1, 2013.

- On Aug. 8, 2012, the Joint Working Group held an open conference call to discuss the 14 comment letters that were received with respect to the July 17 exposure documents.

- On Aug. 21, 2012, the Joint Working Group exposed for comment new draft revisions to AG 38. Consistent with the draft Framework previously adopted by the NAIC, the proposed revisions to AG 38 take a bifurcated approach to in force and prospective business. With respect to in force business, the Working Group adopted a PBR-type gross premium approach to the determination of a minimum reserve for that business with certain additional safeguards to make sure the reserves are sufficiently conservative. With respect to prospective business, new rules will be effective for policies written on or after Jan. 1, 2013. Consistent with these new requirements, most policies will follow a safe-harbor reserving methodology that will result in reserves closely approximating the reserves contemplated by the Life Actuarial (A) Task Force Statement.

- On Aug. 28, 2012, the Joint Working Group held an open conference call to discuss the Aug. 21 exposure of revisions to AG 38. The Joint Working Group adopted the revised AG 38 unanimously.

- On Sept. 6, 2012, the Life Insurance and Annuities (A) Committee and the Financial Condition (E) Committee held a joint open conference call in which the revisions to AG 38 were adopted unanimously.

- On April 9, 2017, the Life Insurance and Annuities (A) Committee adopted proposed revisions to Section 8D and Section 8E of AG 38. The Section 8D revision establishes the most recent version of the Valuation Manual adopted by the Executive (EX) Committee and Plenary as the appropriate statutory authority. The revision to Section 8E indicates that policies issued after Jan. 1, 2013, that are being valued under PBR are no longer subject to AG 38.

5. A Discussion of the Significant Issues

The following topics of the model were discussed extensively with state insurance regulators and interested parties:

- As part of its charges from the Executive (EX) Committee, the Joint Working Group was to make recommendations regarding whether these interim guidelines and/or tools should be applied to in force and/or prospective ULSG
products until such time as the final *Valuation Manual* under Model #820 is adopted and operative. The Joint Working Group determined that it was necessary to amend AG 38 in order to facilitate this project.

- State insurance regulators were concerned that any action taken by the NAIC should create a level playing field between companies that followed the Life Actuarial (A) Task Force Statement and those with different interpretations of AG 38. They also are concerned about the eventual impact of PBR on reserves.

- State insurance regulators were concerned that any changes made to AG 38 complied with existing NAIC model laws and regulations.

- AG 38 itself only provides that the Financial Analysis (E) Working Group will have a role in the process. It stops short of describing the specific process, which will be developed by the Joint Working Group. The revisions to AG 38 for both in force and prospective business provide that the Financial Analysis (E) Working Group will review the reserving methodology used by a company and approved by the domiciliary state. If the Financial Analysis (E) Working Group does not agree with the state of domicile’s decisions with respect to the company’s reserving methodology, the Financial Analysis (E) Working Group will 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. Although the Financial Analysis (E) Working Group will play an important role in coordinating and facilitating the exchange of information between the states, individual state sovereignty is maintained, and neither the Financial Analysis (E) Working Group nor the NAIC have been delegated any regulatory authority under AG 38.

- A remaining issue is whether PBR will be made retroactive with respect to those policies covered under AG 38 after its adoption by the NAIC.

6. **Any Other Important Information**

Work continues on this project, and the Joint Working Group hopes to have processes in place for the review of prospective business that will become effective as of Jan. 1, 2013, and the role of the Financial Analysis (E) Working Group in this process.

*W:\National Meeting\2017\Summer\Plenary\05 A_Cmte_AG 38 8D 8E proposal.pdf*
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Paul Graham and Brian Bayerle, ACLI

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

Actuarial Guideline XLVIII, December 2016

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached

4. State the reason for the proposed amendment? (You may do this through an attachment.)

To clarify that the 2017 CSO is to be used when using the Actuarial Method calculate the NPR as required by Item #5 in the Text Section of Actuarial Guideline XLVIII, Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model 830) (AG 48).

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

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Notes: VM APF 2017-54
5. The Actuarial Method
   A. Description of Actuarial Method

   The Actuarial Method to establish the Required Level of Primary Security for each reinsurance treaty subject to this Actuarial Guideline shall be VM-20, applied on a treaty-by-treaty basis, including all relevant definitions, from the Valuation Manual as then in effect, applied as follows:

   (1) For Covered Policies described in Section 4B(1) above, the Actuarial Method is the greater of the Deterministic Reserve or the Net Premium Reserve (NPR) regardless of whether the criteria for exemption testing can be met. However, if the Covered Policies do not meet the requirements of the Stochastic Reserve exclusion test in the Valuation Manual, then the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR. In addition, if such Covered Policies are reinsured in a reinsurance treaty that also contains Covered Policies described in Section 4B(2) above, the ceding insurer may elect to instead use paragraph 2 below as the Actuarial Method for the entire reinsurance agreement. Whether Paragraph 1 or 2 are used, the Actuarial Method must comply with any requirements or restrictions that the Valuation Manual imposes when aggregating these policy types for purposes of principle-based reserve calculations.

   The mortality basis for the NPR shall be the 2017 CSO Mortality Table.

   (2) For Covered Policies described in Section 4B(2) above, the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR regardless of whether the criteria for exemption testing can be met. The mortality basis for the NPR shall be the 2017 CSO Mortality Table.
PROJECT HISTORY

ACTUARIAL GUIDELINE XLVIII

Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48)

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

The purpose and intent of this Actuarial Guideline are to establish uniform, national standards governing XXX or AXXX reserve financing arrangements and, in connection with such arrangements, to ensure that Primary Security, in an amount at least equal to the Required Level of Primary Security, is held by or on behalf of the ceding insurer. The requirements of this Actuarial Guideline should be viewed as minimum standards and are not a substitute for the diligent analysis of reserve financing arrangements by state insurance regulators.

AG 48, along with two previously adopted components of the XXX/AXXX Reinsurance Framework, became effective in 2015. The two components already adopted are: 1) the new reporting supplement to the annual statement to provide greater transparency pertaining to XXX/AXXX reinsurance transactions; and 2) revised financial analysis procedures to allow states to improve their regulatory review of these transactions.

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 (PBR), 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 opining 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 opining actuary issuing a qualified actuarial opinion reflecting, in part, the risk posed by the noncompliant transaction.

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 Law (#785) to recognize the new regulation.

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

The 2014 members of the Principle-Based Reserving Implementation (EX) Task Force were: Rhode Island (Co-Chair), Tennessee (Co-Chair), Alabama, California, Connecticut, Florida, Iowa, Kansas, Missouri, New York, Ohio, Texas, Utah, Vermont and Virginia.

The 2014 members of the Life Actuarial (A) Task Force were: Texas (Chair), Ohio (Vice Chair), Alabama, California, Connecticut, Florida, Kansas, Minnesota, Nebraska, New Jersey, New York, Oklahoma and Utah

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

The Principle-Based Reserving Implementation (EX) Task Force adopted a framework from the June 4, 2014, report from Rector & Associates. The report included a charge to the Life Actuarial (A) Task Force to develop a level of reserves (Required Level of Primary Security) that must be supported by certain defined assets (Primary Security). The level of reserves is to be calculated by a method referred to as the Actuarial Method.

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

AG 48 was primarily drafted by Rector & Associates, with the Life Actuarial (A) Task Force responsible for drafting 5A, the Actuarial Method. Contributors to the drafting process were the American Council of Life Insurers (ACLI), the American
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)**

On Aug. 14, 2014, the Life Actuarial (A) Task Force exposed the proposed AG 48, Section 5A, the Actuarial Method, for a 30-day public comment period ending Sept. 16.

On Oct. 2, 2014, the Life Actuarial (A) Task Force adopted revisions to AG 48, Section 5A, the Actuarial Method.

On Oct. 30, 2014, the Life Actuarial (A) Task Force voted to recommend the Actuarial Method to the Principle-Based Reserving Implementation (EX) Task Force.

On Nov. 17, 2014, the Principle-Based Reserving Implementation (EX) Task Force adopted AG 48, which establishes uniform national standards for XXX/AXXX captive reserve transactions.


On Oct. 31, 2016, the Task Force exposed revisions necessary to align AG 48 with the proposed Term and Universal Life Insurance Reserve Financing Model Regulation adopted Sept. 30 by the Financial Condition (E) Committee for a 30-day public comment period ending Nov. 29.

The revisions were adopted by the Life Actuarial (A) Task Force on Dec. 1, 2016, by the Life Insurance and Annuities (A) Committee on Dec. 11, 2016, and by the Executive (EX) Committee and Plenary in joint session on Dec. 13, 2016.

On June 29, 2017, the Life Actuarial (A) Task Force exposed a proposed revision to AG 48 that requires the use of the 2017 Commissioners’ Standard Ordinary (CSO) mortality table when determining the net premium reserve (NPR) for the Actuarial Method for a public comment period ending July 10.

The revisions were adopted by the Life Actuarial (A) Task Force on July 13, 2017, and by the Life Insurance and Annuities (A) Committee on July 17, 2017.

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

The significant issues discussed included the development of a new Credit for Reinsurance model regulation and the need to amend Model #785.

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

None.
| VM Maintenance Agenda # | Valuation Manual Reference | Adopted June 15, 2017  
By the Health Insurance and Managed Care (B) Committee | Adopted June 15, 2017  
By the Health Insurance and Managed Care (B) Committee | Adopted June 15, 2017  
By the Health Insurance and Managed Care (B) Committee |
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<td>VM-25</td>
<td>With impending changes to the calculation of the single premium immediate annuities valuation interest rate, this proposed change is to allow for the calculation of the calendar year maximum valuation interest rate for certain claim reserves to remain unchanged. The proposed wording provides for the direct calculation (derived from Appendix A-802) but the formula has been revised to replace W with the single value of .8 and to reduce the formula value of .03 by one hundred basis points.</td>
<td>HATF Adoption Date: 6/2/17</td>
<td>HATF Adoption Date: 6/2/17</td>
<td>HATF Adoption Date: 6/2/17</td>
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| 2017-6                 | VM Section II               | Pending Adoption on August 6, 2017  
By the Life Insurance and Annuities (A) Committee | Pending Adoption on August 6, 2017  
By the Life Insurance and Annuities (A) Committee | Pending Adoption on August 6, 2017  
By the Life Insurance and Annuities (A) Committee |
| 2017-28                | VM-31                       | Adopted July 17, 2017  
By the Life Insurance and Annuities (A) Committee | Adopted July 17, 2017  
By the Life Insurance and Annuities (A) Committee | Adopted July 17, 2017  
By the Life Insurance and Annuities (A) Committee |
<p>|                        |                             | Clarify in VM-20 Section 3.C that the shock lapse for the term NPR is to be applied prior to the collection of the first premium following the level period. | Clarify in VM-20 Section 3.C that the shock lapse for the term NPR is to be applied prior to the collection of the first premium following the level period. | Clarify in VM-20 Section 3.C that the shock lapse for the term NPR is to be applied prior to the collection of the first premium following the level period. |</p>
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<tr>
<th>VM Maintenance Agenda #</th>
<th>Valuation Manual Reference</th>
<th>Adopted July 17, 2017 By the Life Insurance and Annuities (A) Committee</th>
<th>LATF Adoption Date</th>
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<tr>
<td>2017-41</td>
<td>VM-20 Section 4, Section 5 and Section 7</td>
<td>Clarification of the existing VM-20 wording regarding the modeling of policy loans and separate account assets, and the list of assets in starting assets.</td>
<td>7/13/17</td>
</tr>
<tr>
<td>2017-43</td>
<td>VM-20 Appendix 2</td>
<td>Changes the calculation of spreads from quarterly to monthly and provides other changes for clarification.</td>
<td>7/13/17</td>
</tr>
<tr>
<td>2017-52</td>
<td>VM-30</td>
<td>Limits the amount of minimum aggregate reserve required to the amounts required in states in which this company is licensed.</td>
<td>7/13/17</td>
</tr>
<tr>
<td>2017-53</td>
<td>VM-20</td>
<td>To clarify that the 2017 CSO is to be used for all years of issue when applying the Actuarial Method as required by Section 6 of the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).</td>
<td>7/13/17</td>
</tr>
<tr>
<td>2016-2</td>
<td>VM-22</td>
<td>Revises requirements for the maximum valuation interest rate for SPIAs and similar contracts issued after 12/31/17 to be more responsive to the economic environment.</td>
<td>Editorial change 6/15/2017 Adopted 4/6/2017</td>
</tr>
<tr>
<td>2017-7</td>
<td>Section II</td>
<td>Revises and consolidates APF 2017-1 and APF 2017-3. Also excludes from the premium amounts counting toward the threshold, premium for preneed life contracts and premiums representing transfer of reserves from reinsurance assumed transactions.</td>
<td>6/15/2017</td>
</tr>
<tr>
<td>2017-22</td>
<td>Section I</td>
<td>Modify the process for updating the Spread and Default costs table in order to expedite their approval.</td>
<td>6/1/2017</td>
</tr>
<tr>
<td>2017-19</td>
<td>VM-01</td>
<td>This will clarify an inconsistent reference in the footnote to definition 64 about that, in the definition of non-material secondary guarantee, the unloaded CSO is to be used, not the Valuation Basic Table.</td>
<td>5/18/2017</td>
</tr>
<tr>
<td>VM Maintenance Agenda #</td>
<td>Valuation Manual Reference</td>
<td>Adopted by Life Insurance and Annuities (A) Committee May 19, 2017</td>
<td>LATF Adoption Date</td>
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<tr>
<td>2017-9</td>
<td>VM-20 Sections 2.A. and 2.B.</td>
<td>The proposal posits that the term “product minimum NPR” is not proper when referring to a subset of policies within that product. Offers recommendations to provide appropriate wording.</td>
<td>5/11/17</td>
</tr>
<tr>
<td>2017-8</td>
<td>VM-20 Section 3C</td>
<td>A liability exists for recognition of immediate payment of claims but the curtail net premium reserve formula in VM-20 does not recognize one and no reference in VM-20 is made to Actuarial Guideline XXXII.</td>
<td>5/11/17</td>
</tr>
<tr>
<td>2017-16</td>
<td>VM-51 Appendices 4 and 6</td>
<td>Propose revisions make VM 51 Appendix 4 and 6 consistent with the NYDFS and KID 2017 Data Call.</td>
<td>5/11/17</td>
</tr>
<tr>
<td>2017-20</td>
<td>VM-30</td>
<td>Requires the documentation of assumptions to include those related to mortality improvement or deterioration.</td>
<td>5/11/17</td>
</tr>
<tr>
<td>2017-10</td>
<td>VM-20 Section 9.D.1.a, 9.D.5</td>
<td>Use consistent reference to “cash surrender value”. And, in 9.D.5., clarify that the second sentence is a continuation of the logic from the first sentence and applies to the same policies as the first sentence.</td>
<td>4/6/17</td>
</tr>
<tr>
<td>2017-11</td>
<td>VM-20 Section 1.C.8 and 2.G.</td>
<td>Refines the definition of the term &quot;modeled reserve&quot; to capture the necessary references in Section 2.</td>
<td>4/6/17</td>
</tr>
<tr>
<td>2017-15</td>
<td>VM-20 Section 3.A.1</td>
<td>Proposes clarification of seriatim calculation of NPR and reference to Section II.</td>
<td>4/6/17</td>
</tr>
<tr>
<td>2017-21</td>
<td>VM-20 Appendix 2</td>
<td>Remove the tables from VM-20 Appendix 2 and place them on the Related Documents tab of the LATF page to avoid publishing a new VM whenever the tables are updated</td>
<td>4/6/17</td>
</tr>
<tr>
<td>2017-5</td>
<td>VM-20</td>
<td>Update the link in VM-20 Section 9C3g to the mortality improvement factors on the SOA website.</td>
<td>3/2/17</td>
</tr>
</tbody>
</table>
Adopted by the Health Insurance and Managed Care (B) Committee, June 15, 2017
Adopted by the Health Actuarial (B) Task Force, June 2, 2017

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force Amendment Proposal Form***

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

   William C Weller, Consultant to America’s Health Insurance Plans

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

   VM-25 of the Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

   See attachment 1 (paragraph 1 is unchanged, paragraph 2 is all new)

4. State the reason for the proposed amendment? (You may do this through an attachment.)

   With impending changes to the calculation of the single premium immediate annuities valuation interest rate, this proposed change is to allow for the calculation of the calendar year maximum valuation interest rate for certain claim reserves to remain unchanged. The proposed wording provides for the direct calculation (derived from Appendix A-802) but the formula has been revised to replace W with the single value of .8 and to reduce the formula value of .03 by one hundred basis points.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

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**Notes:**
VM-25 HEALTH INSURANCE RESERVES MINIMUM RESERVE REQUIREMENTS

A. Purpose

1. Reserve requirements for individual accident and health insurance policies issued on and after the valuation manual operative date and reserve requirements for group accident and health insurance certificates issued on and after the valuation manual operative date are applicable requirements found in the Accounting Practices and Procedures Manual (APPM), Appendix A, which includes A-10, and applicable requirements found in the APPM Appendix C, which includes AG28, AG44, AG47 and AG50.

2. The following requirement in Exhibit 1 paragraph 5 of Appendix A-10 with respect to claims incurred on or after January 1, 2018:

   For claim reserves on policies not requiring contract reserves, the maximum interest rate is the maximum rate allowed by Appendix A-820 in the valuation of single premium immediate annuities issued on the same date as the claim incurral date, reduced by 100 basis points.

is replaced with:

   For claim reserves on policies not requiring contract reserves, the maximum interest rate \( (I) \) shall be the calendar year statutory valuation interest rates as defined by

   \[
   I = .02 + .8 \times (R - .03)
   \]

   Where \( R \) is the average, over a period of twelve (12) months, ending on June 30 of the calendar year of the claim incurral date, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody’s Investors Service, Inc. The calculated value of \( I \) shall be rounded to the nearer one-quarter of one percent (1/4 of 1%).
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Reggie Mazycz, NAIC
Revise Valuation Manual Section II - Annuity Products to reflect that the minimum requirements for fixed annuity contract valuation interest rates are defined in VM-22.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM-II Reserve Requirements of the Valuation Manual 8/29 adopted version with changes through 12/31/16

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

II. Reserve Requirements

Annuity Products

A. This subsection establishes reserve requirements for all contracts classified as annuity contracts defined in SSAP No. 50 in the AP&P Manual.

B. Minimum reserve requirements for variable annuity contracts and similar business, specified in VM-21, Requirements for Principle-Based Reserves for Variable Annuities, shall be those provided by VM-21. The minimum reserve requirements of VM-21 are considered PBR requirements for purposes of the Valuation Manual.

C. Minimum reserve requirements for fixed annuity contracts are those requirements as found in VM-A and VM-C as applicable, with the exception of the minimum requirements for the valuation interest rate for single premium immediate annuity contracts, and other similar contracts, issued after 12/31/17. The minimum valuation interest rate requirements for those contracts are defined in VM-22.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

The proposed amendment recognizes that the requirements for the maximum valuation interest rate for income annuities are being redefined by modifications to VM-22.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

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Notes:
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Elaine Lam, Rachel Hemphill, Ben Bock, Mike Boerner, Arnold Dicke, Kerry Krantz, John Robinson, Pete Weber, and other members of the VM-31 Drafting Group

Revise VM-31 throughout all sections to achieve the following: (1) minimize redundancies between the Overview Section and the Main Report by reducing Overview Section to an Executive Summary, (2) require standardization of report format, with addition of section headers for guidance, and (3) require submission of the full VM-31 report to domiciliary commissioner on April 1st (and submission of full report to other commissioners upon request).

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

Valuation Manual August 29, 2016, with non-substantive changes through year-end 2016, VM-31 throughout all Sections.

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached pages 2-17.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

In this re-exposure draft, additional edits were made in Sections 2.A, 2.C, 3.C.3.c, 3.D.13.a, and 3.D.13.c to address initial exposure comments.[LE21]

Additional edits have been made to re-exposure draft for consideration. [LE32]

The reasons for the amendment are stated in #1. The specific changes in the proposal include:

(1) Update Section references and numbering, due to changes in Section locations (e.g., insertions and deletions).
(2) Add requirement for entire VM-31 report to be submitted to domiciliary commissioner and other commissioners upon request (cf. Section 2.C).
(4) Add section headers throughout all sections, underlined and separated by an emdash.
(5) Introduce an Executive Summary (replacing the Overview Section), with more limited requirements (cf. Section 3.C.a-e)
(6) Add Guidance Note for Variable Annuities after Section 3.C.2, directing reader to Section 3.E.
(7) Remove Guidance Note for the VM-20 Reserve Supplement after Section 3.C.5.
(8) For previous requirements in Overview Section, delete or move to main report (cf. Sections, 3.C.5-12, 3.D.1, 3.D.6.c/d/f).
(10) Move Reliances to be near Certifications (cf. 3.D.12).
(11) Combine Certifications previously in Overview with those in Main Report (cf. 3.D.13.d-e)
(12) Move Closing paragraph and signatures to the end of the report (cf. 3.D.14)

NAIC Staff Comments:

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Notes:
Section 1: Purpose

These requirements establish the minimum reporting requirements for policies or contracts subject to PBR valuation under the Standard Valuation Law.

Section 2: General Requirements

A. Each year a company shall prepare, under the direction of one or more qualified actuaries, as assigned by the company under the provisions of VM-G, a PBR Actuarial Report if the company computes a deterministic or stochastic reserve as defined in VM-20 for any policy or contract. The PBR Actuarial Report shall consist of one or more sub-reports, each such sub-report covering a group of policies comprised of one or more model segments. Each such sub-report shall be prepared by the qualified actuary assigned responsibility for such group of policies under the provisions of VM-G. The PBR Actuarial Report must include documentation and disclosure sufficient for another actuary qualified in the same practice area to evaluate the work.

A company that does not compute any deterministic or stochastic reserves for a group of policies as a result of the company passing the exclusion tests as defined in VM–20 Section 6 for all policies in that group must develop a sub-report for that group that addresses the requirements of Section 3.D.10. and Section 3.D.1213.c., if applicable.

Guidance Note: A company that computes an aggregate reserve as defined in VM-21 for any policy or contract shall follow the certification and documentation requirements in VM-21. Such certification and documentation requirements in VM-21 are typically submitted to the company’s domiciliary commissioner or the commissioner of any other state in which the company is licensed upon request.[LE23]

B. The PBR Actuarial Report must include descriptions of all material decisions made and information used by the company in complying with the minimum reserve requirements and must comply with the minimum documentation and reporting requirements set forth in Section 3.

C. The Executive Summary of the PBR Actuarial Report shall be submitted to the company’s domiciliary commissioner no later than April 1 of the year following the year to which the PBR Actuarial Report applies. The entire PBR Actuarial Report shall be submitted upon request to the company’s domiciliary commissioner no later than April 1 of the year following the year to which the PBR Actuarial Report applies or within 30 days, if requested after April 1. Similarly, upon request, the company shall submit the entire PBR Actuarial Report or the Executive Summary, upon request, to the commissioner of any other state in which the company is licensed.[LE34]

D. The company shall retain on file, for at least seven years from the date of filing, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions and the results obtained in a principle-based valuation.

Section 3: PBR Actuarial Report Requirements
VM-31  PBR Actuarial Report Requirements for Business Subject to a Principle-Based Reserve Valuation

A. For purposes of this section:

1. For individual life insurance policies, “principle-based reserves” means that deterministic and/or stochastic reserves were calculated for policies under VM-20.

2. For variable annuity contracts, “principle-based reserves” means that reserves were calculated for contracts under VM-21.

B. The PBR Actuarial Report shall contain a table of contents with associated page numbers. The PBR Actuarial Report shall retain and follow the order of the requirements provided in Section 3.C, Section 3.D., and Section 3.E., keeping corresponding headers, and include an explanatory statement for any requirement that is not applicable.

C. Executive Summary – The PBR Actuarial Report shall contain an overview section one executive summary at the beginning of the report which addresses all sub-reports. The overview section shall be submitted to the company’s domiciliary commissioner no later than April 1 of the year following the year to which the PBR Actuarial Report applies and the company shall provide this overview section to any other commissioner upon request. The overview section is a part of the PBR Actuarial Report and is subject to the same confidentiality provisions as the PBR Actuarial Report, even when provided separately. The overview section executive summary shall include the following:

1. Qualified Actuary – An opening paragraph identifying the qualified actuary that has been assigned by the company to prepare each sub-report of the PBR Actuarial Report, the qualifications of the qualified actuary and the relationship of the qualified actuary to the company.

2. Policies – A description of the policies and/or contracts subject to VM-20 or VM-21 and, for VM-20, the groups of policies covered by each sub-report.

Guidance Note: For reporting requirements on Variable Annuity contracts subject to VM-21, proceed directly to Section 3.E.

3. Life PBR Summary – A summary of the critical contents of all sub-reports of the PBR Actuarial Report as detailed in Section 3.D. In particular, this summary shall include:

   a. Materiality – A description of the rationale for determining whether a decision, information, assumption, risk, or other element of a principle-based reserve calculation is material. Such rationale could include such items as a percentage of surplus, a percentage of reserve, or a specific monetary value.

   b. Material Risks – A summary of the material risks within the principle-based valuation subject to close monitoring by the board, the company, the qualified actuary, or any regulators. Include any significant information required to be provided to the board pursuant to VM-G, such as elements materially inconsistent with the company’s overall risk assessment processes.

   c. Changes in Reserve Amounts – A description of any material changes in reserves and an explanation for the changes.

   d. Changes in Methods – A description of any significant changes in the method used to determine assumptions and margins from the prior year and the rationale for the changes.

   e. Assets and Risk Management – A brief description of the asset portfolio, and the
approach used to model risk management strategies (e.g., hedging) and other
derivative programs, including a description of any clearly defined hedging
strategies.

4. Closing Section – A closing section with the signature, credentials, title, telephone number
and e-mail address of the qualified actuary (or qualified actuaries) that authored the
executive summary, the company name and address, and the date signed.

5. Supplement Part 1 – A copy of Part 1 of the VM-20 Reserve Supplement from
the annual statement blank in the PBR Actuarial Report.

6. Supplement Part 2 – A copy of Part 2 Section 1 of the VM-20 Reserve
Supplement from the annual statement blank in the PBR Actuarial Report.

Guidance Note: The VM-20 Reserve Supplement exposed on Nov. 18, 2015, labels the
two reserve tables as Part 1 and Part 2 Section 1. The references here will be adjusted as
needed based on any changes to labels used in the final adopted supplement.

5. For each group of policies covered in a sub-report, a description of the risks determined
material by the qualified actuary assigned to that group of policies and associated with
policies and/or contracts in that group of policies subject to a PBR valuation.

6. For each group of policies covered in a sub-report, a description of those areas where the
qualified actuary relied on others for data, assumptions, projections or analysis in
determining the PBR and a reliance statement from each individual on whom the
qualified actuary relied that includes:

a. The information provided by the individual.

b. A statement as to the accuracy, completeness or reasonableness, as applicable, of
the information provided.

7. For each group of policies covered in a sub-report, a summary of the valuation
assumptions and margins for each major product line subject to a PBR valuation within
that group of policies including:

a. Description of the method used to determine anticipated experience assumptions
for each material risk factor, including the degree to which the assumptions are
based on experience versus actuarial judgment or other factors, and the source of
the experience (e.g., company experience versus industry study).

b. Description of any significant changes from the prior year in the method used to
determine anticipated experience assumptions and the rationale for the change.

c. List of key risk and experience reporting elements that the company is tracking in
order to monitor changes in experience that will be used to update assumptions
and the frequency of the tracking.

d. Description of the method used to determine margins for each material risk
factor.

e. Description of any significant changes from the prior year in the method used to
determine margins and the rationale for the change.

f. Disclosure of the key valuation assumptions, other than prescribed assumptions,
and methods, that are materially inconsistent with the company’s overall risk assessment process recognizing potential differences in financial reporting structures. The disclosure should provide a summary of those risk analyses and management techniques with which the assumptions are inconsistent and the rationale for the inconsistency.

g. Description of any considerations helpful in or necessary to understanding the rationale behind and development of assumptions and margins even if such considerations are not explicitly mentioned in the Valuation Manual.

Guidance Note: The requirements in C.7 above require an executive summary version of the assumptions and margins. Additional details on assumptions and margins are included in later sections of the PBR Actuarial Report.

8. For each group of policies covered in a sub-report, a summary of the approach used to model the assets supporting the group of policies subject to a PBR valuation, including:

a. Method used and rationale for allocating the total asset portfolio into multiple segments, if applicable.

b. Description of the asset portfolio, including the types of assets, duration and their associated quality ratings.

9. A description of the approach used to model risk management strategies (e.g., hedging) and other derivative programs, as well as a summary and description of any clearly defined hedging strategies.

10. A description of the rationale for determining whether a decision, information, assumption, risk or other element of a PBR calculation is material. Such rationale could include such items as a percentage of surplus, a percentage of reserve or a specific monetary value.

11. Paragraphs certifying that the PBR reserve valuation:

a. Was calculated in accordance with VM-05 and VM-20.

b. The assumptions and margins are prudent estimates.

12. A closing paragraph for each group of policies covered by a sub-report, with the signature, title, telephone number and e-mail address of the qualified actuary, the company name and address, and the date signed.

D. Life PBR Actuarial Report – PBR Actuarial Report Requirements for Individual Life Insurance Policies or Contracts

The company shall include in the PBR Actuarial Report and in any sub-report thereof:

1. Assumptions and Margins – A summary of valuation assumptions and margins, including a listing of the final prudent estimate valuation assumptions and margins for the major risk factors and a description of any changes in anticipated experience assumptions or margins since the last PBR Actuarial Report. Also describe the method used to determine assumptions and margins, including the sources of experience and how changes in such experience are monitored.
PBR Actuarial Report Requirements for Business Subject to a Principle-Based Reserve Valuation

2. **Cash-Flow Models** – The following information regarding the cash-flow model(s) used by the company in determining PBR:

   a. **Modeling Systems** – Description of the modeling system(s) used.

   b. **Model Segments** – Description and rationale for the organization of the policies and assets into model segments, consistent with the guidance from VM-20 7.A.1.b and VM-20 7.D.1.b.

   c. **Grouping within Model Segments (Deterministic)** – Description of the approach and rationale used to group assets and policies for the deterministic reserve calculation within each model segment.

   A clear indication shall be provided of how the company met the requirements of Section 2.G. of VM-20 with respect to the grouping of policies. It shall be documented that, upon request, information may be obtained that is adequate to permit the audit of any subgroup of policies to ensure that the reserve amount calculated using a seriatim (policy-by-policy) liability model produces a reserve amount not materially higher than the reserve amount calculated using the grouped liability model.

   d. **Grouping within Model Segments (Stochastic)** – Description of the approach and rationale used to group assets and policies for the stochastic reserve calculation within each model segment if different from the approach used in paragraph 2.c.

   e. **Model Validation** – Description of the approach used to validate model calculations within each model segment for both the deterministic and stochastic models, including: how the model was evaluated for appropriateness and applicability; how the model results compare with actual historical experience; what, if any, risks are not included in the model; the extent to which correlation of different risks is reflected in the margins; and any material limitations of the model.

   f. **Projection Period** – Disclosure of the length of projection period and comments addressing the conclusion that no material amount of business remains at the end of the projection period for both the deterministic and stochastic models.

   g. **Reinsurance Cash Flows** – Description of how reinsurance cash flows are modeled.

3. **Mortality** – The following information regarding the mortality assumptions used by the company in determining PBR:

   a. **Mortality Segments** – Description of each mortality segment and the rationale for selecting the policies to include in each mortality segment.

   b. **Sub-Classes** – If the company sub-divides aggregate company experience into various sub-classes or mortality segments to determine company experience mortality rates, documentation that when the mortality segments are weighted together, the total number of expected claims is not less than the company experience data for the aggregate class.
c. **Underwriting Scoring Procedure** – Description, rationale and results of applying the underwriting scoring procedure to select the industry basic table(s), including the rationale for and results of applying the underwriting scoring procedure and a summary of the analysis performed to evaluate the relationship between underwriting scoring and the anticipated mortality established for mortality segments where the mortality assumption is affected by the application of the underwriting scoring procedure. If underwriting-based justification not involving UCS is being applied, provide similar analysis applicable to the company's methods.

d. **Alternative Data Sources** – If company experience mortality rates for any mortality segment are not based on the experience directly applicable to the mortality segment (whether or not the data source is from the company), then provide a summary containing the following:

i. The source of data, including a detailed explanation of the appropriateness of the data, and the underlying source of data, including how the company experience mortality rates were developed, graduated and smoothed.

ii. Similarities or differences noted between policies in the mortality segment and the policies from the data source (e.g., type of underwriting, marketing channel, average policy size, etc.).

iii. Adjustments made to the experience mortality rates to account for differences between the mortality segment and the data source.

iv. The number of deaths and death claim amounts by major grouping and including: age, gender, risk class, policy duration and other relevant information.

e. **Adjustments for Changes in Practice** – If the company makes adjustments to company experience mortality rates for changes in risk selection and underwriting practices:

i. Rationale for the adjustments.

ii. A description and summary of the published medical or clinical studies used to support the adjustments.

iii. Documentation of the mathematics used to adjust the mortality.

iv. Summary of any other relevant information concerning any adjustments to the experience mortality that affected the mortality assumption.

f. **Credibility** – Description of the method to determine the level of credibility for the company’s mortality exposure period, including:

i. A summary of the level of credibility for each mortality segment, along with an indication of whether the level of credibility was determined at the mortality segment level or at a higher level using aggregate mortality experience.

g. **Company Experience** – If company experience is used, a summary of company experience mortality for each mortality segment.
PBR Actuarial Report Requirements for Business Subject to a Principle-Based Reserve Valuation

h. Industry Tables – To the extent company experience is not used, a description of the industry basic table used for each mortality segment.

i. Adjustments for Mortality Improvement – Description of and rationale for any adjustments to the mortality assumptions for historical mortality improvement up to the valuation date.

j. Adjustments for Impaired Lives or Policyholder Behavior – Description of and rationale for any adjustments to mortality assumptions for impaired lives or policyholder behavior.

k. Anticipated Experience Mortality – If company experience is used, a summary of the approach used to determine the final set of anticipated experience mortality rates, including:
   i. The start and ending period of time used to grade company experience to the industry basic table, including the approach used to grade company experience mortality rates to the industry table for advanced ages (attained age 95-100 or 15 years after policy underwriting).
   ii. Description of the industry basic table used for each mortality segment.
   iii. Description and results of any smoothing technique used.
   iv. Description of any adjustments that were made to ensure reasonable relationships is maintained between mortality segments that reflect the underwriting class or risk class of each mortality segment.
   v. Description and justification to support and demonstrate that the resulting anticipated experience assumptions are at least as great as those expected to actually emerge. The description should include the level of granularity at which the comparison is made (e.g., ordinary life, Term only, preferred term, etc.)

l. Adjustments to Mortality Margins – Description and rationale of any adjustments made to increase margins above the prescribed margin.

m. Actual to Expected Mortality Analysis – At least once every three years, the results of an actual to expected (without margins) analysis.

4. Policyholder Behavior – The following information regarding each policyholder behavior assumption used by the company in determining principle-based reserves:

a. Data Sources – Sources and credibility of the data and an explanation of why the data are reasonable and appropriate for this purpose.

b. Sparse Data – Explanation of how assumptions were determined for periods that were based on less than fully credible or relevant data.

c. Anticipated Experience Assumptions – Description of method used to develop anticipated experience assumptions.

d. Actual to Expected Policyholder Behavior Analysis – At least once every three years, the results of an actual to expected analysis.
e. **Margins and Sensitivity Tests** – Margins used, methodology used to determine the margins and rationale for the particular margins used, including how the results of sensitivity tests were used to determine the margins.

f. **Impact of Non-Guaranteed Elements** – How changes in NGE affect the policyholder behavior assumptions.

g. **Scenario-Dependent Dynamic Formulas** – Description of any scenario-dependent dynamic formula.

h. **Changes from Prior Year** – Changes in anticipated experience assumptions and/or margins since last PBR Actuarial Report.

i. **Flexible Premiums** – For policies that give policyholders flexibility in timing and amount of premium payments, disclose results of sensitivity tests related to the following premium payment patterns: minimum premium payment, no further premium payment, pre-payment of premium assuming a single premium and pre-payment of premiums assuming level premiums.

j. **Anti-Selective Lapses** – Specific to lapses, provide description of and rationale regarding adjustments to lapse and mortality assumptions to account for potential anti-selection.

k. **Competitor Rates** – Competitor rate definition and usage.

5. **Expenses** – The following information regarding the expense assumptions used by the company in determining PBR:

   a. **Allocating Expenses to PBR Policies** – Methodology used to allocate expenses to the individual life insurance policies subject to a PBR valuation.

   b. **Allocating Expenses to Model Segments** – Methodology used to apply the allocated expenses to model segments or sub-segments within the cash-flow model.

   c. **Expense Margins** – Methodology used to determine margins.

6. **Assets** – The following information regarding the asset assumptions used by the company in determining principle-based reserves asset assumptions:

   a. **Starting Assets** – The amount of starting assets supporting the policies subject to a principle-based valuation, and the method and rationale for determining such amount.

   b. **Asset Selection** – Method used and rationale for selecting the assets and apportioning the assets between the policies subject to PBR valuation and those policies not subject to PBR valuation.

   c. **Asset Segmentation** – Method used and rationale for allocating the total asset portfolio into multiple segments, if applicable.

   d. **Asset Description** – Description of the asset portfolio, including the types of assets, duration and their associated quality ratings.

   e.e. **Market Values** – Method used to determine projected market value of assets (if needed for assumed asset sales).
f. Risk Management – Detailed description of model risk management strategies (e.g., hedging) and other derivative programs, including any clearly defined hedging strategies, specific to the groups of policies covered in this sub-report and not discussed in the Executive Summary Section 3.C.3.e.

g.d. Foreign Currency Exposure – Analysis of exposure to foreign currency fluctuations.

h.e. Maximum Net Spread Adjustment Factor – Summary of the results of the steps for determining the maximum net spread adjustment factor for each model segment, including the method used to determine option adjusted spreads for each existing asset.

i.f. Net Asset Earned Rates – A summary of the path of net asset earned rates for each model segment calculated for the deterministic reserve.

j.g. Investment Expenses – Investment expense assumptions.

k.h. Prepayment, Call and Put Functions – Prepayment, call and put functions.

l.i. Asset Collar – If for all model segments combined, the aggregate annual statement value of starting assets is less than 98% or greater than the larger of NPR or 102% of the final aggregate minimum modeled reserve, documentation that supports the conclusion that the aggregate minimum modeled reserve is not materially understated as a result of the estimate of the amount of starting assets.

m.j. Residual Risks and Frictional Costs – With respect to modeling of derivative programs if a company assumes that residual risks and frictional costs have a value of zero, a demonstration that a value of zero is an appropriate expectation.

n.k. Policy Loans – Description of how policy loans are modeled, including documentation that if the company substitutes assets that are a proxy for policy loans, the modeled reserve produces reserves that are no less than those produced by modeling existing loan balances explicitly.

o.l. General Account Equity Investments – Description of an approach and rationale used to group general account equity investments, including non-registered indexed products, including an analysis of the proxy construction process that establishes the relationship between the investment return on the proxy and the specific equity investment category.

p.m. Separate Account Funds – Description of the approach and rationale used to group separate account funds and subaccounts, including analysis of the proxy construction process that establishes a firm relationship between the investment return on the proxy and the specific variable funds.


r.o. Investment Strategy and Reinvestment Assumptions – Description of the asset investment strategy used in the model, including asset reinvestment and disinvestment assumptions, and documentation supporting the appropriateness of the model investment strategy compared to the actual investment policy of the company.
VM-31 PBR Actuarial Report Requirements for Business Subject to a Principle-Based Reserve Valuation

s.p.—Alternative Investment Strategy – Documentation that the model investment strategy does not produce a modeled reserve that is less than the modeled reserve that would result by assuming an alternative investment strategy in which all fixed income reinvestment assets are public non-callable bonds with gross asset spreads, asset default costs and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating of 6 (“A2/A”) and 50% PBR credit rating of 9.3 (“Aa2/AA”).

t.q.—Number of Scenarios – Number of scenarios used for the stochastic reserves and the rationale for that number.

u.r.—Scenario Reduction Techniques – If a scenario reduction technique is used, a description of the technique and documentation of how the company determined that the technique meets the requirements of Section 2.G. of VM-20.

7. Revenue-Sharing Assumptions – The following information regarding the revenue-sharing assumptions used by the company in determining PBR:

a. Agreements and Guarantees – Description of revenue-sharing agreements and the nature of any guarantees underlying the revenue-sharing income included in the projections, including: the terms and limitations of the agreements; relationship between the company and the entity providing the revenue-sharing income; benefits and risk to the company and the entity providing the revenue-sharing income of continuing the arrangement; the likelihood that the company will collect the revenue-sharing income during the term of the agreement; the ability of the company to replace the services provided by the entity providing the revenue-sharing income; and the ability of the entity providing the revenue-sharing income to replace the service provided by the company.

b. Amounts Included – The amount of revenue-sharing income and a description of the rationale for the amount of revenue-sharing income included in the projections, including any reduction for expenses.

c. Revenue-Sharing Margins – The level of margin in the prudent estimate revenue-sharing income assumptions and description of the rationale for the margin for uncertainty.

8. Reinsurance – The following information regarding the reinsurance assumptions used by the company in determining PBR:

a. Agreements – For those reinsurance agreements included in the calculation of the minimum reserve as per VM-20 Section 8.A, a description of each reinsurance agreement, including, but not limited to, the type of agreement, the counterparty, the risks reinsured, the portion of business reinsured and whether the agreement complies with the requirements of the credit for reinsurance under the terms of the AP&P Manual.

b. Assumptions – Description of reinsurance assumptions used to determine the cash flows included in the model.

c. Separate Stochastic Analysis – To the extent that a single deterministic valuation assumption for risk factors associated with certain provisions of reinsurance agreements will not adequately capture the risk of the company, a description of the separate stochastic analysis that was used outside the cash-flow model to
PBR Actuarial Report Requirements for Business Subject to a Principle-Based Reserve Valuation VM-31

quantify the impact on reinsurance cash flows to and from the company. The description should include which variables are modeled stochastically.

d. **Multiple Agreement Allocation Method** – If a policy is covered by more than one reinsurance agreement, description of method to allocate reinsurance cash flows from each agreement.

e. **Counterparty Assets** – Pursuant to VM-20 Section 8.C.14, if the company concludes that modeling the assets supporting reserves held by a counterparty is not necessary, documentation of the testing and logic leading to that conclusion.

9. **Non-Guaranteed Elements** – The following information, where applicable, regarding the NGE assumptions used by the company in determining PBR:

a. **Modeling** – Description of the approach used to model NGEs, including a discussion of how future NGE amounts were adjusted in scenarios to reflect changes in experience and including how lag in timing of any change in NGE relative to date of recognition of change in experience was reflected in projected NGE amounts.

b. **NGE Margins** – Description of the approach to establish a margin for conservatism.

c. **Past Practices and Policies** – Description of how the company’s past NGE practices and established NGE policies were reflected in projected NGE amounts.

d. **Consistency** – Description of the following: (i) whether and how projected levels of NGEs in the model are consistent with experience assumptions used in each scenario; and (ii) whether and how policyholder behavior assumptions are consistent with the NGE are assumed in the model.

e. **Conditional Exclusion** – State if and how the provision in Section 7.C.5 of VM-20 allowing conditional exclusion of a portion of an NGE is used.

i. If used, is the provision used for any purpose other than recognition of subsidies for participating business.

ii. If this provision is being used, discuss how prevention of double counting of assets is ensured.

**Guidance Note:** Examples of considerations include: (1) if the subsidy is provided by a downstream company, and the carrying value of the downstream company is reported as an asset on the company’s books, where is the offsetting liability reported; or (2) if the subsidy is provided by another block of business within the company, is the subsidy included in cash-flow testing of the “other block”?

f. **Interest Crediting Strategy** – Description of interest crediting strategy.

10. **Exclusion Tests** – The following information regarding the deterministic and stochastic exclusion tests, if calculated:
a. **Exclusion Test Policies** – Identification and description of each group of policies using the deterministic and stochastic exclusion tests, including contract type and risk profile, and rationale for each grouping of policies.

b. **Type of Stochastic Exclusion Test** – For each group of policies which the company elects to exclude from stochastic reserve requirements, the stochastic exclusion test used (passing the stochastic exclusion ratio test or stochastic exclusion demonstration test, or certification that the group of policies does not contain material interest, tail or asset risk).

c. **Stochastic Exclusion Ratio Test** – For groups of policies for which the stochastic reserve exclusion ratio test is used, results of the 16 scenarios and the test ratio.

d. **Stochastic Exclusion Demonstration Test** – For groups of policies for which the stochastic reserve exclusion demonstration method test is used, the rationale for using the demonstration method test and a demonstration supporting the exclusion in the initial exclusion year and at least once every three calendar years subsequent to the initial exclusion that complies with the following:

i. The demonstration shall take into account whether changing conditions over the current and two subsequent calendar years would be likely to change the conclusion to exclude the group of policies from the stochastic modeling requirement. If, as of the end of any calendar year, the company determines the minimum reserve for the group of policies no longer adequately provides for all material risks, the exclusion shall be discontinued, and the policies shall be included in the stochastic modeling calculations.

ii. The demonstration may be based on analysis from a date that precedes the initial or subsequent exclusion period.

iii. The demonstration shall provide a reasonable assurance that the stochastic reserve calculated on a stand-alone basis for only those policies subject to the stochastic modeling exclusion would not be greater than the minimum reserve for such policies.

iv. The demonstration shall provide an effective evaluation of the residual risk exposure resulting from risk mitigation techniques such as derivative programs and reinsurance.

**Guidance Note:** Examples of acceptable methods to demonstrate that the exclusion requirements are met for a group of policies include, but are not limited to:

a) Demonstrate that the greater of the deterministic reserve and the NPR, less any associated deferred premium asset is greater than the stochastic reserve calculated on a stand-alone basis.

b) Demonstrate that the greater of (1) the NPR less any associated premium asset and (2) the deterministic reserve is greater than the scenario reserve that results from each of a sufficient number of adverse deterministic scenarios.

c) Demonstrate that the greater of (1) NPR less any associated premium asset and (2) the deterministic reserve is greater than the stochastic...
e. **Certification Method** – For groups of policies for which the certification method is used, support for the certification including supporting analysis and tests.

f. **Deterministic Exclusion Test** – For groups of policies that pass the stochastic exclusion test and for which the company chooses not to calculate stochastic reserves, the results of the deterministic exclusion test for each group of policies.

11. **Additional Information** – The following additional information:

a. **Impact of Individual Margins** – The impact of individual margins on the deterministic reserve for each risk factor, or group of risk factors, that has a material impact on the deterministic reserve determined for each model segment by subtracting (i) from (ii):

i. The deterministic reserve for all policies, but with the reserve calculated based on the anticipated experience assumption for the risk factor and prudent estimate assumptions for all other risk factors.

ii. The deterministic reserve for all policies as reported.

b. **Impact of Aggregate Margins** – An estimate of the aggregate impact of all margins on the deterministic reserve for each model segment. This shall be determined for each model segment by subtracting (i) from (ii):

i. The deterministic reserve for all policies, but with the reserve calculated based on anticipated experience assumptions for all risk factors prior to the addition of any margins.

ii. The deterministic reserves for all policies as reported.

c. **Impact of Implicit Margins** – For purposes of the disclosures required in 11a and 11b above:

i. If the company believes the method used to determine anticipated experience mortality assumptions includes an implicit margin, the company can adjust the anticipated experience assumptions to remove this implicit margin. For example, to the extent the company expects mortality improvement after the valuation date, any such mortality improvement is an implicit margin and, therefore, is an acceptable adjustment to the anticipated experience assumptions for this purpose. If any such adjustment is made, the company shall document the rationale and method used to determine the anticipated experience assumption.

ii. Since the company is not required to determine an anticipated experience reserve calculated on a stand-alone basis, but using a representative sample of policies in the stochastic modeling calculations.
assumption or a prudent estimate assumption for risk factors that are
prescribed for the deterministic reserve (i.e., interest rates movements,
equity performance, default costs and net spreads on reinvestment
assets), when determining the impact of margins, the prescribed
assumption shall be deemed to be the prudent estimate assumption for
the risk factor, and the company can elect to determine an anticipated
experience assumption for the risk factor, based on the company's
anticipated experience for the risk factor. If this is elected, the company
shall document the rationale and method used to determine the
anticipated experience assumption. If the mortality segments do not
qualify for the simplified method to determine prudent estimate mortality
assumptions, the anticipated experience assumption for mortality is the
credibility adjusted experience rates.

d. Sensitivity Tests – An explanation of how the results of sensitivity tests and
varying assumptions were used or considered in developing assumptions
including a description of, results of, and action taken with respect to sensitivity
tests performed.

e. Material Risks Not Fully Reflected – A description of material risks not fully
reflected in the cash-flow model used to calculate the stochastic reserve,
including:

i. A description of each element of the cash-flow model for which this
provision has been made in the stochastic reserve (e.g., risk factors,
policy benefits, asset classes, investment strategies, risk mitigation
strategies, etc.).

ii. A description of the approach used by the company to provide for these
risks in the stochastic reserve outside the cash-flow model, a summary of
the rationale for selecting this approach and the key assumptions
justifying the underlying approach.

iii. If there is more than one model element included in this provision,
clarifying whether a separate provision was determined for each element,
or collectively for groups of two or more elements and explaining the
methodology, supporting rationale and key assumptions for how separate
provisions were combined.

f. Impact of Aggregation – Summary of the impact of aggregation on the stochastic
reserve.

g. Use of Date Preceding Valuation Date – If the company uses a date that precedes
the valuation date to calculate the reserves, the company shall explain why the
use of such date will not produce a material change in the results if the results
were based on the valuation date. Such explanation shall describe the process the
qualified actuary used to determine the adjustment, the amount of the adjustment
and the rationale for why the adjustments are appropriate.

h. Approximations and Simplifications – Description of any approximations and
simplifications used in reserve calculations.

12. Reliance Descriptions and Statements – A description of those areas where the qualified
actuary relied on others for data, assumptions, projections or analysis in determining the
PBR and a reliance statement from each individual on whom the qualified actuary relied that includes:

a. Listing – The name, title, and qualifications of the individual and the information provided.

b. Statements – A statement as to the accuracy, completeness or reasonableness, as applicable, of the information provided.

13.12. Certifications

a. Investment Officer and Qualified Actuary on Investments – A certification from a duly authorized investment officer that the modeled asset investment strategy is consistent with the company’s current investment strategy.

b. Qualified Actuary on Investments – and an actuarial certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Report or this sub-report, regarding the modeling of clearly defined hedging strategies.

c. b. Senior Management – A certification from senior management certifying that the principle-based valuation complies with VM-G (Corporate Governance Guidance for Principle-Based Reserves).

d. e. -- Qualified Actuary on Interest Rate and Volatility Risks – Certification, by the qualified actuary assigned responsibility under VM-G for a group of policies that qualifies for exclusion from the requirement to calculate a stochastic reserve under the provisions of VM-20, Section 6 A[LE213]B.1.a.iii, that this group of policies is not subject to material interest rate risk or asset return volatility risk.

e. d. -- Qualified Actuary on Accordance with VM-05 and VM-20 – Certification by the qualified actuary, for the groups of policies for which responsibility was assigned[LE314], that the PBR reserve valuation was calculated in accordance with VM-05 and VM-20.

f.e. -- Qualified Actuary on Assumptions and Margins – Certification by the qualified actuary, for the groups of policies for which responsibility was assigned[LE315], that the assumptions used in the PBR valuation, other than assumptions used for risk factors that are prescribed or stochastically modeled, and margins are prudent estimates assumptions (as defined in VM-01) and the margins applied therein are appropriate[LE316]

14. Closing Paragraph – A closing paragraph for each group of policies covered by a sub-report, with the signature, credentials, title, telephone number and e-mail address of the qualified actuary, the company name and address, and the date signed.

E. Variable Annuity PBR Actuarial Report – PBR Actuarial Report Requirements for Variable Annuity Contracts

**Guidance Note:** See documentation and reporting requirements in VM-21.
This page intentionally left blank.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Staff of Office of Principle-Based Reserving, California Department of Insurance – Add floors to actual policy fund value ($e_{n\infty}$), funded policy fund value ($f_{n\infty}$).

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:


3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached Appendix. NOTE: This amendment is a clarification only and as such is Non-Substantive.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

See attached Appendix.

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**NAIC Staff Comments:**

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**Notes:** VM Maintenance Agenda Item 2017-34 rev
Appendix

**ISSUE:**

Add floors to actual policy fund value ($e_t+x$), funded policy fund value ($f_t+x$).

**SECTION:**

VM-20 Section 3.B.5.d.ii

**RELINE:**

ii. Let: $r_{x+t} = \text{the ratio } \min(\frac{e_t+x}{f_t+x}, 1), \text{ but not greater than } 1$, with ($e_t+x$) and ($f_t+x$) defined as below:

\[
e_{t+x} = \max(\text{the actual policy fund value on the valuation date } t, 0).
\]

\[
f_{t+x} = \max(\text{the policy fund value on the valuation date } t \text{ is that amount which, together with the payment of the future level gross premiums determined in Subsection 3.B.5.a above, keeps the policy in force for the entire period coverage is to be provided, based on the policy guarantees of mortality, interest and expenses, } $0.01).\]

Then set $r_{x+t}$ equal to:

1 if $f_{t+x} \leq 0$

\[
\min(\frac{e_{t+x}}{f_{t+x}}, 1), \text{ otherwise}
\]

**REASONING:**

Given that there are ULSG policies in force by virtue of a positive shadow account when they have a negative actual fund value, it seems necessary to floor $e_{t+x}$ at zero. A policy with heavy front-end expense charges could create a negative value of $f_{t+x}$, so it similarly seems desirable necessary to cover that possibility, however remote. Floor $f_{t+x}$ at $0.01$ (since it serves as a denominator).

The newest changes also eliminate the confusion surrounding the use of commas that had arisen about the definition of $f_{t+x}$ in an earlier draft of this APF.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Staff of Office of Principle-Based Reserving, California Department of Insurance – Clarifying language for the SDP in Section 9.C.6.b.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:


3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached Appendix. NOTE: This amendment is a clarification only and as such is Non-Substantive.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

See attached Appendix.

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**Notes:** VM Maintenance Agenda Item 2017-35
Appendix

ISSUE:

Need additional clarity on what is meant by “Sufficient Data Period”.

SECTION:


REDLINE:

ii. The company shall determine the sufficient data period by identifying the last policy duration at which sufficient company experience data exists (using all the sources defined in Subsection 9.C.2.b). This period ends at the last policy duration that has 50 or more claims (i.e., no duration beyond this point has 50 claims or more) subject to the limits in Column 2 of the applicable table in 9.C.6.b.iii.b. The sufficient data period may be determined at a more aggregate level than the mortality segment if the company based its mortality on aggregate experience and then used a methodology to subdivide the aggregate class into various sub-classes or mortality segments.

iii. Beginning in the policy duration at which sufficient company experience data no longer exists, use the guidelines in the applicable table below to linearly grade from the company experience mortality rates with margins to 100% of the applicable industry basic table with margins. (The determination of the applicable industry basic table is described in Section 9.C.3.) Grading must begin and end no later than the policy durations shown in the applicable table below, based on the level of credibility of the data as provided in Subsection 9.C.4.

REASONING:

The VM seems ambiguous as to what exactly the SDP is, because of the contrast between SDP in 9.C.6.b.ii and “number of years for data to be considered sufficient” in the current 9.C.6.b.iii.a. Is the SDP the amount before or after all limits are applied?
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Joel Steinberg, Chief Actuary & Chief Risk Officer, New York Life Insurance Company. Clarify in VM-20 Section 3.C that the shock lapse for the term NPR is to be applied prior to the collection of the first premium following the level period.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM-20: Section 3.C.3.v, August 29, 2016 adopted version

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

Section 3.C.3.v in VM-20 defines the shock lapse as “The lapse rate for the first year following a rate increase.” Based on this wording, an actuary may interpret that the prescribed shock lapse can be applied after the payment of the first premium following the level period, as long as the shock lapse is applied within the first year after the level period.

This is inconsistent with the guidance note in Section 3.B.4.a, which states that the net premium reserve should be projected assuming “that the policies subject to the shock lapse in each year do not pay the higher premium in that year.” Therefore, we recommend clarifying Section 3.C.3.v to be consistent with the guidance note.

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Notes: VM Maintenance Agenda Item 2017-39
3. Lapse Rates

a. For net premium reserve amounts calculated according to Section 3.B.5, the lapse rates used shall be 0% per year during the premium paying period and 0% per year thereafter.

b. For net premium reserve amounts calculated according to Section 3.B.4, the annual lapse rates used shall vary by level premium period as stated below:

i. 10% per year during any level premium period of less than five years, except as noted in iii and iv.

ii. 6% per year during any level premium period of five or more years, except as noted in iii and iv.

iii. For any policy with values subject to the requirements of Actuarial Guideline XLV {AG-45 in Appendix C of the Accounting Practices and Procedures Manual} the annual lapse rate is 6% for the first half of the initial level premium period, and 0% for the remainder of the initial level premium period.

iv. 10% per year during any premium paying period after an initial level premium period of less than five years.

v. The lapse rate for the first year following a rate increase in the final year of a level premium period, applied after any death benefit or endowment benefits assumed payable in the final year, and prior to the payment of the increased premium rate, shall be determined based on the length of the level premium periods before and after the increase as well as the percent increase in the gross premium per $1000 as shown in the table below instead of what would otherwise apply from i through iv above.

<table>
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<tr>
<th>Length of Premium Period Prior to Increase</th>
<th>Length of Premium Period after Increase</th>
<th>Percent Increase in Gross Premium Per $1000</th>
<th>Lapse Rate for the Final Year After of the Level Premium Increase Period (Shock Lapse)</th>
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<tr>
<td>1&lt;PP≤5</td>
<td>1</td>
<td>Any</td>
<td>50%</td>
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<tr>
<td>1&lt;PP≤5</td>
<td>1&lt;PP</td>
<td>Any</td>
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</tr>
<tr>
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<td>&lt; 400%</td>
<td>70%</td>
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<td>5&lt;PP≤10</td>
<td>1</td>
<td>Over 400%</td>
<td>80%</td>
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<td>Any</td>
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<tr>
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Life Actuarial (A) Task Force

Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Dave Neve, chairperson of the American Academy of Actuaries Life Reserves Work Group.
Clarification of the existing VM-20 wording regarding the modeling of policy loans and separate account assets, and the list of assets in starting assets.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:


3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

The current VM-20 wording is somewhat confusing in regard to the treatment of policy loans and separate account (SA) assets. Per Section 7.D., the opening balance of policy loans and SA assets as of the valuation date are included in starting assets. But then in section 4.A., the opening balance of policy loans and SA assets are included as a cash outflow in the PV of benefits, expenses and related amounts. Including the opening balance of policy loans and SA assets in starting assets, but then treating them as cash outflows at time 0 has led to confusion in how to properly model these types of assets. This proposal does not alter the reserve calculation, but moves the “time 0” cash flows for policy loans and SA assets listed in section 4.A.3. to the beginning of section 4.A. as an adjustment to the deterministic reserve. The proposal also clarifies the process to accumulate these assets in section 4.B. and Section 5.B.

This proposal also tightens up the current wording of the SA transfer cash flows in Section 4.A.4.b., and adds clarifying wording to the calculation of the deterministic reserve in Section 4.A. and the list of items in starting assets in Section 7.D.

These changes have no impact on the reserve calculation; they only add clarifying wording.

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Notes: VM Maintenance Agenda Item 2017-41
Section 4. Deterministic Reserve

For a group of one or more policies for which a deterministic reserve is to be calculated, the company shall calculate the deterministic reserve for the group using the method described in either Subsection A or Subsection B of this section.

A. Calculate the deterministic reserve equal to the actuarial present value of benefits, expenses, and related amounts less the actuarial present value of premiums and related amounts, less the positive or negative PIMR balance at the valuation date allocated to the group of one or more policies being modeled under Section 7.D.6, plus the balance of separate account assets on the valuation date, and plus the policy loan balance at the valuation date with appropriate reflection of any relevant due, accrued or unearned loan interest (if policy loans are explicitly modeled under Section 7.F.3.b) where:

1. Cash flows are projected amounts in compliance with the applicable requirements in Section 7, 8 and 9 over economic scenario described in Section 7.G.1, and further described in Appendix 1E.

2. Present values are calculated using the path of discount rates for the corresponding model segment determined in compliance with Section 7.H.

3. The actuarial present value of benefits, expenses and related amount equals the sum of:
   a. Present value of future benefits, but before netting the repayment of any policy loans;

   Guidance Note: Future benefits include but are not limited to death and cash surrender benefits.
   
   b. Present value of future expenses excluding federal income taxes and expenses paid to provide fraternal benefits in lieu of federal income taxes;
   
   c. Policy account value invested in the separate account at the valuation date; and
   
   d. Policy loan balance at the valuation date with appropriate reflection of any relevant due, accrued or unearned loan interest, if policy loans are explicitly modeled under Section 7.F.3.

4. The actuarial present value of premiums and related amounts equals the sum of the present values of:
   a. Future gross premium payments and/or other applicable revenue;
   
   b. Future net cash flows to or from the general account, or from or to the separate account, less cash flows from the general account to the separate account;
   
   c. Future net policy loan cash flows, if policy loans are explicitly modeled under Section 7.F.3.b;

   Guidance Note: Future net policy loan cash flows include: policy loan interest paid in cash plus repayments of policy loan principal, including repayments occurring at death or surrender (note that the future benefits in Section 4.A.3.a. are before consideration of policy loans), less additional policy loan principal (but excluding policy loan interest that is added to the policy loan principal balance).

B. Calculate the deterministic reserve as a – b, where

\[ a = \text{the aggregate annual statement value of those starting assets which, when projected along with all premium and investment income, result in the liquidation of all projected future benefits and expenses by the end of the projection horizon. Under this alternative, the following considerations apply:} \]

1. Cash flows are projected in compliance with the applicable requirements in Section 7, Section 8 and Section 9 over the single scenario described in Section 7.G.1.

2. The requirements for future benefits and premiums in Section 4.A apply as well to the calculation of the deterministic reserve under this subsection.
3. The balance of policy loans on the valuation date (if explicitly modeled under Section 7.F.3.b) and the balance of separate account assets on the valuation date are projected forward modeled each period in compliance with the applicable changes in these asset balances as defined in Section 7.

\[ b = \text{that portion of the PIMR amount allocated under Section 7.D}. \]

Section 5. Stochastic Reserve

B. Calculate the scenario reserve for each stochastically generated scenario as follows:

1. For each model segment at the model start date and end of each projection year, calculate the discounted value of the negative of the projected statement value of general account and separate account assets using the path of discount rates for the model segment determined in compliance with Section 7.H.4 from the projection start date to the end of the respective projection year. The balance of policy loans on the valuation date (if explicitly modeled under Section 7.F.3.b) and the balance of separate account assets on the valuation date are projected forward modeled each period in compliance with the applicable changes in these asset balances as defined in Section 7.

Section 7 Cash Flow Models

D. Starting Assets

1. For each model segment, the company shall select starting assets such that the aggregate annual statement value of the assets at the projection start date equals the estimated value of the modeled reserve plus the PIMR balance on the projection start date, allocated to the policies in the appropriate model segment, subject to the following:

   a. Starting asset values shall include the relevant balance of any due, accrued or unearned investment income.

2. For an asset portfolio that supports both policies that are subject and not subject to these requirements, the company shall determine an equitable method to apportion the total amount of starting assets between the subject and non-subject policies.

3. If for all model segments combined, the aggregate annual statement value of starting assets is less than 98% or greater than the larger of NPR or 102% of the final modeled reserve, the company shall provide documentation in the PBR Actuarial Report that provides reasonable assurance that the modeled reserve is not materially understated as a result of the estimate of the amount of starting assets.

3.4. The company shall select starting assets for each model segment that consists of the following:

   a. All separate account assets supporting the policies.

   b. All policy loans supporting the policies that are explicitly modeled under Section 7.F.3.b.

   c. The relevant balance of any due, accrued or unearned investment income

   d. All derivative instruments held at the projection start date that are part of a derivative program and can be appropriately allocated to the model segment.

   e. An amount of other general account assets such that the aggregate value of starting assets meets the requirements in Section 7.D.1. These assets shall generally be selected on a consistent basis from one reserve valuation to the next. Any material change in the selection methodology shall be documented in the PBR Actuarial Report.

F. Cash Flows from Invested Assets

3. Determine cash flows for each projection interval for policy loan assets by modeling existing loan balances either explicitly, or by substituting assets that are a proxy for policy loans (e.g., bonds, cash, etc.) subject to the following:
b. If the company models policy loans explicitly, the company shall:

i. Treat policy loan activity as an aspect of policyholder behavior and subject to the requirements of Section 9.D.

ii. For both the deterministic reserve and the stochastic reserve, assign loan balances either to exactly match each policy’s utilization or to reflect average utilization over a model segment or sub-segments.

iii. Model policy loan interest in a manner consistent with policy provisions and with the scenario. In calculating the deterministic reserve and stochastic reserve, include interest paid in cash as a positive policy loan cash flow in that projection interval, per Section 4.A.4, but do not include interest added to the loan balance as a policy loan cash flow (the increased balance will require increased repayment cash flows in future projection intervals).

iv. Model policy loan principal repayments, including those which occur automatically upon death or surrender. In calculating the deterministic reserve and the stochastic reserve, include policy loan principal repayments as a positive policy loan cash flow, per Section 4.A.4.

v. Model additional policy loan principal. In calculating the deterministic and stochastic reserve, include additional policy loan principal as a negative policy loan cash flow, per Section 4.A.4. (but do not include interest added to the loan balance as a negative policy loan cash flow).
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Submitted jointly by John Bruins on behalf of ACLI and Larry Bruning on behalf of the NAIC

The issue involves changing both the timing of the spread calculations and the frequency of calculating the current spreads as defined in VM-20 Appendix 2 and defining the NAIC web-site location of where the VM-20 spread and default cost tables can be accessed.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

Valuation Manual for 2017, VM-20 Appendix 2

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See changes on attachment

4. State the reason for the proposed amendment? (You may do this through an attachment.)

In order for companies to have the spread data needed to perform a valuation on the valuation date, the spread data needs to be available on or before the valuation date. This change would have the information developed 8 business days prior to the valuation date to give NAIC staff time to compile and review values, then post to the website in advance of the valuation date. In addition the frequency of calculating current spreads will be changed from quarterly to monthly to more closely match the valuation date on which modeling takes place.

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Notes: VM APF 2017-43
Appendix 2. Tables for Calculating Asset Default Costs and Asset Spreads, Including Basis of Tables

This appendix describes the basis for certain prescribed asset default cost and asset spread tables to be updated and published periodically by the NAIC, via website. Asset default cost tables will be updated on an annual basis. The data source used to update the asset default cost tables is Moody’s. The current market benchmark spreads and the current benchmark swap spreads will be updated on a monthly basis. The long-term benchmark spreads and the long-term benchmark swap spreads will be updated on a quarterly basis. The data sources used to update the spread tables are JP Morgan and Bank of America. The NAIC will provide access to the published tables via links which may be found on the NAIC website home page (www.naic.org) under the Industry tab of the website. These tables are needed for insurers to comply with the requirements of Subsection 9.F for asset default costs and asset spreads in VM-20.

D. Illustrative Current Market Benchmark Spreads

Current market benchmark spreads published by the NAIC are intended to represent average market spreads at the valuation date for public non-callable corporate bonds and interest rate swaps. They are used to establish the initial spread environment in the cash flow model for purposes of modeling reinvestment assets and disinvestment and for modeling prescribed default costs. Section 9.F calls for both spreads and default costs to grade from initial to long-term conditions by the start of projection year four. Ultimately, the NAIC will need to publish current market benchmark spreads on a website on a quarterly basis. The current process to determine current market benchmark spreads is as follows:

1. Extract valuation data the Investment Grade bond index spread data determined as of the 8th last business day prior to the end of the month by ratings category and maturity bucket (e.g., download JLLI (JPMorgan US Liquid Index) Interpolated Spread over Treasury data for All Industries) from JP Morgan and Bank of America. Adjust the Bank of America Investment Grade bond spread data for the maturity buckets 10-15 years and 15+ years to a single maturity bucket of 10+ years (using a weighting process) to align with the JP Morgan maturity bucket of 10+ years. Average the JP Morgan and Bank of America Investment Grade bond spreads as of the 8th last business day prior to the end of the month by ratings category and maturity bucket.

2. Extract valuation data the Below Investment Grade bond index spread data determined as of the 8th last business day prior to the end of the month by ratings category (e.g., download JPMorgan Domestic High Yield Index Spread to Worst data by Rating Tier), from JP Morgan and Bank of America, and assume that the Below Investment Grade spread curve is flat across maturities. Average the JP Morgan and Bank of America Below Investment Grade bond spreads as of the 8th last business day prior to the end of the month by ratings category.

3. Transform the averaged spread data into a matrix that varies by ratings category notch (e.g., Aaa, Aa1, Aa2, Aa3, A1… Caa2, Caa3, Ca) and maturity (1, 2 … 30) using a smoothing algorithm to ensure that in the new matrix: (a) the rows are monotonic by rating category, (b) the investment grade columns are monotonic by maturity, and (c) the columns on the borderline between investment grade and below investment grade (Baa3/BBB-) is interpolated between Baa2/BBB and Ba1/BB+

4. Publish the resulting Investment Grade and Below Investment Grade current market benchmark spreads in separate tables.

In subsection F below:

1. Table F shows Current Market Benchmark Spreads as of 9/30/2009 for Investment Grade bonds.

2. Table G shows Current Market Benchmark Spreads as of 9/30/2009 for Below Investment Grade bonds.

E. Long-Term Benchmark Spreads
Long-term benchmark spreads published by the NAIC are the assumed long-term average spreads for non-callable public bonds and interest rate swaps. They are used to establish the long-term spread environment in the cash flow model for purposes of modeling reinvestment assets and disinvestment. They are also used as the normative spreads when calculating the spread related factor in the asset default cost methodology. Ultimately, the NAIC will need to publish these spreads on a website. The current process to determine the long-term benchmark spreads mean benchmark spreads is as follows:

1. Extract daily Investment Grade bond index spread data for the prescribed observation period (rolling 15 year period) ending on the 8th last business day prior to the end of the quarter by ratings category and maturity bucket (e.g., download JULI (JPMorgan US Liquid Index) Interpolated Spread over Treasury data for All Industries) from JP Morgan and Bank of America. Adjust the Bank of America Investment Grade spread data for the maturity buckets 10-15 years and the 15+ years to a single maturity bucket of 10+ years (using a weighting process) to align with the JP Morgan maturity bucket of 10+ years. Average the JP Morgan and Bank of America daily Investment Grade Bond spreads over the observation period by ratings category and maturity bucket.

2. Extract daily Below Investment Grade bond index spread data for the prescribed observation period (rolling 15 year period) ending on the 8th last business day prior to the end of the quarter by ratings category (e.g., download JPMorgan Domestic High Yield Index Spread to Worst data by Rating Tier), from JP Morgan and Bank of America, and assume that the Below Investment Grade spread curve is flat across maturities. Average the JP Morgan and Bank of America daily Below Investment Grade bond spreads over the observation period by ratings category.

3. For the primary asset rating category (whole letter “A” rated 7-10 year maturity bucket), or nearest similar category, calculate the “85% conditional mean average” by first excluding the 7.5% highest and 7.5% lowest daily observations over the prescribed observation period and then computing the mean of the remaining daily business trading day observations.

4. Calculate the “85% conditional mean” for each of the other rating categories and maturity buckets over the prescribed observation period after excluding the observations from the same business trading days excluded in step 3. In developing Tables H and I, a 9.25 year averaging period was used, specifically 7/1/2000 through 9/30/2009.

5. Transform the averaged spread data into a matrix that varies by rating category notch (e.g., Aaa, Aa1, Aa2, Aa3, A1…,Caa2, Caa3, Ca) and maturity (1, 2 … 30) using a smoothing algorithm to ensure that in the new matrix: (a) the rows are monotonic by rating category, (b) the investment grade columns are monotonic by maturity, and (c) the columns on the borderline between investment grade and below investment grade (Baa3/BBB-) are interpolated between Baa2/BBB and Ba1/BB+.

4. Publish the resulting Investment Grade and Below Investment Grade long-term benchmark spreads in separate tables.

Drafting Note: A description of the development of the prescribed interest rate swap spreads needs to be added. The process is similar but the data source is different.

F. Current Benchmark Swap Spreads

1. Extract swap spread data determined as of the 8th last business day prior to the end of the month by maturity. For Bank of America data convert the swap rate for each maturity to a swap spread by subtracting the corresponding maturity treasury yield from the swap rate. For JP Morgan, the swap spread is provided for each maturity.

2. Average the BOA swap spread with the JP Morgan swap spread by maturity determined as of the 8th last business day prior to the end of the month.

3. Publish the Current Benchmark Swap Spreads by maturity in a table.

G. Long-Term Benchmark Swap Spreads
1. Extract daily swap spread data over the prescribed observation period (rolling 15 year period) ending on the 8th last business day prior to the end of the quarter. For Bank of America data convert the daily swap rate for each maturity to a swap spread by subtracting the corresponding maturity treasury yield from the swap rate. For JP Morgan the daily swap spread is provided for each maturity.

2. Average the daily BOA swap spread data with the daily JP Morgan swap spread data by maturity over the prescribed observation (rolling 15 year period).

3. Calculate the 85% conditional mean for each of the 32 maturity categories (3 month, 6 month, 1 year, 2 year, ..., 30 year) using the same business trading days as were used in the 85% conditional mean for long-term bonds spreads.

4. Publish the Long-Term Benchmark Swap Spreads in a table.

**Drafting Note:** Two key considerations for the NAIC going forward will be the source of the spread data and the historical observation period. It has not yet been explored whether a source other than JULI (JP Morgan) would be preferable. Ideally the current and long-term benchmark spreads should come from the same source. A seven-year observation period was originally chosen because consistent and reliable data was only available back to 2000, and examples were being created based on a 2007 valuation date. It is recommended that the observation period be allowed to lengthen as more years of data are available, and that ultimately a rolling average of a maximum numbers of years be established such as 10 years or 15 years.

In subsection F below:

1. Table H shows Long-Term Mean Benchmark Spreads as of 9/30/2009 for Investment Grade bonds.
2. Table I shows Long-Term Mean Benchmark Spreads as of 9/30/2009 for Below Investment Grade bonds.
3. Table J shows Long-Term Benchmark Swap Spreads.

F. Tables
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Brian Bayerle, ACLI, Modify VM-30 to correct for companies that are not national in scope.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:


3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)


   c. Meet the requirements of the insurance laws and regulations of the state of [state of domicile].

      (Use one of the following phrases as appropriate)

      “are at least as great as the minimum aggregate amounts required by any state in which this company is licensed.”

      or

      “are at least as great as the minimum aggregate amounts required by any state in which this company is licensed, with the exception of the following states [list states]. For each listed state, a separate statement of actuarial opinion was submitted to that state that complies with the requirements of that state.”

4. State the reason for the proposed amendment? (You may do this through an attachment.)

   This requirement is drafted for a company that is licensed in all states, and is not easily adopted for a company that operates in fewer states. The prior AOMR (Model 822) did address this by specifically providing a statement that the reserves “ are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;” As VM-30 is worded, it would apply the requirements of any state, including states in which the company is not licensed. We therefore recommend a variation of the Model AOMR language as outlined.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

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<th>Dates:</th>
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<tr>
<td>Considered</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Paul Graham and Brian Bayerle, ACLI

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

Valuation Manual August 29, 2016, with non-substantive changes through year-end 2016, VM-20 Section 3.C.1

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached

4. State the reason for the proposed amendment? (You may do this through an attachment.)

To clarify that the 2017 CSO is to be used for all years of issue when applying the Actuarial Method as required by Section 6 of the Term and Universal Life Insurance Reserve Financing Model Regulation (#787)

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

<table>
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<td></td>
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</tr>
</tbody>
</table>

Notes: VM APF 2017-53
SECTION 3.C.1. of VM-20

b. Subject to the conditions defined in 3.C.1.c., the 2017 CSO Mortality Tables as defined in VM-M Section 1.H. is required as the valuation standard for ordinary life policies issued on or after Jan. 1, 2020, and subject to this Section. A company may elect to apply this table to determine minimum reserve standards to one or more plans of insurance for policies issued on or after Jan. 1, 2017. The 2017 CSO Mortality Tables shall be used for the Actuarial Method, as defined in the Term and Universal Life Insurance Reserve Financing Model Regulation (#787), for all policy issue dates.

c. Conditions for application of the 2017 CSO:
   i. For each plan of insurance with separate rates for smokers and nonsmokers, an insurer may use:
      a) Composite mortality tables to determine minimum reserve liabilities; or
      b) Smoker and nonsmoker mortality to determine minimum reserve liabilities if nonforfeiture values are also determined using smoker and nonsmoker mortality.
   ii. For plans of insurance without separate rates for smokers and nonsmokers, the composite mortality tables shall be used.
   iii. For the purpose of determining minimum reserve values and amounts of paid-up nonforfeiture benefits, the 2017 CSO Mortality Table may, at the option of the company for each plan of insurance, be used in its ultimate or select and ultimate form.

d. At the election of the company, for any one or more specified plans of insurance and subject to satisfying the conditions stated in 3.C.1.e., the 2017 CSO Preferred Class Structure Mortality Table may be substituted in place of the 2017 CSO Smoker or Nonsmoker Mortality Table as the minimum valuation standard for policies issued on or after Jan. 1, 2017, or for any policies valued using the Actuarial Method, as defined in the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Staff of Office of Principle-Based Reserving, California Department of Insurance – Complete references to margins in Section 9.C.6.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:


3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached Appendix. NOTE: This amendment is a clarification only and as such is Non-Substantive.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

See attached Appendix.

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**NAIC Staff Comments:**

<table>
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<tr>
<th>Dates: Received</th>
<th>Reviewed by Staff</th>
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<tbody>
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</tbody>
</table>

**Notes:** VM Maintenance Agenda Item 2017-32
ISSUE:

For clarity, add reference to 9.C.5.d, which discusses additional margin under certain circumstances.

SECTION:


REDLINE:

VM-20 Section 9.C.6.a:

a. If applicable industry basic tables are used in lieu of company experience, the prudent estimate assumptions for each mortality segment shall equal the respective mortality rates in the applicable industry basic tables as provided in Subsection 9.C.3, plus the prescribed margin as provided in Subsections 9.C.5.c and any additional margin as provided in Subsection 9.C.5.d.

VM-20 Section 9.C.6.b.i:

i. For each mortality segment, use the company experience mortality rates (as defined in Subsection 9.C.2) for policy durations in which there exists sufficient company experience data (as defined below in paragraph ii), plus the prescribed margin as provided in Subsection 9.C.5.b and any additional margin as provided in Subsection 9.C.5.d.

REASONING:

The prescribed margin encompasses both 9.C.5.b/c and also the potential additional margin laid out in 9.C.5.d.
VM-22: MAXIMUM VALUATION INTEREST RATES FOR INCOME ANNUITIES

Guidance Note: Over time, the NAIC intends for VM-22 to contain the valuation requirements for all annuity products not covered by VM-21. For now, the purpose of VM-22 is limited to prescribing the valuation interest rates, but not the valuation methodology, to be used for some, but not all, of the products that are within the intended scope of VM-22. All reserve requirements for non-variable annuities that are not within the defined scope of VM-22 (I. A and I. B below) are contained in Appendices VM-A and VM-C. These reserve requirements are not intended to change the reserve requirements for annuities in the accumulation phase. The valuation interest rates for the products in the defined scope of VM-22 (I.A and I. B below) supersede those described in Appendices VM-A and VM-C, but they do not otherwise change how those Appendices are to be interpreted. VM-C IX-B provided guidance on valuation interest rates and is therefore superseded by these requirements for products in scope. Any interest rate references in VM-C IX-C are also superseded by these requirements.

Table of Contents
Section 1. Purpose and Scope
Section 2. Definitions
Section 3. Determination of the Statutory Maximum Valuation Interest Rate

Section 1. Purpose and Scope

A. These requirements form part of the Commissioner’s Annuity Reserve Valuation Method (CARVM) (and Commissioner’s Reserve Valuation Method (CRVM) for certain contracts1) for single premium immediate annuity contracts and other similar contracts or supplementary contracts, and define, for policies, contracts or supplementary contracts issued after December 31, 2017, the maximum valuation interest rate determined as of the Premium Determination Date that complies with the Standard Valuation Law (SVL).

B. The following categories of annuities or contract features, whether group or individual, including both life contingent and term certain only contracts, directly written or assumed through reinsurance, are covered by this Section of the Valuation Manual:
1. Immediate annuity contracts;
2. Deferred income annuity contracts;
3. Structured settlements in payout or deferred status;
4. Payout annuities resulting from settlement options or annuitizations from other contracts;
5. Supplementary contracts; and
6. Contracts containing other similar fixed income payment streams, including those attributable to contingent deferred annuities and guaranteed lifetime income benefits once the underlying contract funds are exhausted.

1 SVL Section 5.C.(2) Group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended.
Section 2. Definitions

A. Portfolio Credit Quality Distribution – This term means the prescribed asset credit rating distribution as follows:
   - 5% Treasuries
   - 15% Aa bonds (5% Aa1, 5% Aa2, 5% Aa3)
   - 40% A bonds (13.33% A1, 13.33% A2, 13.33% A3)
   - 40% Baa bonds (13.33% Baa1, 13.33% Baa2, 13.33% Baa3)

Guidance Note: The credit quality designations above have the same meaning as in VM-20, subsection 9.F.3.

B. Daily Treasury Rate – This term means the Daily Treasury Yield Curve Rate for a given maturity as published by the U.S. Department of the Treasury.

Guidance Note: The source for these rates is: https://www.treasury.gov

C. Expected Default Cost – This term means a vector of annual default costs by weighted average life calculated as a weighted average of the VM-20 prescribed annual default costs (Table A) in effect for the quarter prior to the Premium Determination Date for the Portfolio Credit Quality Distribution, as published on the Life Actuarial Task Force (LATF) website of the NAIC website home page (www.naic.org) under the Industry tab of the website.

D. Reference Period - This term means the length of time, rounded to the nearest year, from the Premium Determination Date to the date of the last non-life-contingent payment under the individual contract or group certificate, as applicable.

Guidance Note: The definition of Reference Period assumes a series of material, substantially similar payments and materiality is relative to the life-contingent payments. If the payments are not substantially similar, the actuary should apply prudent judgment and select the Valuation Rate Bucket with Macaulay duration that is a best fit to the Macaulay duration of the payments in question.

E. Jumbo Contract – This term means a contract with an initial consideration equal to or greater than $250,000,000. Considerations for contracts issued to the same party within 90 days shall be combined for purposes of determining whether a contract meets this threshold.

F. Non-jumbo Contract – This term means a contract that does not meet the definition of the Jumbo Contract.

G. Expected Spread – This term means a vector of spreads by weighted average life, calculated as a weighted average of the VM-20 prescribed spreads (Table F) for the quarter prior to the Premium Determination Date for the Portfolio Credit Quality Distribution, as published on the Life Actuarial Task Force (LATF) website of the NAIC website home page (www.naic.org) under the Industry tab of the website.

H. Quarterly Treasury Rate – This term means the average of the Daily Treasury Rates defined in Subsection 2B above for a given maturity over the calendar quarter prior to the Premium Determination Date.
I. Premium Determination Date – This term means the date upon which the premium is determined by the insurance company and is committed to by the client. This term is generally defined as the issue date. For supplementary contracts and annuitizations, this would normally be the date of election of the supplementary contracts and the annuitizations, but a company may use the valuation rate basis in effect when the original contract was issued with domestic commissioner approval.

Guidance Note: The Premium Determination Date is intended to be a date proximate to the date of the investment of the assets that support the contract. As examples,
- for a group annuity for which the company locks in investment yields at the time of a quote, but the contract is issued subsequently, that “lock-in-date” should be used by the company on a consistent basis;
- for a single-premium immediate annuity contract, this would normally be the issue date;
- for a supplementary contract, however, this date would normally be the date of annuitization. The definition permits, subject to the domestic commissioner’s approval, the use of some other date. An example of such a situation includes using the issue date of the original deferred annuity contract for annuitizations. Approval would normally be granted when the domestic commissioner has been provided satisfactory demonstration that the company employs an appropriate asset/liability matching strategy.

J. Initial Age – Age as of the last birthday as of the Premium Determination Date. For joint life contracts or certificates, the Initial Age means the Initial Age of the younger annuitant. For contracts with impaired lives being valued using a rated age, Initial Age means the rated age. For contracts with impaired lives being valued using a substandard mortality table, Initial Age is based on an equivalent rated age.

Section 3. Determination of the Statutory Maximum Valuation Interest Rate
A. Valuation Rate Buckets
1. For the purpose of the calculation of the statutory maximum valuation interest rate, each contract or certificate is to be assigned to one of four Valuation Rate Buckets labeled A through D.
2. For contracts or certificates without life contingencies, Valuation Rate Buckets are assigned based on the length of the Reference Period (RP), as follows:

<table>
<thead>
<tr>
<th>RP ≤ 5Years</th>
<th>5Y &lt; RP ≤ 10Y</th>
<th>10Y &lt; RP ≤ 15Y</th>
<th>RP &gt; 15Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
</tbody>
</table>

3. For contracts or certificates with life contingencies, Valuation Rate Buckets are assigned based on the length of the Reference Period (RP) and the Initial Age of the annuitant, as follows:

<table>
<thead>
<tr>
<th>Initial Age</th>
<th>RP ≤ 5Y</th>
<th>5Y &lt; RP ≤ 10Y</th>
<th>10Y &lt; RP ≤ 15Y</th>
<th>RP &gt; 15Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>90+</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
</tbody>
</table>
4. Except as provided in Subsection 3A.5 below, for group annuity contracts, the statutory maximum valuation rate shall be determined separately for each certificate holder, based on their Initial Age and the certificate Reference Period.

5. For group annuity contracts purchased under a retirement or deferred compensation plan with multiple annuity form options available to the certificate holder, the statutory maximum valuation rate shall be based on the normal form of payout as defined in the contract or as is evidenced by the underlying pension plan documents or census file. If the normal form of payout cannot be determined, the statutory maximum valuation rate shall be based on the most conservative annuity form available to the certificate holder.

B. Maximum Valuation Interest Rate

1. The statutory maximum valuation interest rate is determined based on the Valuation Rate Bucket defined in Subsection 3A and the Premium Determination Date of the contract or certificate.

2. Quarterly Valuation Rate is defined as follows:
   \[ I_q = R + S - D - E \]
   Where:
   a. \( R \) is the Reference Rate defined in Subsection 3C;
   b. \( S \) is the Spread defined in Subsection 3D;
   c. \( D \) is the Default Cost defined in Subsection 3E; and
   d. \( E \) is the spread deduction defined as 0.25%.

3. Daily Valuation Rate is defined as follows:
   \[ I_d = I_q + C_d - C_q \]
   Where:
   a. \( I_q \) is the Quarterly Valuation Rate for the calendar quarter preceding the business day immediately preceding the contract’s Premium Determination Date;
   b. \( C_d \) is the Daily Corporate Rate defined in Subsection 3F for the business day immediately preceding the contract’s Premium Determination Date; and
   c. \( C_q \) is the Average Daily Corporate Rate defined in Subsection 3F corresponding to the period used to develop \( I_q \), which is the calendar quarter preceding the calendar quarter during which \( I_q \) is the Quarterly Valuation Rate.

Guidance Note: As an example, for a contract with an 8/17/17 Premium Determination Date, the dates associated with the variables for the Daily Valuation Rate would be as follows:

\( I_q: 6/30/17 \)

\( C_d: 8/16/17 \)

\( C_q \) = the average Daily Corporate Rate over the period 1/1/17 to 3/31/17.
4. For Jumbo Contracts, the statutory maximum valuation interest rate is the Daily Valuation Rate rounded to the nearest one-hundredth of one percent (1/100 of 1%).
5. For Non-jumbo Contracts, the statutory maximum valuation interest rate is the Quarterly Valuation Rate rounded to the nearest one-fourth of one percent (1/4 of 1%).

C. Reference Rate
The Reference Rate is the weighted average of the Quarterly Treasury Rates calculated using the following weights based on the contract’s Valuation Rate Bucket:

<table>
<thead>
<tr>
<th>Bucket</th>
<th>2 Year</th>
<th>5 Year</th>
<th>10 Year</th>
<th>30 Year</th>
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<tbody>
<tr>
<td>A</td>
<td>26.8%</td>
<td>51.6%</td>
<td>20.7%</td>
<td>0.9%</td>
</tr>
<tr>
<td>B</td>
<td>10.1%</td>
<td>30.3%</td>
<td>50.0%</td>
<td>9.6%</td>
</tr>
<tr>
<td>C</td>
<td>4.7%</td>
<td>15.8%</td>
<td>50.2%</td>
<td>29.2%</td>
</tr>
<tr>
<td>D</td>
<td>2.5%</td>
<td>8.3%</td>
<td>28.8%</td>
<td>60.5%</td>
</tr>
</tbody>
</table>

**Guidance Note:** Unrounded weights are used in the calculation. Appendix 1 explains how the weights are developed.

D. Spread
The spread is the weighted average of the Expected Spreads calculated using the following weights based on the contract’s Valuation Rate Bucket:

<table>
<thead>
<tr>
<th>Bucket</th>
<th>2 Year</th>
<th>5 Year</th>
<th>10 Year</th>
<th>30 Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>26.8%</td>
<td>51.6%</td>
<td>20.7%</td>
<td>0.9%</td>
</tr>
<tr>
<td>B</td>
<td>10.1%</td>
<td>30.3%</td>
<td>50.0%</td>
<td>9.6%</td>
</tr>
<tr>
<td>C</td>
<td>4.7%</td>
<td>15.8%</td>
<td>50.2%</td>
<td>29.2%</td>
</tr>
<tr>
<td>D</td>
<td>2.5%</td>
<td>8.3%</td>
<td>28.8%</td>
<td>60.5%</td>
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E. Default Cost
The Default Cost is the weighted average of the Expected Default Costs calculated using the following weights based on the contract’s Valuation Rate Bucket:

<table>
<thead>
<tr>
<th>Bucket</th>
<th>2 Year</th>
<th>5 Year</th>
<th>10 Year</th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>26.8%</td>
<td>51.6%</td>
<td>21.6%</td>
</tr>
</tbody>
</table>
**Guidance Note:** These weights are based on duration and asset liability cash flow matching analysis for representative annuities within each Valuation Rate Bucket. Tables 3 to 5 are identical, except that for Table 5, the 10 year and 30 year columns are combined since VM-20 default rates are only published for maturities of up to 10 years.

### F. Daily Corporate Rate

The Daily Corporate Rate is the weighted average of the Bank of America Merrill Lynch U.S. corporate effective yields calculated using the following weights based on the contract’s Valuation Rate Bucket:

<table>
<thead>
<tr>
<th>Bucket</th>
<th>1Y – 3Y</th>
<th>3Y – 5Y</th>
<th>5Y – 7Y</th>
<th>7Y – 10Y</th>
<th>10Y – 15Y</th>
<th>+15Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>26.8%</td>
<td>25.8%</td>
<td>25.8%</td>
<td>10.3%</td>
<td>10.3%</td>
<td>0.9%</td>
</tr>
<tr>
<td>B</td>
<td>10.1%</td>
<td>15.2%</td>
<td>15.2%</td>
<td>25.0%</td>
<td>25.0%</td>
<td>9.6%</td>
</tr>
<tr>
<td>C</td>
<td>4.7%</td>
<td>7.9%</td>
<td>7.9%</td>
<td>25.1%</td>
<td>25.1%</td>
<td>29.2%</td>
</tr>
<tr>
<td>D</td>
<td>2.5%</td>
<td>4.1%</td>
<td>4.1%</td>
<td>14.4%</td>
<td>14.4%</td>
<td>60.5%</td>
</tr>
</tbody>
</table>

The Average Daily Corporate Rate means the average of the Daily Corporate Rates over a given calendar quarter.

**Guidance Note:** The columns correspond to the groupings that Bank of America Merrill Lynch publishes. The source for these rates is the St. Louis Federal Reserve website: [https://research.stlouisfed.org/fred2/categories/32347](https://research.stlouisfed.org/fred2/categories/32347)

- To access a specific series, search the St. Louis Fed website for the series name by inputting the name into the Search box in the upper right corner, or input the following web address: [https://research.stlouisfed.org/fred2/series/[replace with series name from below]].
- **Index Series Names:**

<table>
<thead>
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<tr>
<td>1Y - 3Y</td>
<td>BAMLC1A0C13YEY</td>
</tr>
<tr>
<td>3Y - 5Y</td>
<td>BAMLC2A0C35YEY</td>
</tr>
<tr>
<td>5Y - 7Y</td>
<td>BAMLC3A0C57YEY</td>
</tr>
<tr>
<td>7Y - 10Y</td>
<td>BAMLC4A0C710YEY</td>
</tr>
<tr>
<td>10Y - 15Y</td>
<td>BAMLC7A0C1015YEY</td>
</tr>
<tr>
<td>15Y+</td>
<td>BAMLC8A0C15PYEY</td>
</tr>
</tbody>
</table>
Guidance Note: LATF intends to review the weights in the above tables 3-6, and when necessary, update them to better reflect changes in the shape of the yield curve and/or the level of market interest rates. A brief description of the weight calculation methodology is provided in Attachment A.

G. Multiple Premiums

The prescribed methodology applies to single premium contracts providing fixed benefits. For contracts involving multiple premium payments, the benefits purchased by each premium shall be valued using the valuation interest rate in effect at the time the premium was determined and committed to by the purchaser.

H. Immaterial Premium Change

If the premium changes by an immaterial amount subsequent to the original Premium Determination Date, such as due to a data correction, the original Premium Determination Date shall be used.
Appendix 1

In the fourth quarter of each calendar year, the weightings used within each Valuation Rate Bucket for determining the applicable valuation interest rates for the following calendar year will be updated using the following process:

1. Each Valuation Rate Bucket has a set of representative annuity forms. These annuity forms are as follows:
   a. Bucket A:
      i. Single Life Annuity age 91 with 0 and 5-year certain periods
      ii. 5-year certain only
   b. Bucket B:
      i. Single Life Annuity age 80 and 85 with 0, 5, and 10-year certain periods
      ii. 10-year certain only
   c. Bucket C:
      i. Single Life Annuity age 70 with 0 and 15-year certain periods
      ii. Single Life Annuity age 75 with 0, 10 and 15-year certain periods
      iii. 15-year certain only
   d. Bucket D:
      i. Single Life Annuity age 55, 60, and 65 with 0 and 15-year certain periods
      ii. 25-year certain only
2. Annual cash flows are projected assuming annuity payments are made at the end of each year. These cash flows are averaged for each Valuation Rate Bucket across the annuity forms for that Bucket using the statutory valuation mortality table effective for the following calendar year for individual annuities for males.
3. The average daily rates in the third quarter for the 2-yr, 5-yr, 10-yr and 30-yr US Treasuries are calculated as input to calculate the present values in step 4.
4. The average cash flows are summed into four time period groups: years 1-3, years 4-7, years 8-15 and years 16-30. (Note, the present value of cash flows beyond year 30 is included in the years 16-30 Bucket. This present value is based on the lower of 3% and the 30-year Treasury rate input in Step3.)
5. The present value of each summed cash flow group in Step 4 is then calculated by using the Step 3 US Treasury rates for the mid-point of that group (and using the linearly interpolated US Treasury rate when necessary).
6. The duration weighted present value of the cash flows is determined by multiplying the present value of the cash flow groups by the midpoint of the time period for each applicable group.
7. Weightings for each cash flow time period group within a Valuation Rate Bucket are calculated by dividing the duration weighted present value of the cash flow by the sum of the duration weighted present value of cash flow for each Valuation Rate Bucket. Note, unrounded weights are used to calculate the single valuation rate for each Valuation Rate Bucket.
1. Identify yourself, your affiliation and a very brief description (title) of the issue.

LATF Companywide Exemption Drafting Group: (TX, OH, IL, MI, MN, PA, WI)

APF addresses a number of issues submitted for the companywide exemption. These issues include:

- RBC 450% requirement: Concerns meeting this for companies that are smaller or close to this threshold.
- Material ULSG scope: Problems in current scope include not allowing application for the companywide exemption if a company sold a material ULSG in 2017 and never again.
- Preneed premium: Large preneed volume could disqualify application for companywide exemption even though preneed is exempted from PBR.
- Assumed reinsurance reserve: Assumed reserve reported as ordinary life premium could disqualify application for companywide exemption.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:


3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

Reasons include those reflected in 1) above along with additional comments provided below:

- RBC 450% requirement: Edits remove the RBC requirements for companies with less than $50 million in ordinary life premium and allows commissioner discretion to continue the exemption for one year if this requirement is met in the prior year. This reduces issues for companies who are borderline in meeting the RBC requirement.
- Material ULSG scope: Edits address issues in scope and address any material ULSG in current year which was previously not addressed.
- Preneed premium: Edits remove preneed premium from the ordinary life premium.
- Assumed reinsurance reserve: Edits remove this from the ordinary life premium. Such amount were not considered for this exemption and understood not to be intended.
- Other edits were provided for clarification.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

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**Notes:** VM APF 2017-7
**Companywide Life PBR Exemption**

1. A company meeting all of the following conditions may file a statement of exemption for ordinary life insurance policies issued, directly or assumed, during the current calendar year that would otherwise be subject to VM-20, with its domestic commissioner prior to July 1 of that year certifying that these conditions are met based on premiums and other values from the prior calendar year financial annual statements and certifying that condition 2d is to be met for any universal life policies with secondary guarantees (ULSG) business issued as of the current calendar year-end valuation date since the operative date of the *Valuation Manual* meets the definition for non-material secondary guarantee. The statement of exemption must also be included with the NAIC filing for the second quarter of that year. The domestic commissioner may reject such statement prior to Sept. 1 and require the company to follow the requirements of VM-20 for the Ordinary Life policies. For a company that met the conditions for exemption in either of the two prior years and meets conditions 2a, 2c, and 2d currently but does not meet condition 2b currently, the domestic commissioner may grant the exemption for the current year on an exception basis. Otherwise, the minimum reserve requirements for its Ordinary Life policies of an exempt company subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

2. **Conditions for Exemption:**
   
a. The company has less than $300 million of ordinary life premiums\(^1\) and, if the company is a member of an NAIC group of life insurers, the group has combined ordinary life premiums\(^1\) of less than $600 million, reported in their prior calendar year annual statements, and

b. The company with at least $50,000,000 of ordinary life premiums\(^1\) has must have reported Total Adjusted Capital (TAC) of at least 450% of the Authorized Control Level RBC as reported in the prior calendar year annual statement, in the most recent risk-based capital (RBC) report, or has less than $50,000,000 of ordinary life premiums\(^1\).

and

c. The appointed actuary has provided an unqualified opinion on the reserves for the prior calendar year, and

and

d. Every ULSG policy issued or assumed by the company with an issue date on or after the operative date of the *Valuation Manual* 1/1/2020 and in force on the company’s annual statement for the current calendar year-end valuation date only has secondary guarantees that meet the VM-01 definition of a non-material secondary guarantee ULSG product.

---

\(^1\)Premiums are measured as direct plus reinsurance assumed from an unaffiliated company from the Ordinary Life line of business reported in the prior calendar year L & H annual statement, Exhibit 1 Part 1, Column 3, “Ordinary Life Insurance”, excluding premiums for pre-need life contracts and excluding amounts that represent the transfer of reserves in-force as of the effective date of a reinsurance assumed transaction and are reported in Exhibit 1 Part 1, Column 3 as Ordinary Life Insurance premium. Pre-need is as defined in VM-0201.
Companywide Life PBR Exemption

1. A company meeting all of the following conditions may file a statement of exemption for ordinary life insurance policies issued, directly or assumed, during the current calendar year that would otherwise be subject to VM-20, with their domestic commissioner prior to July 1 of that year certifying that these conditions 2a, 2b, and 2c are met based on premiums and other values from the prior calendar year financial annual statements and certifying that condition 2d is to be met any universal life policies with secondary guarantees (ULSG) business issued as of the current calendar year-end valuation date since the operative date of the Valuation Manual meets the definition for non-material secondary guarantee. The statement of exemption must also be included with the NAIC filing for the second quarter of that year. The domestic Commissioner may reject such statement prior to Sept. 1 and require the company to follow the requirements of VM-20 for the Ordinary Life policies. For a company that met the conditions for exemption in either of the two prior years and meets conditions 2a, 2c, and 2d currently but does not meet the condition 2b currently, the domestic Commissioner may grant the exemption for the current year on an exception basis. Otherwise, the minimum reserve requirements for the Ordinary Life policies of an exempt company subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

2. Conditions for Exemption:

a. The company has less than $300 million of ordinary life premiums1 and, if the company is a member of an NAIC group of life insurers, the group has combined ordinary life premiums1 of less than $600 million, reported in their prior calendar year annual statements.

and

b. The company with at least $50,000,000 of ordinary life premiums2, has must have reported Total Adjusted Capital (TAC) of at least 450% of the Authorized Control Level (RLC) as reported in the prior calendar year annual statement, in the most recent risk-based capital (RBC) report, or has less than $50,000,000 of ordinary life premiums1.

and

c. The appointed actuary has provided an unqualified opinion on the reserves for the prior calendar year.

and

d. Any ULSG policies issued or assumed by the company with an issue date on or after the operative date of the Valuation Manual 1/1/2020 and in force on the company’s annual statement for the current calendar year-end valuation date only has secondary guarantees that meet the VM-01 definition of a non-material secondary guarantee ULSG product.

---

1 Premiums are measured as direct plus reinsurance assumed from an unaffiliated company from the Ordinary Life line of business reported in the prior calendar year L & H annual statement, Exhibit 1 Part 1, Column 3, “Ordinary Life Insurance”, excluding premiums for pre-need life contracts and excluding amounts that represent the transfer of reserves in-force as of the effective date of a reinsurance assumed transaction and are reported in Exhibit 1 Part 1, Column 3 as Ordinary Life Insurance premium. Pre-need is as defined in VM-0201.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Reggie Mazyck, Life Actuary, NAIC

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

Valuation Manual, Section I, Introduction, Paragraph 6, Process for Updating Valuation Manual, Subparagraph iii, Updates to Designated Tables

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

Updating the tables in VM-20, Appendix 2 currently requires a 14-day public comment period, followed by a vote for adoption at the next LATF meeting following the close of the comment period. These requirements retard the process of making the tables available for industry use as close to the end of the calendar quarter as possible. This proposal offers a means to expedite the approval process to allow for an earlier availability of the designated tables.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

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Notes: VM Maintenance  Agenda 2017-22
   A. Task Force Procedures
      i. Updates to Designated Tables

Certain designated tables related to asset spreads, default costs and valuation interest rates contained in the Valuation Manual are intended to be routinely updated on a periodic basis, as they provide current reference data integral to reserve annual calculations (e.g., those located in Appendix 2 of VM-20, Requirements for Principle-Based Reserves for Life Products, which have a prescribed process for annual and quarterly updates involving limited judgment for routine updates specifically prescribed in the Valuation Manual). Updates to these tables are not considered to be an amendment of the Valuation Manual itself, and are not subject to the requirements of Section 11C of Model #820 for the amendment of the Valuation Manual, directing the updating of these tables. Updates to these designated tables will be exposed. These routine updates will not require exposure or adoption by the Life Actuarial (A) Task Force/Health Actuarial (B) Task Force for a minimum 14-day public comment period. If no comments are received, the Life Actuarial (A) Task Force will vote on the item at the next regularly scheduled meeting. If comments are received, the Life Actuarial (A)/Task Force/Health Actuarial (B) Task Force will hold at least one open meeting (in person or members, interested regulators and interested parties by conference call) to consider comments. NAIC staff will immediately following completion of the update.

Any changes to the process for updating these tables will be considered a substantive change and be subject to the typical procedure for Valuation Manual amendments.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

VM Review Drafting Group, clarify definition of non-material secondary guarantee

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:


3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

In VM-01, Definition 64. Non-material secondary guarantee

64. The term ‘non-material secondary guarantee’ is a secondary guarantee (SG) which meets the following parameters at time of issue:

o The policy has only one secondary guarantee and that secondary guarantee is in the form of a required premium (specified annual or cumulative premium),
o The duration of the SG for each policy is no longer than 20 years from issue through issue age 60, grading down by 2/3 year for each higher issue age to age 82, thereafter 5 years.
o The present value of the required premium under the SG must be at least as great as the present value of net premiums resulting from the appropriate Valuation Basic Table (VBT) unloaded CSO table over the maximum SG duration allowable under the contract (in aggregate and subject to above duration limit)
    • Present values use minimum allowable VBT unloaded CSO table rates (preferred tables are subject to existing qualification requirements) and the maximum valuation interest rate as defined in VM-20 Section 3.C.2.
    • The minimum premium consists of the annual required premium over the maximum SG duration

Note: VBT is the Valuation Basic Table, which is, the unloaded version of the applicable Commissioners Standard Ordinary (CSO) table is available on the SOA website.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

Since the Valuation Basic Table and the unloaded CSO are not the same tables, this will clarify an inconsistent reference in the footnote to definition 64 about which table to use. The table is the same as is used for the formula reserves for the business in question.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

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Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Staff of Office of Principle-Based Reserving, California Department of Insurance – Minimum Reserve logic and SR methodology warrant some minor clarification.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:


3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See Appendices A and B attached. NOTE: This amendment is a clarification only and as such is Non-Substantive.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

Please see Appendices A and B.

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NAIC Staff Comments:

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<td>Valuation Manual Maintenance Agenda 2017-9</td>
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Appendix A

ISSUE:
The term “product minimum NPR” is not proper when referring to a subset of policies within that product.

SECTION:
VM-20 Section 2.A

Section 2: Minimum Reserve

A. All policies subject to these requirements shall be included in one of the product groups defined by paragraphs 1 – 3 below. The company may elect to exclude one or more groups of policies from the stochastic reserve calculation and/or the deterministic reserve calculation. When excluding a group of policies from a reserve calculation, the company must document that the applicable exclusion test defined in Section 6 is passed for that group of policies.

The minimum reserve for each product group is defined by paragraphs 1 – 3, and the total minimum reserve equals the sum of 1, 2 and 3 below, defined as:

1. Term Policies — All term policies are to be included in b. unless the company has elected to exclude a group of policies from the stochastic reserve calculation and has applied the stochastic exclusion test defined in Section 6, passed the test and documented the results.

   a. For the group of term policies subject to Section 3.A.1 for which the company did not compute the stochastic reserve: the sum of the policy minimum NPR’s for those policies the product minimum NPR plus the excess, if any, of the deterministic reserve for those policies determined pursuant to Section 4 over the quantity (A–B) where A = the sum of the policy minimum NPR’s the product minimum NPR for those policies, and B = any due and deferred premium asset held on account of those policies.

   b. For the group of term policies subject to Section 3.A.1 for which the company computes all three reserve calculations: the sum of the policy minimum NPR’s for those policies the product minimum NPR plus the excess, if any, of the greater of the deterministic reserve for those policies determined pursuant to Section 4 and the stochastic reserve for those policies determined pursuant to Section 5 over the quantity (A–B) where A = the sum of the policy minimum NPR’s the product minimum NPR for those policies, and B = any due and deferred premium asset held on account of those policies.

2. Universal Life with Secondary Guarantee (ULSG) Policies — All ULSG policies are to be included in b. unless the company has elected to exclude a group of policies from the stochastic reserve calculation and has applied the stochastic exclusion test defined in Section 6, passed the test and documented the results.

   a. For the group of ULSG policies subject to Section 3.A.1 for which the company did not compute the stochastic reserve: the sum of the policy minimum NPR’s for those policies the product minimum NPR plus the excess, if any, of the deterministic reserve for those policies determined pursuant to Section 4 over the quantity (A–B) where A = the sum of the policy minimum NPR’s the product minimum NPR for those policies, and B = any due and deferred premium asset held on account of those policies.

   b. For the group of universal life insurance with secondary guarantee policies subject to Section 3.A.1 for which the company computes all three reserve calculations: the sum of the policy minimum NPR’s for those policies product minimum reserve plus the excess, if any, of the greater of the deterministic reserve for those policies determined pursuant to Section 4 and the stochastic reserve for those policies determined pursuant to Section 5 over the quantity (A–B) where A = the sum of the policy minimum NPR’s the product minimum NPR for those policies, and B = any due and deferred premium asset held on account of those policies.
3. Life Insurance Policies Subject to Section 3.A.2. – All life insurance policies subject to 3.A.2. are to be included in:

a. For the group of policies subject to Section 3.A.2 for which the company did not compute the deterministic reserve nor the stochastic reserve: the sum of the policy minimum NPR’s the product minimum NPR for those policies.

b. For the group of policies subject to Section 3.A.2. for which the company did not compute the stochastic reserve but did compute the deterministic reserve: the sum of the policy minimum NPR’s for those policies the product minimum NPR plus the excess, if any, of the deterministic reserve for those policies determined pursuant to Section 4 over the quantity (A–B) where A = the sum of the policy minimum NPR’s the product minimum reserve for those policies, and B = any due and deferred premium asset held on account of those policies.

c. For the group of policies subject to Section 3.A.2. for which the company computes all three reserve calculations: the sum of the policy minimum NPR’s the product minimum NPR for those policies plus the excess, if any, of the greater of the deterministic reserve for those policies determined pursuant to Section 4 and the stochastic reserve for those policies determined pursuant to Section 5 over the quantity (A–B) where A = the sum of the policy minimum NPR’s the product minimum net premium reserve for those policies, and B = any due and deferred premium asset held on account of those policies.

Section 3.F: Minimum Reserve

F. The minimum NPR for a product group (term, ULSG, all other) is the sum of the policy minimum NPR determined in E. for the policies in the product group.[HR3]

REASONING:
More correct use of terminology, invoking use of a term defined in Section 3.E rather than 3.F. The current wording, which we are proposing to revise, refers to an entire product group, but it should instead be referring to just the policies in the particular group whose policy minimum NPR’s are being calculated here. Now, the term “minimum NPR for a product group” is no longer used in the VM other than in definition 3.F.
**ISSUE:**
Clarify that SR is not apportioned like DR.

**SECTION:**
VM-20 Section 2.B

**REDLINE:**
Section 3 defines the requirements for the policy NPR, and Subsection 3.F. defines how that reserve is attributed to a product group. Section 4 defines the requirements for the deterministic reserve, and Subsection 4.C. defines how that reserve is attributed to a product group. Section 5 defines the requirements for the stochastic reserve, and Subsection 5.G. defines how that reserve is apportioned among determined for each product groups.

**REASONING:**
VM-20 Section 2.B appears to refer to SR being apportioned similarly to DR, when this is not the case.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Kerry Krantz, Florida Office of Insurance Regulation

A liability exists for recognition of immediate payment of claims but the curtate net premium reserve formula in VM-20 does not recognize one and no reference in VM-20 is made to Actuarial Guideline XXXII.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM-20: Valuation Manual Adopted 8/29/16 with Non-substantive changes through 12/31/16 (see Errata)

Section 3: Net Premium Reserve  C. Net Premium Reserve Assumptions

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

3. Lapse Rates
   No changes through ii.

   ii. The lapse rate for the policy for durations t+1 and later shall be set equal to:
      \[ L_{x+t} = R_{x+t} \cdot 0.01 + (1 - R_{x+t}) \cdot 0.005 \cdot r_{x+t} \]
      Where \( r_{x+t} \) is the ratio determined in Subsection 3.B.5.d.ii.

4. The net premium reserve shall reflect the immediate payment of claims, or an additional reserve defined in Actuarial Guideline XXXII shall be reported in the Miscellaneous section of Exhibit 5.

D. NPR Calculation and Cash Surrender Value Floor

4. State the reason for the proposed amendment? (You may do this through an attachment.)

The current net premium reserve formula is curtate. A reserve for immediate payment of claims is appropriate. SSAP 51, life contracts states in paragraph 16:

   16. The reserving methodologies and assumptions used in computation of policy reserves shall meet the provisions of Appendices A-820 and A-822 and the actuarial guidelines found in Appendix C of this Manual. Actuarial Guideline XXXII is in Appendix C.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

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Notes: VM Maintenance Agenda 2017-8
Appendix 4: Mortality Data Format

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<td>5</td>
<td>NAIC Company Code</td>
<td>Your NAIC Company Code</td>
</tr>
<tr>
<td>2</td>
<td>6–9</td>
<td>4</td>
<td>Observation Year</td>
<td>Enter calendar date. If calendar year is 2017 or prior, use format YYYYMMDD.</td>
</tr>
<tr>
<td>3</td>
<td>10–29</td>
<td>20</td>
<td>Policy Number</td>
<td>Enter policy number. For joint life policies, enter policy numbers with length less than 20. If there are more than two lives, enter one number per row.</td>
</tr>
<tr>
<td>4</td>
<td>30–32</td>
<td>3</td>
<td>Segment Number</td>
<td>If only one policy segment exists, enter segment number '1.' For a single life policy, the base policy is to be put in the record with segment number '1.' Subsequent policy segments are in separate records with information about that coverage and differing segment numbers. For joint life policies, the base policy of the first life is to be put in a record with segment number '1,' and the base policy of the second life is to be put in a separate record with segment number '2.' Joint life policies with more than two lives are not to be submitted. Subsequent policy segments are in separate records with information about that coverage and differing segment numbers. If they have the same underlying evaluation, policy segments with the same policy number are to be submitted for: a) single life policies; b) joint life policies; c) term/paid up riders; or, d) purchase of additional amounts of insurance including purchase through dividend.</td>
</tr>
<tr>
<td>5</td>
<td>33–34</td>
<td>2</td>
<td>State of Issue</td>
<td>Use standard, two-letter state abbreviation codes (e.g., NY for New York)</td>
</tr>
<tr>
<td>6</td>
<td>35</td>
<td>1</td>
<td>Gender</td>
<td>0 = Unknown or unable to subdivide&lt;br&gt;1 = Male&lt;br&gt;2 = Female&lt;br&gt;3 = Unsex – Unknown or unable to identify&lt;br&gt;4 = Unisex – Male&lt;br&gt;5 = Unisex – Female</td>
</tr>
<tr>
<td>7</td>
<td>36–43</td>
<td>8</td>
<td>Date of Birth</td>
<td>Enter the numeric date of birth in YYYYMMDD format</td>
</tr>
<tr>
<td>8</td>
<td>44</td>
<td>1</td>
<td>Age Basis</td>
<td>0 = Nearest Birthday&lt;br&gt;1 = Age Last Birthday&lt;br&gt;2 = Age Next birthday</td>
</tr>
<tr>
<td>9</td>
<td>45–47</td>
<td>3</td>
<td>Issue Age</td>
<td>Enter the insurance issue age</td>
</tr>
<tr>
<td>10</td>
<td>48–55</td>
<td>8</td>
<td>Issue Date</td>
<td>Enter the numeric calendar year in YYYYMMDD format. If a converted policy, use the issue date of the converted policy.</td>
</tr>
</tbody>
</table>

Drafting Note: Professional actuarial organization will need to develop either age next birthday mortality tables or procedure to adapt existing mortality tables to age next birthday basis.
<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| 11   | 56     | 1 | Smoker Status (at issue)           | Smoker status should be submitted where reliable.  
0 = Unknown  
1 = No tobacco usage  
2 = Nonsmoker  
3 = Cigarette smoker  
4 = Tobacco user                                                                 |
| 12   | 57     | 1 | Preferred Class Structure Indicator | 0 = If no reliable information on multiple preferred and standard classes is available or if the policy segment was issued substandard or if there were no multiple preferred and standard classes available for this policy segment, or if preferred information is unknown.  
1 = If this policy was issued in one of the available multiple preferred and standard classes for this policy segment, Note: If Preferred Class Structure Indicator is 0 or if preferred information is unknown, leave next four items blank. |
| 13   | 58     | 1 | Number of Classes in Nonsmoker Preferred Class Structure | If Preferred Class Structure Indicator preferred indicator is 0 or if smoker Smoker status Status is 0, 3 or 4, or if preferred information is unknown, leave blank. For nonsmoker or no tobacco usage policies that could have been issued as one of multiple preferred and standard classes, enter the number of nonsmoker preferred and standard classes available at time of issue. |
| 14   | 59     | 1 | Nonsmoker Preferred Class          | If Preferred Class Structure Indicator preferred indicator is 0 or if smoker Smoker status Status is 0, 3 or 4, or if preferred information is unknown, leave blank. For nonsmoker policy segments that could have been issued as one of multiple preferred and standard classes:  
0 = Unknown preferred or standard class  
1 = Best preferred class  
2 = Next Best preferred class after 1  
3 = Next Best preferred class after 2  
4 = Next Best preferred class after 3  
5 = Next Best preferred class after 4  
6 = Next Best preferred class after 5  
7 = Next Best preferred class after 6  
8 = Next Best preferred class after 7  
9 = Next Best preferred class after 8  
Note: The policy segment with the highest Nonsmoker Preferred Class number should have that number equal to the number of classes in Nonsmoker Preferred Class structure. |
<p>| 15   | 60     | 1 | Number of Classes in Smoker Preferred Class Structure | If Preferred Class Structure Indicator preferred indicator is 0 or if smoker Smoker status Status is 0, 1 or 2, or if preferred information is unknown, leave blank. For smoker or tobacco user policies that could have been issued as one of multiple preferred and standard classes, enter the number of smoker preferred and standard classes available at time of issue. |</p>
<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>61</td>
<td>1</td>
<td>Smoker Preferred Class</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank. For smoker policy segments that could have been issued as one of multiple preferred and standard classes: 0 = Unknown preferred or standard class 1 = Best preferred class 2 = Next Best preferred class after 1 3 = Next Best preferred class after 2 4 = Next Best preferred class after 3 5 = Next Best preferred class after 4 6 = Next Best preferred class after 5 7 = Next Best preferred class after 6 8 = Next Best preferred class after 7 9 = Next Best preferred class after 8 Note: The policy segment with the highest Smoker Preferred Class number should have that number equal to the number of classes in Smoker Preferred Class Structure.</td>
</tr>
<tr>
<td>17</td>
<td>62–63</td>
<td>2</td>
<td>Type of Underwriting Requirements</td>
<td>If underwriting requirement of ordinary business is reliably known, use code other than “99.” Ordinary business does not include separate lines of business such as simplified issue/guaranteed issue, worksite, individually solicited group life, direct response, final expense, pre-need, home service, and COLI/BOLI/CHOLI. 01 = Underwritten, but unknown whether fluid was collected 02 = Underwritten with no fluid collection 03 = Underwritten with fluid collected 06 = Term Conversion 07 = Group Conversion 09 = Not Underwritten 99 = For issues where underwriting requirement unknown or unable to subdivide</td>
</tr>
<tr>
<td>18</td>
<td>64</td>
<td>1</td>
<td>Substandard Indicator</td>
<td>0 = Policy segment is not substandard 1 = Policy segment is substandard 2 = Policy segment is uninsurable Note: 1. All policy segments that are substandard need to be identified as such. 2. Submission of substandard policies is optional. 3. All policy segments that are substandard need to be identified as either substandard or uninsurable. 4. If feasible, identify substandard policy segments where temporary flat extra has ceased as substandard. All policies that are not substandard need to be identified. Submission of substandard policies is optional. If feasible, identify substandard policy segments where temporary flat extra has ceased as substandard.</td>
</tr>
</tbody>
</table>
Plan

Exclude from contribution: spouse and children under family policies or riders. If Form for additional Plan codes was submitted for this policy, enter unique three digit plan number(s) that differ from the plan numbers below:

| 000 | If unable to distinguish among plan types listed below. |
| 100 | Joint life plan unable to distinguish among joint life plan types listed below. |

**Traditional Whole Life Plans: Permanent Plans:**

- **010** = Traditional fixed premium fixed benefit permanent plan
- **011** = Permanent life (traditional) with term
- **012** = Single premium whole life
- **013** = Econolife (permanent life with lower premiums in the early years)
- **014** = Excess Interest Whole Life
- **015** = First to die whole life plan (submit separate records for each life)
- **016** = Second to die whole life plan (submit separate records for each life)
- **017** = Joint whole life plan unknown whether 015 or 016 (submit separate records for each life)
- **018** = Permanent products with non-level death benefits
- **019** = Permanent plans 010, 011, 012, 013, 014, 015, 016, 017, 018 combined (i.e. unable to separate)

**Term Insurance Plans:**

- **020** = Term (traditional level benefit and attained age premium)
- **021** = Term (level death benefit with guaranteed level premium for 5 years and anticipated level term period for 5 years)
- **211** = Term (level death benefit with guaranteed level premium for 5 years and anticipated level term period for 10 years)
- **212** = Term (level death benefit with guaranteed level premium for 5 years and anticipated level term period for 15 years)
- **213** = Term (level death benefit with guaranteed level premium for 5 years and anticipated level term period for 20 years)
- **214** = Term (level death benefit with guaranteed level premium for 5 years and anticipated level term period for 25 years)
- **215** = Term (level death benefit with guaranteed level premium for 5 years and anticipated level term period for 30 years)
- **022** = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 10 years)
- **221** = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 15 years)
- **222** = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 20 years)
223 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 25 years)
224 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 25 years)
023 = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 30 years)
231 = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 20 years)
232 = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 25 years)
233 = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 30 years)
024 = Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 20 years)
241 = Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 25 years)
242 = Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 30 years)
025 = Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 25 years)
251 = Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 30 years)
026 = Term (level death benefit with guaranteed level premium for 30 years and anticipated level term period for 30 years)
027 = Term (level death benefit with guaranteed level premium for period equal to anticipated level term period where the period is other than 5, 10, 15, 20, 25 or 30 years)
271 = Term (level death benefit with guaranteed level premium period not equal to anticipated level term period, where the periods are other than 5, 10, 15, 20, 25 or 30 years)
028 = Term (decreasing benefit)
040 = Select ultimate term (premium depends on issue age and duration)
041 = Return of premium term (level death benefit with guaranteed level premium for 15 years)
042 = Return of premium term (level death benefit with guaranteed level premium for 20 years)
043 = Return of premium term (level death benefit with guaranteed level premium for 25 years)
044 = Return of premium term (level death benefit with guaranteed level premium for 30 years)
045 = Return of premium term (level death benefit with guaranteed level premium for period other than 15, 20, 25 or 30 years)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>046</td>
<td>E economical term</td>
</tr>
<tr>
<td>059</td>
<td>Term plans, unable to classify</td>
</tr>
<tr>
<td>101</td>
<td>First to die term plan (submit separate records for each life)</td>
</tr>
<tr>
<td>102</td>
<td>Second to die term plan (submit separate records for each life)</td>
</tr>
<tr>
<td>103</td>
<td>Joint term plan unknown whether 101 or 102 (submit separate records for each life)</td>
</tr>
</tbody>
</table>

**Universal Life Plans:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>061</td>
<td>Single premium universal life</td>
</tr>
<tr>
<td>062</td>
<td>Universal life (decreasing risk amount)</td>
</tr>
<tr>
<td>063</td>
<td>Universal life (level risk amount)</td>
</tr>
<tr>
<td>064</td>
<td>Universal life (unknown whether code 062 or 063)</td>
</tr>
<tr>
<td>065</td>
<td>First to die universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>066</td>
<td>Second to die universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>067</td>
<td>Joint life universal life plan unknown whether code 065 or 066 (submit separate records for each life)</td>
</tr>
<tr>
<td>068</td>
<td>Indexed Universal Life</td>
</tr>
</tbody>
</table>

**Universal Life Plans with Secondary Guarantees:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>071</td>
<td>Single premium universal life with secondary guarantees</td>
</tr>
<tr>
<td>072</td>
<td>Universal life with secondary guarantees (decreasing risk amount)</td>
</tr>
<tr>
<td>073</td>
<td>Universal life with secondary guarantees (level risk amount)</td>
</tr>
<tr>
<td>074</td>
<td>Universal life with secondary guarantees (unknown whether code 072 or 073)</td>
</tr>
<tr>
<td>075</td>
<td>First to die universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>076</td>
<td>Second to die universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>077</td>
<td>Joint life universal life plan with secondary guarantees unknown whether code 075 or 076 (submit separate records for each life)</td>
</tr>
<tr>
<td>078</td>
<td>Indexed Universal Life with Secondary Guarantees</td>
</tr>
</tbody>
</table>

**Variable Life Plans:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>080</td>
<td>Variable life</td>
</tr>
<tr>
<td>081</td>
<td>Variable universal life (decreasing risk amount)</td>
</tr>
<tr>
<td>082</td>
<td>Variable universal life (level risk amount)</td>
</tr>
<tr>
<td>083</td>
<td>Variable universal life (unknown whether code 081 or 082)</td>
</tr>
<tr>
<td>084</td>
<td>First to die variable universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>085</td>
<td>Second to die variable universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>086</td>
<td>Joint life variable universal life plan unknown whether code 084 or 085 (submit separate records for each life)</td>
</tr>
</tbody>
</table>
### Variable Life Plans with Secondary Guarantees:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>090</td>
<td>Variable life with secondary guarantees</td>
</tr>
<tr>
<td>091</td>
<td>Variable universal life with secondary guarantees (decreasing risk amount)</td>
</tr>
<tr>
<td>092</td>
<td>Variable universal life with secondary guarantees (level risk amount)</td>
</tr>
<tr>
<td>093</td>
<td>Variable universal life with secondary guarantees (unknown whether code 091 or 092)</td>
</tr>
<tr>
<td>094</td>
<td>First to die variable universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>095</td>
<td>Second to die variable universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>096</td>
<td>Joint life variable universal life plan with secondary guarantees (unknown whether code 094 or 095 (submit separate records for each life)</td>
</tr>
</tbody>
</table>

### Nonforfeiture:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>098</td>
<td>Extended term</td>
</tr>
<tr>
<td>099</td>
<td>Reduced Paid-Up</td>
</tr>
<tr>
<td>198</td>
<td>Extended Term for joint life (submit separate records for each life)</td>
</tr>
<tr>
<td>199</td>
<td>Reduced Paid-Up for joint life (submit separate records for each life)</td>
</tr>
</tbody>
</table>

### Table

<table>
<thead>
<tr>
<th>In-force Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>If the policy segment was not in-force at the end of the calendar year of observation</td>
</tr>
<tr>
<td>1</td>
<td>If the policy segment was in-force at the end of the calendar year of observation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Face Amount of Insurance at Issue</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>69-80</td>
<td>Face amount of the policy segment at its issue date rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount and do not include cash value.</td>
</tr>
<tr>
<td>81-92</td>
<td>Face amount of the policy segment at the beginning of the calendar year of observation rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount, and do not include cash value. If the policy was issued during the observation year, the Face Amount at the beginning of the Observation year should be blank.</td>
</tr>
<tr>
<td>93-104</td>
<td>Face amount of the policy segment at the end of the calendar year of observation rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount, and do not include cash value. If Inforce indicator is 0, enter face amount of the policy segment at the time of termination, if available, otherwise leave blank.</td>
</tr>
</tbody>
</table>
## Death Claim Amount

If the *In-force* indicator is 1, leave blank.

Death claim amount rounded to the nearest dollar. If *In-force* indicator is 0 and *Cause of termination* is ‘04’, then enter the face amount that was paid.

If *In-force* indicator is 0 and *Cause of termination* is not ‘04’, then leave blank.

If the policy provides payment of cash value in addition to face amount, include face amount, and do not include cash value.

## Termination Reported Date

If the *In-force* indicator is 1, leave blank.

Enter in the format YYYYMMDD the eight-digit calendar date that the termination was reported.

## Actual Termination Date

If *In-force* indicator is 1, leave blank.

Enter in the format YYYYMMDD the eight-digit calendar date when the termination occurred.

If termination is due to death (*Cause of termination* is ‘04’), enter actual date of death.

If termination is lapse due to non-payment of premium (*Cause of termination* is ‘14’), enter the last day the premium was paid to.

## Cause of Termination

If the *In-force* indicator is 1, leave blank.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Termination type unknown or unable to subdivide</td>
</tr>
<tr>
<td>01</td>
<td>Reduced Paid-Up</td>
</tr>
<tr>
<td>02</td>
<td>Extended Term</td>
</tr>
<tr>
<td>03</td>
<td>Voluntary unable to subdivide among 01, 02, 07, 09, 10, 11 or 13</td>
</tr>
<tr>
<td>04</td>
<td>Death</td>
</tr>
<tr>
<td>07</td>
<td>1035 exchange</td>
</tr>
<tr>
<td>09</td>
<td>Term conversion (unknown whether attained or original)</td>
</tr>
<tr>
<td>10</td>
<td>Attained age term conversion</td>
</tr>
<tr>
<td>11</td>
<td>Original age term conversion</td>
</tr>
<tr>
<td>12</td>
<td>Coverage expired or contract reached end of mortality table</td>
</tr>
<tr>
<td>13</td>
<td>Surrendered for full cash value</td>
</tr>
</tbody>
</table>
## Appendix 6: Policyholder Behavior Data Format

| 28  | 135–144 | 10 | Level Term Annualized Premium at Issue | For each segment of level term segments insurance plans with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, of VM 51–Mortality Format, enter the annualized premium set at issue.

Except for level term segments specified above, leave blank for non-base segments.

For the base segments for ULSG, and VLSG with plan codes 071 through 078 and 090 through 096 of Item 19, Plan, enter the annualized billed premium set at issue.

Round to the nearest dollar.

If unknown, leave blank.

| 29  | 145–154 | 10 | Term Annualized Premium at the Beginning of Observation Year | For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, of VM 51–Mortality Format, enter the annualized premium for the policy year that includes the beginning of the observation year.

Except for level term segments specified above, leave blank for non-base segments.

For the base segments for ULSG and VLSG with plan codes 071 through 078 and 090 through 096 of Item 19, Plan, enter the annualized billed premium for the policy year that includes the beginning of the observation year.

Round to the nearest dollar.

For policies issued in the observation year, leave blank.

If unknown, leave blank.

If there is no premium, leave this field blank.

| 30  | 155–164 | 10 | Term Annualized Premium at the End of Observation Year, if available. Otherwise Annualized Premium as of Actual Termination Date | For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan. For each segment that has Item 20, with the Inforce Indicator=1, of VM 51–Mortality Format, enter the annualized premium for the policy year that includes either: 1) the end of the observation year; or 2) the actual termination date. Otherwise, enter the annualized premium that would have been paid at the end of the observation year. If end of year premium not available, enter the annualized premium as of the Actual Termination Date (Item 26).

Except for level term segments specified above, leave blank for non-base segments.

For the base segments for ULSG and VLSG with plan codes 071 through 078 and 090 through 096 of Item 19, Plan, use the annualized billed premium. For base...
segments that have Item 20, with the Inforce Indicator =1, enter the annualized billed premium for the policy year that includes the end of the observation year. Otherwise, enter the annualized billed premium that would have been paid at the end of the observation year. If end of year premium not available, enter the annualized premium as of the Actual Termination Date (Item 26).

Round to the nearest dollar.

If there is no premium unknown, leave this field blank.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>165–166</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Premium Mode</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 = Annual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>02 = Semiannual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>03 = Quarterly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>04 = Monthly Bill Sent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>05 = Monthly Automatic Payment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>06 = Semimonthly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>07 = Biweekly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>08 = Weekly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>09 = Single Premium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10 = Other / Unknown</td>
</tr>
</tbody>
</table>

| 32 | 167-178 | 10 |
| Cumulative Premium Collected at the Beginning of Observation Year |
| If not ULSG or VLSG, leave blank. |
| For ULSG, and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan: |
| 1) Leave non-base segments blank. |
| 2) For base segments: |
| Enter the cumulative premium collected as of the beginning of the observation year. |
| Round to the nearest dollar. |
| For policies issued in the observation year, leave blank. If unknown, leave blank. |

<p>| 33 | 177-186 | 10 |
| Cumulative Premium Collected at the End of Observation Year if available. Otherwise Cumulative Premium Collected as of Actual Termination Date |
| If not ULSG or VLSG, leave blank. |
| For ULSG, and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan: |
| 1) Leave non-base segments blank. |
| 2) For base segments inforce at the end of the observation year: Enter the cumulative premium collected as of the end of the observation year. |
| 3) For base segments terminated during the observation year: Enter the cumulative premium collected as of the Actual Termination Date (Item 26). |
| Round to the nearest dollar. |
| If unknown, leave blank. |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>187-188</td>
<td>2</td>
<td>ULSG/VLSG Premium Type</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For non-base segments, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If not ULSGL or VLSG, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>00 = Unknown</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>01 = Single premium</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>02 = ULSG/VLSG Whole Life Level premium</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>03 = Lower premium (term like)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>04 = Other</td>
</tr>
<tr>
<td>35</td>
<td>189-190</td>
<td>2</td>
<td>Type of Secondary Guarantee</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For non-base segments, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If not ULSGL or VLSG, leave blank.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>00 = Unknown</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>01 = Cumulative Premium without Interest (Single Tier)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>02 = Cumulative Premium without Interest (Multiple Tier)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>03 = Cumulative Premium without Interest (Other)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>04 = Cumulative Premium with Interest (Single Tier)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>05 = Cumulative Premium with Interest (Multiple Tier)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>06 = Cumulative Premium with Interest (Other)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>11 = Shadow Account (Single Tier)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>12 = Shadow Account (Multiple Tier)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>13 = Shadow Account (Other)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>21 = Both Cumulative Premium without Interest and Shadow Account</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>22 = Both Cumulative Premium with Interest and Shadow Account</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>23 = Other, not involving either Cumulative Premium or Shadow Account</td>
</tr>
</tbody>
</table>

<p>|36 | 191-200 | 10 | Cumulative Minimum Premium at the Beginning of Observation Year |
|   |   |   | If not ULSG or VLSG, leave blank. |
|   |   |   | For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan: |
|   |   |   | If Item 35, Type of Secondary Guarantee is blank, 00, 11, 12, 13 or 23, leave blank. |
|   |   |   | If Item 35, Type of Secondary Guarantee is 01, 02, 03, 04, 05, 06, 21 or 22: |
|   |   |   | 1) Leave non-base segments, blank. |
|   |   |   | 2) For base segments: Enter the cumulative minimum premiums, including applicable interest, for all policy years up to the beginning of the observation year. |</p>
<table>
<thead>
<tr>
<th>37</th>
<th>201-210</th>
<th>10</th>
<th>Cumulative Minimum Premium at the End of Observation Year/ Actual Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>If not ULSG or VLSG, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If Item 35, Type of Secondary Guarantee is blank, 00, 11, 12, 13 or 23, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If Item 35, Type of Secondary Guarantee is 01, 02, 03, 04, 05, 06, 21 or 22:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1) Leave non-base segments blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2) For base segments inforce at the end of the</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>observation year: Enter the cumulative minimum</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>premiums, including applicable interest, up to the</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>end of the observation year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3) For base segments terminated during the observation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>year: Enter the cumulative minimum premiums, including applicable interest, up to the</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Actual Termination Date (Item 26)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Round to the nearest dollar.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If unknown, leave blank.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>38</th>
<th>211-220</th>
<th>10</th>
<th>Shadow Account Amount at the Beginning of Observation Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>If not ULSG, or VLSG, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If Item 35, Type of Secondary Guarantee is blank, 00, 01, 02, 03, 04, 05, 06, or 23 leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If Item 35, Type of Secondary Guarantee is 11, 12, 21 or 22:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1) Leave non-base segments blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2) For base segments:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Enter total amount of the Shadow Account at the</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>beginning of the observation year. The Shadow Account</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>can be positive, zero or negative.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Round to the nearest dollar.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For policies issued in the observation year, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If unknown, leave blank.</td>
</tr>
<tr>
<td>39</td>
<td>221-230</td>
<td>10</td>
<td><strong>Shadow Account Amount at the End of Observation Year/ Actual Termination Date</strong></td>
</tr>
<tr>
<td>----</td>
<td>---------</td>
<td>----</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If not ULSG or VLSG, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If Item 35, Type of Secondary Guarantee is blank, 00, 01, 02, 03, 04, 05, 06, or 23 leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If Item 35, Type of Secondary Guarantee is 11, 12, 13, 21 or 22:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1) Leave non-base segments blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2) For base segments in force at the end of the observation year: Enter the total amount of the Shadow Account at the end of the observation year. The Shadow Account can be positive, zero or negative.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3) For base segments terminated during the observation year: Enter the total amount of the Shadow Account as of the Actual Termination Date (Item 26). The Shadow Account can be positive, zero or negative.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Round to the nearest dollar.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If unknown, leave blank.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>40</th>
<th>231-240</th>
<th>10</th>
<th><strong>Account Value at the Beginning of Observation Year</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>For non-base segments, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If not ULSG or VLSG, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan: this is the policy Account Value as of the beginning of the observation year. The policy Account Value can be positive, zero or negative.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Round to the nearest dollar.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For policies issued in the observation year, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If unknown, leave blank.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>41</th>
<th>241-250</th>
<th>10</th>
<th><strong>Account Value at the End of Observation Year / Actual Termination Date</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>For non-base segments, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If not ULSG or VLSG, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1) If policy is in force at the end of observation year: Enter the policy Account Value at the end of the Observation Year. The policy Account Value can be positive, zero or negative.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2) If policy terminated during the observation year:</td>
</tr>
</tbody>
</table>
| 42 | 251-260 | 10 | **Amount of Surrender Charge at the Beginning of Observation Year** | For non-base segments, leave blank.  
If not ULSG or VLSG, leave blank.  
For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan, enter the dollar amount of the Surrender Charge as of the beginning of the observation year.  
Round to the nearest dollar.  
For policies issued in the observation year, leave blank.  
If unknown, leave blank. |
| 43 | 261-270 | 10 | **Amount of Surrender Charge at the End of Observation Year / Actual Termination Date** | For non-base segments, leave blank.  
If not ULSG or VLSG, leave blank.  
For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan:  
1) If policy is in force at the end of observation year:  
Enter the dollar amount of the Surrender Charge at the end of the Observation Year.  
2) If policy terminated during the observation year:  
Enter the dollar amount of the Surrender Charge as of the Actual Termination Date (Item 26).  
Round to the nearest dollar.  
If unknown, leave blank |
| 44 | 271-272 | 2 | **Operative Secondary Guarantee at the Beginning of Observation Year** | The company defines whether or not a secondary guarantee is in effect for a policy with a secondary guarantee at the beginning of the Observation Year.  
If Item 35, Type of Secondary Guarantee is blank, leave blank.  
If Item 35, Type of Secondary Guarantee is 00 through 23:  
1) Leave non-base segments blank. |
For base segments:
- 00 = If Unknown whether the Secondary Guarantee is in effect
- 01 = If Secondary Guarantee is not in effect
- 02 = If Secondary Guarantee is in effect
- 03 = If all Secondary Guarantees have expired

If Item 35, Type of Secondary Guarantee is blank, leave blank.

If Item 35, Type of Secondary Guarantee is 00 through 23:
1) Leave non-base segments blank.
2) If base segments inforce at the end of observation year, enter the appropriate value below as of the end of observation year:
   - 00 = If Unknown whether the Secondary Guarantee is in effect
   - 01 = If Secondary Guarantee is not in effect
   - 02 = If Secondary Guarantee is in effect
   - 03 = If all Secondary Guarantees have expired
3) If base segments terminated during the observation year, enter the appropriate value below as of the Actual Termination Date (Item 26):
   - 00 = If Unknown whether the Secondary Guarantee is in effect
   - 01 = If Secondary Guarantee is not in effect
   - 02 = If Secondary Guarantee is in effect
   - 03 = If all Secondary Guarantees have expired

State of Domicile
Use standard, two letter, state abbreviations codes (e.g., FL for Florida) for the state of Domicile.
If unknown, leave blank.

Note: For Appendix 6 — Policyholder Behavior Format, all of the other items that had been in the exposed version of Appendix 6 — Policyholder Behavior Format have been deleted.
Section 1: Scope

A. General

1. The following provisions contain the requirements for the actuarial opinion of reserves and for supporting actuarial memoranda in accordance with Section 3 of the Standard Valuation Law, and are collectively referred to as Actuarial Opinion and Memorandum (AOM) requirements.

2. Actuarial opinion and supporting actuarial memoranda requirements are provided in this VM-30 for companies that file the life, accident and health annual statement, or the fraternal annual statement. Companies that file the property/casualty (P/C) annual statement or the health annual statement will follow the actuarial opinion and supporting actuarial memoranda requirements pursuant to the instructions for those annual statements. Such companies are not subject to actuarial opinion and supporting actuarial memoranda requirements in this VM-30 unless the instructions for the P/C annual statement or the instructions for the health annual statement provide for requirements in VM-30.

Guidance Note: It is the intent to allow the annual statement instructions to address all issues relating to the actuarial opinion and memorandum for these two statements (P/C annual statement and the health annual statement), but not preclude the use of requirements as appropriate in VM-30 in the instructions for these two statements.

3. The AOM requirements shall be applied in a manner that allows the appointed actuary to use his or her professional judgment in performing the actuarial analysis and developing the actuarial opinion and supporting actuarial memoranda, conforming to relevant ASOP. However, a state commissioner has the authority to specify methods of analysis and assumptions when, in the commissioner’s judgment, these specifications are necessary for the actuary to render an acceptable opinion relative to the adequacy of reserves and related actuarial items. For purposes of this VM-30, the requirements of Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model 830) (AG 48), of the AP&P Manual, shall be applicable.

Guidance Note: It is expected that AG 48 will be modified after Dec. 31, 2016, to coordinate with the Credit for Reinsurance Model (#785). In the event that the coordination leads to a renumbering of the actuarial guideline, VM-30 must be updated to reflect the new number.

4. These AOM requirements are applicable to an annual statement with a year-ending date on or after the operative date of the Valuation Manual. A statement of actuarial opinion on the adequacy of the reserves and related actuarial items and a supporting actuarial memorandum is required each year.
5. The requirements for an opinion apply to each company filing an annual statement, not to the holding company or group of companies. A single opinion is required for the company.

B. Definitions

1. The term “actuarial opinion” means the opinion of an appointed actuary regarding reserves and related actuarial items.

2. The term “Actuarial Standards Board” means the board established by the Academy to develop and promulgate ASOP.

3. The term “annual statement” means the statutory financial statements a company must file using the annual blank with a state insurance commissioner as required under state insurance law.

4. The term “asset adequacy analysis” means an analysis of the adequacy of reserves and other liabilities being tested, in light of the assets supporting such reserves and other liabilities, as specified in the opinion.

5. The term “commissioner” means the chief insurance regulator of a state, district or territory of the U.S.

6. The term “adverse opinion” means an actuarial opinion in which the appointed actuary determines that the reserves and liabilities are not adequate. (An adverse opinion does not meet Section 3.A.7.e.)

7. The term “qualified opinion” means an actuarial opinion in which the appointed actuary determines the reserves for a certain item/s are in question because they cannot be reasonably estimated or the actuary is unable to render an opinion on those items. Such qualified opinion should state whether the stated reserve amount makes adequate provision for the liabilities associated with the specified reserves, except for the item/s to which the qualification relates. The actuary is not required to issue a qualified opinion if the actuary reasonably believes that the item/s in question is not likely to be material. (A qualified opinion does not meet one or more of the statements in Section 3.A.7.a through Section 3.A.7.d.)

8. The term “inconclusive opinion” means an actuarial opinion in which the appointed actuary determines the actuary cannot reach a conclusion due to deficiencies or limitations in the data, analyses, assumptions or related information. The actuary’s ability to give an opinion is dependent upon data, analyses, assumptions and related information that are sufficient to support a conclusion. An inconclusive opinion shall include a description of the reasons why a conclusion could not be reached.

9. An appointed actuary is a qualified actuary who:

a. Is appointed by the board of directors, or its equivalent, or by a committee of the board, by Dec. 31 of the calendar year for which the opinion is rendered.

b. Is a member of the Academy.

c. Is familiar with the valuation requirements applicable to life and health insurance.
d. Has not been found by the commissioner (or if so found has subsequently been reinstated as a qualified actuary), following appropriate notice and hearing to have:

i. Violated any provision of, or any obligation imposed by, the insurance law or other law in the course of his or her dealings as a qualified actuary.

ii. Been found guilty of fraudulent or dishonest practices.

iii. Demonstrated incompetency, lack of cooperation or untrustworthiness to act as a qualified actuary.

iv. Submitted to the commissioner during the past five years, pursuant to these AOM requirements, an actuarial opinion or memorandum that the commissioner rejected because it did not meet the provisions of this regulation including standards set by the Actuarial Standards Board.

v. Resigned or been removed as an actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards.

e. Has not failed to notify the commissioner of any action taken by any commissioner of any other state similar to that under paragraph d above.

Section 2: General Requirements for Submission of Statement of a Life Actuarial Opinion

A. General

1. The statement of an appointed actuary, entitled “Statement of Actuarial Opinion,” setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with Section 3.A must be included with an annual statement.

2. Within five business days of the appointment of an appointed actuary, the company shall notify the domiciliary commissioner of the name, title (and, in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and shall state in the notice that the person meets the requirements of an appointed actuary. Once these notices are furnished, no further notice is required with respect to this person unless the actuary ceases to be appointed or retained or ceases to meet the requirements of an appointed actuary.

3. If an actuary who was the appointed actuary for the immediately preceding filed actuarial opinion is replaced by an action of the board of directors, the insurer shall within five business days notify the insurance department of the state of domicile of this event. The insurer shall also furnish the domiciliary commissioner with a separate letter within 10 business days of the above notification stating whether in the 24 months preceding such event there were any material disagreements with the former appointed actuary regarding the content of the opinion. The disagreements required to be reported in response to this paragraph include both those resolved to the former actuary’s satisfaction and those not resolved to the former actuary’s satisfaction. The insurer shall also in writing request such former actuary to furnish a letter addressed to the insurer stating whether the actuary agrees with the statements contained in the insurer’s letter and, if not, stating the reasons for which he does not agree. Additionally, the insurer shall furnish such responsive letter
from the former actuary to the domiciliary commissioner together with its
own. B. Standards for Asset Adequacy Analysis

1. The asset adequacy analysis must conform to the Standards of Practice as promulgated from time to
time by the Actuarial Standards Board and to any additional standards under these AOM requirements,
which standards are to form the basis of the statement of actuarial opinion in accordance with these
AOM requirements.

2. The asset adequacy analysis must be based on methods of analysis as are deemed appropriate for
such purposes by the Actuarial Standards Board.

C. Liabilities to Be Covered

1. The statement of actuarial opinion must apply to all in-force business on the annual statement date,
whether directly issued or assumed, regardless of when or where issued.

2. If the appointed actuary determines as the result of asset adequacy analysis that a reserve should be
held in addition to the aggregate reserve held by the company and calculated in accordance with the
requirements set forth in the Valuation Manual, the company shall establish the additional reserve.

3. Additional reserves established under subparagraph 2 above and determined not to be necessary by
the appointed actuary in subsequent years may be released. Any amounts released shall be disclosed in
the actuarial opinion for the applicable year. The release of such reserves would not be deemed an
adoption of a lower standard of valuation.

Section 3: Requirements Specific to Life Actuarial Opinions

A. Statement of Actuarial Opinion Based On an Asset Adequacy Analysis

1. The statement of actuarial opinion shall consist of:

a. A table of key indicators to alert the reader to any changes from the prescribed language (see Section
3.A.3).

b. An identification section identifying the appointed actuary and his or her qualifications (see Section

c. A scope section identifying the subjects on which an opinion is to be expressed and describing the
scope of the appointed actuary’s work, including a tabulation delineating the reserves and related
actuarial items that have been analyzed for asset adequacy and the method of analysis (see
Section3.A.5), and identifying the reserves and related actuarial items covered by the opinion that have
not been so analyzed.

d. A reliance section describing those areas, if any, where the appointed actuary has relied upon other
experts for data, assumptions, projections or analysis (e.g., anticipated cash flows from currently owned

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assets, including variation in cash flows according to economic scenarios [see Section 3.A.6]), supported by a statement of each such expert in the form prescribed by Section 3.A.12.

e. An opinion section expressing the appointed actuary’s opinion with respect to the adequacy of the supporting assets to mature the liabilities (see Section 3.A.7).

f. A relevant comments section.

2. Each section must be clearly designated. For each section, there is prescribed wording described in Section 3.A.3 through Section 3.A.7 for that section. If the appointed actuary changes this wording or adds additional wording to clarify the prescribed wording, the appropriate box in the table of key indicators must be checked, and the appointed actuary shall provide the following information for that section in the relevant comments section of the opinion:

a. A description of the additional or revised wording in the opinion.

b. The rationale for using the additional or revised wording.

c. An explanation of the impact, if any, that the additional or revised wording has on the opinion.

The prescribed wording should be modified only if needed to meet the circumstances of a particular case, and the appointed actuary should, in any case, use language that clearly expresses the actuary’s professional judgment.

3. The table of key indicators is to be at the top of the opinion and is to be completed consistent with the remainder of the opinion. The only options are those presented below:

Identification Section
Prescribed Wording Only
Prescribed Wording with Additional Wording
Revised Wording

Scope Section
Prescribed Wording Only
Prescribed Wording with Additional Wording
Revised Wording

Reliance Section
Prescribed Wording Only
Prescribed Wording with Additional Wording
Revised Wording
Opinion Section

Prescribed Wording Only

Prescribed Wording with Additional Wording

Revised Wording

Relevant Comments

Comments are Included

The actuarial memorandum includes “deviation from standard” wording regarding conformity with an ASOP.

4. The identification section should specifically indicate the appointed actuary’s relationship to the company, qualifications for acting as appointed actuary and date of appointment, as well as specify that the appointment was made by the board of directors, or its equivalent, or by a committee of the board.

This section should contain only one of the following:

For a member of the Academy who is an employee of the organization, the identification section of the opinion should contain all of the following sentences if the appointed actuary is using the prescribed wording:

“I, [name and title], am an employee of [insurance company name] and a member of the American Academy of Actuaries. I was appointed on [date of appointment] in accordance with the requirements of the Valuation Manual. I meet the Academy qualification standards for rendering the opinion.”

For a consultant who is a member of the Academy, the identification section of the opinion should contain all of the following sentences if the appointed actuary is using the prescribed wording:

“I, [name and title of consultant], am associated with the firm of [name of consulting firm]. I am a member of the American Academy of Actuaries. I was appointed on [date of appointment] in accordance with the requirements of the Valuation Manual. I meet the Academy qualification standards for rendering the opinion.”

Guidance Note: It is not necessary for an appointed actuary to be reappointed under the Valuation Manual. For purposes of the identification section, appointment in accordance with the requirements of the Actuarial Opinion and Memorandum Regulation (#822) qualifies as being in accordance with the Valuation Manual.

5. The scope section should contain only the following statement (including all specified lines even if the value is zero) if the appointed actuary is using the prescribed wording:

“I have examined the assumptions and methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the company, as prepared for filing with state...
regulatory officials, as of December 31, 20. Tabulated below are those reserves and related actuarial items which have been subjected to asset adequacy analysis.”

Asset Adequacy Tested Amounts—Reserves and Related Actuarial Items

<table>
<thead>
<tr>
<th>Statement Item</th>
<th>Formula Reserves</th>
<th>Principle-Based Reserves</th>
<th>Additional Reserves</th>
<th>Analysis Method</th>
<th>Other Amount</th>
<th>Total Amount (1)+(2)+(3)+(4)</th>
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Exhibit 5

A Life Insurance
B Annuities
C Supplementary Contracts Involving Life Contingencies
D Accidental Death Benefit
E Disability—Active
F Disability—
Disabled
G Miscellaneous
Total
Exhibit 6
A Active Life
Reserve
B Claim Reserve
Total
Exhibit 7
Premium and Other
Deposit Funds
Guaranteed Interest
Contracts
Supplemental
Contracts
Annuities Certain
Asset Adequacy Tested Amounts—Reserves and Related Actuarial Items
Statement Item
Formula Reserves
(1)
Principle-Based
Reserves
(2)
Additional Reserves
(a) (3)
Analysis Method
(b)
Other Amount
(4)
Total Amount (1)+(2)+(3)+(4)
(5)
Dividend Accumulations or Refunds
Total Exhibit 7
Exhibit 8 Part 1
1 Life
2 Health
Total Exhibit 8, Part 1
Separate Accounts
(Page 3 of the Annual Statement of the Separate Accounts, Lines 1 and 2)
Other Reserves and Related Actuarial Items Tested
<<include a description and the location of other reserves and related actuarial items
\[d\] TOTAL RESERVES

a. The additional reserves are the reserves established under Section 2.C.2.

b. The appointed actuary should indicate the method of analysis, determined in accordance with the standards for asset adequacy analysis referred to in Section 2.B of these AOM requirements, by means of symbols that should be defined in footnotes to the table. If more than one method of analysis is used for any single annual statement line or line from the above table, an additional line for each method of analysis shall be provided with the method of analysis identified for each line.

IMR (General Account, Page____Line_____
(Separate Accounts, Page____Line_____)
AVR (Page____Line____)

Net Deferred and Uncollected Premium

c. Allocated amount of AVR.

6. The reliance section should contain only one of the following if the appointed actuary is using the prescribed wording:

If the appointed actuary has not relied upon other experts for data, assumptions, projections or analysis, the reliance section should include only the following statement:

“My examination included a review of the data, assumptions, projections and analysis and of the underlying basic asset and liability data, and such tests of the assumptions, projections and analysis I considered necessary. I also reconciled the underlying basic asset and liability data to the extent applicable to [exhibits and schedules listed as applicable] of the company’s current annual statement.”

If the appointed actuary has relied upon other experts for data, assumptions, projections or analysis, the reliance section should include only the following statement:

“In forming my opinion on [specify types of reserves], I relied upon data, assumptions, projections or analysis prepared by [name and title each expert providing the data, assumptions, projections, or analysis] as certified in the attached statements. I evaluated that data, assumptions, projections or analysis for reasonableness and consistency. I also reconciled data to the extent applicable to [list applicable exhibits and schedules] of the company’s current annual statement. In other respects, my examination included review of the assumptions, projections, and analysis used and tests of the assumptions, projections and analysis I considered necessary. I have received documentation from the experts listed above that supports the data, assumptions, projections and analysis.”

The appointed actuary shall attach to their opinion a statement by each expert relied upon in the form prescribed by Section 3.A.12.

7. The opinion section should include only the following statement if the actuary is using prescribed wording:

“In my opinion, the reserves and related actuarial items concerning the statement items identified above:

a. Are computed in accordance with presently accepted ASOP consistently applied and are fairly stated, in accordance with sound actuarial principles.

b. Are based on assumptions and methods that produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions.

c. Meet the requirements of the insurance laws and regulations of the state of [state of domicile].
(Use one of the following phrases as appropriate)

“are at least as great as the minimum aggregate amounts required by any state”

or

“are at least as great as the minimum aggregate amounts required by any state with the exception of the following states [list states]. For each listed state, a separate statement of actuarial opinion was submitted to that state that complies with the requirements of that state.”

d. Are computed on the basis of assumptions and methods consistent with those used in computing the corresponding items in the annual statement of the preceding year-end (with any exceptions noted below).

e. Include provision for all reserves and related actuarial items that ought to be established.

The reserves and related actuarial items, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on the assets, and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision, according to presently accepted ASOP, for the anticipated cash flows required by the contractual obligations and related expenses of the company. (At the discretion of the commissioner, this language may be omitted for an opinion filed on behalf of a company doing business only in this state and in no other state.)

The methods, considerations and analyses used in forming my opinion conform to the appropriate ASOP as promulgated by the Actuarial Standards Board, which form the basis of this statement of opinion.

This opinion is updated annually as required by statute. To the best of my knowledge, there have been no material changes from the applicable date of the annual statement to the date of the rendering of this opinion that should be considered in reviewing this opinion.

The impact of unanticipated events subsequent to the date of this opinion is beyond the scope of this opinion. The analysis of the asset adequacy portion of this opinion should be viewed recognizing that the company’s future experience may not follow all the assumptions used in the analysis.”

8. The opinion may include a relevant comments section. The relevant comments section should provide a brief description of each item. A detailed analysis of each item should be included in the actuarial memorandum.

Guidance Note: An example of a relevant comment is if there has been any material change in the assumptions or methods from those previously employed, a portion of the relevant comment section can describe that change in the statement of opinion by including a description of the changes such as: “A material change in assumptions or methods was made during the past year, but such change accords with accepted actuarial standards.” A brief description of the change would follow.
Other examples of items to include in the relevant comments section include topics of regulatory importance, descriptions of the reason for qualifying an opinion or explanations for an aspect of the annual statement that is not already sufficiently explained in the annual statement.

9. The opinion should conclude with the signature of the appointed actuary responsible for providing the actuarial opinion and the date when the opinion was rendered. The signature and date should appear in the following format:

Signature of Appointed Actuary
Printed Name of Appointed Actuary
Address of Appointed Actuary
Telephone Number of Appointed Actuary
Email Address of Appointed Actuary
Date

10. If the appointed actuary is able to form an opinion that is not qualified, adverse or inconclusive as those terms are defined in Section 1.B, the actuary should issue a statement of unqualified opinion. If the opinion is adverse, qualified or inconclusive, the appointed actuary should issue an adverse, qualified or inconclusive opinion explicitly stating the reason for such opinion. In all circumstances, the category of opinion should be accurately identified in the TABLE of KEY INDICATORS section of the opinion.

11. The adoption for new issues or new claims or other new liabilities of an assumption that differs from a corresponding assumption used for prior new issues or new claims or other new liabilities is not a change in assumptions within the meaning of this section (i.e., Section 3.A).

12. If the appointed actuary relies on other experts for data, assumptions, projections or analysis in forming the actuarial opinion, the actuarial opinion should identify the experts the actuary is relying upon and a precise identification of the information provided by the experts. In addition, the experts on whom the appointed actuary relies shall provide a certification that identifies the specific information provided; states that supporting documentation was provided; opines on the accuracy, completeness or reasonableness of the information provided; and describes their qualifications. This certification shall include the signature, name, title, company, address and telephone number of the person rendering the certification, as well as the date on which it is signed.

B. Description of the Actuarial Memorandum, Including an Asset Adequacy Analysis and Regulatory Asset Adequacy Issues Summary

1. The appointed actuary shall prepare a memorandum to the company describing the analysis done in support of his or her opinion regarding the reserves. The memorandum shall be made available for examination by a commissioner upon request but shall be returned to the company after such examination and shall not be considered a record of the insurance department nor subject to automatic filing with a commissioner.
2. In preparing the memorandum, the appointed actuary may rely on, and include as a part of his or her own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of Section 3.A.2, with respect to the areas covered in such memoranda, and so state in their memoranda.

3. Any actuary engaged by the commissioner under [insert reference to Section 3 of the state’s Standard Valuation Law] shall have the same status as an examiner for purposes of obtaining data from the company, and the work papers and documentation of the actuary shall be retained by the commissioner—provided, however, that any information provided by the company to the actuary and included in the work papers shall be considered as material provided by the company to the commissioner and shall be kept confidential to the same extent as is prescribed by law with respect to other material provided by the company to the commissioner pursuant to the statute governing these AOM requirements. The actuary shall not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer pursuant to these AOM requirements for any one of the current year or the preceding three years.

4. The memorandum shall include the following statement:

   “Actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate standards of practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum.”

5. An appropriate allocation of assets in the amount of the IMR, whether positive or negative, shall be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the asset valuation reserve; these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.

6. The amount of the assets used for the AVR shall be disclosed in the table of reserves and liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets shall be disclosed in the memorandum.

7. The appointed actuary shall retain on file, for at least seven years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions and the results obtained.

8. When an actuarial opinion is provided, the memorandum shall demonstrate that the analysis has been done in accordance with the standards for asset adequacy referred to in Section 2.B and any additional standards specified in these AOM requirements.

9. When an actuarial opinion is provided, the memorandum shall specify for reserves:
a. Product descriptions, including market description, underwriting and other aspects of a risk profile and the specific risks the appointed actuary deems significant.

b. Source of liability in force.

c. Reserve method and basis.

d. Investment reserves.

e. Reinsurance arrangements.

f. Identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account or under a separate account policy or contract and the methods used by the appointed actuary to provide for the guarantees in the asset adequacy analysis.

g. Documentation of assumptions used for lapse rates (both base and excess), interest crediting rate strategy, mortality (including base assumptions and future mortality improvement or deterioration), policyholder dividend strategy, competitor or market interest rate, annuitization rates, commissions and expenses, and morbidity. The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions and whether the assumptions contribute to the conclusion that the reserves make provision for “moderately adverse conditions”.

10. When an actuarial opinion is provided, the memorandum shall specify for assets:

a. Portfolio descriptions, including a risk profile disclosing the quality, distribution and types of assets.

b. Investment and disinvestment assumptions.

c. Source of asset data.

d. Asset valuation bases.

e. Documentation of assumptions made for default costs, bond call function, mortgage prepayment function, determining market value for assets sold due to disinvestment strategy and determining yield on assets acquired through the investment strategy. The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

11. When an actuarial opinion is provided, the memorandum shall specify for the analysis basis:

a. Methodology.

b. Rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed.
c. Rationale for degree of rigor in analyzing different blocks of business. (Include in the rationale the level of “materiality” that was used in determining how rigorously to analyze different blocks of business).

d. Criteria for determining asset adequacy. (Include in the criteria the precise basis for determining if assets are adequate to cover reserves under “moderately adverse conditions” or other conditions as specified in relevant ASOP).

e. Whether the impact of federal income taxes was considered and the method of treating reinsurance in the asset adequacy analysis.

12. When an actuarial opinion is provided, the memorandum shall contain:

a. Summary of material changes in methods, procedures or assumptions from the prior year’s asset adequacy analysis.

b. Summary of results.

c. Conclusions.

13. The appointed actuary shall prepare a regulatory asset adequacy issues summary, the contents of which are specified in Section 3.B.14. The regulatory asset adequacy issues summary will be submitted to the domiciliary commissioner no later than April 1 of the year following the year for which a statement of actuarial opinion based on asset adequacy is required, and shall be available to any other commissioners on request. A commissioner shall keep the regulatory asset adequacy issues summary confidential to the same extent and under the same conditions as the actuarial memorandum.

a. The regulatory asset adequacy issues summary shall include:

i. The following key indicator. The only options are those presented below:

   This opinion is unqualified: Yes No

   If the response is “No,” the appointed actuary shall explain the reason(s) why the opinion is not unqualified in a manner that is satisfactory to the commissioner.

ii. Descriptions of the scenarios tested (including whether those scenarios are stochastic or deterministic) and the sensitivity testing done relative to those scenarios. If negative ending surplus results under certain tests in the aggregate, the actuary should describe those tests and the amount of additional reserve as of the valuation date, which, if held, would eliminate the negative aggregate surplus values. Ending surplus values shall be determined by either extending the projection period until the in force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in-force. The actuary shall provide a summary of the testing results, tabular or otherwise, sufficient to provide a clear understanding of the basis for the actuarial opinion. This summary shall include clarifying explanations of the results as needed.
iii. The extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different from the assumptions used in the previous asset adequacy analysis.

iv. The amount of reserves and the identity of the product lines that had been subjected to asset adequacy analysis in the prior opinion but were not subject to analysis for the current opinion.

v. Comments on any interim results that may be of significant concern to the appointed actuary.

vi. The methods used by the actuary to recognize the impact of reinsurance on the company’s cash flows, including both assets and liabilities, under each of the scenarios tested.

vii. Whether the actuary has been satisfied that all options, whether explicit or embedded, in any asset or liability (including, but not limited to, those affecting cash flows embedded in fixed income securities) and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

b. The regulatory asset adequacy issues summary shall contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and shall be signed and dated by the appointed actuary rendering the actuarial opinion.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Staff of Office of Principle-Based Reserving, California Department of Insurance – Clarification issues: (1) Use consistent reference to “cash surrender value” and (2) Add “ULSG” in a sentence that only applies to ULSG

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:


3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.) Please see Appendix. These changes are intended to be regarded as non-substantive.

4. State the reason for the proposed amendment? (You may do this through an attachment.) Please see Appendix.

NAIC Staff Comments:

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Notes: VM Maintenance Agenda 2017-10
Appendix

ISSUE:

Use consistent reference to “cash surrender value”. And, in 9.D.5., clarify that the second sentence is a continuation of the logic from the first sentence and applies to the same policies as the first sentence.

SECTION:


REDLINE:

VM-20 Section 9.D.1.a

a. Reflect expectations regarding variations in anticipated policyholder behavior relative to characteristics that have a material impact on the modeled reserve, which may include gender, attained age, issue age, policy duration, time to maturity, tax status, level of account and cash surrender value, surrender charges, transaction fees or other policy charges, distribution channel, product features, and whether the policyholder and insured are the same person.

VM-20 Section 9.D.5

5. For a universal life policy that guarantees coverage to remain in force as long as the secondary guarantee requirement is met and during projection periods in which the cash surrender value is zero or minimal, industry experience, for purposes of complying with Section 9.A.6, shall be the Lapse Experience Under Term-to-100 Insurance Policies published by the Canadian Institute of Actuaries in October 2007. During projection periods in which the cash surrender value of such ULSG policy is zero or minimal, the assumption shall grade from credible company experience to the rates in the Lapse Experience Under Term-to-100 Insurance Policies published by the Canadian Institute of Actuaries in October 2007 in five projection years from the last duration where substantially credible experience is available.

Guidance Note: The term “minimal cash surrender value” means that the cash surrender value is of such small value that its presence would not significantly affect a policyholder’s decision to lapse the policy in comparison to a situation with zero cash surrender value.

REASONING:

In VM-01, “cash surrender value” is defined, but in VM-20 just “cash value” is used (VM-20 Section 9.D.1.a, 9.D.5 and Guidance Note following 9.D.5). If “cash value” is being used synonymously with “cash surrender value”, we request that the term “cash surrender value” always be used for clarity and consistency. Likewise, purely for maximum clarity, we request that a reference to ULSG be put into the second sentence of 9.D.5.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Staff of Office of Principle-Based Reserving, California Department of Insurance – Definition of modeled reserve needs correction.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

Valuation Manual August 29, 2016, with non-substantive changes through year-end 2016, VM-20 Section 1.C.8 and 2.G.

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

Please see Appendix attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

Please see Appendix.

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Notes: VM Maintenance Agenda Item 2017-11
ISSUE:
Definition needs to be corrected.

SECTION:
VM-20 Sections 1.C.8 and 2.G

REDLINE:
The term "modeled reserve" means the deterministic reserve on the policies determined under Section 2.A.1.a, 2.A.2.a, 2.A.3.b plus the greater of the deterministic reserve and the stochastic reserve on the policies determined under Section 2.A.1.b, 2.A.2.b and 2.A.3.c.

Guidance Note: Examples include, but are not limited to:

1. Choosing a reduced set of scenarios from a larger set or an alternative set consistent with prescribed models and parameters.

2. Generating a smaller liability or asset model to represent the full seriatim model using grouping compression techniques, or other similar simplifications.

(REMOVE GUIDANCE NOTE TO AFTER VM-20 SECTION 2.G)

REASONING:

The current definition of modelled reserve has incorrect VM-20 2.A references.

Also, the Guidance Note is out of place. It looks like it belongs with VM-20 Section 2.G on page 20-5.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Staff of Office of Principle-Based Reserving, California Department of Insurance – Suggest clarification on NPR’s default basis being seriatim.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:


3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

Please see Appendix attached. This revision is intended to be non-substantive.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

Please see Appendix.

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**Notes:** VM Maintenance Agenda Item 2017-15
Appendix

ISSUE:
Suggest clarification on seriatim calculation of NPR and clarify reference to Section II.

SECTION:
VM-20 Section 3.A.1

REDLINE:
The NPR for each term policy and for each ULSG policy must be determined on a seriatim basis pursuant to Section 3. Determination of the NPR on a non-seriatim basis is allowable as a simplification, approximation, or modelling efficiency technique if the requirements of Section 2.G are met.

Guidance Note: When valuing term riders pursuant to Section II A.2 Riders and Supplemental Benefits, the reserve requirements for term policies are applicable.

REASONING:
If NPR is expected to almost always be done on a seriatim basis, if it will almost always be preferable and computationally feasible, we request that it be stated explicitly that the default for NPR is seriatim.

Also, clarify the reference to Section II in the guidance note.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Reggie Mazyck, Life Actuary, NAIC

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

Valuation Manual, VM-20, Requirements For Principle-Based Reserves for Life Products, Appendix 2, Section F

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

Tables A through K in VM-20, Appendix 2, Section F will be removed and replaced with the following notification:

“Current and historical versions of tables A through K used for calculating asset default costs and asset spreads are available on the Related Documents tab of the NAIC Life Actuarial (A) Task Force webpage.”

A hyperlink to the tables will be posted in VM-20, Appendix 2.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

Section F of VM-20 Appendix 2 houses tables for calculating asset default costs and asset spreads. Default costs tables are updated annually. Spread tables are updated quarterly. As tables are updated they are posted to the Related Documents tab on the Life Actuarial (A) Task Force webpage. The Valuation Manual should also be updated to recognize the table changes. The task of updating the Valuation Manual updated quarterly to accommodate the table updates is burdensome. The current requirements for updating the tables necessitate that a new version of the Valuation Manual be made available after each update. Revising VM-20 Appendix 2, to direct companies to the Task Force webpage will provide the industry with access to the newly adopted tables, while alleviating the need for quarterly adoptions of the full Valuation Manual.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

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Notes: VM Maintenance Agenda Item 2017-21
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Reggie Mazyck, NAIC
Update the link in VM-20 Section 9C3g to the mortality improvement factors on the SOA website.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM-20 Section 9C3g of the Valuation Manual 8/29 adopted version with changes through 12/31/16

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

The initial link was:

www.soa.org/ Research/Experience-Study/Ind-Life/Valuation/research-YYYY-improve-scale-recommendation.aspx

The new link is:

www.soa.org/Research/Experience-Study/Ind-Life/Valuation/research-mortality-improvement-YYYY.aspx

4. State the reason for the proposed amendment? (You may do this through an attachment.)

The link in VM-20 Section 9C3g must be changed to recognize changes made by the SOA

* This form is not intended for minor corrections, such as formatting, grammar, cross–references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

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Notes:
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) Subgroup of the Life Actuarial (A) Task Force at the request of the Contingent Deferred Annuity (A) Working Group of the Life Insurance and Annuities (A) Committee.

2. NAIC staff support contact information:

Reggie Mazyck, rmazyck@naic.org, Phone: 202-471-3991
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.

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

Revise to exclude contingent deferred annuities (CDAs), which, due to their structure, cannot comply with the terms of the model.

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?**

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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?**

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**Explanation, if necessary:** States will want to include this clarification, to acknowledge that nonforfeiture benefits for CDAs cannot currently be calculated under this model, but does not foreclose the possibility that a method for calculating nonforfeiture benefits for CDAs could be devised at some point in the future.

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?**

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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
This Act shall be known as the Standard Nonforfeiture Law for Individual Deferred Annuities.

Section 2. Applicability

A. This Act shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this state through an agent or other representative of the company issuing the contract.

B. Sections 3 through 8 shall not apply to contingent deferred annuities.

C. Notwithstanding Subsection B, the commissioner shall have the authority to prescribe, by regulation, nonforfeiture benefits for contingent deferred annuities that are, in the opinion of the commissioner, equitable to the policyholder, appropriate given the risks insured, and to the extent possible, consistent with general intent of this law.

Drafting Note: It is expected that any regulation prescribing specific nonforfeiture requirements for the CDAs and promulgated by the commissioner under Subsection C above would apply only to the CDA contracts issued subsequent to the effective date of such regulation.

Section 3. Nonforfeiture Requirements

A. In the case of contracts issued on or after the operative date of this Act as defined in Section 13, no contract of annuity, except as stated in Section 2, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the contractholder, upon cessation of payment of considerations under the contract:

(1) That upon cessation of payment of considerations under a contract, or upon the written request of the contract owner, the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in Sections 5, 6, 7, 8 and 10;
(2) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of a paid-up annuity benefit a cash surrender benefit of such amount as is specified in Sections 5, 6, 8 and 10. The company may reserve the right to defer the payment of the cash surrender benefit for a period not to exceed six (6) months after demand therefor with surrender of the contract after making written request and receiving written approval of the commissioner. The request shall address the necessity and equitability to all policyholders of the deferral;

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of the benefits; and

(4) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which the benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

B. Notwithstanding the requirements of this section, a deferred annuity contract may provide that if no considerations have been received under a contract for a period of two (2) full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from prior considerations paid would be less than $20 monthly, the company may at its option terminate the contract by payment in cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis on the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by this payment shall be relieved of any further obligation under the contract.

Section 4. Minimum Values

The minimum values as specified in Sections 5, 6, 7, 8 and 10 of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

A. (1) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at rates of interest as indicated in Subsection B of the net considerations (as hereinafter defined) paid prior to such time, decreased by the sum of Paragraphs (a) through (d) below:

(a) Any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in Subsection B;

(b) An annual contract charge of $50, accumulated at rates of interest as indicated in Subsection B;

(c) Any premium tax paid by the company for the contract, accumulated at rates of interest as indicated in Subsection B; and

Drafting Note: The premium tax credit is only permitted if the tax is actually paid by the company. If the tax is paid and subsequently credited back to the company, such as upon early termination of the contract, the tax credit may not be taken.

(d) The amount of any indebtedness to the company on the contract, including interest due and accrued.

(2) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent (87.5%) of the gross considerations credited to the contract during that contract year.

B. The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three percent (3%) per annum and the following, which shall be specified in the contract if the interest rate will be reset:
The five-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or average over a period, rounded to the nearest 1/20th of one percent, specified in the contract no longer than fifteen (15) months prior to the contract issue date or redetermination date under Section 4B(4);

Reduced by 125 basis points;

Where the resulting interest rate is not less than one percent (1%); and

The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in Subsection B(2) above by up to an additional 100 basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Lacking such a demonstration that is acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.

C. The commissioner may adopt rules to implement the provisions of Section 4C and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the commissioner determines adjustments are justified.

Section 5. Computation of Present Value

Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Present value shall be computed using the mortality table, if any, and the interest rates specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

Section 6. Calculation of Cash Surrender Value

For contracts that provide cash surrender benefits, the cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit that would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent (1%) higher than the interest rate specified in the contract for accumulating the net considerations to determine maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

Section 7. Calculation of Paid-up Annuity Benefits

For contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine maturity value, and increased by any additional amounts credited by the company to the contract. For contracts that do not provide any death benefits prior to the commencement of any annuity payments, present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.
Section 8. Maturity Date

For the purpose of determining the benefits calculated under Sections 6 and 7, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

Section 9. Disclosure of Limited Death Benefits

A contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

Section 10. Inclusion of Lapse of Time Considerations

Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

Section 11. Proration of Values; Additional Benefits

For a contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of Sections 5, 6, 7, 8 and 10, additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this Act. The inclusion of such benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

Section 12. Rules

The commissioner may adopt rules to implement the provisions of this Act.

Section 13. Effective Date

After the effective date of this Act, a company may elect to apply its provisions to annuity contracts on a contract form-by-contract form basis before the second anniversary of the effective date of this Act. In all other instances, this Act shall become operative with respect to annuity contracts issued by the company after the second anniversary of this Act.
PROJECT HISTORY

STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES (#805)

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

In late 2012, the Life Insurance and Annuities (A) Committee charged the Contingent Deferred Annuity (A) Working Group with evaluating the adequacy of existing laws and regulations as applied to contingent deferred annuities (CDAs) and whether additional solvency and consumer protection standards are required. The Working Group submitted its report, findings and recommendations to the Committee at the 2013 Spring National Meeting. Among its findings, the Working Group found that: 1) CDAs do not easily fit into the category of fixed or variable annuity; 2) review of solvency and consumer protection standards are necessary; and 3) tools to assist states in reviewing CDA product filings and solvency oversight of CDAs should be established. The Working Group also identified issues that would be more appropriately addressed by other existing NAIC groups with the specific subject-matter expertise.

During the 2013 Fall National Meeting, the Life Insurance and Annuities (A) Committee gave the Life Actuarial (A) Task Force a charge to recommend a manner to specifically exempt CDAs from the Standard Nonforfeiture Law for Individual Deferred Annuities (#805). The Executive (EX) Committee approved the request for model law development to Model #805 at the 2016 Summer National Meeting.

At the 2016 Fall National Meeting, the Life Insurance and Annuities (A) Committee adopted amendments to Model #805 recommended by the Life Actuarial (A) Task Force to exempt CDAs from certain sections of Model #805, with which, due to their structure, they cannot comply. The revisions to Model #805 exempt CDAs from the sections of the Model #805 that prescribe computational methods and minimum nonforfeiture values for deferred annuities, but would allow the insurance commissioner to specify separate nonforfeiture standards, if needed, at a later time.

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

Contingent Deferred Annuity (A) Working Group of the Life Actuarial (A) Task Force. The following states participated: Tomasz Serbinowski (UT), Chair; Perry Kupferman (CA); Bob Chester (CT); Nicole Boyd (KS); Felix Schirripa (NJ); Mike Boerner, Jan Graeber and Phil Reyna (TX); and Craig Chupp and Ern Johnson (VA).

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

The charge was given to the Life Actuarial (A) Task Force at the 2013 Fall National Meeting to recommend a manner to specifically exempt CDAs from Model 805. The Task Force appointed the Contingent Deferred Annuity (A) Working Group to complete the charge. The Executive (EX) Committee approved the request for model law development to Model #805 at the 2016 Summer National Meeting.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The Contingent Deferred Annuity (A) Working Group, chaired by Mr. Serbinowski, completed the charge to exclude CDAs from the scope of Model #805.

In addition to the Working Group members, the following interested state insurance regulators participated: Mike Yanacheak (IA); Rhonda Ahrens (NE); and Pete Weber (OH).

The following interested parties participated: American Council of Life Insurers (ACLI); Center for Economic Justice (CEJ); American Academy of Actuaries (Academy); and Lewis & Ellis Inc.

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 Working Group began working on the charge in open conference calls beginning in the spring of 2014. Draft recommendations were posted on the Working Group’s web page, and comments were solicited. Draft revisions to Model #805 were adopted by the Life Insurance and Annuities (A) Committee at the 2016 Fall National Meeting.
6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group’s response).

The revisions sought to achieve two objectives: 1) exempt CDAs from the current nonforfeiture requirements; and 2) preserve state insurance commissioners’ authority to prescribe CDA-specific nonforfeiture requirements in the future.

The Life Actuarial (A) Task Force received multiple comments to the effect that the revisions to Model #805 would likely result in a non-uniform treatment of CDAs across the country, with individual states establishing different nonforfeiture standards for CDAs. The Task Force noted that many NAIC model laws grant state insurance commissioners’ rulemaking authority and that this has never been viewed as contrary to the NAIC’s stated mission of encouraging uniformity.

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

None.

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The Health Insurance and Managed Care (B) Committee met Aug. 7, 2017. During this meeting, the Committee:

1. Heard a federal legislative and regulatory update, which included information on the U.S. Congress’ possible efforts to stabilize the individual market, including efforts related to ensuring the continuation of the cost-sharing reduction (CSR) payments.

2. Heard a presentation from the Blue Cross and Blue Shield Association (BCBSA) concerning its efforts to address the opioid use disorder issue, including its strategy and initiatives to support this effort. The presentation included a discussion of the BCBSA’s five-year vision to dramatically reduce the number of opioids prescribed coupled with a dramatic increase in the number of individuals receiving evidence-based treatment for substance use disorder and addiction. The BCBSA’s goal is to leverage the resources and expertise within the BCBSA system to turn the tide on substance use disorder and addiction through: 1) education and awareness; 2) partnering with the provider community to advance evidence-based treatment; and 3) prevent fraud and diversion of prescription opioids.

3. Heard a presentation from FAIR Health Inc. describing its health mission, its stakeholders and its health private claims repository. The presentation also included information on the applied uses of its data, such as: 1) management and operational support; 2) fee schedules and reimbursement; 3) public health and consumer engagement; and 4) policy and research. States also use FAIR Health data for purposes such as workers’ compensation fee schedules, dental claims reimbursement for disabled pediatric patients, out-of-network claims pricing, and a benchmark for consumer cost transparency and dispute resolution.

4. Adopted its June 15 and Spring National Meeting minutes, which included the following action:
   a. Adopted a new actuarial guideline, *The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG LTC)*. The AG LTC is intended to increase the uniformity, transparency and accuracy of long-term care insurance (LTCI) reserves starting with year-end 2017 filings. The actuarial guideline, in summary: 1) requires the use of appropriate assumptions, including regarding future rate increases, underlying LTCI reserves; 2) clarifies the use of aggregation of LTCI and other blocks’ reserves; 3) provides documentation requirements for assumptions and reserve results; and 4) provides the means for the reserve analysis to be available to state insurance regulators in all states in which a company is licensed. These revisions are to be considered for adoption by the Executive (EX) Committee and Plenary during its meeting Aug. 9.
   b. Adopted revisions to VM-25, Health Insurance Reserves Minimum Reserve Requirements, of the *Valuation Manual*, for group long-term disability (GLTD) interest rate reserving requirements. The revisions allow for the calculation of the calendar year maximum valuation interest rate for certain reserves to remain unchanged in light of impending changes to the calculation of single premium immediate annuities valuation interest rate.
   c. Discussed its tentative agenda for the Summer National Meeting.

5. Adopted the following subgroup, working group and task force reports: Consumer Information (B) Subgroup; CO-OP Solvency and Receivership (B) Subgroup; Medical Loss Ratio Quality Improvement Activities (B) Subgroup; Health Care Reform Regulatory Alternatives (B) Working Group; Health Actuarial (B) Task Force; Regulatory Framework (B) Task Force; and Senior Issues (B) Task Force.

6. Received the Long-Term Care Insurance (B/E) Task Force report and adopted its 2017 charges. Refer to the Financial Condition (E) Committee report for details.

7. Adopted the Health Actuarial (B) Task Force’s request for an extension of model law development for the *Health Insurance Reserves Model Regulation (#10)* concerning revisions to reflect appropriate LTCI reserving standards.

8. Discussed whether it would be beneficial to develop a “Pharmacy 101” education course to increase state insurance regulators’ understanding of the pharmaceutical industry and prescription drug benefit management, including pharmaceutical benefit managers’ (PBMs) role in the process. The Committee decided to move forward with the project and, as a starting point, requested that the states submit information to NAIC staff on what potential topics to include in the course.
THE APPLICATION OF ASSET ADEQUACY TESTING TO LONG-TERM CARE INSURANCE RESERVES

Background

The Health Insurance Reserves Model Regulation (#010) and the NAIC Valuation Manual (VM-25) contain requirements for the calculation of long-term care insurance (LTC) reserves. Regulators have observed a lack of uniform practice in the implementation of tests of reserve adequacy and reasonableness of LTC reserves. The reserve adequacy testing required by Model #10 and VM-25 does not provide regulators comfort as to the reserve adequacy of companies with material blocks of LTC business. As such, regulators must rely upon asset adequacy analysis required by the NAIC Valuation Manual (VM-30) to evaluate the solvency position of companies with sizable blocks of LTC business. This Guideline is intended to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for the asset adequacy testing applied to a company’s LTC block of contracts. In particular, this Guideline:

1. Specifies that the appropriate form of asset adequacy analysis may be in the form of a gross premium valuation or in a more robust form, such as cash-flow testing, with Actuarial Standards of Practice providing guidance in this area;
2. Clarifies the type of adequacy testing methods that must be used for aggregation with other blocks of business to be allowed for asset adequacy analysis purposes;
3. Requires a uniform approach to supporting acceptable assumptions regarding future LTC premium rate increases;
4. Provides requirements for documentation of assumptions associated with all key LTC risks; and
5. Provides requirements for documentation of standalone LTC asset adequacy testing results.

Note: It is anticipated that the requirements contained in this Guideline will be incorporated into the NAIC Valuation Manual (VM-30) at a future date, effective for a future valuation year. This Guideline will cease to apply to annual statutory financial statements at the time the corresponding VM-30 requirements become effective.

Text

1. Effective Date

This Guideline shall be effective for reserves reported with the December 31, 2017 and subsequent annual statutory financial statements.

2. Authority

Pursuant to Section 1, paragraph 3, of VM-30 of the NAIC Valuation Manual, the commissioner shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner’s judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

3. Scope

This Guideline shall apply to a company with over 10,000 inforce lives covered by long-term care insurance contracts as of the valuation date. All long-term care insurance contracts, whether directly written or assumed through reinsurance are included. Accelerated death benefit products or other combination products where the substantial risk of the product is associated with life insurance or an annuity are not subject to this Guideline.
4. Asset Adequacy Analysis of LTC Business

A. As stated in Actuarial Standard of Practice (ASOP) No. 22, multiple asset adequacy analysis methods, including cash-flow testing and gross premium valuation, are available to actuaries for this analysis. The method of analysis used for LTC shall conform with ASOP No. 22 in recognition of the typical significant asset- and liability-related risks associated with LTC.

B. Asset adequacy analysis specific to all inforce LTC business, and without consideration of results for other block of business within the company, must be performed for valuations associated with the December 31, 2017 and subsequent annual statutory financial statements. The analysis shall comply with applicable Actuarial Standards of Practice, including standards regarding identification of key risks. Material assumptions associated with the LTC business shall be determined testing moderately adverse deviations in actuarial assumptions.

C. When determining whether additional reserves are necessary:

1. A reserve deficiency in the LTC block may be aggregated with sufficiencies in the company’s other blocks of business for the purposes of developing an actuarial opinion, if cash-flow testing is used for both the LTC business and for all significant blocks of non-LTC business within a company. If a reserve deficiency in the LTC block is not offset with sufficiencies in the company’s other blocks of business, then additional reserves shall be established as required by section 2.C.2. of VM-30.

2. If cash-flow testing is not used for testing of the LTC business, then a reserve deficiency revealed from another method, e.g., a gross premium valuation, utilized for purposes of asset adequacy analysis of the LTC block under this Guideline shall not be offset with sufficiencies in the company’s other blocks of business. The additional reserves under this Guideline shall be established based only upon the adequacy of the reserves in the LTC block.

D. When determining the effect of investment returns or the time value of money:

1. In the case where cash-flow testing is used, the company must allocate investment income to the LTC block of business consistently with the way investment income generated by the General Account is managed. If, however, a segment of the General Account is used to manage the investment risk for LTC business, the investment income generated by assets from that segment should be appropriately represented within the asset adequacy analysis.

2. In the case where a gross premium valuation method is used or asset cash flows are not explicitly modeled, the discount rate used by the actuary must reflect consideration of the yield on current assets held to support the liability as well as future yields on assets purchased with future premium income and reinvestments or anticipated divesture of existing assets.

E. The analysis shall only anticipate premium rate increases based upon a rate increase plan that is documented, is supported by and has been approved by management, is highly likely to be undertaken, and contains rate increase requests and timelines by jurisdiction. The assumptions used in the analysis should reflect a reasonable estimate of regulatory approved amounts and implementation timelines.

5. Documentation Required

The documentation requirements below are to be incorporated as a separate section of the appointed actuary’s Actuarial Memorandum required by the VM-30 or in a special Actuarial Memorandum containing LTC-specific information and shall be submitted to the commissioner of the company’s state of domicile. The separate section of the companywide Actuarial Memorandum or the special Actuarial Memorandum shall be available to other state insurance commissioners in which the company is licensed upon request to the company. The confidentiality provisions regarding the Actuarial Memorandum contained in VM-30 are applicable to the separate section of the Actuarial Memorandum and to the special Memorandum.

A. Results of the asset adequacy analysis of the LTC business shall be reported and documented in the separate section of the Actuarial Memorandum or the special Memorandum, as appropriate.
B. Assumptions on mortality shall be documented to state the reference standard valuation table, if applicable, and explicitly cite adjustments, select factors, and mortality improvement factors, where applicable. If a reference standard valuation table is not used in setting the mortality assumption, then a table of rates and comparison of the applied rates to rates from an unmodified standard mortality table for sample issue ages shall be provided. A summary of experience or other actuarial support of assumptions used shall be documented.

C. Assumptions on voluntary lapse shall be documented in table format by duration band and by other factors such as gender, marital status, with versus without inflation rider, and length of benefit period impacting the lapse assumption, where applicable. A summary of experience or other support of assumptions shall be documented.

D. Assumptions on morbidity shall be documented and actuarial support of the assumption shall be provided. If an outside source is used as the basis for morbidity assumptions, then the rationale for the applicability of that source and any adjustments to the factors from that source shall be documented.

E. Assumptions on investment returns and interest rates shall be documented. If a simplified approach is applied, such as implicit reflection of projected investment returns through the use of discount rates in a gross premium valuation as contemplated in Section 4.D.2., then justification shall be provided.

F. Any rate increases already approved shall be documented by jurisdiction with approved implementation timelines. Assumptions on future rate increases shall be documented by policy form or policy grouping. Such documentation should adequately describe the way in which future rate increase assumptions are developed. Unless the appointed actuary has operational responsibility for carrying out the rate increase plan specified in Section 4.E., the Memorandum shall contain a signed and dated reliance statement from the person with operational responsibility for carrying out such actions that the rate increase plan(s) provided to the appointed actuary appropriately reflects management’s plan.

G. Documentation of any other material assumptions shall be provided.

H. Documentation shall be provided for assumptions that have significantly changed from the prior year’s analysis.
PROJECT HISTORY

ACTUARIAL GUIDELINE LTC
THE APPLICATION OF ASSET ADEQUACY TESTING TO LONG-TERM CARE INSURANCE RESERVES

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

The *Health Insurance Reserves Model Regulation* (#10) and the *NAIC Valuation Manual* (VM-25, Health Insurance Reserves Minimum Reserve Requirements) contain requirements for the calculation of long-term care insurance (LTCI) reserves. State insurance regulators have observed a lack of uniform practice in the implementation of tests of reserve adequacy and reasonableness of long-term care (LTC) reserves. The reserve adequacy testing required by Model #10 and VM-25 does not provide state insurance regulators comfort as to the reserve adequacy of companies with material blocks of LTC business. As such, state insurance regulators must rely upon asset adequacy analysis required by the *NAIC Valuation Manual* (VM-30, Actuarial Opinion and Memorandum Requirements) to evaluate the solvency position of companies with sizable blocks of LTC business. This guideline is intended to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for the asset adequacy testing applied to a company’s LTC block of contracts.

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

The Long-Term Care Valuation (B) Subgroup, comprising state insurance regulator representatives from California, Connecticut, Florida, Kansas, Maine, Nevada, New Mexico, New York, Texas and Utah oversaw the drafting of the proposed actuarial guideline. The Subgroup was directed by the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force to coordinate and oversee the drafting.

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

The Long-Term Care Actuarial (B) Working Group charged the Long-Term Care Valuation (B) Subgroup to expose a draft of the proposed actuarial guideline at its Aug. 25, 2016, meeting. The charge is in accordance with the Health Actuarial (B) Task Force charge to “study the minimum standards applicable to statutory reserves for LTCI. Ensure Model #10 remains open to accommodate any necessary changes to the standards. Begin developing a principle-based framework for a set of minimum standards.”

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 draft actuarial guideline was first exposed in August 2016 and has received substantial vetting over the subsequent months in sessions at NAIC national meetings and in conference calls. A revised draft of the proposed guideline was exposed on May 18, 2017. State insurance regulators, consumer advocates and industry representatives have had the opportunity to provide input. The version adopted by the Long-Term Care Actuarial (B) Working Group on May 31, 2017, reflects the contributions of several parties. The American Council of Life Insurers (ACLI) and America’s Health Insurance Plans (AHIP) provided a statement on May 26, 2017, encouraging adoption of the guideline, and the vote of Working Group members was unanimous in support. The Health Actuarial (B) Task Force adopted the final version of the guideline during its June 2, 2017, conference call, as did the Health Insurance and Managed Care (B) Committee on its June 15, 2017, conference call.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Please see 4.

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

Please see 5.

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

None.
The Property and Casualty Insurance (C) Committee met Aug. 8, 2017. During this meeting, the Committee:

1. Adopted its July 28 minutes, which included the following action:
   a. Adopted changes to the Committee’s charges to disband the Crop Insurance (C) Working Group and Risk Retention (C) Working Group and move their charges under the Committee; and disband the Consumer Outreach and Assistance Post-Disaster (C) Subgroup; Catastrophe Response (C) Working Group; and Earthquake (C) Working Group and move their charges under the Catastrophe Insurance (C) Working Group.

2. Adopted its July 18 minutes, which included the following action:
   a. Adopted its June 8 minutes, which included the following action:
      i. Adopted its Spring National Meeting minutes.
      ii. Adopted a Request for Model Law Development related to travel insurance.
      iii. Adopted the Title Insurance Consumer Tool.
      iv. Heard an update from the Insurance Services Office (ISO) on private flood insurance products.
   b. Adopted a Request for Model Law Development related to lender-placed insurance.
   c. Heard a report on private flood insurance data collected through the NAIC Annual Statement.
   d. Discussed possible consolidation of Committee groups.

3. Adopted the following task force and working group reports: Casualty Actuarial and Statistical (C) Task Force; Surplus Lines (C) Task Force; Title Insurance (C) Task Force; Workers’ Compensation (C) Task Force; Advisory Organization Examination Oversight (C) Working Group; Auto Insurance (C/D) Working Group; Catastrophe Insurance (C) Working Group; Catastrophe Response (C) Working Group; Climate Change and Global Warming (C) Working Group; Creditor-Placed Insurance Model Act Review (C) Working Group; Crop Insurance (C) Working Group; Earthquake (C) Study Group; Medical Professional Liability (C) Working Group; Public Adjuster (C/D) Working Group; Risk Retention (C) Working Group; Sharing Economy (C) Working Group; Terrorism Insurance Implementation (C) Working Group; Transparency and Readability of Consumer Information (C) Working Group; and Travel Insurance (C) Working Group.

4. Adopted the Auto Insurance (C/D) Working Group’s proposal to collect data from statistical agents in order to study the personal auto insurance market.

5. Adopted an extension for revisions to the Creditor-Placed Insurance Model Act (#375).


7. Adopted new charges for the Casualty Actuarial and Statistical (C) Task Force to develop an actuarial qualifications attestation, clarify expectations of a 3-year experience requirement, and require actuarial recertification.

8. Heard a federal update including information on the reauthorization of the National Flood Insurance Program.

9. Heard from Commissioner David Altmaier (FL); Commissioner James J. Donelon (LA); and Commissioner Mike Chaney (MS) regarding activities related to the private market writing flood risk.

10. Heard industry updates related to private flood insurance from ISO, Lloyd’s, and NFS Edge Insurance Agency.

11. Heard a presentation on a new approach to consumer tools that incorporates technology and mobile devices.

12. Heard a presentation on mitigation discounts, including what states have done to encourage or mandate insurance policyholder discounts for mitigation efforts.
Explanation of the Document and Instructions for Use of Hyperlinks

This document is designed to be a “clickable” online document that leverages the reasons adults read—to learn answers to questions. After the first section, it is assumed that it will not be something consumers will read through from beginning to end. Instead, it is assumed they will go to the questions to which they want answers and in the order they want the information. Thus, some information is repeated in different sections of the document.

This document is intended to be used in individual states, and as such it is modifiable and there are sections that require state-specific information. Many of the state-specific inserts are simply the name of the state or name of the insurance department. There are two other state-specific inserts of great importance: 1) what is and is not included in the title insurance premium; and 2) whether insurers may compete with different title insurance rates or are required to use the same rates. States are not limited to the suggestions provided in the drafting notes and may modify the document to meet state specific requirements. The drafting notes are intended to call attention to some of the areas where a state may need to make modifications based on known variances that exist in the regulation of title insurance.

Since this is a Word document, the hyperlinks work by placing the cursor on the underlined, italicized, bold word or phrase, holding the Ctrl key, and right clicking the mouse, causing the cursor to move to the related text. You can return to the starting point by clicking the Undo button in Word or typing Ctrl Z. When created as a web page for Internet use, simply clicking on the link will move the user to the related text.
What Is Title Insurance?

Do I Have to Buy It? Do I Want to Buy It?

When you buy property (land or land with a building such as a home), the seller transfers the title to the property to you. Title to property means legal ownership of the property. Some problems with the title could prevent the seller from transferring the property title to a buyer or prevent a lender from issuing a mortgage loan.

Title insurance helps to make sure the seller can transfer the title to you. It also may help protect you if a problem with the title comes up after you buy or refinance property. Title insurance doesn’t guarantee there are no problems with a title. But it does guarantee that there are no problems with the title that would prevent a sale or refinance of the property.

If you borrow money to buy a property or if you refinance your mortgage, you have to buy a loan title policy because the lender requires it. You pay the premium once for each new loan title policy (also known as a lender’s title policy). This loan policy protects the lender. The loan policy stays in force as long as the mortgage loan exists.

You don’t have to buy an owner’s title policy when you buy a property, but this policy gives you protection above the protection of the loan title policy. You buy (and pay for) an owner’s policy once each time you buy a property, and it stays in force—keeps protecting you—for as long as you own the property.

Premium discounts may be available to lower your premium. The most common premium discount is a refinance or reissue discount. Ask your title agent or title insurer about discounts.

In [Input Name of State], [pick one from A and one from B]

A. 1. Title insurers may charge different premium rates. Shop to find the lowest premium.

A.2 Title insurers are required by the [department of insurance] to charge the same premium for the same loan and owner’s policies.

B.1. The premium you pay for title insurance in [insert state] does not cover title search or examination. You will be charged a separate fee for these services in addition to the premium charged for the title insurance.

B.2. The premium you pay for title insurance in [insert state] covers title search and examination as well as the title policy. There should not be a separate charge for title search or examination.

While your lender may require you to buy a loan title policy, you always have the right to choose the title agent and title insurance company. If your real estate agent, attorney, lender, home builder or other real estate professional tells you that you’re required to use a particular title agent or title insurer, that’s not true, and you should report this to [state insurance department] and the U.S. Consumer Financial Protection Bureau.

The [state insurance department] and the U.S. Consumer Financial Protection Bureau have more information about title insurance. They also will take your complaint if you feel you haven’t been treated fairly.

With title insurance, you get a title search, a title commitment and a title insurance policy. In a title search, the title agent or title insurance company searches public records for any problems with the title, such as someone other than the seller having a legal right to the property.

The title commitment is the insurance company’s promise to issue a title insurance policy under certain conditions. The title insurance policy is the title insurance company’s promise to try to fix some problems missed during the title search or to pay your lender or you if the title problems can’t be fixed. Remember, a title insurance policy doesn’t guarantee there are no problems with a title but that there are no problems with the title that would prevent a sale or refinance of the property.
There is more information on each of these topics:

What is title insurance?

Does my homeowners insurance cover title problems?

What is the difference between a clean title and a marketable title?

What is a title search? Why is it important?

What is a title commitment? Why is it important?

What if a title search finds a problem with a title?

Are there title insurance policies that cover title problems that can’t be fixed?

What is a title exception?

Can the title agent or title insurer remove title exceptions?

Are there title insurance policies that cover problems that happen after I buy a property or refinance a mortgage? What is an extended coverage title policy? What’s an endorsement on a title insurance policy?

What happens if I file a title insurance claim?

Can I sue the title insurer for not paying a claim? What is mandatory arbitration?

What’s a loan title insurance policy? What’s a lender’s title insurance policy? Do I have to buy it? Do I have to buy title insurance if I have a mortgage or refinance a mortgage? Why do I have to buy title insurance?

How does a loan title insurance policy protect me?

What is owner’s title insurance? Do I have to buy it?

Why do I need an owner’s title policy if I have a loan title policy?

Are there different types of owner’s title policies? What are the differences and what do they cost?

What should I watch for when I shop for title insurance? What is an affiliated business arrangement? Why am I getting a notice about an affiliated business arrangement?

Do all title insurance agents and companies charge the same premium?

Are there discounts for title insurance?

How many times do I have to pay for title insurance?

What does it mean if the title insurance agent also provides settlement (or closing) services?

What does the title insurance premium cover in [State]?

How do I shop for title insurance? Where do I find a title agent or title insurer?

Can I choose the title agent and title insurer for a loan policy, or does the lender choose?

How can I learn about any consumer complaints or regulator actions against a title insurance agent or company for unfair or illegal practices? How can I file a complaint against a title insurance agent or company?

How can I learn more about title insurance?
What if I have a complaint about title insurance?

What is title insurance?

When you buy property (land or land with a building such as a home), the seller transfers the title to the property to you. **Title** to property means legal ownership of the property. Some problems with the title could prevent the seller from transferring the property title to a buyer or prevent a lender from issuing a mortgage loan.

**Title insurance** helps to make sure the seller can transfer a title to you. It also may help protect you if a problem with the title comes up after you buy or refinance a property. Title insurance doesn’t guarantee there are no problems with a title. But it does guarantee that there are no problems with the title that would prevent a sale or refinance of a property.

The **title insurance policy** is the title insurance company’s promise to try to fix some problems missed during the title search or to pay your lender or you if the title problems can’t be fixed.

If you borrow money to buy property or if you refinance your mortgage, you have to buy a **loan title policy** because the lender requires it. You pay the premium once for each new **loan title policy** (also known as a **lender's title policy**). This loan policy protects the lender. The loan policy stays in force as long as the mortgage loan exists.

You don’t have to buy an **owner's title policy** when you buy a property, but this policy gives you protection above the protection of the loan title policy. You buy (and pay for) an owner’s policy once each time you buy a property, and it stays in force—keeps protecting you—for as long as you own the property.

Premium **discounts** may be available to lower your premium. The most common premium discount is a **refinance or reissue discount**. Ask your title agent or title insurer about discounts.

Does my homeowners insurance cover title problems?

No.

What’s the difference between a clean title and a marketable title?

Clean or clear title means ownership of the property with no other legal claims on the property. Title insurance doesn’t guarantee there are no legal claims on the property. Instead, title insurance guarantees a marketable title—one that has no legal claims on the property that would prevent the seller from transferring the property title or a lender from financing (or refinancing) the property.

What is a title search? Why is it important?

The path to title insurance includes a title search, a title commitment and a title insurance policy. In a **title search**, the title agent or title insurance company searches public records for any problems with the title, such as someone other than the seller having a legal right to the property. Most title problems found in a search must be fixed before an insurer will issue a title insurance policy. Some things that can create a title problem are:

- Someone other than the seller (for a purchase) or you (for a refinance) has a legal right to the property. An example might be a building contractor who wasn’t paid and has a legal hold on the property until he or she is paid what’s owed (a **mechanic’s lien**).
- A tax lien for unpaid taxes.
- A mistake in the land records that could mean that land you thought was part of the property isn’t.

A title search is important because certain problems with a title would mean a seller couldn’t legally transfer the title, and a lender wouldn’t lend you money to buy the property. The title search is important to you because you don’t want title problems after you buy the property.
**What is a title commitment? Why is it important?**

Once a title search is finished, you’ll get a title commitment. The title commitment is the insurance company’s promise to issue a title insurance policy under certain conditions. This document is the insurer’s offer to write a policy if you pay the premium. It lists possible problems with the title—problems that title insurance will not cover and that may need to be fixed before the lender will lend you money to buy the property. One such problem is a mechanic’s lien. An example of a mechanic’s lien would be if the seller didn’t pay a contractor who made renovations to the property, and the contractor put a legal hold—a mechanic’s lien—on the property until he or she is paid what’s owed.

The title commitment also lists problems the title insurance won’t cover. For example, if property doesn’t have access to a street, the title commitment would show that and that the title insurance policy doesn’t cover problems related to this.

You can (and should) review the title commitment before you buy a title insurance policy. A title commitment is important because it tells you what was found in the title search and what a title insurance policy will (and won’t) cover.

**What if a title search finds a problem with a title?**

A title search may find problems with the title that make it impossible for the seller to transfer the title to you or that make a lender unwilling to lend you money to buy the property. A title agent can fix most of these title problems. This is called curing the title or clearing the title. Often, the title problem is an unpaid bill to a contractor or a government office. The title agent will work with the seller (in a property purchase) or you (in a property refinance) to get the bill paid. Sometimes a title problem can’t be fixed, and the title insurance company won’t issue a title policy or will only issue a title policy that doesn’t cover that problem. A title exception is something a standard title insurance policy doesn’t cover. An example is an easement, such as a utility company’s right to use your property for specific purposes.

**Are there title insurance policies that cover title problems that can’t be fixed?**

Yes. Extended coverage policies—sometimes called the homeowner’s title insurance policy—will cover title problems that can’t be fixed before the purchase or refinance. For example, the extended coverage policy will cover some title problems that happen after the policy is issued.

**Can the title agent or title insurer remove title exceptions?**

A title exception is something a standard title insurance policy doesn’t cover. Title exceptions are typically for problems not recorded (or documented) in the public records the title agent or insurance company searched. Examples include easements, boundary disputes, and mechanic’s liens or taxes owed but not shown in the public record. When you get your title commitment, ask your title agent if there are title exceptions to understand what the policy won’t cover.

**Are there title insurance policies that cover problems that happen after I buy or refinance a property? What is an extended coverage title policy? What’s an endorsement on a title insurance policy?**

All title insurance policies cover problems with a title that happened before you bought or refinanced the property. But there are policies that will cover some problems that happen after you buy or refinance a property. Ask about an extended coverage policy. An extended coverage title policy can cover problems a standard title policy doesn’t. For example, suppose your local government changes the laws that define how you can use your property (often called permissible uses) after you buy or refinance a property.
An extended coverage policy could cover that problem when most title insurance wouldn’t. An extended coverage policy lists the coverages it adds to the standard title insurance policy.

You also can ask about endorsements. Each endorsement on your title insurance policy adds specific coverage to the standard title insurance policy. An example of an endorsement might be one that would cover you if you learn that your home is actually across the property line and you are forced to remove that portion of the building.

You’ll almost always see endorsements on a loan title insurance policy. Ask what they cover, why they were added, how much they add to the cost of the policy and if they’re required. You may have no choice but to pay for the endorsements on a loan policy.

**DRAFTING NOTE:** Modify the response above if extended coverage policies are not available in your state.

**What happens if I file a title insurance claim?**

Title insurance guarantees there are no problems with the title that would keep you from transferring title or financing (or refinancing) a mortgage. If you have title insurance and a problem with the title comes up after you buy or refinance the property, you can file a claim. After you file a claim, the title insurer will try to fix the problem (if the policy covers the problem). But, title insurers don't guarantee they can fix your title. Sometimes titles can’t be fixed. If the title insurer can’t fix the problem, it will pay the lender (if you have a mortgage) and/or pay you (if you have an owner’s policy) up to the amount of the loss. The claim payment won’t be more than the amount of coverage in the policy.

**Can I sue the title insurer for not paying a claim? What is mandatory arbitration?**

If there’s a problem with your title and you file a claim, the title insurance company may not pay your claim. For example, an insurer might not pay a claim because the insurer determines the policy doesn’t cover the problem. You may not agree with the title insurance company’s decision to deny the claim. You could ask your state insurance department for help. But, if all attempts to get your claim paid fail, you may be able to go to court to enforce your rights under the title insurance policy unless your policy has a mandatory arbitration provision.

Some title insurance policies replace your right to go to court to settle a dispute with the title insurer with a requirement to use mandatory binding arbitration. Mandatory binding arbitration means that any dispute must go to arbitration, and the decision of the arbitrator is final. Going to arbitration is very different from going to court. Typically, the insurance company picks the arbitrator, and you can’t appeal the ruling of the arbitrator.

You may reject the mandatory arbitration provision in a title insurance policy, but you may have to pay a higher premium to do that.

**DRAFTING NOTE:** Modify the response above if mandatory arbitration is not allowed in your state.

**What’s a loan title insurance policy? What’s a lender’s title insurance policy? Do I have to buy it? Do I have to buy title insurance if I have a mortgage or refinance a mortgage? Why do I have to buy title insurance?**

A loan policy (sometimes called a lender’s policy) is a title insurance policy that protects the lender’s interest in the property. The amount of coverage required is the same as the amount of the mortgage (the amount you borrowed to buy or refinance the property).

Lenders probably will require you to buy a loan policy when you apply for a mortgage to buy a property or refinance a property you already own.

Even though the lender requires you to buy a loan policy and the policy protects the lender, you pay for the policy. You only pay for the policy once (when you buy it), and the lender is covered until the mortgage is paid. The amount of coverage goes down as you pay down the mortgage.

You have the right to shop for and choose the title agent and title insurer for a loan policy. You don’t have to use the title agent or insurer your real estate agent, mortgage lender, builder, attorney or other real estate professional recommends.
How does a loan title insurance policy protect me?

A loan title insurance policy protects the lender—not you. But your lender probably won’t give you a mortgage to buy the property unless you buy a loan title insurance policy.

What is an owner’s title insurance policy? Do I have to buy it?

An owner’s title insurance policy protects you if there’s a problem with the title after you buy the property. The coverage is for the full price you paid for the property plus legal costs.

You don’t have to buy an owner’s title policy, but it can protect you.

Title insurance policies and coverages vary; ask questions when you shop.

Some important things to know about owner’s title insurance:

- You buy and pay for it only once. You’re covered as long as you own your property for title problems that happened before you bought or refinanced the property. If a problem the policy covers comes up after you sell the property, you may be covered for that too.
- The coverage in an owner’s title policy won’t increase as the value of your property increases over time—unless you get an endorsement to cover that increase in value.
- Defending your title can be expensive if there’s a problem. If your owner’s title policy covers the problem, the policy also will cover those legal defense costs.
- You have the right to shop for and choose the title agent and insurer you want. You don’t have to use the title agent or insurer your real estate agent, mortgage lender, builder, attorney or other real estate professional recommends.

Why do I need an owner’s title policy if I have a loan title policy?

An owner’s title insurance policy protects you if there’s a problem with the title after you buy the property. The coverage is for the full price you paid for the property plus legal costs.

A loan policy protects the lender, not you. But you probably can’t get financing for your property unless you buy a loan title insurance policy.

Are there different types of owner’s title policies? What are the differences, and what do they cost?

Yes. There’s a standard owner’s title policy and an extended coverage owner’s policy, often called a homeowner’s title policy. The extended coverage owner’s policy gives you more protection, including coverage for some problems that happen after the policy is issued. Also, the coverage amounts in an extended coverage owner’s policy increase over time with inflation. You can compare the differences at [insert link].

DRAFTING NOTE: Delete the last sentence of the paragraph above if no comparison tool is available in your state. If a comparison tool is available in your state, insert the link to the tool in the last sentence of the paragraph above.

What should I watch for when I shop for title insurance? What is an affiliated business arrangement? Why am I getting a notice about an affiliated business arrangement?

A real estate agent, lender or other real estate professional may recommend that you use a particular title agent or insurer for title insurance and closing services. Or they may assume that you’ll use a particular company without asking you. Both are called a referral.

Professionals may make a referral based on good service or lower costs in the past. Or they may make a referral because they have a formal relationship with a title insurance company or agent. If the professional will make money for the referral because of a formal relationship, this is called an “affiliated business arrangement” or “AfBA.” In that case, the professional who made the referral is required to tell you about the relationship. The law requires that you should get a separate written notice called a disclosure about the relationship.

Remember that whoever pays for the title insurance is allowed to choose where and from whom to buy the insurance.
Ask questions if a professional who recommends a particular title agent or title insurer makes statements such as these if you tell them that you want to find your own title insurance agent or company:

“If you choose another title agent, your closing may be delayed.”

“Everyone charges the same price.”

“We’ll give you a discount on [something else] but only if you use our title agent.”

If you're told any of these things or you feel pressured to use a specific company or agent, contact the state insurance department [insert state insurance department website link] or the U.S. Consumer Financial Protection Bureau (www.consumerfinance.gov/complaint/).

Do all title insurance agents and companies charge the same premium?

**DRAFTING NOTE:** Choose Version 1 or Version 2, depending on the situation in your state. Insert the appropriate regulator terminology as needed for [regulator of insurance].

**VERSION 1:** Yes. In [state], the [regulator of insurance] sets title insurance rates. Every title insurance company will charge you the same premium. But, the title insurer could charge you for other title and closing services (link to below). So you should shop around for title and closing services.

**DRAFTING NOTE:** Add the following sentence in states with title insurance premium calculators.

You can check the premium for title insurance by using the title insurance premium calculator at [insert state insurance department website link].

**VERSION 2:** No. In [state], title insurers can compete on price. So you should shop around to compare title insurance premiums. Be sure to ask what title and closing activities (link to below) the title insurance premium covers and doesn’t cover. Shop around for the best price and service.

**DRAFTING NOTE:** Add the following sentence in states with title insurance price tools.

Our insurance department has a tool to compare title insurance prices at [insert link to insurance department price tools].

Are there discounts for title insurance?

Yes. Ask about discounts that might reduce the title insurance premium. For example, you may get a discount if you refinance or sell your property within a few years of a recent title search. Ask your title insurance agent about a **reissue or refinance discount**.

**DRAFTING NOTE:** In states where a simultaneous issue discount is available, insert the following after “refinance discount.” “Also, if you buy a loan policy and an owner’s policy at the same time, expect a discount on one of the policies. Ask how much the discount will be.”

How many times do I have to pay for title insurance?

You pay only one **premium** for the lifetime of a title insurance policy. You pay a premium each time you buy a new loan title policy when you refinance, but only once for an owner’s title policy when you buy a property.

What does it mean if the title insurance agent also provides settlement (or closing) services?

Settlement (or closing) services include preparing documents related to buying/selling or refinancing and arranging for and witnessing when documents are signed.

**DRAFTING NOTE:** Include the following sentence in states in which settlement (or closing) services are not included in the title insurance premium.

Settlement (or closing) services fees are not included in the title insurance premium.
Some settlement (or closing) services fees are:

- Escrow fee – To accept, hold and pay money related to the closing.
- Document prep fee – To draft legal documents.
- Overnight fee – To send documents to/from buyers/borrowers/sellers/other involved parties who aren’t local, such as to pay off mortgages and send loan documents back to the lender.
- Recording and handling fee – To organize, send and track documents to the public records recording office.

Remember, you have the right to shop around for all of these services.

What does the title insurance premium cover in [State]?

The services included in the title insurance premium are different in each state. The services that a title insurance premium covers in [State] are:

DRAFTING NOTE: States should complete the list below by adding other services and a description.

- **Title Search** – Searching for information about who has the title to the property.
- **Title Examination** – Looking at (examining) the title information for problems.
- **Title Insurance** – The title insurer’s promise to protect you (and/or the lender) if there’s a problem with the title.

DRAFTING NOTE: States should complete the statement below.

In [insert state], a title agent, title insurer, attorney or other professional may charge a separate fee for [insert non-included activities and descriptions].

Can I choose the title agent and title insurer, or does the lender choose?

Whoever pays for the insurance is allowed to choose where and from whom to buy the insurance. You have that right even for a loan policy that protects the lender.

How do I shop for title insurance? Where do I find a title agent or title insurer?

- Use online shopping tools to help you compare companies.

DRAFTING NOTE: Include (and modify as needed) the following sentence if the state insurance department’s website has a list of title agents and/or title insurers on its website and/or information about title insurance: Visit your state insurance department website at [insert state insurance department website link] for [insert customized list of tools and information available on state site].

- Ask someone you trust, such as a friend or relative, with recent home buying or refinancing experience.
- Search the Internet for “title insurance” or “title agent,” and add your city or state.
- Ask your real estate agent or attorney for the names of title agents. Also ask if they will make money to recommend a particular title agent or title insurer.
- Most states have an association of title agents and title insurers (a trade association). Check out their web page for a list of members. You can find your state here (www.alta.org/consumer/index.cfm). Remember, trade associations aren’t government agencies, and not all title agents and title insurers belong to them.

Can I choose the title agent and title insurer for a loan policy, or does the lender choose?

Yes, you choose. While your lender may require you to buy a loan title policy, you always have the right to choose the title agent and title insurance company.
How can I learn about any consumer complaints or regulator actions against a title insurance agent or company for unfair or illegal practices? How can I file a complaint against a title insurance agent or company?

DRAFTING NOTE: States that do not post information about complaints and/or enforcement actions and market conduct exams on their departmental website should omit the next sentence(s).

Our state insurance department has information about complaints. Visit our website at [insert state insurance department website link].

You can search our insurance department’s website for enforcement actions and market conduct examinations (an insurance department review of the insurance company’s compliance with state laws).

You can file a complaint against a title insurer or agent at [insert state insurance department website link].

The U.S. Consumer Financial Protection Bureau (CFPB) accepts consumer complaints. You can search the complaint database for your title insurance agent or insurer at www.consumerfinance.gov/complaintdatabase/.

You’ll also find enforcement actions by the CFPB that involve title agents, title insurers and other real estate professionals at www.consumerfinance.gov/policy-compliance/enforcement/actions/.


How can I learn more about title insurance?

State insurance departments regulate title agents and insurers, so visit our website at [insert state insurance department website link].

You can learn more about the entire process of buying a home and getting a mortgage from the “Know Before You Owe” tool from the U.S. Consumer Financial Protection Bureau (CFPB) at www.consumerfinance.gov/know-before-you-owe/. You can learn more about title insurance at www.consumerfinance.gov/askcfpb/164/what-is-owners-title-insurance.html.

You also can learn more from title agents, title insurers and their trade associations. The American Land Title Association (ALTA) has information for consumers at www.alta.org/consumer/index.cfm. ATLA may have a list of title insurance agents and insurers near you. Remember, ALTA isn’t a government agency.

What if I have a complaint about title insurance?

If you believe you’ve been treated unfairly, contact our insurance department at [insert state insurance department website link] to file a complaint.

You also can file a complaint with the U.S. Consumer Financial Protection Bureau (CFPB) at www.consumerfinance.gov/complaint/
PROJECT HISTORY

TITLE INSURANCE CONSUMER SHOPPING TOOL

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

The Title Insurance Consumer Shopping Tools (C) Working Group was charged to develop a title insurance tool for consumers based on the information contained in the Title Insurance Consumer Shopping Tool that was developed by this group and adopted by the Executive (EX) Committee and Plenary at the 2015 Fall National Meeting. It was the opinion of the consumer representatives that unbiased, comprehensive title insurance information was not widely available to consumers. The Working Group set out to condense the content developed in its initial shopping tool into a concise web-based format.

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

The Title Insurance Consumer Shopping Tools (C) Working Group was responsible for drafting the title insurance tool.

Participating States: Colorado; Indiana; Kansas; Louisiana; Maryland; Missouri; New Mexico; Ohio; Texas; and Utah.

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

Charge: Develop a title insurance tool for consumers based on the information contained in the Title Insurance Consumer Shopping Tool template adopted by the Property and Casualty Insurance (C) Committee at the 2015 Summer National Meeting.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The title insurance consumer tool was drafted by the full Working Group with input from interested regulators and interested parties.

Interested Regulators: Amanda Gibson (AR); Jeffrey Joseph, Matthew Guy, Joel Meyer and Kelly Fleck (FL); Michael Draminski (MI); Wes Chance (MS); Shane Mattheis (SD); Mike Beavers (VA); Fritz Denzer (WA); and Donna Stewart (WY).

Interested Parties: American Land Title Association; Center for Economic Justice; Brenda Cude (NAIC Consumer Representative); and Wells Fargo Home Mortgage.

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 Working Group met via conference call to hear comments and draft the title insurance consumer tool on the following days: March 21, 2017; Jan. 25, 2017; Aug. 11, 2016; June 2, 2016; and March 28, 2016. During its March 21, 2017, conference call, the Working Group voted to adopt the title insurance tool in its current form.

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

Due to the state-specific nature of title insurance, the tool does not provide content that would be used on a national basis. Instead, the tool is intended to be a resource for the states to develop their own consumer information, and it includes drafting notes to call attention to areas that are subject to change according to state law and market practice. The tool is also presented in a question-and-answer format with hyperlinks to showcase how a state might post the information on its web page or in a mobile application.

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

Not applicable.

W:\National Meeting\2017\Summer\Plenary\12_C_Cmte_TitleInsuranceConsumerTool_PH.pdf

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

The Market Regulation and Consumer Affairs (D) Committee met Aug. 8, 2017. During this meeting, the Committee:

1. Adopted its July 20 meeting minutes, which included the following action:
   a. Adopted its Spring National Meeting minutes.
   b. Adopted the Lender-Placed Market Conduct Annual Statement (MCAS) Data Call and Definitions.
   c. Adopted revisions to the Health MCAS Data Call and Definitions.
   d. Adopted revisions to Chapter 18 of the *Market Regulation Handbook* to provide resources to insurance examiners on how to recognize whether affiliated business arrangements are operating in compliance with applicable state and federal law.
   e. Adopted revisions to Operations/Management Standard 2 of Chapter 21 of the *Market Regulation Handbook* to correspond with the updates to the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651).
   f. Received an update on the pilot program of the Voluntary Market Regulation Certification Program.

2. Adopted revisions to Chapter 13—Standardized Data Requests of the *Market Regulation Handbook* to provide guidance on the use of standardized data requests.

3. Adopted the following data requests for the life line of business: 1) claims standardized data request; 2) declinations standardized data request; 3) policy in force standardized data request; and 4) replacement standardized data request.

4. Adopted revised procedures for selecting new MCAS lines of business to clarify the Market Analysis Procedures (D) Working Group is no longer charged with the development of MCAS blanks but is still charged with considering recommendations for additional lines of business for the MCAS collection process.

5. Adopted revisions to the charge of the Pre-Dispute Mandatory Arbitration Clauses (D) Working Group to broaden the range of options available to the Working Group for addressing pre-dispute mandatory arbitration, choice-of-law and choice-of-venue clauses, and to allow different recommendations regarding personal and commercial lines of business.

6. Adopted the Auto Insurance (C/D) Study Group’s proposed data collection for the purpose of studying affordability and availability of private passenger automobile insurance.

7. Received an update on the activities of the International Association Insurance Supervisors (IAIS). Insurance Core Principle (ICP) 18 (Intermediaries) and ICP 19 (Conduct of Business) have been circulated for public consultation and will be discussed at the next IAIS Market Conduct Working Group meeting Sept. 21–22.

8. Discussed the potential consideration by the Executive (EX) Committee/Plenary to add the data element “Average Gross Placement Rate During Period” to the proposed Lender-Placed MCAS Data Call and Definitions.

9. Adopted the reports of its task forces and working groups: Antifraud (D) Task Force; Market Information Systems (D) Task Force; Producer Licensing (D) Task Force; Market Regulation Certification (D) Working Group; Market Conduct Examination Standards (D) Working Group; Market Actions (D) Working Group; Market Analysis Procedures (D) Working Group; Market Conduct Annual Statement (D) Working Group; Pre-Dispute Mandatory Arbitration Clauses (D) Working Group; Auto Insurance (C/D) Study Group; and Public Adjuster (C/D) Working Group.
Property & Casualty Market Conduct Annual Statement Lender-Placed

Data Call & Definitions

Lines of Business: Lender-Placed Auto and Lender-Placed Homeowners

Reporting Period: January 1, 2018 through December 31, 2018

Filing Deadline: June 30, 2019

Proposed filing deadlines are: 1st Year – June 30, 2019; Subsequent years – April 30

Contact Information

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCAS Administrator</td>
<td>The person responsible for assigning who may view and input company data.</td>
</tr>
<tr>
<td>MCAS Contact</td>
<td>The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.</td>
</tr>
<tr>
<td>MCAS Attestors</td>
<td>The person who attests to the completeness and accuracy of the MCAS data.</td>
</tr>
</tbody>
</table>

Interrogatories

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed auto coverage? (Y/N)</td>
<td>Comment (if necessary)</td>
</tr>
<tr>
<td>If Yes, enter the percentage of all lender-placed auto policies/certificates issued during the period which were single-interest lender-placed auto.</td>
<td></td>
</tr>
<tr>
<td>Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed auto coverage? (Y/N)</td>
<td>Comment (if necessary)</td>
</tr>
<tr>
<td>If Yes, enter the percentage of all lender-placed auto policies/certificates issued during the period which were dual-interest lender-placed auto.</td>
<td></td>
</tr>
<tr>
<td>Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners hazard coverage? (Y/N)</td>
<td>Comment (if necessary)</td>
</tr>
<tr>
<td>If Yes, enter the percentage of all lender-placed homeowners hazard policies/certificates issued during the period which were single-interest lender-placed homeowners hazard.</td>
<td></td>
</tr>
<tr>
<td>Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed homeowners hazard coverage? (Y/N)</td>
<td>Comment (if necessary)</td>
</tr>
<tr>
<td>If Yes, enter the percentage of all lender-placed homeowners hazard policies/certificates issued during the period which were dual-interest lender-placed homeowners hazard.</td>
<td></td>
</tr>
</tbody>
</table>
## Data Call & Definitions

<table>
<thead>
<tr>
<th>Question</th>
<th>Comment (if necessary)</th>
</tr>
</thead>
</table>
| Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners flood coverage? (Y/N)  
  If Yes, enter the percentage of all lender-placed homeowners flood policies/certificates issued during the period which were single-interest lender-placed homeowners flood. |                        |
| Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed homeowners flood coverage? (Y/N)  
  If Yes, enter the percentage of all lender-placed homeowners flood policies/certificates issued during the period which were dual-interest lender-placed homeowners flood. |                        |
| Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners wind-only coverage? (Y/N)  
  If Yes, enter the percentage of all lender-placed homeowners wind-only policies/certificates issued during the period which were single-interest lender-placed homeowners wind-only. |                        |
| Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed homeowners wind-only coverage? (Y/N)  
  If Yes, enter the percentage of all lender-placed homeowners wind-only policies/certificates issued during the period which were dual-interest lender-placed homeowners wind-only. |                        |
| Was the company still actively writing policies/certificates in the state at year end? (Y/N) |                        |
| Has the company had a significant event/business strategy that would affect data for this reporting period? (Y/N) (If yes, add additional comments) | Comment (if necessary) |
| Has this block of business or part of this block of business been sold, closed or moved to another company during the year? (Y/N) (If yes, add additional comments) | Comment (if necessary) |
| How does the company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? For example: Re-open original claim/open new claim | Comment |
| Does the company require third parties it contracts with to forward insurance-related complaints to the company so the company may report the complaints in its complaints logs? (Y/N) (Add additional comment if desired) | Comment (if necessary) |
| Does the company monitor third parties it contracts with to ensure insurance complaints are forwarded to the company? (Y/N) (Add additional comment if desired) | Comment (if necessary) |
## Data Call & Definitions

<table>
<thead>
<tr>
<th>Claims Comments</th>
<th>Comment (if necessary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underwriting Comments</td>
<td>Comment (if necessary)</td>
</tr>
</tbody>
</table>

## Coverages

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Indicator (State for which data is being submitted)</td>
<td>Automatically loaded</td>
</tr>
<tr>
<td>NAIC Company Code</td>
<td>Automatically loaded</td>
</tr>
<tr>
<td>NAIC Group Code</td>
<td>Automatically loaded</td>
</tr>
<tr>
<td>Coverage Identifier</td>
<td>Automatically loaded</td>
</tr>
<tr>
<td>Number of claims open at the beginning of the period</td>
<td></td>
</tr>
<tr>
<td>Number of claims opened during the period</td>
<td></td>
</tr>
<tr>
<td>Number of claims closed during the period, with payment</td>
<td></td>
</tr>
<tr>
<td>Number of claims closed during the period, without payment</td>
<td></td>
</tr>
<tr>
<td>Number of claims remaining open at the end of the period</td>
<td></td>
</tr>
<tr>
<td>Number of claims closed with payment within 0-30 days</td>
<td></td>
</tr>
<tr>
<td>Number of claims closed with payment within 31-60 days</td>
<td></td>
</tr>
<tr>
<td>Number of claims closed with payment within 61-90 days</td>
<td></td>
</tr>
<tr>
<td>Number of claims closed with payment within 91-180 days</td>
<td></td>
</tr>
<tr>
<td>Number of claims closed with payment within 181-365 days</td>
<td></td>
</tr>
<tr>
<td>Number of claims closed with payment beyond 365 days</td>
<td></td>
</tr>
<tr>
<td>Number of claims closed without payment within 0-30 days</td>
<td></td>
</tr>
<tr>
<td>Number of claims closed without payment within 31-60 days</td>
<td></td>
</tr>
<tr>
<td>Number of claims closed without payment within 61-90 days</td>
<td></td>
</tr>
<tr>
<td>Number of claims closed without payment within 91-180 days</td>
<td></td>
</tr>
</tbody>
</table>

## Lender-Placed Auto and Homeowners Claims Activity, Counts Reported by Claimant, by Coverage

Report the number of reserves/lines/features opened for each coverage part per claim.
### Property & Casualty Market Conduct Annual Statement Lender-Placed

#### Data Call & Definitions

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of claims closed without payment within 181-365 days</td>
</tr>
<tr>
<td>Number of claims closed without payment beyond 365 days</td>
</tr>
<tr>
<td>Median days to final payment</td>
</tr>
<tr>
<td>Number of suits open at beginning of the period</td>
</tr>
<tr>
<td>Number of suits opened during the period</td>
</tr>
<tr>
<td>Number of suits closed during the period</td>
</tr>
<tr>
<td>Number of suits closed during the period with consideration for the borrower</td>
</tr>
<tr>
<td>Number of suits open at end of the period</td>
</tr>
</tbody>
</table>

### Lender-Placed Auto and Home Underwriting Elements

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Indicator (State for which data is being submitted) Automatically loaded</td>
</tr>
<tr>
<td>NAIC Company Code Automatically loaded</td>
</tr>
<tr>
<td>NAIC Group Code Automatically loaded</td>
</tr>
<tr>
<td>Coverage Identifier Automatically loaded</td>
</tr>
<tr>
<td>Number of master policies in-force at beginning of the period</td>
</tr>
<tr>
<td>Number of master policies added during the period</td>
</tr>
<tr>
<td>Number of master policies canceled for any reason during the period</td>
</tr>
<tr>
<td>Number of master policies in-force at the end of the period</td>
</tr>
<tr>
<td>Number of certificates in-force at the beginning of the period</td>
</tr>
<tr>
<td>Number of certificates written during the period</td>
</tr>
<tr>
<td>Number of certificates in-force at the end of the period</td>
</tr>
<tr>
<td>Number of certificates flat-cancelled during the period</td>
</tr>
<tr>
<td>Number of certificates cancelled for reasons other than flat cancellations during the period</td>
</tr>
<tr>
<td>Number of flat cancellations on certificates within 45 days of placement</td>
</tr>
<tr>
<td>Number of flat cancellations on certificates within 45-90 days of placement</td>
</tr>
<tr>
<td>Number of flat cancellations on certificates after 90 days from placement</td>
</tr>
<tr>
<td>Number of individual policies in-force at the beginning of the period</td>
</tr>
<tr>
<td>Number of individual policies written during the period</td>
</tr>
<tr>
<td>Number of individual policies in-force at the end of the period</td>
</tr>
<tr>
<td>Number of individual policies cancelled for reasons other than flat cancellations during the period</td>
</tr>
<tr>
<td>Number of individual policies flat-cancelled during the period</td>
</tr>
<tr>
<td>Number of flat cancellations on individual policies within 45 days of placement</td>
</tr>
<tr>
<td>Number of flat cancellations on individual policies within 45-90 days of placement</td>
</tr>
<tr>
<td>Number of flat cancellations on individual policies after 90 days from placement</td>
</tr>
</tbody>
</table>
## Property & Casualty Market Conduct Annual Statement Lender-Placed

### Data Call & Definitions

<table>
<thead>
<tr>
<th>Description</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dollar amount of gross written premium during the period</td>
<td>Dollar amount of gross written premium during the period</td>
</tr>
<tr>
<td>Dollar amount of net written premium during the period</td>
<td>Net written premium during period for policies/certificates for which no separate charge is made to the borrower</td>
</tr>
<tr>
<td>Dollar amount of premium earned during the period</td>
<td>Dollars of claims paid during the period</td>
</tr>
<tr>
<td>Dollars of claims incurred during the period</td>
<td>Number of complaints received directly from the DOI</td>
</tr>
<tr>
<td>Number of complaints received directly from any person or entity other than the DOI</td>
<td>Number of complaints received directly from any person or entity other than the DOI</td>
</tr>
</tbody>
</table>

### Participation Requirements:

All companies licensed and reporting at least $50,000 of lender-placed auto or $50,000 of lender-placed homeowners (hazard, wind-only and flood collectively) gross premium within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

### Definitions:

Lender-placed insurance has the same meaning as “Creditor-placed insurance” to be reported in the Credit Insurance Experience Exhibit (CIEE) of the Statutory Annual Statement. Lender-placed insurance means insurance that is purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss, expense or damage to the property as a result of fire, theft, collision or other risk of loss that would either impair a creditor’s interest or adversely affect the value of collateral.

Except for data element “Net premium written during period for policies/certificates for which no separate charge is made to the borrower,” report experience for lender-placed insurance products for which a separate charge is made to the borrower regardless of whether the charge to the borrower is made at loan origination, periodically while the loan is outstanding or following issuance of coverage under the master policy.

Lender-placed auto has the same meaning as “creditor-placed auto” to be reported in the CIEE. Lender-placed auto means lender-placed insurance on autos, boats or other vehicles.

Lender-placed homeowners has the same means as “creditor-placed homeowners” to be reported in the CIEE. Lender-placed homeowners means lender-placed insurance on homes, mobile homes and other real estate.

In determining what business to report for a particular state, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the CIEE. Specifically, the business to be reported is the direct business of the reporting company. Reinsurance ceded is not deducted and reinsurance assumed is not included.
Property & Casualty Market Conduct Annual Statement Lender-Placed

Data Call & Definitions

Lender-placed homeowners hazard means that portion of lender-placed homeowners required to be reported in the CIEE covering perils other than flood or wind-only (in those states in which insurers may exclude wind coverage).

Lender-placed homeowners flood means that portion of lender-placed homeowners required to be reported in the CIEE covering the peril of flood only.

Lender-placed wind-only means that portion of lender-placed homeowners required to be reported in the CIEE covering the peril of wind only.

Single-interest means insurance that protects only the creditor’s interest in the collateral securing the debtor’s credit.

Dual-interest means insurance that protects the creditor’s and the debtor’s interest in the collateral securing the debtor’s credit transaction. Dual-interest includes insurance commonly referred to as limited dual-interest.

Cancellations – Includes all cancellations of the policies/certificates where the cancellation was executed during the reporting year regardless of the date of placement of the coverage. See also Flat Cancellation

Certificate – Lender-placed insurance issued under a master policy for an individual vehicle or property, respectively.

Example:
• If the insurer issues 300 certificates under a lender-placed master policy or policies, report 300.

Claim – A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy/certificate. Each claimant/insured reporting a loss is counted separately.

Include:
• Both first and third party claims.

Exclude:
• An event reported for “information only”.
• An inquiry of coverage if a claim has not actually been presented (opened) for payment.
• A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.

Claims Closed With Payment – Claims closed with payment where the claim was closed during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported or between the date of the final payment and the date the request for supplemental payment was received. See also “Date of Final Payment”.

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Property & Casualty Market Conduct Annual Statement Lender-Placed

Data Call & Definitions

Exclude:

- Claims where payment was made for company loss adjustment expenses if no payment was made to an insured/claimant.
- Claims that are closed because the amount claimed is below the insured’s deductible.

Clarifications:

- If a claim is reopened for the sole purpose of refunding the insured’s deductible, do not count it as a paid claim.
- For claims where the net payment is $0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims.

Calculation Clarification:

- For each coverage identifier, the sum of the claims settled with payment across each closing time interval should equal the total number of claims closed with payment during the reporting period.

Handling additional payment on previously reported claim/subsequent supplemental payment for claims closed with payment during the reporting period:

- If a claim is reopened for a subsequent supplemental payment, count the reopened claim as a new claim. Calculate a separate aging on the supplemental payment from the time the request for supplemental payment was received to the date the final payment was made.

Claims Closed Without Payment – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported and/or reopened. See also “Date of Final Payment”.

Include:

- All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
- Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.
- A demand for payment for which it was determined that no relevant policy/certificate was in-force at the time of the loss if a claim file was set up and the loss was investigated.
- Claims that are closed because the amount claimed is below the insured’s deductible.

Complaints Received Directly from any Person or Entity Other than the Department of Insurance – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state’s insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.
Property & Casualty Market Conduct Annual Statement Lender-Placed

Data Call & Definitions

Include:
- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
- Complaints received from third parties, including, but not limited to, lenders or servicers

Complaints Received Directly from the Department of Insurance - All complaints:
- As identified by the DOI as a complaint.
- Related to LPI or insurance tracking.
- Sent or otherwise forwarded by the DOI to the reporting company.

Date of Final Payment - The date final payment was issued to the insured/claimant.
Calculation Clarification:
- If partial payments were made on the claim, the claim would be considered closed with payment if the final payment was made during the reporting period regardless of the date of loss or when the claim was received.
- Report a claim as “closed with payment” or “closed without payment” if it is closed in the company’s claims system during the reporting period (even if the final payment was issued in a prior reporting period.)
- If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company’s claims system, would you report the days to final payment.

Example:
- A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
  - The claim would be reported as open in the “00” MCAS submission and closed in the “01” MCAS submission.
  - The number of days to final payment would be calculated as 30 days and reported in the “01” MCAS submission.

Date the Claim was Reported - The date an insured or claimant first reported his or her claim to either the company or insurance agent.

Dollars of Claims Incurred During Period - The total dollars incurred for claims for the particular type of lender-placed insurance during the period. Include incurred claim dollars only for lender-placed insurance for which a separate charge is made to the borrower.

Dollars of Claims Paid During Period - The total dollars paid for claims for the particular type of lender-placed insurance during the period. Include paid claim dollars only for lender-placed insurance for which a separate charge is made to the borrower.

Flat Cancellation - The coverage was cancelled effective the date of coverage with 100% refund of premium.
Property & Casualty Market Conduct Annual Statement Lender-Placed

Data Call & Definitions

Gross Premium Written During Period - The total premium written before any reductions for refunds for the particular type of lender-placed insurance during the reporting period. Include premium only for lender-placed insurance for which a separate charge is made to the borrower.

In-force - A master policy, individual policy, or certificate in effect during the reporting period.

Individual Policy - Lender-placed insurance issued for an individual vehicle or property, respectively.

Example:
- If the insurer issues 300 lender-placed policies for individual vehicles or properties (as opposed to issuing master policies to lenders or servicers), report 300.

Lawsuit - An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits in the MCAS blank:
- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer - A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting company before the lawsuit was brought.

Master Policy - A group policy providing coverage for the vehicles or property serving as collateral for a portfolio of loans. Individual coverage, typically in the form of a certificate, is issued from the Master Policy at the direction of the lender/servicer or automatically at the point in time when the borrower’s required voluntary insurance ceases to be in-force.
**Property & Casualty Market Conduct Annual Statement Lender-Placed**

**Data Call & Definitions**

**Median Days to Final Payment** - The median value for all claims closed with payment during the period.

Calculation for claims with one final payment date during the reporting period:
- Date the claim was reported to the company to the date of final payment.

Calculation for claims with multiple final payment dates during the reporting period:
- Date the request for supplemental payment was received to the date of final payment (for each different final payment date.)

Exclude:
- Subrogation payments.

Calculation Clarification / Example:
- To determine the Median Days to Final Payment you must first determine the number of days it took to settle each claim. This is the difference between the date the claim was reported to the company, or the date the request for supplemental payment was received, to the date of final payment. The Median Days to Final Payment is the median value of the number of days it took to settle all claims closed with payment during the period.

**Median** - A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

Consider the following simple example of the number of days it took to settle each of the following seven claims:

<table>
<thead>
<tr>
<th>Days to Settle</th>
<th>Nbr 1</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
<th>Nbr 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nbr 1</td>
<td>2</td>
<td></td>
<td></td>
<td>5</td>
<td></td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>Nbr 2</td>
<td></td>
<td>4</td>
<td></td>
<td></td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nbr 3</td>
<td></td>
<td></td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nbr 4</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nbr 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nbr 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Nbr 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20</td>
</tr>
</tbody>
</table>

In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, & 4) and 3 values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values as demonstrated below.

<table>
<thead>
<tr>
<th>Days to Settle</th>
<th>Nbr 1</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nbr 1</td>
<td>2</td>
<td></td>
<td></td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nbr 2</td>
<td></td>
<td>4</td>
<td></td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nbr 3</td>
<td></td>
<td></td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nbr 4</td>
<td></td>
<td></td>
<td></td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nbr 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Nbr 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20</td>
</tr>
</tbody>
</table>

Median Days to Final Payment = (5 + 6)/2 = 5.5

*The median should be consistent with the paid claim counts reported in the closing time intervals.*
Example: A carrier reports the following closing times for paid claims.

**Closing Time# of Claims**

<table>
<thead>
<tr>
<th>Closing Time</th>
<th># of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>22</td>
</tr>
<tr>
<td>31-60</td>
<td>13</td>
</tr>
<tr>
<td>61-90</td>
<td>18</td>
</tr>
<tr>
<td>91-180</td>
<td>11</td>
</tr>
<tr>
<td>181-365</td>
<td>12</td>
</tr>
<tr>
<td>&gt;365</td>
<td>15</td>
</tr>
</tbody>
</table>

The sum of the claims reported across each closing time interval is 91, so that the median is the 46th claim. This claim falls into the closing time interval “61-90 days.” Any reported median that falls outside of this range (i.e. less than 61 or greater than 90) will indicate a data error.

**NAIC Company Code** - The five-digit code assigned by the NAIC to all U.S. domiciled companies which filed a Financial Annual Statement with the NAIC.

**NAIC Group Code** - The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of a holding company.

**Net Premium Written During Period** - Gross premium written less refunds for the particular type of lender-placed insurance during the reporting period. Include premium only for lender-placed insurance for which a separate charge is made to the borrower.

**Net Premium Written During Period for Policies/Certificates for Which No Separate Charge is Made to the Borrower** - Gross premium written less refunds for the particular type of lender-placed insurance during the reporting period. Include premium only for lender-placed insurance for which no separate charge is made to the borrower.

**Premiums Earned During Period** - Earned premiums for the particular type of lender-placed insurance during the reporting period. Include premium only for lender-placed insurance for which a separate charge is made to the borrower.
Proposed Amendment

Lender-Placed Market Conduct Annual Statement (MCAS) Data Call and Definitions

Data Element: Average Gross Placement Rate During Period

Data Element Definition: Average Gross Placement Rate means the total number of coverages placed before cancellations during the reporting period divided by the average number exposures during the reporting period. Average number of exposures means the average number of vehicles covered by Lender Placed Auto policies or average number of properties covered by Lender Placed Home policies during the reporting period.
**Health Market Conduct Annual Statement**  
**Data Call & Definitions**

**Line of Business:** Health  
**Reporting Period:** January 1, 2018 through December 31, 2018  
**Filing Deadline:** May 31, 2019

**Contact Information**

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCAS Administrator</td>
<td>The person responsible for assigning who may view and input company data.</td>
</tr>
<tr>
<td>MCAS Contact</td>
<td>The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.</td>
</tr>
<tr>
<td>MCAS Attestor</td>
<td>The person who attests to the completeness and accuracy of the MCAS data.</td>
</tr>
</tbody>
</table>

**Interrogatories**

<table>
<thead>
<tr>
<th>In-exchange - Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report? (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-exchange - Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report? (Y/N)</td>
</tr>
<tr>
<td>In-exchange - Does the company have Catastrophic data to report? (Y/N)</td>
</tr>
<tr>
<td>In-exchange - Does the company have Multi-State (Individual) data to report? (Y/N)</td>
</tr>
<tr>
<td>In-exchange - Does the company have Multi-State (Small Group) data to report? (Y/N)</td>
</tr>
<tr>
<td>In-exchange - Number of small groups in-force at the end of the reporting period</td>
</tr>
<tr>
<td>In-exchange - Does the company have an additional voluntary level of review for grievances? (Y/N)</td>
</tr>
<tr>
<td>In-exchange Comments</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out-of-exchange - Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report? (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-exchange - Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report? (Y/N)</td>
</tr>
<tr>
<td>Out-of-exchange - Does the company have Grandfathered or Transitional plan data to report? (Y/N)</td>
</tr>
<tr>
<td>Out-of-exchange - Does the company have Catastrophic data to report? (Y/N)</td>
</tr>
</tbody>
</table>
### Health Market Conduct Annual Statement

#### Data Call & Definitions

<table>
<thead>
<tr>
<th>Question</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-exchange - Does the company have Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report? (Y/N)</td>
<td></td>
</tr>
<tr>
<td>Out-of-exchange - Does the company have Student Coverage data to report? (Y/N)</td>
<td></td>
</tr>
<tr>
<td>Out-of-exchange - Number of small groups in-force at the end of the reporting period</td>
<td></td>
</tr>
<tr>
<td>Out-of-exchange - Number of large groups in-force at the end of the reporting period</td>
<td></td>
</tr>
<tr>
<td>Out-of-exchange - Does the company have an additional voluntary level of review for grievances? (Y/N)</td>
<td></td>
</tr>
<tr>
<td>Out-of-exchange Comments</td>
<td>Comment (if necessary)</td>
</tr>
</tbody>
</table>
## Products

<table>
<thead>
<tr>
<th>Product Identifiers</th>
<th>Explanation of Product Identifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>IEIH</td>
<td>In-exchange Individual Health insurance coverage other than transitional, grandfathered, or multi-state policies</td>
</tr>
<tr>
<td>IESG</td>
<td>In-exchange Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies</td>
</tr>
<tr>
<td>IECA</td>
<td>In-exchange Catastrophic</td>
</tr>
<tr>
<td>IEMI</td>
<td>In-exchange Multi-State - Individual</td>
</tr>
<tr>
<td>IEMS</td>
<td>In-exchange Multi-State - Small Group</td>
</tr>
<tr>
<td>OEIH</td>
<td>Out-of-exchange Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic or student</td>
</tr>
<tr>
<td>OESG</td>
<td>Out-of-exchange Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies</td>
</tr>
<tr>
<td>OEGT</td>
<td>Out-of-exchange Grandfathered/ Transitional Plans</td>
</tr>
<tr>
<td>OECA</td>
<td>Out-of-exchange Catastrophic</td>
</tr>
<tr>
<td>OELG</td>
<td>Out-of-exchange Large Group comprehensive major medical and managed care (Minimum Essential Coverage) policies</td>
</tr>
<tr>
<td>OESC</td>
<td>Out-of-exchange Student Coverage</td>
</tr>
</tbody>
</table>

### Notes:

1) The following products are reported by metal level (Bronze, Silver, Gold and Platinum): IEIH, IESG, IEMI, IEMS, OEIH and OESG except for questions designated with *+. When designated with *, the products are reported in aggregate.

2) The OEGT product is reported with the following breakouts: Large Group, Small Group and Individual

3) Questions designated with + are not reported for the following products (Small Groups): IESG, IEMS, OESG and OEGT(Small Group Only).
# Health Market Conduct Annual Statement

## Data Call & Definitions

### Schedule 1 - Policy Administration

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Indicator (State for which data is being submitted)</td>
</tr>
<tr>
<td>NAIC Company Code</td>
</tr>
<tr>
<td>NAIC Group Code</td>
</tr>
<tr>
<td>Coverage Identifier</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Earned premiums for the reporting year</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Number of new policies issued during the period</td>
</tr>
<tr>
<td>+ Number of policies renewed during the period</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member months for policies issued during the period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member months for policies renewed during the period</td>
</tr>
</tbody>
</table>

| + Number of policy terminations and cancellations initiated by the consumer |
| + Number of policy terminations and cancellations due to non-payment of premium |

| Number of lives impacted on terminations and cancellations initiated by the policyholder |
| Number of lives impacted on policies terminated and cancelled due to non-payment |

| * Number of rescissions |
| Number of lives impacted by rescissions |

* - These data elements are not reported at the metal level. Instead they are reported in aggregate for the following products: IEIH, IESG, IEMI, IEMS, OEH, and OESG.

+ - These data elements are not reported for the following small group products: IESG, IEMS, OESG, and OEGT (Small Group Only).

### Schedule 2A - Prior Authorizations (Prospective Utilization Review Requests) - Excluding Pharmacy

| State Indicator (State for which data is being submitted) | Automatically loaded |
|----------------------------------------------------------|
| NAIC Company Code | Automatically loaded |
| NAIC Group Code | Automatically loaded |

| * Number of prior authorizations requested |
| * Number of prior authorizations approved |
| * Number of prior authorizations denied |

*Number of prior authorizations requested for mental health benefits, behavioral benefits, and substance use disorders

*Number of prior authorizations requested for mental health benefits, behavioral benefits, and substance use disorders denied
Health Market Conduct Annual Statement
Data Call & Definitions

Schedule 2B - Prior Authorizations (Prospective Utilization Review Requests) - Pharmacy Only

<table>
<thead>
<tr>
<th>State Indicator (State for which data is being submitted)</th>
<th>Automatically loaded</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAIC Company Code</td>
<td>Automatically loaded</td>
</tr>
<tr>
<td>NAIC Group Code</td>
<td>Automatically loaded</td>
</tr>
<tr>
<td>*Number of prior authorizations requested</td>
<td></td>
</tr>
<tr>
<td>*Number of prior authorizations approved</td>
<td></td>
</tr>
<tr>
<td>*Number of prior authorizations denied</td>
<td></td>
</tr>
</tbody>
</table>

* - These data elements are not reported at the metal level. Instead they are reported in aggregate for the following products: IEIH, IESG, IEMI, IEMS, OEIH and OESG.

Schedule 3 - Claims Administration (Excluding Pharmacy)

<table>
<thead>
<tr>
<th>State Indicator (State for which data is being submitted)</th>
<th>Automatically loaded</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAIC Company Code</td>
<td>Automatically loaded</td>
</tr>
<tr>
<td>NAIC Group Code</td>
<td>Automatically loaded</td>
</tr>
<tr>
<td>Number of claims received</td>
<td></td>
</tr>
<tr>
<td>Number of claims submitted by network providers</td>
<td></td>
</tr>
<tr>
<td>Number of claims submitted by out of network providers</td>
<td></td>
</tr>
<tr>
<td>Number of claim denials for in-network claims</td>
<td></td>
</tr>
<tr>
<td>In-network claims denied within 0-30 days</td>
<td></td>
</tr>
<tr>
<td>In-network Claims denied within 31-60 days</td>
<td></td>
</tr>
<tr>
<td>In-network Claims denied within 61-90 days</td>
<td></td>
</tr>
<tr>
<td>In-network Claims denied beyond 90 days</td>
<td></td>
</tr>
<tr>
<td>Number of in-network denied, rejected or returned - Claims Submission Coding Error(s)</td>
<td></td>
</tr>
<tr>
<td>Number of in-network denied, rejected or returned - Prior Authorization Needed</td>
<td></td>
</tr>
<tr>
<td>Number of in-network denied, rejected or returned - Non-Covered Benefit or Benefit Limitation</td>
<td></td>
</tr>
<tr>
<td>Number of in-network denied, rejected or returned - Not Medically Necessary (Excluding Behavioral Health Benefits)</td>
<td></td>
</tr>
<tr>
<td>Number of in-network denied, rejected or returned - Not Medically Necessary (Behavioral)</td>
<td></td>
</tr>
</tbody>
</table>
## Health Market Conduct Annual Statement
### Data Call & Definitions

<table>
<thead>
<tr>
<th><strong>Health Benefits Only)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of claim denials for out-of-network claims</td>
<td></td>
</tr>
<tr>
<td>Out-of-network claims denied within 0-30 days</td>
<td></td>
</tr>
<tr>
<td>Out-of-network Claims denied within 31-60 days</td>
<td></td>
</tr>
<tr>
<td>Out-of-network Claims denied within 61-90 days</td>
<td></td>
</tr>
<tr>
<td>Out-of-network Claims denied beyond 90 days</td>
<td></td>
</tr>
<tr>
<td><strong>Number of out-of-network denied, rejected or returned – Claims Submission Coding Error(s)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number of out-of-network denied, rejected or returned – Prior Authorization Needed</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number of out-of-network denied, rejected or returned – Non-Covered Benefit or Benefit Limitation</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number of out-of-network denied, rejected or returned – Not Medically Necessary (Excluding Behavioral Health Benefits)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number of out-of-network denied, rejected or returned – Not Medically Necessary (Behavioral Health Benefits Only)</strong></td>
<td></td>
</tr>
<tr>
<td>Number of paid claims for in-network services</td>
<td></td>
</tr>
<tr>
<td>In-network claims paid within 0-30 days</td>
<td></td>
</tr>
<tr>
<td>In-network claims paid within 31-60 days</td>
<td></td>
</tr>
<tr>
<td>In-network claims paid within 61-90 days</td>
<td></td>
</tr>
<tr>
<td>In-network claims paid beyond 90 days</td>
<td></td>
</tr>
<tr>
<td>Number of paid claims for out-of-network services</td>
<td></td>
</tr>
<tr>
<td>Out-of-network claims paid within 0-30 days</td>
<td></td>
</tr>
<tr>
<td>Out-of-network claims paid within 31-60 days</td>
<td></td>
</tr>
<tr>
<td>Out-of-network claims paid within 61-90 days</td>
<td></td>
</tr>
<tr>
<td>Out-of-network claims paid beyond 90 days</td>
<td></td>
</tr>
<tr>
<td>Claims paid</td>
<td></td>
</tr>
<tr>
<td>Insured/beneficiary co-payment responsibility</td>
<td></td>
</tr>
<tr>
<td>Insured coinsurance responsibility</td>
<td></td>
</tr>
<tr>
<td>Insured deductible responsibility</td>
<td></td>
</tr>
</tbody>
</table>
### Schedule 4 - Claims Administration (Pharmacy Only)

<table>
<thead>
<tr>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>State Indicator (State for which data is being submitted)</td>
<td>Automatically loaded</td>
</tr>
<tr>
<td>NAIC Company Code</td>
<td>Automatically loaded</td>
</tr>
<tr>
<td>NAIC Group Code</td>
<td>Automatically loaded</td>
</tr>
<tr>
<td>*Number of claims received</td>
<td></td>
</tr>
<tr>
<td>*Number of claim denials for in-network claims</td>
<td></td>
</tr>
<tr>
<td>*Number of claim denials for out-of-network claims</td>
<td></td>
</tr>
<tr>
<td>*Number of paid claims for in-network services</td>
<td></td>
</tr>
<tr>
<td>*Number of paid claims for out-of-network services</td>
<td></td>
</tr>
<tr>
<td>*Claims paid</td>
<td></td>
</tr>
<tr>
<td>*Insured/beneficiary co-payment responsibility</td>
<td></td>
</tr>
<tr>
<td>*Insured coinsurance responsibility</td>
<td></td>
</tr>
<tr>
<td>*Insured deductible responsibility</td>
<td></td>
</tr>
</tbody>
</table>

* - These data elements are not reported at the metal level. Instead they are reported in aggregate for the following products: IEIH, IESG, IEMI, IEMS, OEIH and OESG.

### Schedule 5 - Consumer Requested Internal Reviews (Grievances - Including Pharmacy)

<table>
<thead>
<tr>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>State Indicator (State for which data is being submitted)</td>
<td>Automatically loaded</td>
</tr>
<tr>
<td>NAIC Company Code</td>
<td>Automatically loaded</td>
</tr>
<tr>
<td>NAIC Group Code</td>
<td>Automatically loaded</td>
</tr>
<tr>
<td>Number of customer requests for internal reviews of grievances involving adverse determinations (Do not include additional voluntary levels of reviews.)</td>
<td></td>
</tr>
<tr>
<td>Number of adverse determinations upheld upon request for internal review (Do not include additional voluntary levels of reviews.)</td>
<td></td>
</tr>
<tr>
<td>Number of adverse determinations overturned upon request for internal review (Do not include additional voluntary levels of reviews.)</td>
<td></td>
</tr>
<tr>
<td>Number of customer requests for internal reviews of grievances not involving adverse determinations</td>
<td></td>
</tr>
</tbody>
</table>
### Schedule 6 - Consumer Requested External Reviews (Including Pharmacy)

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Indicator</td>
<td>(State for which data is being submitted) <strong>Automatically loaded</strong></td>
</tr>
<tr>
<td>NAIC Company Code</td>
<td><strong>Automatically loaded</strong></td>
</tr>
<tr>
<td>NAIC Group Code</td>
<td><strong>Automatically loaded</strong></td>
</tr>
<tr>
<td><em>Number of customer requested appeals on final adverse determinations to an external review organization</em></td>
<td></td>
</tr>
<tr>
<td><em>Number of final adverse determinations upheld upon request for external review</em></td>
<td></td>
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<tr>
<td><em>Number of final adverse determinations overturned upon request for external review</em></td>
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</tbody>
</table>

* - These data elements are not reported at the metal level. Instead they are reported in aggregate for the following products: IEIH, IESG, IEMI, IEMS, OEIH and OESG.

**Participation Requirements:** All companies licensed and reporting at least $50,000 of health earned premium for all coverages reportable in MCAS within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

**Report by Situs of Contract:** The allocation of premium and claims between jurisdictions should be based upon situs of the contract. For purpose of this exhibit, situs of the contract is defined as “the jurisdiction in which the contract is issued or delivered as stated in the contract.” For individual business sold through an association, the allocation shall be based on the issue state of the certificate of coverage. When the association is made up of employers, it should be reported as large group or small group depending on the size of each employer. For employer business issued through a group trust, the allocation shall be based on the location of each employer. For employer business issued through a multiple employer welfare association the allocation should be based on the location of each employer. (NAIC Annual Statement Instructions for the Supplemental Health Care Exhibit)
General Definitions:

**Exchange (Marketplace)** - 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.

**In-exchange** - Health insurance coverage acquired through the Exchange (marketplace) as described above.

**Out-of-exchange** - Health insurance coverage acquired outside the Exchange (marketplace) as described above.

**Health Insurance Coverage** - 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 & Medicaid Services (CMS) guidance nor is it intended to include self-funded plans.

**Metal Level (Bronze)** - Health insurance coverage 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.

**Metal Level (Silver)** - Health insurance coverage 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.

**Metal Level (Gold)** - 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.

**Metal Level (Platinum)** - 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.

**Catastrophic** - 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.

**Individual Health Insurance Coverage** - Health insurance coverage offered in the individual market, but does not include short-term limited duration insurance.

**Grandfathered Plan** - 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.

**Multi-State** - Health insurance coverage created by ACA operated under contract with The U.S. Office of Personnel Management (OPM) and available in multiple states.

**Small Group Health Insurance Coverage** - Health insurance coverage offered in the small group market.

**Student Coverage** - Individual health insurance coverage 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 health insurance coverage 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 health insurance coverage 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.

**Transitional Plan** - Plans that are issued pursuant to the policy promulgated by the Centers for Medicare & 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 cancelled 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-grandfathered health insurance coverage 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.
Schedule 1 Definitions:

**Rescission** - A rescission is a cancellation or discontinuance of coverage that has retroactive effect due to fraudulent or material misrepresentation. (Does not include cancellations for non-payment.)

**Earned Premium** - Total premium earned from all policies (contracts) written by the insurer during the specified period.

**Number of policies issued** - Number of policies (contracts) for health insurance coverage issued during the specified period.

**Number of policies renewed** - Number of policies (contracts) for health insurance coverage renewed during the specified period. If the policyholder number remains the same, count the policy (contract) as renewed.

**Member months for policies issued** - The sum of total number of lives insured on policies (contracts) issued 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.

**Member months for policies renewed** - The sum of total number of lives insured on policies (contracts) renewed 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.

**Number of policy terminations and cancellations initiated by the consumer** - Number of policies (contracts) terminated at the insured's request.

**Number of policy terminations and cancellations due to non-payment of premium** - Number of policies (contracts) terminated because the insured never paid, or stopped paying, the required premium for coverage.

**Number of lives impacted on terminations and cancellations initiated by the consumer** - Total number of lives which were no longer covered as a result of policies (contracts) terminated at the insured's request. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

**Number of lives impacted on policies terminated and cancelled due to non-payment** - 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.

**Number of rescissions** - Number of policies (contracts) cancelled as a result of a rescission.
Number of lives impacted by rescissions - Total number of lives which were no longer covered as a result of rescissions. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

Schedule 2 Definitions:

Prior Authorization - A decision by a carrier in advance of the provision of a health care service that the service (including specialist care, habilitation and rehabilitation services, and mental health and substance use disorder services), treatment plan, or medical device and equipment is medically necessary or a covered service. Sometimes called preauthorization, prior approval or precertification.

Behavioral Health Benefits - Benefits to assist those with mental health or substance abuse issues.

Mental Health Benefits - Benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Disease (ICD), or State guidelines).

Substance Use Disorders Benefits - Benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Disease (ICD), or State guidelines).

Schedules 3 and 4 Definitions:

Claim - For the purposes of this data call a claim means any individual line of service within a bill for services.

Number of claims received - Number of claims 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 claim means any individual line of service.

Denied Claims - The denial of a claim is the fully adjudicated decision by a carrier to not pay or reimburse a fully completed health care claim submitted for an insured or provider. A claim considered as eligible (e.g. applied to deductible or co-payment), but without a payment, is not a denied claim.
Claims Denied, Rejected or Returned (reported within the following claim categories) - A notification, such as an EOB, will serve as the trigger for required reporting within the claim categories. The notification sent to the provider or consumer will indicate any issues found that are causing the claim to have an unpaid status. A single claim may be returned, rejected or denied multiple times before being finalized. Each return, rejection and denial would be reported.

Each return, rejection and denial should be reported in each category that is applicable.

- **Claims Submission Coding Error(s)** - This category includes claims that were denied because the claim as presented had errors including for example missing claims data or information, incorrect patient information or mismatched treatment or diagnosis codes. This grouping should include claims denials for “unbundling”

- **Prior Authorization Needed** - This category includes denials resulting from missing or incomplete prior authorization documentation submitted with the claim as required under the policy terms.

- **Non-covered benefit or benefit limitation** - This category includes claim denials that are not covered under the plan or, if covered, have a specified limitation which has been exceeded. Experimental, investigational, and cosmetic procedures are common examples of types of services which are typically not covered. Coverage policies may also limit the number of visits, or limit coverage for certain types of providers or the numbers of days that DME is authorized.

- **Not Medically Necessary (Excluding Behavioral Health)** - This category includes claim denials for services or supplies that do not meet medical necessity standards for the diagnosis or treatment of a specific illness, injury, condition, disease or its symptoms according to evidence-based clinical standards of care.

- **Not Medically Necessary (Behavioral Health Benefits Only)** - This category includes claim denials for services or supplies that do not meet medical necessity standards for the diagnosis or treatment of a specific illness, injury, condition, disease or its symptoms according to evidence-based clinical standards of care.

**Number of claims submitted by in-network providers** - 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.

**Number of claims submitted by out-of-network Providers** - 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.

**Number of claim denials for in-network claims** - 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.

**In-Network claims denial stratification of days** - A grouping of number of days that it
has taken to deny in-network claims. (0-30, 31-60, 61-90, 90+).

**Number of claims denials for out-of-network claims** - 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 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.

**Out-of-network claims denial stratification of days** - A grouping of number of days that it
has taken to deny out-of-network claims. (0-30, 31-60, 61-90, 90+).

**Number of paid claims for in-network services** - Total 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 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.

**In-network claims payment stratification of days** - A grouping of number of days that it
has taken to pay in-network claims. (0-30, 31-60, 61-90, 90+).

**Number of paid claims for out-of-network services** - 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.

**Out-of-network claims payment stratification of days** - A grouping of number of days that it
has taken to pay out-of-network claims. (0-30, 31-60, 61-90, 90+).

**Claims Paid** - Total dollar value of payments by the carrier for benefits reflected in claimants’
Explanations of Benefits (EOBs) for the requested period.
**Insured/beneficiary co-payment responsibility** - 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.

**Insured coinsurance responsibility** - 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.

**Insured deductible responsibility** - 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.

**Schedules 5 and 6 Definitions:**

**Adverse Determination** - A rescission, 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.

**External Review** - An independent review of an adverse determination or final adverse determination.

**External (Independent) Review Organization** - An entity that conducts independent external review of adverse determinations or final adverse determination.

**Grievance** - 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 (appeal) 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.

**Grievance for Non-Adverse Determination** - A grievance arising from any issue other than an adverse determination.

**Internal Review** - 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.
**Overtuned Decision** - A reversal of a denial of an adverse determination by a health carrier or its designee utilization review organization.

**Upheld Decision** - A denial of an adverse determination that has been found to be supported by a health carrier or its designee utilization review organization.

**Voluntary Review Level** - A level of review beyond the normal internal appeals process.
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<tbody>
<tr>
<td><strong>INTERROGATORIES</strong></td>
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<tr>
<td>01</td>
<td>In-Exchange - Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report? (Y/N)</td>
<td>--</td>
</tr>
<tr>
<td>02</td>
<td>In-Exchange - Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report? (Y/N)</td>
<td>--</td>
</tr>
<tr>
<td>03</td>
<td>In-Exchange - Does the company have Catastrophic data to report? (Y/N)</td>
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<tr>
<td>04</td>
<td>In-Exchange - Does the company have Multi-State (Individual) data to report? (Y/N)</td>
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<tr>
<td>05</td>
<td>In-Exchange - Does the company have Multi-State (Small Group) data to report? (Y/N)</td>
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<tr>
<td>06</td>
<td>In-Exchange - Number of small groups in-force at the end of the reporting period.</td>
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<tr>
<td>07</td>
<td>In-Exchange - Does the company have an additional voluntary level of review for grievances? (Y/N)</td>
<td>--</td>
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<tr>
<td>08</td>
<td>In-Exchange Comments.</td>
<td></td>
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<tr>
<td>09</td>
<td>Out-of-Exchange - Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report? (Y/N)</td>
<td>--</td>
</tr>
<tr>
<td>10</td>
<td>Out-of-Exchange - Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report? (Y/N)</td>
<td>--</td>
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<tr>
<td>11</td>
<td>Out-of-Exchange - Does the company have Grandfathered or Transitional plan data to report? (Y/N)</td>
<td>--</td>
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<tr>
<td>12</td>
<td>Out-of-Exchange - Does the company have Catastrophic data to report? (Y/N)</td>
<td>--</td>
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<tr>
<td>13</td>
<td>Out-of-Exchange - Does the company have Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report? (Y/N)</td>
<td>--</td>
</tr>
<tr>
<td>14</td>
<td>Out-of-Exchange - Does the company have Student Coverage data to report? (Y/N)</td>
<td>--</td>
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<tr>
<td>15</td>
<td>Out-of-Exchange - Number of small groups in-force at the end of the reporting period.</td>
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<tr>
<td>16</td>
<td>Out-of-Exchange - Number of large groups in-force at the end of the reporting period.</td>
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<tr>
<td>17</td>
<td>Out-of-Exchange - Does the company have an additional voluntary level of review for grievances? (Y/N)</td>
<td>--</td>
</tr>
<tr>
<td>18</td>
<td>Out-of-Exchange Comments.</td>
<td></td>
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<tr>
<td>Policy Administration</td>
<td>Bronze</td>
<td>Silver</td>
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<tr>
<td>-------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>19 Earned premiums for Reporting Year</td>
<td></td>
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<tr>
<td>20 Number of new policies issued during the period</td>
<td></td>
<td></td>
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<tr>
<td>21 Number of policies renewed during the period</td>
<td></td>
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<tr>
<td>22 Number of policies issued during the period</td>
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<tr>
<td>23 Number of policies renewed during the period</td>
<td></td>
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<tr>
<td>24 Number of policy terminations and cancellations initiated by consumer</td>
<td></td>
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<tr>
<td>25 Number of policy terminations and cancellations due to non-payment of premium</td>
<td></td>
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<tr>
<td>26 Number of lives impacted on terminations and cancellations initiated by the policyholder</td>
<td></td>
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<tr>
<td>27 Number of lives impacted on policies terminated and cancelled due to non-payment</td>
<td></td>
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<tr>
<td>28 Number of rescissions.</td>
<td></td>
<td></td>
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<tr>
<td>29 Number of lives impacted by rescissions.</td>
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</tbody>
</table>

Prior Authorizations (Prospective Utilization Review Requests)
Excluding Pharmacy

| 30 Number of prior authorizations requested.                                       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |
| 31 Number of prior authorizations approved.                                        |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |
| 32 Number of prior authorizations denied.                                          |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |
| 33 Number of prior authorizations requested for mental health benefits, behavioral health benefits, and substance use disorders. |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |
| 34 Number of prior authorizations for mental health benefits, behavioral health benefits, and substance use disorders denied. |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |
| 35 Number of prior authorizations for mental health benefits, behavioral health benefits, and substance use disorders approved. |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |

Prior Authorizations (Prospective Utilization Review Requests)
Pharmacy Only

| 36 Number of prior authorizations requested.                                       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |
| 37 Number of prior authorizations approved.                                        |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |
| 38 Number of prior authorizations denied.                                          |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |        |        |      |          |       |

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**IN-EXCHANGE**

<table>
<thead>
<tr>
<th>Claims Administration (Excluding Pharmacy)</th>
<th>Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic or student</th>
<th>Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies</th>
<th>Catastrophic</th>
<th>Multi-State(Individual)</th>
<th>Multi-State (Small Group)</th>
</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>Number of claims received.</td>
<td></td>
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<tr>
<td>40</td>
<td>Number of claims submitted by network providers.</td>
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<tr>
<td>41</td>
<td>Number of claims submitted by out-of-network providers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Number of claim denials for in-network claims.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>43</td>
<td>In-network claims denied within 0-30 days.</td>
<td></td>
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<tr>
<td>44</td>
<td>In-network claims denied within 31-60 days.</td>
<td></td>
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<tr>
<td>45</td>
<td>In-network Claims denied beyond 90 days.</td>
<td></td>
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<tr>
<td>47</td>
<td>Number of in-network denied, rejected or returned - Claims Submission Coding Error(s).</td>
<td></td>
<td></td>
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<tr>
<td>48</td>
<td>Number of in-network denied, rejected or returned - Prior Authorization Needed.</td>
<td></td>
<td></td>
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<tr>
<td>49</td>
<td>Number of in-network denied, rejected or returned - Non-Covered Benefit or Benefit Limitation.</td>
<td></td>
<td></td>
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<tr>
<td>50</td>
<td>Number of in-network denied, rejected or returned - Not Medically Necessary (Excluding Behavioral Health Benefits).</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>51</td>
<td>Number of in-network denied, rejected or returned - Not Medically Necessary (Behavioral Health Benefits Only).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>52</td>
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<td>53</td>
<td>Out-of-network claims denied within 0-30 days.</td>
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<td>Out-of-network Claims denied within 31-60 days.</td>
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<td>Out-of-network Claims denied within 61-90 days.</td>
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<td>Number of paid claims for in-network services.</td>
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<td>In-network claims paid within 0-30 days.</td>
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<td>In-network claims paid within 31-60 days.</td>
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<td>In-network claims paid within 61-90 days.</td>
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<td>In-network claims paid beyond 90 days.</td>
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<td>94 Number of policies renewed during the period.</td>
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<td>95 Member months for policies issued during the period.</td>
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<td>97 Number of policy terminations and cancellations initiated by consumer.</td>
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<td>98 Number of policy terminations and cancellations due to non-payment of premium.</td>
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<td>99 Number of lives impacted on terminations and cancellations initiated by the policyholder.</td>
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<td>100 Number of lives impacted on policies terminated and cancelled due to non-payment.</td>
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<td>101 Number of rescissions.</td>
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<td>102 Number of lives impacted by rescissions.</td>
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<td>Prior Authorizations (Prospective Utilization Review Requests) Excluding Pharmacy</td>
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<td>106 Number of prior authorizations requested for mental health benefits, behavioral health benefits, and substance use disorders.</td>
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<td>Prior Authorizations (Prospective Utilization Review Requests) Pharmacy Only</td>
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<td>110 Number of prior authorizations approved.</td>
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<td>111 Number of prior authorizations denied.</td>
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<td>112 Number of claims received</td>
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<td>113 Number of claims submitted by network providers</td>
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<td>116 In-network claims denied within 0-30 days</td>
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<td>119 In-network Claims denied beyond 90 days</td>
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<td>120 Number of in-network denied, rejected or returned - Claims Submission Coding Error(s)</td>
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<td>123 Number of in-network denied, rejected or returned - Not Medically Necessary (Excluding Behavioral Health Benefits)</td>
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<td>146 Insured/beneficiary co-payment responsibility.</td>
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<td>150 Number of claim denials for in-network claims.</td>
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<td>155 Insured/beneficiary co-payment responsibility.</td>
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<td>158 Number of customer requests for internal reviews of grievances involving adverse determinations (Do not include additional voluntary levels of reviews.)</td>
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<td>161 Number of customer requests for internal reviews of grievances not involving adverse determinations.</td>
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<td>162 Number of customer requested appeals on final adverse determinations to an external review</td>
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<td>163 Number of final adverse determinations upheld upon request for external review.</td>
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Report of
Financial Condition (E) Committee

The Financial Condition (E) Committee met Aug. 8, 2017. During this meeting, the Committee:

1. Adopted its Spring National Meeting minutes;

2. Adopted its July 17 and May 12 minutes, which included the following action:
   a) Adopted a model law development request to consider amendments to the Life and Health Insurance Guaranty Association Model Act (#520).
   b) Discussed proposed new investment disclosures.

3. Received a report from the Long-Term Care Insurance (B/E) Task Force and adopted its 2017 and 2018 proposed charges.

4. Adopted the reports of the following task forces and working groups: 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; Valuation of Securities (E) Task Force; Group Capital Calculation (E) Working Group; Group Solvency Issues (E) Working Group; Mortgage Guaranty Insurance (E) Working Group; NAIC/AICPA (E) Working Group; National Treatment and Coordination (E) Working Group; Risk-Focused Surveillance (E) Working Group; and Variable Annuities Issues (E) Working Group.

5. Adopted technical changes to the Investment of Insurers Model Act (#280).


7. Discussed comments received on proposed new investment disclosures, including possible alternatives. Further discussion is expected.

Note: Items adopted within the Financial Condition (E) Committee’s task force and working group reports that are considered technical, non-controversial and not significant by NAIC standards (i.e., they do not include model laws, model regulations, model guidelines or items considered to be controversial) will be considered for adoption by the Executive (EX) Committee and Plenary through the Financial Condition (E) Committee’s technical changes report process. Pursuant to this process, which was adopted by the NAIC in 2009, a listing of the various technical changes will be sent to the NAIC members shortly after completion of the Summer National Meeting, and the members will have 10 days to comment with respect to those items. If no objections are received with respect to a particular item, the technical changes will be considered adopted by the NAIC membership and effective immediately.
To: Joint (EX) Executive Committee/Plenary  
From: Superintendent Eric A. Cioppa, Chair of the Financial Condition (E) Committee  
Re: Technical Edits to Model #280  
Date: August 8, 2017

In 2016, the Valuation of Securities (E) Task Force and the Statutory Accounting Principles (E) Working Group, in response to regulations adopted by the U.S. Securities and Exchange Commission (SEC), adopted revisions impacting the accounting and reporting of money market mutual funds. As part of the revisions, the concept of a “Class One Money Market Mutual Fund List” was eliminated.

With the changes in statutory accounting guidelines, it was identified that reference to class one money market mutual funds is included in the Investments of Insurers Model Act (#280). Although states have already been contacted to review and update state statutes / legislation accordingly, technical edits were suggested to remove reference to the Class One list from Model #280. Per an assessment from NAIC legal, these technical edits would fall within an exception to the normal Model Law update process and are necessitated as the concept of a Class One list no longer exists. Additionally, technical edits were supported to correct the definitions for repurchase and reverse repurchase transactions. (These definitions were reversed between the two terms.)

During the 2017 Spring National Meeting, the Statutory Accounting Principles (E) Working Group exposed technical edits to Model #280 to remove reference to the Class One list as well as to correct the repurchase and reverse repurchase terms. No comments were received from the exposure and the Working Group, the Accounting Practices & Procedures (E) Task Force, and the Financial Condition (E) Committee adopted the proposed edits.

Pursuant to the direction of the Working Group, this memorandum requests that the Joint (EX) Executive Committee/Plenary approval as well.

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INVESTMENTS OF INSURERS MODEL ACT
(Defined Limits Version)

ARTICLE I. GENERAL PROVISIONS

Section 1. Purpose and Scope
Section 2. Definitions
Section 3. General Investment Qualifications
Section 4. Authorization of Investments by the Board of Directors
Section 5. Prohibited Investments
Section 6. Loans to Officers and Directors
Section 7. Valuation of Investments
Section 8. Regulations

ARTICLE II. LIFE AND HEALTH INSURERS

Section 9. Applicability
Section 10. General Three Percent Diversification, Medium and Lower Grade Investments and Canadian Investments
Section 11. Rated Credit Instruments
Section 12. Insurer Investment Pools
Section 13. Equity Interests
Section 14. Tangible Personal Property Under Lease
Section 15. Mortgage Loans and Real Estate
Section 16. Securities Lending, Repurchase, Reverse Repurchase and Dollar Roll Transactions
Section 17. Foreign Investments and Foreign Currency Exposure
Section 18. Derivative Transactions
Section 19. Policy Loans
Section 20. Additional Investment Authority

ARTICLE III. PROPERTY AND CASUALTY, FINANCIAL GUARANTY AND MORTGAGE GUARANTY INSURERS

Section 21. Applicability
Section 22. Reserve Requirements
Section 23. General Five Percent Diversification, Medium and Lower Grade Investments and Canadian Investments
Section 24. Rated Credit Instruments
Section 25. Insurer Investment Pools
Section 26. Equity Interests
Section 27. Tangible Personal Property Under Lease
Section 28. Mortgage Loans and Real Estate
Section 29. Securities Lending, Repurchase, Reverse Repurchase and Dollar Roll Transactions
Section 30. Foreign Investments and Foreign Currency Exposure
Section 31. Derivative Transactions
Section 32. Additional Investment Authority

Statement of Principles

The development of regulation of the investments of insurers requires an analysis of the complexities, uncertainties, competitive forces and frequent changes in the investment markets and in the insurance business, the diversity among insurers, and the need for a balance among risk, reward and liquidity of an insurer’s investments. It also requires an analysis of how to safeguard the
financial condition of domestic insurers and at the same time to permit domestic insurers to be competitive with insurer's domiciled in other states and with other financial industries that operate under different regulatory regimes.

Each state is urged to determine through independent study which methods are best suited to its needs and whether its existing regulatory structure may be improved by using provisions of model laws recommended by the National Association of Insurance Commissioners (NAIC) or existing regulatory structures in other states or industries.

This model law is not considered by the NAIC to exhaust regulatory methods to address the regulation of investments of insurers. Nor is this model law recommended by the NAIC to be used as a standard for the examination of insurers unless substantially similar provisions are found in the statutes and regulations of the state of domicile of the insurer.

**ARTICLE I. GENERAL PROVISIONS**

**Section 1. Purpose and Scope**

A. Purpose

The purpose of this Act is to protect the interests of insureds by promoting insurer solvency and financial strength. This will be accomplished through the application of investment standards that facilitate a reasonable balance of the following objectives:

1. To preserve principal;
2. To assure reasonable diversification as to type of investment, issuer and credit quality; and
3. To allow insurers to allocate investments in a manner consistent with principles of prudent investment management to achieve an adequate return so that obligations to insureds are adequately met and financial strength is sufficient to cover reasonably foreseeable contingencies.

B. Scope

This Act shall apply only to investments and investment practices of domestic insurers and United States branches of alien insurers entered through this state. This Act shall not apply to separate accounts of an insurer except to the extent that the provisions of [see Drafting Note 2] so provide.

**Drafting Note 1:** This Act does not define the types of insurers subject to its provisions, leaving this to other sections of the code since state laws treat insurers writing various lines of insurance differently. For example, if an entity is authorized to operate as a health maintenance organization, the state may provide additional investment authority commensurate to operating as a health maintenance organization.

**Drafting Note 2:** Insert a cross-reference to the section of the code governing separate accounts that states when the provisions of this Act are applicable to investments in separate accounts, either aggregated with an insurer’s general account investments or treated as if the assets in each separate account were all of an insurer’s admitted assets. Except to the extent specifically provided in that section, this Act has no application to the investments of separate accounts. If the code does not so provide, then Section 1B must be amended to provide that this Act does not apply to separate accounts.
Section 2. Definitions

For purposes of this Act:

A. “Acceptable collateral” means:
   (1) As to securities lending transactions, and for the purpose of calculating counterparty exposure amount, cash, cash equivalents, letters of credit, direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or any agency of the United States, or by the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation, and as to lending foreign securities, sovereign debt rated 1 by the SVO;
   (2) As to reverse repurchase transactions, cash, cash equivalents and direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or an agency of the United States, or by the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation; and
   (3) As to reverse repurchase transactions, cash and cash equivalents.

B. “Acceptable private mortgage insurance” means insurance written by a private insurer protecting a mortgage lender against loss occasioned by a mortgage loan default and issued by a licensed mortgage insurance company, with an SVO 1 designation or a rating issued by a nationally recognized statistical rating organization equivalent to an SVO 1 designation, that covers losses to an eighty percent (80%) loan-to-value ratio.

C. “Accident and health insurance” means protection which provides payment of benefits for covered sickness or accidental injury, excluding credit insurance, disability insurance, accidental death and dismemberment insurance and long-term care insurance.

D. “Accident and health insurer” means a licensed life or health insurer or health service corporation whose insurance premiums and required statutory reserves for accident and health insurance constitute at least ninety-five percent (95%) of total premium considerations or total statutory required reserves, respectively.

E. “Admitted assets” means assets permitted to be reported as admitted assets on the statutory financial statement of the insurer most recently required to be filed with the commissioner, but excluding assets of separate accounts, the investments of which are not subject to the provisions of this Act.

 Drafting Note 3: If the code contains a definition of admitted assets, insert “determined in accordance with the requirements of [insert section defining admitted assets].”

 Drafting Note 4: Whenever the term “commissioner” appears, the title of the chief insurance regulatory official shall be inserted.

F. “Affiliate” means, as to any person, another person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person.
G. “Asset-backed security” means a security or other instrument, excluding a mutual fund, evidencing an interest in, or the right to receive payments from, or payable from distributions on, an asset, a pool of assets or specifically divisible cash flows which are legally transferred to a trust or another special purpose bankruptcy-remote business entity, on the following conditions:

1. The trust or other business entity is established solely for the purpose of acquiring specific types of assets or rights to cash flows, issuing securities and other instruments representing an interest in or right to receive cash flows from those assets or rights, and engaging in activities required to service the assets or rights and any credit enhancement or support features held by the trust or other business entity; and

2. The assets of the trust or other business entity consist solely of interest bearing obligations or other contractual obligations representing the right to receive payment from the cash flows from the assets or rights. However, the existence of credit enhancements, such as letters of credit or guarantees, or support features such as swap agreements, shall not cause a security or other instrument to be ineligible as an asset-backed security.

H. “Business entity” includes a sole proprietorship, corporation, limited liability company, association, partnership, joint stock company, joint venture, mutual fund, trust, joint tenancy or other similar form of business organization, whether organized for-profit or not-for-profit.

I. “Cap” means an agreement obligating the seller to make payments to the buyer, with each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interests exceeds a predetermined number, sometimes called the strike rate or strike price.

J. “Capital and surplus” means the sum of the capital and surplus of the insurer required to be shown on the statutory financial statement of the insurer most recently required to be filed with the commissioner.

K. “Cash equivalents” means short-term, highly rated and highly liquid investments or securities readily convertible to known amounts of cash without penalty and so near maturity that they present insignificant risk of change in value. Cash equivalents include money market mutual fundsgovernment money market mutual funds and class one money market mutual funds. For purposes of this definition:

1. “Short-term” means investments with a remaining term to maturity of ninety (90) days or less; and

2. “Highly rated” means an investment rated “P-1” by Moody’s Investors Service, Inc., or “A-1” by Standard and Poor’s division of The McGraw Hill Companies, Inc. or its equivalent rating by a nationally recognized statistical rating organization recognized by the SVO.

L. “Class one bond Listed bond mutual fund” means a mutual fund that at all times qualifies for investment using the bond class one reserve factor inclusion on the “bond fund list” under within the Purposes and Procedures of the Securities Valuation Office NAIC Investment Analysis Office or any successor publication.
Drafting Note 5: SVO publications are currently under revision. Certain references to the Purposes and Procedures of the Securities Valuation Office may, after these revisions are complete, require reference to the Valuations of Securities publication or other NAIC publications.

M. “Class one money market mutual fund” means a money market mutual fund that at all times qualifies for investment using the bond class one reserve factor under the Purposes and Procedures of the Securities Valuation Office or any successor publication. [Class one money market mutual fund list eliminated September 30, 2016]

N. “Code” means [insert reference to adopting state’s insurance code].

O. “Collar” means an agreement to receive payments as the buyer of an option, cap or floor and to make payments as the seller of a different option, cap or floor.

P. “Commercial mortgage loan” means a loan secured by a mortgage, other than a residential mortgage loan.

Q. “Construction loan” means a loan of less than three (3) years in term, made for financing the cost of construction of a building or other improvement to real estate, that is secured by the real estate.

R. “Control” means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract (other than a commercial contract for goods or non-management services), or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote or holds proxies representing ten percent (10%) or more of the voting securities of another person. This presumption may be rebutted by a showing that control does not exist in fact. The commissioner may determine, after furnishing all interested persons notice and an opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

S. “Counterparty exposure amount” means:

(1) The net amount of credit risk attributable to a derivative instrument entered into with a business entity other than through a qualified exchange, qualified foreign exchange, or cleared through a qualified clearinghouse (“over-the-counter derivative instrument”). The amount of credit risk equals:

   (a) The market value of the over-the-counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurer; or

   (b) Zero if the liquidation of the derivative instrument would not result in a final cash payment to the insurer.

(2) If over-the-counter derivative instruments are entered into under a written master agreement which provides for netting of payments owed by the respective parties, and the domiciliary jurisdiction of the counterparty is either within the United States or if not within the United States, within a foreign jurisdiction listed in the Purposes and Procedures of the NAIC.
Investments of Insurers Model Act

Investment Analysis Securities Valuation Office as eligible for netting, the net amount of credit risk shall be the greater of zero or the net sum of:

(a) The market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment to the insurer; and

(b) The market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment by the insurer to the business entity.

(3) For open transactions, market values shall be determined at the end of the most recent quarter of the insurer’s fiscal year and shall be reduced by the market value of acceptable collateral held by the insurer or placed in escrow by one or both parties.

T. “Covered” means that an insurer owns or can immediately acquire, through the exercise of options, warrants or conversion rights already owned, the underlying interest in order to fulfill or secure its obligations under a call option, cap or floor it has written, or has set aside under a custodial or escrow agreement cash or cash equivalents with a market value equal to the amount required to fulfill its obligations under a put option it has written, in an income generation transaction.

U. “Credit tenant loan” means a mortgage loan which is made primarily in reliance on the credit standing of a major tenant, structured with an assignment of the rental payments to the lender with real estate pledged as collateral in the form of a first lien.

V. (1) “Derivative instrument” means an agreement, option, instrument or a series or combination thereof:

(a) To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or

(b) That has a price, performance, value or cash flow based primarily upon the actual or expected price, level, performance, value or cash flow of one or more underlying interests.

(2) Derivative instruments include options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, futures and any other agreements, options or instruments substantially similar thereto or any series or combination thereof and any agreements, options or instruments permitted under regulations adopted under Section 8. Derivative instruments shall not include an investment authorized by Sections 11 through 17, 19 and 24 through 30.

W. “Derivative transaction” means a transaction involving the use of one or more derivative instruments.

X. “Direct” or “directly,” when used in connection with an obligation, means that the designated obligor is primarily liable on the instrument representing the obligation.
Y. “Dollar roll transaction” means two (2) simultaneous transactions with different settlement dates no more than ninety-six (96) days apart, so that in the transaction with the earlier settlement date, an insurer sells to a business entity, and in the other transaction the insurer is obligated to purchase from the same business entity, substantially similar securities of the following types:

1. Asset-backed securities issued, assumed or guaranteed by the Government National Mortgage Association, the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation or their respective successors;


Z. “Domestic jurisdiction” means the United States, Canada, any state, any province of Canada or any political subdivision of any of the foregoing.

AA. “Equity interest” means any of the following that are not rated credit instruments:

1. Common stock;

2. Preferred stock;

3. Trust certificate;

4. Equity investment in an investment company other than a money market mutual fund or a class one listed bond mutual fund;

5. Investment in a common trust fund of a bank regulated by a federal or state agency;

6. An ownership interest in minerals, oil or gas, the rights to which have been separated from the underlying fee interest in the real estate where the minerals, oil or gas are located;

7. Instruments which are mandatorily, or at the option of the issuer, convertible to equity;

8. Limited partnership interests and those general partnership interests authorized under Section 5D;

9. Member interests in limited liability companies;

10. Warrants or other rights to acquire equity interests that are created by the person that owns or would issue the equity to be acquired; or

11. Instruments that would be rated credit instruments except for the provisions of Subsection 2RRR (2) of this section.

BB. “Equivalent securities” means:

1. In a securities lending transaction, securities that are identical to the loaned
securities in all features including the amount of the loaned securities, except as to certificate number if held in physical form, but if any different security shall be exchanged for a loaned security by recapitalization, merger, consolidation or other corporate action, the different security shall be deemed to be the loaned security;

(2) In a repurchase transaction, securities that are identical to the purchased sold securities in all features including the amount of the purchased sold securities, except as to the certificate number if held in physical form; or

(3) In a reverse repurchase transaction, securities that are identical to the sold purchased securities in all features including the amount of the sold purchased securities, except as to the certificate number if held in physical form.

CC. “Floor” means an agreement obligating the seller to make payments to the buyer in which each payment is based on the amount by which a predetermined number, sometimes called the floor rate or price, exceeds a reference price, level, performance or value of one or more underlying interests.

DD. “Foreign currency” means a currency other than that of a domestic jurisdiction.

EE. (1) “Foreign investment” means an investment in a foreign jurisdiction, or an investment in a person, real estate or asset domiciled in a foreign jurisdiction, that is substantially of the same type as those eligible for investment under this Act, other than under Sections 17 and 30. An investment shall not be deemed to be foreign if the issuing person, qualified primary credit source or qualified guarantor is a domestic jurisdiction or a person domiciled in a domestic jurisdiction, unless:

(a) The issuing person is a shell business entity; and

(b) The investment is not assumed, accepted, guaranteed or insured or otherwise backed by a domestic jurisdiction or a person, that is not a shell business entity, domiciled in a domestic jurisdiction.

(2) For purposes of this definition:

(a) “Shell business entity” means a business entity having no economic substance, except as a vehicle for owning interests in assets issued, owned or previously owned by a person domiciled in a foreign jurisdiction;

(b) “Qualified guarantor” means a guarantor against which an insurer has a direct claim for full and timely payment, evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction; and

(c) “Qualified primary credit source” means the credit source to which an insurer looks for payment as to an investment and against which an insurer has a direct claim for full and timely payment, evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction.
FF. “Foreign jurisdiction” means a jurisdiction other than a domestic jurisdiction.

GG. “Forward” means an agreement (other than a future) to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of, one or more underlying interests.

HH. “Future” means an agreement, traded on a qualified exchange or qualified foreign exchange, to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of, one or more underlying interests.

II. “Government money market mutual fund” means a money market mutual fund that at all times:

(1) Invests only in obligations issued, guaranteed or insured by the federal government of the United States or collateralized repurchase agreements composed of these obligations; and

(2) Qualifies for investment without a reserve under the *Purposes and Procedures of the NAIC Investment Analysis Securities Valuation Office* or any successor publication.

JJ. “Government sponsored enterprise” means a:

(1) Governmental agency; or

(2) Corporation, limited liability company, association, partnership, joint stock company, joint venture, trust or other entity or instrumentality organized under the laws of any domestic jurisdiction to accomplish a public policy or other governmental purpose.

KK. “Guaranteed or insured,” when used in connection with an obligation acquired under this Act, means that the guarantor or insurer has agreed to:

(1) Perform or insure the obligation of the obligor or purchase the obligation; or

(2) Be unconditionally obligated until the obligation is repaid to maintain in the obligor a minimum net worth, fixed charge coverage, stockholders’ equity or sufficient liquidity to enable the obligor to pay the obligation in full.

LL. “Hedging transaction” means a derivative transaction which is entered into and maintained to reduce:

(1) The risk of a change in the value, yield, price, cash flow or quantity of assets or liabilities which the insurer has acquired or incurred or anticipates acquiring or incurring; or
(2) The currency exchange rate risk or the degree of exposure as to assets or liabilities which an insurer has acquired or incurred or anticipates acquiring or incurring.

MM. “High grade investment” means a rated credit instruments rated 1 or 2 by the SVO.

NN. “Income” means, as to a security, interest, accrual of discount, dividends or other distributions, such as rights, tax or assessment credits, warrants and distributions in kind.

OO. “Income generation transaction” means a derivative transaction involving the writing of covered call options, covered put options, covered caps or covered floors that is intended to generate income or enhance return.

PP. “Initial margin” means the amount of cash, securities or other consideration initially required to be deposited to establish a futures position.

QQ. “Insurance future” means a future relating to an index or pool that is based on insurance-related items.

RR. “Insurance futures option” means an option on an insurance future.

SS. “Investment company” means an investment company as defined in Section 3(a) of the Investment Company Act of 1940 (15 U.S.C. §§ 80a-1 et seq.), as amended, and a person described in Section 3(c) of that Act.

TT. “Investment company series” means an investment portfolio of an investment company that is organized as a series company and to which assets of the investment company have been specifically allocated.

UU. “Investment practices” means transactions of the types described in Sections 16, 18, 29 or 31.

VV. “Investment subsidiary” means a subsidiary of an insurer engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer if each subsidiary agrees to limit its investment in any asset so that its investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations or avoid any other provisions of this Act applicable to the insurer. As used in this subsection, the total investment of the insurer shall include:

1. Direct investment by the insurer in an asset; and
2. The insurer’s proportionate share of an investment in an asset by an investment subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary’s investment by the percentage of the insurer’s ownership interest in the subsidiary.

WW. “Investment strategy” means the techniques and methods used by an insurer to meet its investment objectives, such as active bond portfolio management, passive bond portfolio management, interest rate anticipation, growth investing and value investing.
XX. “Letter of credit” means a clean, irrevocable and unconditional letter of credit issued or confirmed by, and payable and presentable at, a financial institution on the list of financial institutions meeting the standards for issuing letters of credit under the Purposes and Procedures of the NAIC Investment Analysis Securities Valuation Office or any successor publication. To constitute acceptable collateral for the purposes of Sections 16 and 29, a letter of credit must have an expiration date beyond the term of the subject transaction.

YY. “Limited liability company” means a business organization, excluding partnerships and ordinary business corporations, organized or operating under the laws of the United States or any state thereof that limits the personal liability of investors to the equity investment of the investor in the business entity.

ZZ. “Lower grade investment” means a rated credit instrument rated 4, 5 or 6 by the SVO.

AAA. “Market value” means:
(1) As to cash and letters of credit, the amounts thereof; and
(2) As to a security as of any date, the price for the security on that date obtained from a generally recognized source or the most recent quotation from such a source or, to the extent no generally recognized source exists, the price for the security as determined in good faith by the parties to a transaction, plus accrued but unpaid income thereon to the extent not included in the price as of that date.

BBB. “Medium grade investment” means a rated credit instrument rated 3 by the SVO.

CCC. “Money market mutual fund” means a mutual fund that meets the conditions of 17 Code of Federal Regulations Par. 270.2a-7, under the Investment Company Act of 1940 (15 U.S.C. §§ 80a-1 et seq.), as amended or renumbered.

DDD. “Mortgage loan” means an obligation secured by a mortgage, deed of trust, trust deed or other consensual lien on real estate.

EEE. “Multilateral development bank” means an international development organization of which the United States is a member.

FFF. “Mutual fund” means an investment company or, in the case of an investment company that is organized as a series company, an investment company series, that, in either case, is registered with the United States Securities and Exchange Commission under the Investment Company Act of 1940 (15 U.S.C. §§ 80a-1 et seq.), as amended.

GGG. “NAIC” means the National Association of Insurance Commissioners.

HHH. “Obligation” means a bond, note, debenture, trust certificate including an equipment certificate, production payment, negotiable bank certificate of deposit, bankers’ acceptance, credit tenant loan, loan secured by financing net leases and other evidence of indebtedness for the payment of money (or participations, certificates or other evidences of an interest in any of the foregoing), whether constituting a general obligation of the issuer or payable only out of certain revenues or certain funds.
pledged or otherwise dedicated for payment.

III. “Option” means an agreement giving the buyer the right to buy or receive (a “call option”), sell or deliver (a “put option”), enter into, extend or terminate or effect a cash settlement based on the actual or expected price, level, performance or value of one or more underlying interests.

JJJ. “Person” means an individual, a business entity, a multilateral development bank or a government or quasi-governmental body, such as a political subdivision or a government sponsored enterprise.

KKK. “Potential exposure” means the amount determined in accordance with the NAIC Annual Statement Instructions.

LLL. “Preferred stock” means preferred, preference or guaranteed stock of a business entity authorized to issue the stock, that has a preference in liquidation over the common stock of the business entity.

MMM. “Qualified bank” means:

   (1) A national bank, state bank or trust company that at all times is no less than adequately capitalized as determined by standards adopted by United States banking regulators and that is either regulated by state banking laws or is a member of the Federal Reserve System; or

   (2) A bank or trust company incorporated or organized under the laws of a country other than the United States that is regulated as a bank or trust company by that country’s government or an agency thereof and that at all times is no less than adequately capitalized as determined by the standards adopted by international banking authorities.

NNN. “Qualified business entity” means a business entity that is:

   (1) An issuer of obligations or preferred stock that are rated 1 or 2 by the SVO or an issuer of obligations, preferred stock or derivative instruments that are rated the equivalent of 1 or 2 by the SVO or by a nationally recognized statistical rating organization recognized by the SVO; or

   (2) A primary dealer in United States government securities, recognized by the Federal Reserve Bank of New York.

OOO. “Qualified clearinghouse” means a clearinghouse for, and subject to the rules of, a qualified exchange or a qualified foreign exchange, which provides clearing services, including acting as a counterparty to each of the parties to a transaction such that the parties no longer have credit risk as to each other.

PPP. “Qualified exchange” means:

   (1) A securities exchange registered as a national securities exchange, or a securities market regulated under the Securities Exchange Act of 1934 (15 U.S.C. §§ 78 et seq.), as amended;

   (2) A board of trade or commodities exchange designated as a contract market by
the Commodity Futures Trading Commission or any successor thereof;

(3) Private Offerings, Resales and Trading through Automated Linkages (PORTAL); 

(4) A designated offshore securities market as defined in Securities Exchange Commission Regulation S, 17 C.F.R. Part 230, as amended; or 

(5) A qualified foreign exchange.

QQQ. "Qualified foreign exchange” means a foreign exchange, board of trade or contract market located outside the United States, its territories or possessions:

(1) That has received regulatory comparability relief under Commodity Futures Trading Commission (CFTC) Rule 30.10 (as set forth in Appendix C to Part 30 of the CFTC’s Regulations, 17 C.F.R. Part 30);

(2) That is, or its members are, subject to the jurisdiction of a foreign futures authority that has received regulatory comparability relief under CFTC Rule 30.10 (as set forth in Appendix C to Part 30 of the CFTC’s Regulations, 17 C.F.R. Part 30) as to futures transactions in the jurisdiction where the exchange, board of trade or contract market is located; or

(3) Upon which foreign stock index futures contracts are listed that are the subject of no-action relief issued by the CFTC’s Office of General Counsel, provided that an exchange, board of trade or contract market that qualifies as a “qualified foreign exchange” only under this subsection shall only be a “qualified foreign exchange” as to foreign stock index futures contracts that are the subject of no-action relief.

RRR. (1) “Rated credit instrument” means a contractual right to receive cash or another rated credit instrument from another entity which instrument:

(a) Is rated or required to be rated by the SVO;

(b) In the case of an instrument with a maturity of 397 days or less, is issued, guaranteed or insured by an entity that is rated by, or another obligation of such entity is rated by, the SVO or by a nationally recognized statistical rating organization recognized by the SVO;

(c) In the case of an instrument with a maturity of 90 days or less is issued by a qualified bank;

(d) Is a share of a class-one listed bond mutual fund; or

(e) Is a share of a money market mutual fund.

(2) However, “rated credit instrument” does not mean:

(a) An instrument that is mandatorily, or at the option of the issuer, convertible to an equity interest; or

(b) A security that has a par value and whose terms provide that the
issuer’s net obligation to repay all or part of the security’s par value is determined by reference to the performance of an equity, a commodity, a foreign currency or an index of equities, commodities, foreign currencies or combinations thereof.

SSS. “Real estate” means:

(1) (a) Real property;

(b) Interests in real property, such as leaseholds, minerals and oil and gas that have not been separated from the underlying fee interest;

(c) Improvements and fixtures located on or in real property; and

(d) The seller’s equity in a contract providing for a deed of real estate.

(2) As to a mortgage on a leasehold estate, real estate shall include the leasehold estate only if it has an unexpired term (including renewal options exercisable at the option of the lessee) extending beyond the scheduled maturity date of the obligation that is secured by a mortgage on the leasehold estate by a period equal to at least twenty percent (20%) of the original term of the obligation or ten (10) years, whichever is greater.

TTT. “Replication transaction” means a derivative transaction that is intended to replicate the performance of one or more assets that an insurer is authorized to acquire under this Act. A derivative transaction that is entered into as a hedging transaction shall not be considered a replication transaction.

UUU. “Repurchase transaction” means a transaction in which an insurer sells purchases securities from to a business entity that and is obligated to repurchase the purchased sold securities or equivalent securities from the insurer business entity at a specified price, either within a specified period of time or upon demand.

VVV. “Required liabilities” means total liabilities required to be reported on the statutory financial statement of the insurer most recently required to be filed with the commissioner.

WWW. “Residential mortgage loan” means a loan primarily secured by a mortgage on real estate improved with a one-to-four family residence.

XXX. “Reverse repurchase transaction” means a transaction in which an insurer sells purchases securities to-from a business entity and that is obligated to repurchase the sold-purchased securities or equivalent securities from the business entityinsurer at a specified price, either within a specified period of time or upon demand.

YYY. “Secured location” means the contiguous real estate owned by one person.

ZZZ. “Securities lending transaction” means a transaction in which securities are loaned by an insurer to a business entity that is obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period of time or upon demand.

AAAA. “Series company” means an investment company that is organized as a series
company, as defined in Rule 18f-2(a) adopted under the Investment Company Act of 1940 (15 U.S.C. §§ 80a-1 et seq.), as amended.

BBBB. “Sinking fund stock” means preferred stock that:

1. Is subject to a mandatory sinking fund or similar arrangement that will provide for the redemption (or open market purchase) of the entire issue over a period not longer than forty (40) years from the date of acquisition; and

2. Provides for mandatory sinking fund installments (or open market purchases) commencing not more than ten and one half (10.5) years from the date of issue, with the sinking fund installments providing for the purchase or redemption, on a cumulative basis commencing ten (10) years from the date of issue, of at least two and one half percent (2.5%) per year of the original number of shares of that issue of preferred stock.

 CCC. “Special rated credit instrument” means a rated credit instrument that is:

1. An instrument that is structured so that, if it is held until retired by or on behalf of the issuer, its rate of return, based on its purchase cost and any cash flow stream possible under the structure of the transaction, may become negative due to reasons other than the credit risk associated with the issuer of the instrument; however, a rated credit instrument shall not be a special rated credit instrument under this subsection if it is:

   a. A share in a class one-listed bond mutual fund;

   b. An instrument, other than an asset-backed security, with payments of par value fixed as to amount and timing, or callable but in any event payable only at par or greater, and interest or dividend cash flows that are based on either a fixed or variable rate determined by reference to a specified rate or index;

   c. An instrument, other than an asset-backed security, that has a par value and is purchased at a price no greater than one hundred ten percent (110%) of par;

   d. An instrument, including an asset-backed security, whose rate of return would become negative only as a result of a prepayment due to casualty, condemnation or economic obsolescence of collateral or change of law;

   e. An asset-backed security that relies on collateral that meets the requirements of Subparagraph (b) of this paragraph, the par value of which collateral:

      i. Is not permitted to be paid sooner than one half of the remaining term to maturity from the date of acquisition;

      ii. Is permitted to be paid prior to maturity only at a premium sufficient to provide a yield to maturity for the investment, considering the amount prepaid and reinvestment rates at the time of early repayment, at least equal to the yield to
maturity of the initial investment; or

(iii) Is permitted to be paid prior to maturity at a premium at least equal to the yield of a treasury issue of comparable remaining life; or

(f) An asset-backed security that relies on cash flows from assets that are not prepayable at any time at par, but is not otherwise governed by Subparagraph (e) of this paragraph, if the asset-backed security has a par value reflecting principal payments to be received if held until retired by or on behalf of the issuer and is purchased at a price no greater than one hundred five percent (105%) of such par amount.

(2) An asset-backed security that:

(a) Relies on cash flows from assets that are prepayable at par at any time;

(b) Does not make payments of par that are fixed as to amount and timing; and

(c) Has a negative rate of return at the time of acquisition if a prepayment threshold assumption is used with such prepayment threshold assumption defined as either:

(i) Two (2) times the prepayment expectation reported by a recognized, publicly available source as being the median of expectations contributed by broker dealers or other entities, except insurers, engaged in the business of selling or evaluating such securities or assets. The prepayment expectation used in this calculation shall be, at the insurer's election, the prepayment expectation for pass-through securities of the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation, the Government National Mortgage Association, or for other assets of the same type as the assets that underlie the asset-backed security, in either case with a gross weighted average coupon comparable to the gross weighted average coupon of the assets that underlie the asset-backed security; or

(ii) Another prepayment threshold assumption specified by the commissioner by regulation promulgated under Section 8.
(3) For purposes of Subparagraph 2 of this subsection, if the asset-backed security is purchased in combination with one or more other asset-backed securities that are supported by identical underlying collateral, the insurer may calculate the rate of return for these specific combined asset-backed securities in combination. The insurer must maintain documentation demonstrating that such securities were acquired and are continuing to be held in combination.

DDDD. “State” means a state, territory or possession of the United States of America, the District of Columbia or the Commonwealth of Puerto Rico.

EEEE. “Substantially similar securities” means securities that meet all criteria for substantially similar specified in the NAIC Accounting Practices and Procedures Manual, as amended, and in an amount that constitutes good delivery form as determined from time to time by the Public Securities Administration.

FFFF. “SVO” means the Securities Valuation Office of the NAIC or any successor office established by the NAIC.

GGGG. “Swap” means an agreement to exchange or to net payments at one or more times based on the actual or expected price, level, performance or value of one or more underlying interests.

HHHH. “Underlying interest” means the assets, liabilities, other interests or a combination thereof underlying a derivative instrument, such as any one or more securities, currencies, rates, indices, commodities or derivative instruments.

IIII. “Unrestricted surplus” means the amount by which total admitted assets exceed 125 percent of the insurer’s required liabilities.

JJJJ. “Warrant” means an instrument that gives the holder the right to purchase an underlying financial instrument at a given price and time or at a series of prices and times outlined in the warrant agreement. Warrants may be issued alone or in connection with the sale of other securities, for example, as part of a merger or recapitalization agreement, or to facilitate divestiture of the securities of another business entity.

Section 3. General Investment Qualifications

A. Insurers may acquire, hold or invest in investments or engage in investment practices as set forth in this Act. Investments not conforming to this Act shall not be admitted assets.

Drafting Note 6: It may be necessary to modify the language in Section 3A to address investments in affiliated entities permitted under other portions of the code.

B. Subject to Subsection C of this section, an insurer shall not acquire or hold an investment as an admitted asset unless at the time of acquisition it is:

(1) Eligible for the payment or accrual of interest or discount (whether in cash or other securities), eligible to receive dividends or other distributions or is otherwise income producing; or
(2) Acquired under Sections 15C, 16, 18, 20, 28C, 29, 31 or 32 or under the authority of sections of the code other than this Act.

C. An insurer may acquire or hold as admitted assets investments that do not otherwise qualify as provided in this Act if the insurer has not acquired them for the purpose of circumventing any limitations contained in this Act, if the insurer acquires the investments in the following circumstances and the insurer complies with the provisions of Sections 5 and 7 as to the investments:

(1) As payment on account of existing indebtedness or in connection with the refinancing, restructuring or workout of existing indebtedness, if taken to protect the insurer’s interest in that investment;

(2) As realization on collateral for an obligation;

(3) In connection with an otherwise qualified investment or investment practice, as interest on or a dividend or other distribution related to the investment or investment practice or in connection with the refinancing of the investment, in each case for no additional or only nominal consideration;

(4) Under a lawful and bona fide agreement of recapitalization or voluntary or involuntary reorganization in connection with an investment held by the insurer; or

(5) Under a bulk reinsurance, merger or consolidation transaction approved by the commissioner if the assets constitute admissible investments for the ceding, merged or consolidated companies.

D. An investment or portion of an investment acquired by an insurer under Subsection C of this section shall become a nonadmitted asset three (3) years (or five (5) years in the case of mortgage loans and real estate) from the date of its acquisition, unless within that period the investment has become a qualified investment under a section of this Act other than Subsection C of this section, but an investment acquired under an agreement of bulk reinsurance, merger or consolidation may be qualified for a longer period if so provided in the plan for reinsurance, merger or consolidation as approved by the commissioner. Upon application by the insurer and a showing that the nonadmission of an asset held under Subsection C of this section would materially injure the interests of the insurer, the commissioner may extend the period for admissibility for an additional reasonable period of time.

E. Except as provided in Subsections F and H of this section, an investment shall qualify under this Act if, on the date the insurer committed to acquire the investment or on the date of its acquisition, it would have qualified under this Act. For the purposes of determining limitations contained in this Act, an insurer shall give appropriate recognition to any commitments to acquire investments.

F. (1) An investment held as an admitted asset by an insurer on the effective date of this Act which qualified under [insert reference to state’s prior code provisions on insurer investments] shall remain qualified as an admitted asset under this Act.
(2) Each specific transaction constituting an investment practice of the type described in this Act that was lawfully entered into by an insurer and was in effect on the effective date of this Act shall continue to be permitted under this Act until its expiration or termination under its terms.

G. Unless otherwise specified, an investment limitation computed on the basis of an insurer’s admitted assets or capital and surplus shall relate to the amount required to be shown on the statutory balance sheet of the insurer most recently required to be filed with the commissioner. For purposes of computing any limitation based upon admitted assets, the insurer shall deduct from the amount of its admitted assets the amount of the liability recorded on its statutory balance sheet for:

(1) The return of acceptable collateral received in a reverse repurchase transaction or a securities lending transaction;

(2) Cash received in a dollar roll transaction; and

(3) The amount reported as borrowed money in the most recently filed financial statement to the extent not included in Paragraphs (1) and (2) of this subsection.

H. An investment qualified, in whole or in part, for acquisition or holding as an admitted asset may be qualified or requalified at the time of acquisition or a later date, in whole or in part, under any other section, if the relevant conditions contained in the other section are satisfied at the time of qualification or requalification.

I. An insurer shall maintain documentation demonstrating that investments were acquired in accordance with this Act, and specifying the section of this Act under which they were acquired.

J. An insurer shall not enter into an agreement to purchase securities in advance of their issuance for resale to the public as part of a distribution of the securities by the issuer or otherwise guarantee the distribution, except that an insurer may acquire privately placed securities with registration rights.

K. Notwithstanding the provisions of this Act, the commissioner, for good cause, may order under the state’s administrative procedures or equivalent, an insurer to nonadmit, limit, dispose of, withdraw from or discontinue an investment or investment practice. The authority of the commissioner under this subsection is in addition to any other authority of the commissioner.

L. Insurance futures and insurance futures options are not considered investments or investment practices for purposes of this Act.

Section 4. Authorization of Investments by the Board of Directors

A. An insurer’s board of directors shall adopt a written plan for acquiring and holding investments and for engaging in investment practices that specifies guidelines as to the quality, maturity and diversification of investments and other specifications including investment strategies intended to assure that the investments and investment practices are appropriate for the business conducted by the insurer, its liquidity needs and its capital and surplus. The board shall review and assess the insurer’s technical investment and administrative capabilities and expertise before
adopting a written plan concerning an investment strategy or investment practice.

B. Investments acquired and held under this Act shall be acquired and held under the supervision and direction of the board of directors of the insurer. The board of directors shall evidence by formal resolution, at least annually, that it has determined whether all investments have been made in accordance with delegations, standards, limitations and investment objectives prescribed by the board or a committee of the board charged with the responsibility to direct its investments.

C. On no less than a quarterly basis, and more often if deemed appropriate, an insurer’s board of directors or committee of the board of directors shall:

(1) Receive and review a summary report on the insurer’s investment portfolio, its investment activities and investment practices engaged in under delegated authority, in order to determine whether the investment activity of the insurer is consistent with its written plan; and

(2) Review and revise, as appropriate, the written plan.

D. In discharging its duties under this section, the board of directors shall require that records of any authorizations or approvals, other documentation as the board may require and reports of any action taken under authority delegated under the plan referred to in Subsection A of this section shall be made available on a regular basis to the board of directors.

E. In discharging their duties under this section, the directors of an insurer shall perform their duties in good faith and with that degree of care that ordinarily prudent individuals in like positions would use under similar circumstances.

F. If an insurer does not have a board of directors, all references to the board of directors in this Act shall be deemed to be references to the governing body of the insurer having authority equivalent to that of a board of directors.

Section 5. Prohibited Investments

An insurer shall not, directly or indirectly:

A. Invest in an obligation or security or make a guarantee for the benefit of or in favor of an officer or director of the insurer, except as provided in Section 6;

B. Invest in an obligation or security, make a guarantee for the benefit of or in favor of, or make other investments in a business entity of which ten percent (10%) or more of the voting securities or equity interests are owned directly or indirectly by or for the benefit of one or more officers or directors of the insurer, except as authorized in the [insert reference to holding company law] or provided in Section 6;

C. Engage on its own behalf or through one or more affiliates in a transaction or series of transactions designed to evade the prohibitions of this Act;

D. (1) Invest in a partnership as a general partner, except that an insurer may make an investment as a general partner:

(a) If all other partners in the partnership are subsidiaries of the insurer;
(b) For the purpose of:

(i) Meeting cash calls committed to prior to the effective date of this Act;

(ii) Completing those specific projects or activities of the partnership in which the insurer was a general partner as of the effective date of this Act that had been undertaken as of that date; or

(iii) Making capital improvements to property owned by the partnership on the effective date of this Act if the insurer was a general partner as of that date; or

(c) In accordance with Section 3C;

(2) This subsection shall not prohibit a subsidiary or other affiliate of the insurer from becoming a general partner; or

E. Invest in or lend its funds upon the security of shares of its own stock, except that an insurer may acquire shares of its own stock for the following purposes, but the shares shall not be admitted assets of the insurer:

(1) Conversion of a stock insurer into a mutual or reciprocal insurer or a mutual or reciprocal insurer into a stock insurer;

(2) Issuance to the insurer’s officers, employees or agents in connection with a plan approved by the commissioner for converting a publicly held insurer into a privately held insurer under [insert reference to the section of the code providing for approval of a conversion plan] or in connection with other stock option and employee benefit plans; or

(3) In accordance with any other plan approved by the commissioner.

Section 6. Loans to Officers and Directors

A. (1) Except as provided in Section 6B, an insurer shall not, without the prior written approval of the commissioner, directly or indirectly:

(a) Make a loan to or other investment in an officer or director of the insurer or a person in which the officer or director has any direct or indirect financial interest;

(b) Make a guarantee for the benefit of or in favor of an officer or director of the insurer or a person in which the officer or director has any direct or indirect financial interest; or

(c) Enter into an agreement for the purchase or sale of property from or to an officer or director of the insurer or a person in which the officer or director has any direct or indirect financial interest.

(2) For purposes of this section, an officer or director shall not be deemed to have a financial interest by reason of an interest that is held directly or indirectly through the ownership of equity interests representing less than two percent
(2%) of all outstanding equity interests issued by a person that is a party to the transaction, or solely by reason of that individual's position as a director or officer of a person that is a party to the transaction.

(3) This subsection does not permit an investment that is prohibited by Section 5.

(4) This subsection does not apply to a transaction between an insurer and any of its subsidiaries or affiliates that is entered into in compliance with the [insert reference to holding company law], other than a transaction between an insurer and its officer or director.

B. An insurer may make, without the prior written approval of the commissioner:

(1) Policy loans in accordance with the terms of the policy or contract and Section 19;

(2) Advances to officers or directors for expenses reasonably expected to be incurred in the ordinary course of the insurer's business or guarantees associated with credit or charge cards issued or credit extended for the purpose of financing these expenses;

(3) Loans secured by the principal residence of an existing or new officer of the insurer made in connection with the officer's relocation at the insurer's request, if the loans comply with the requirements of Section 15 or 28 and the terms and conditions otherwise are the same as those generally available from unaffiliated third parties;

(4) Secured loans to an existing or new officer of the insurer made in connection with the officer's relocation at the insurer's request, if the loans:
   (a) Do not have a term exceeding two (2) years;
   (b) Are required to finance mortgage loans outstanding at the same time on the prior and new residences of the officer;
   (c) Do not exceed an amount equal to the equity of the officer in the prior residence; and
   (d) Are required to be fully repaid upon the earlier of the end of the two (2) year period or the sale of the prior residence; and

(5) Loans and advances to officers or directors made in compliance with state or federal law specifically related to the loans and advances by a regulated non-insurance subsidiary or affiliate of the insurer in the ordinary course of business and on terms no more favorable than available to other customers of the entity.
Section 7. Valuation of Investments

For the purposes of this Act, the value or amount of an investment acquired or held, or an investment practice engaged in, under this Act, unless otherwise specified in this code, shall be the value at which assets of an insurer are required to be reported for statutory accounting purposes as determined in accordance with procedures prescribed in published accounting and valuation standards of the NAIC, including the Purposes and Procedures of the Securities Valuation NAIC Investment Analysis Office, the Valuation of Securities manual, the Accounting Practices and Procedures manual, the Annual Statement Instructions or any successor valuation procedures officially adopted by the NAIC.

Section 8. Regulations

The commissioner may, in accordance with [insert reference to administrative procedures act or other statutes concerning promulgation of regulations], promulgate regulations implementing the provisions of this Act.

ARTICLE II. LIFE AND HEALTH INSURERS

Section 9. Applicability

This Article shall apply to the investments and investment practices of life and health insurers, subject to the provisions of Section 1B.

Section 10. General Three Percent Diversification, Medium and Lower Grade Investments and Canadian Investments

A. General Three Percent Diversification

(1) Except as otherwise specified in this Act, an insurer shall not acquire, directly or indirectly through an investment subsidiary, an investment under this Act if, as a result of and after giving effect to the investment, the insurer would hold more than three percent (3%) of its admitted assets in investments of all kinds issued, assumed, accepted, insured or guaranteed by a single person, or five percent (5%) of its admitted assets in investments in the voting securities of a depository institution or any company that controls the institution.

(2) This three percent (3%) limitation shall not apply to the aggregate amounts insured by a single financial guaranty insurer with the highest generic rating issued by a nationally recognized statistical rating organization.

(3) Asset-backed securities shall not be subject to the limitations of Paragraph (1) of this subsection, however an insurer shall not acquire an asset-backed security if, as a result of and after giving effect to the investment, the aggregate amount of asset-backed securities secured by or evidencing an interest in a single asset or single pool of assets held by a trust or other business entity, then held by the insurer would exceed three percent (3%) of its admitted assets.
B. Medium and Lower Grade Investments

(1) An insurer shall not acquire, directly or indirectly through an investment subsidiary, an investment under Sections 11, 14, 17 or counterparty exposure under Section 18D if, as a result of and after giving effect to the investment:

(a) The aggregate amount of medium and lower grade investments then held by the insurer would exceed twenty percent (20%) of its admitted assets;

(b) The aggregate amount of lower grade investments then held by the insurer would exceed ten percent (10%) of its admitted assets;

(c) The aggregate amount of investments rated 5 or 6 by the SVO then held by the insurer would exceed three percent (3%) of its admitted assets;

(d) The aggregate amount of investments rated 6 by the SVO then held by the insurer would exceed one percent (1%) of its admitted assets; or

(e) The aggregate amount of medium and lower grade investments then held by the insurer that receive as cash income less than the equivalent yield for Treasury issues with a comparative average life, would exceed one percent (1%) of its admitted assets.

(2) An insurer shall not acquire, directly or indirectly through an investment subsidiary, an investment under Sections 11, 14, 17 or counterparty exposure under Section 18D if, as a result of and after giving effect to the investment:

(a) The aggregate amount of medium and lower grade investments issued, assumed, guaranteed, accepted or insured by any one person or, as to asset-backed securities secured by or evidencing an interest in a single asset or pool of assets, then held by the insurer would exceed one percent (1%) of its admitted assets; or

(b) The aggregate amount of lower grade investments issued, assumed, guaranteed, accepted or insured by any one person or, as to asset-backed securities secured by or evidencing an interest in a single asset or pool of assets, then held by the insurer would exceed one half of one percent (.5%) of its admitted assets.

(3) If an insurer attains or exceeds the limit of any one rating category referred to in this subsection, the insurer shall not thereby be precluded from acquiring investments in other rating categories subject to the specific and multi-category limits applicable to those investments.

C. Canadian Investments

(1) An insurer shall not acquire, directly or indirectly through an investment subsidiary, a Canadian investment authorized by this Act, if as a result of and after giving effect to the investment, the aggregate amount of these investments then held by the insurer would exceed forty percent (40%) of its
admitted assets, or if the aggregate amount of Canadian investments not acquired under Section 11B then held by the insurer would exceed twenty-five percent (25%) of its admitted assets.

(2) However, as to an insurer that is authorized to do business in Canada or that has outstanding insurance, annuity or reinsurance contracts on lives or risks resident or located in Canada and denominated in Canadian currency, the limitations of Paragraph (1) of this subsection shall be increased by the greater of:

(a) The amount the insurer is required by Canadian law to invest in Canada or to be denominated in Canadian currency; or

(b) One hundred fifteen percent (115%) of the amount of its reserves and other obligations under contracts on lives or risks resident or located in Canada.

Section 11. Rated Credit Instruments

Subject to the limitations of Subsection F of this section, an insurer may acquire rated credit instruments:

A. Subject to the limitations of Section 10B, but not to the limitations of Section 10A, an insurer may acquire rated credit instruments issued, assumed, guaranteed or insured by:

(1) The United States; or

(2) A government sponsored enterprise of the United States, if the instruments of the government sponsored enterprise are assumed, guaranteed or insured by the United States or are otherwise backed or supported by the full faith and credit of the United States.

B. (1) Subject to the limitations of Section 10B, but not to the limitations of Section 10A, an insurer may acquire rated credit instruments issued, assumed, guaranteed or insured by:

(a) Canada; or

(b) A government sponsored enterprise of Canada, if the instruments of the government sponsored enterprise are assumed, guaranteed or insured by Canada or are otherwise backed or supported by the full faith and credit of Canada;

(2) However, an insurer shall not acquire an instrument under this subsection if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this subsection would exceed forty percent (40%) of its admitted assets.
C. (1) Subject to the limitations of Section 10B, but not to the limitations of Section 10A, an insurer may acquire rated credit instruments, excluding asset-backed securities:

   (a) Issued by a government money market mutual fund, a class one money market mutual fund or a class one listed bond mutual fund;

   (b) Issued, assumed, guaranteed or insured by a government sponsored enterprise of the United States other than those eligible under Subsection A of this section;

   (c) Issued, assumed, guaranteed or insured by a state, if the instruments are general obligations of the state; or

   (d) Issued by a multilateral development bank;

(2) However, an insurer shall not acquire an instrument of any one fund, any one enterprise or entity or any one state under this subsection if, as a result of and after giving effect to the investment, the aggregate amount of investments then held in any one fund, enterprise or entity or state under this subsection would exceed ten percent (10%) of its admitted assets.

D. Subject to the limitations of Section 10, an insurer may acquire preferred stocks that are not foreign investments and that meet the requirements of rated credit instruments if, as a result of and after giving effect to the investment:

   (1) The aggregate amount of preferred stocks then held by the insurer under this subsection does not exceed twenty percent (20%) of its admitted assets; and

   (2) The aggregate amount of preferred stocks then held by the insurer under this subsection which are not sinking fund stocks or rated P1 or P2 by the SVO does not exceed ten percent (10%) of its admitted assets.

E. Subject to the limitations of Section 10, in addition to those investments eligible under Subsections A, B, C and D of this section, an insurer may acquire rated credit instruments that are not foreign investments.

F. An insurer shall not acquire special rated credit instruments under this section if, as a result of and after giving effect to the investment, the aggregate amount of special rated credit instruments then held by the insurer would exceed five percent (5%) of its admitted assets.

Drafting Note 7: In states which have not adopted Secondary Mortgage Market Enhancement Act of 1984, as amended (SMMEA) override legislation, obligations of Federal National Mortgage Association, Federal Home Loan Mortgage Corporation, and other mortgage-backed or mortgage related securities as defined in Section 106 of Title I of SMMEA (15 U.S.C. § 77r-1) may be invested in to the same extent as allowed under Section 11A, whether or not they are rated credit instruments authorized in Section 11A. Appropriate changes to Section 11 or other Sections of this Act may be necessary.
Section 12. Insurer Investment Pools

A. An insurer may acquire investments in investment pools that:

(1) Invest only in:

(a) Obligations that are rated 1 or 2 by the SVO or have an equivalent of an SVO 1 or 2 rating (or, in the absence of a 1 or 2 rating or equivalent rating, the issuer has outstanding obligations with an SVO 1 or 2 or equivalent rating) by a nationally recognized statistical rating organization recognized by the SVO and have:

(i) A remaining maturity of 397 days or less or a put that entitles the holder to receive the principal amount of the obligation which put may be exercised through maturity at specified intervals not exceeding 397 days; or

(ii) A remaining maturity of three (3) years or less and a floating interest rate that resets no less frequently than quarterly on the basis of a current short-term index (federal funds, prime rate, treasury bills, London InterBank Offered Rate (LIBOR) or commercial paper) and is subject to no maximum limit, if the obligations do not have an interest rate that varies inversely to market interest rate changes;

(b) Government money market mutual funds or class one money market mutual funds; or

(c) Securities lending, repurchase and reverse repurchase transactions that meet all the requirements of Section 16, except the quantitative limitations of Section 16D; or

(2) Invest only in investments which an insurer may acquire under this Act, if the insurer's proportionate interest in the amount invested in these investments does not exceed the applicable limits of this Act.

B. For an investment in an investment pool to be qualified under this Act, the investment pool shall not:

(1) Acquire securities issued, assumed, guaranteed or insured by the insurer or an affiliate of the insurer;

(2) Borrow or incur any indebtedness for borrowed money, except for securities lending and reverse repurchase transactions that meet the requirements of Section 16 except the quantitative limitations of Section 16D; or

(3) Permit the aggregate value of securities then loaned or sold to, purchased from or invested in any one business entity under this section to exceed ten percent (10%) of the total assets of the investment pool.

C. The limitations of Section 10A shall not apply to an insurer's investment in an investment pool, however an insurer shall not acquire an investment in an investment pool under this section if, as a result of and after giving effect to the
investment, the aggregate amount of investments then held by the insurer under this section:

(1) In any one investment pool would exceed ten percent (10%) of its admitted assets;

(2) In all investment pools investing in investments permitted under Subsection A(2) of this section would exceed twenty-five percent (25%) of its admitted assets; or

(3) In all investment pools would exceed thirty-five percent (35%) of its admitted assets.

D. For an investment in an investment pool to be qualified under this Act, the manager of the investment pool shall:

(1) Be organized under the laws of the United States or a state and designated as the pool manager in a pooling agreement;

(2) Be the insurer, an affiliated insurer or a business entity affiliated with the insurer, a qualified bank, a business entity registered under the Investment Advisors Act of 1940 (15 U.S.C. §§ 80a-1 et seq.), as amended or, in the case of a reciprocal insurer or interinsurance exchange, its attorney-in-fact, or in the case of a United States branch of an alien insurer, its United States manager or affiliates or subsidiaries of its United States manager;

(3) Compile and maintain detailed accounting records setting forth:

   (a) The cash receipts and disbursements reflecting each participant’s proportionate investment in the investment pool;

   (b) A complete description of all underlying assets of the investment pool (including amount, interest rate, maturity date (if any) and other appropriate designations); and

   (c) Other records which, on a daily basis, allow third parties to verify each participant’s investment in the investment pool; and

(4) Maintain the assets of the investment pool in one or more accounts, in the name of or on behalf of the investment pool, under a custody agreement with a qualified bank. The custody agreement shall:

   (a) State and recognize the claims and rights of each participant;

   (b) Acknowledge that the underlying assets of the investment pool are held solely for the benefit of each participant in proportion to the aggregate amount of its investments in the investment pool; and

   (c) Contain an agreement that the underlying assets of the investment pool shall not be commingled with the general assets of the custodian qualified bank or any other person.

E. The pooling agreement for each investment pool shall be in writing and shall provide that:
(1) An insurer and its affiliated insurers or, in the case of an investment pool investing solely in investments permitted under Subsection A(1) of this section, the insurer and its subsidiaries, affiliates or any pension or profit sharing plan of the insurer, its subsidiaries and affiliates or, in the case of a United States branch of an alien insurer, affiliates or subsidiaries of its United States manager, shall, at all times, hold one hundred percent (100%) of the interests in the investment pool;

(2) The underlying assets of the investment pool shall not be commingled with the general assets of the pool manager or any other person;

(3) In proportion to the aggregate amount of each pool participant’s interest in the investment pool:
   (a) Each participant owns an undivided interest in the underlying assets of the investment pool; and
   (b) The underlying assets of the investment pool are held solely for the benefit of each participant;

(4) A participant, or in the event of the participant’s insolvency, bankruptcy or receivership, its trustee, receiver or other successor-in-interest, may withdraw all or any portion of its investment from the investment pool under the terms of the pooling agreement;

(5) Withdrawals may be made on demand without penalty or other assessment on any business day, but settlement of funds shall occur within a reasonable and customary period thereafter not to exceed five (5) business days. Distributions under this paragraph shall be calculated in each case net of all then applicable fees and expenses of the investment pool. The pooling agreement shall provide that the pool manager shall distribute to a participant, at the discretion of the pool manager:
   (a) In cash, the then fair market value of the participant’s pro rata share of each underlying asset of the investment pool;
   (b) In kind, a pro rata share of each underlying asset; or
   (c) In a combination of cash and in kind distributions, a pro rata share in each underlying asset; and

(6) The pool manager shall make the records of the investment pool available for inspection by the commissioner.

Section 13. Equity Interests

A. Subject to the limitations of Section 10, an insurer may acquire equity interests in business entities organized under the laws of any domestic jurisdiction.
B. An insurer shall not acquire an investment under this section if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this section would exceed twenty percent (20%) of its admitted assets, or the amount of equity interests then held by the insurer that are not listed on a qualified exchange would exceed five percent (5%) of its admitted assets. An accident and health insurer shall not be subject to this section but shall be subject to the same aggregate limitation on equity interests as a property and casualty insurer under Section 26 and also to the provisions of Section 22 of this Act.

C. An insurer shall not acquire under this section any investments that the insurer may acquire under Section 15.

D. An insurer shall not short sell equity investments unless the insurer covers the short sale by owning the equity investment or an unrestricted right to the equity instrument exercisable within six (6) months of the short sale.

Section 14. Tangible Personal Property Under Lease

A. (1) Subject to the limitations of Section 10, an insurer may acquire tangible personal property or equity interests therein located or used wholly or in part within a domestic jurisdiction either directly or indirectly through limited partnership interests and general partnership interests not otherwise prohibited by Section 5D, joint ventures, stock of an investment subsidiary or membership interests in a limited liability company, trust certificates or other similar instruments.

(2) Investments acquired under Paragraph (1) of this subsection shall be eligible only if:

(a) The property is subject to a lease or other agreement with a person whose rated credit instruments in the amount of the purchase price of the personal property the insurer could then acquire under Section 11; and

(b) The lease or other agreement provides the insurer the right to receive rental, purchase or other fixed payments for the use or purchase of the property, and the aggregate value of the payments, together with the estimated residual value of the property at the end of its useful life and the estimated tax benefits to the insurer resulting from ownership of the property, shall be adequate to return the cost of the insurer’s investment in the property, plus a return deemed adequate by the insurer.

B. The insurer shall compute the amount of each investment under this section on the basis of the out-of-pocket purchase price and applicable related expenses paid by the insurer for the investment, net of each borrowing made to finance the purchase price and expenses, to the extent the borrowing is without recourse to the insurer.

C. An insurer shall not acquire an investment under this section if, as a result of and after giving effect to the investment, the aggregate amount of all investments then held by the insurer under this section would exceed:
(1) Two percent (2%) of its admitted assets; or
(2) One half of one percent (.5%) of its admitted assets as to any single item of
tangible personal property.

D. For purposes of determining compliance with the limitations of Section 10,
investments acquired by an insurer under this section shall be aggregated with those
acquired under Section 11, and each lessee of the property under a lease referred to
in this section shall be deemed the issuer of an obligation in the amount of the
investment of the insurer in the property determined as provided in Subsection B of
this section.

E. Nothing in this section is applicable to tangible personal property lease arrangements
between an insurer and its subsidiaries and affiliates under a cost sharing
arrangement or agreement permitted under [insert reference to holding company
law].

Section 15. Mortgage Loans and Real Estate

A. Mortgage Loans

(l) Subject to the limitations of Section 10, an insurer may acquire, either
directly, indirectly through limited partnership interests and general
partnership interests not otherwise prohibited by Section 5D, joint ventures,
stock of an investment subsidiary or membership interests in a limited
liability company, trust certificates, or other similar instruments, obligations
secured by mortgages on real estate situated within a domestic jurisdiction,
but a mortgage loan which is secured by other than a first lien shall not be
acquired unless the insurer is the holder of the first lien. The obligations held
by the insurer and any obligations with an equal lien priority, shall not, at
the time of acquisition of the obligation, exceed:

(a) Ninety percent (90%) of the fair market value of the real estate, if the
mortgage loan is secured by a purchase money mortgage or like
security received by the insurer upon disposition of the real estate;

(b) Eighty percent (80%) of the fair market value of the real estate, if the
mortgage loan requires immediate scheduled payment in periodic
installments of principal and interest, has an amortization period of
thirty (30) years or less and periodic payments made no less
frequently than annually. Each periodic payment shall be sufficient to
assure that at all times the outstanding principal balance of the
mortgage loan shall be not greater than the outstanding principal
balance that would be outstanding under a mortgage loan with the
same original principal balance, with the same interest rate and
requiring equal payments of principal and interest with the same
frequency over the same amortization period. Mortgage loans
permitted under this subsection are permitted notwithstanding the
fact that they provide for a payment of the principal balance prior to
the end of the period of amortization of the loan. For residential
mortgage loans, the eighty percent (80%) limitation may be increased
to ninety-seven percent (97%) if acceptable private mortgage
insurance has been obtained; or
(c) Seventy-five percent (75%) of the fair market value of the real estate for mortgage loans that do not meet the requirements of Subparagraphs (a) or (b) of this paragraph.

(2) For purposes of Paragraph (1) of this subsection, the amount of an obligation required to be included in the calculation of the loan-to-value ratio may be reduced to the extent the obligation is insured by the Federal Housing Administration or guaranteed by the Administrator of Veterans Affairs, or their successors.

(3) A mortgage loan that is held by an insurer under Section 3F or acquired under this section and is restructured in a manner that meets the requirements of a restructured mortgage loan in accordance with the NAIC Accounting Practices and Procedures Manual or successor publication shall continue to qualify as a mortgage loan under this Act.

(4) Subject to the limitations of Section 10, credit lease transactions that do not qualify for investment under Section 11 with the following characteristics shall be exempt from the provisions of Paragraph (1) of this subsection:

(a) The loan amortizes over the initial fixed lease term at least in an amount sufficient so that the loan balance at the end of the lease term does not exceed the original appraised value of the real estate;

(b) The lease payments cover or exceed the total debt service over the life of the loan;

(c) A tenant or its affiliated entity whose rated credit instruments have a SVO 1 or 2 designation or a comparable rating from a nationally recognized statistical rating organization recognized by the SVO has a full faith and credit obligation to make the lease payments;

(d) The insurer holds or is the beneficial holder of a first lien mortgage on the real estate;

(e) The expenses of the real estate are passed through to the tenant, excluding exterior, structural, parking and heating, ventilation and air conditioning replacement expenses, unless annual escrow contributions, from cash flows derived from the lease payments, cover the expense shortfall; and

(f) There is a perfected assignment of the rents due pursuant to the lease to, or for the benefit of, the insurer.

B. Income Producing Real Estate

(1) An insurer may acquire, manage and dispose of real estate situated in a domestic jurisdiction either directly or indirectly through limited partnership interests and general partnership interests not otherwise prohibited by Section 5D, joint ventures, stock of an investment subsidiary or membership interests in a limited liability company, trust certificates, or other similar instruments. The real estate shall be income producing or intended for improvement or development for investment purposes under an existing
program (in which case the real estate shall be deemed to be income producing).

(2) The real estate may be subject to mortgages, liens or other encumbrances, the amount of which shall, to the extent that the obligations secured by the mortgages, liens or encumbrances are without recourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with Subsections D(2) and D(3) of this section.

C. Real Estate for the Accommodation of Business

An insurer may acquire, manage, and dispose of real estate for the convenient accommodation of the insurer’s (which may include its affiliates) business operations, including home office, branch office and field office operations.

(1) Real estate acquired under this subsection may include excess space for rent to others, if the excess space, valued at its fair market value, would otherwise be a permitted investment under Subsection B of this section and is so qualified by the insurer;

(2) The real estate acquired under this subsection may be subject to one or more mortgages, liens or other encumbrances, the amount of which shall, to the extent that the obligations secured by the mortgages, liens or encumbrances are without recourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with Subsection D(4) of this section; and

(3) For purposes of this subsection, business operations shall not include that portion of real estate used for the direct provision of health care services by an accident and health insurer for its insureds. An insurer may acquire real estate used for these purposes under Subsection B of this section.

D. Quantitative Limitations

(1) An insurer shall not acquire an investment under Subsection A of this section if, as a result of and after giving effect to the investment, the aggregate amount of all investments then held by the insurer under Subsection A of this section would exceed:

   (a) One percent (1%) of its admitted assets in mortgage loans covering any one secured location;

   (b) One quarter of one percent (.25%) of its admitted assets in construction loans covering any one secured location; or

   (c) Two percent (2%) of its admitted assets in construction loans in the aggregate.

(2) An insurer shall not acquire an investment under Subsection B of this section if, as a result of and after giving effect to the investment and any outstanding guarantees made by the insurer in connection with the investment, the aggregate amount of investments then held by the insurer under Subsection
B of this section plus the guarantees then outstanding would exceed:

(a) One percent (1%) of its admitted assets in one parcel or group of contiguous parcels of real estate, except that this limitation shall not apply to that portion of real estate used for the direct provision of health care services by an accident and health insurer for its insureds, such as hospitals, medical clinics, medical professional buildings or other health facilities used for the purpose of providing health services; or

(b) Fifteen percent (15%) of its admitted assets in the aggregate, but not more than five percent (5%) of its admitted assets as to properties that are to be improved or developed.

(3) An insurer shall not acquire an investment under Subsections A or B of this section if, as a result of and after giving effect to the investment and any guarantees made by the insurer in connection with the investment, the aggregate amount of all investments then held by the insurer under Subsections A and B of this section plus the guarantees then outstanding would exceed forty-five percent (45%) of its admitted assets. However, an insurer may exceed this limitation by no more than thirty percent (30%) of its admitted assets if:

(a) This increased amount is invested only in residential mortgage loans;

(b) The insurer has no more than ten percent (10%) of its admitted assets invested in mortgage loans other than residential mortgage loans;

(c) The loan-to-value ratio of each residential mortgage loan does not exceed sixty percent (60%) at the time the mortgage loan is qualified under this increased authority, and the fair market value is supported by an appraisal no more than two (2) years old, prepared by an independent appraiser;

(d) A single mortgage loan qualified under this increased authority shall not exceed one half of one percent (0.5%) of its admitted assets;

(e) The insurer files with the commissioner, and receives approval from the commissioner for, a plan that is designed to result in a portfolio of residential mortgage loans that is sufficiently geographically diversified; and

(f) The insurer agrees to file annually with the commissioner records that demonstrate that its portfolio of residential mortgage loans is geographically diversified in accordance with the plan.

(4) The limitations of Section 10 shall not apply to an insurer’s acquisition of real estate under Subsection C of this section. An insurer shall not acquire real estate under Subsection C of this section if, as a result of and after giving effect to the acquisition, the aggregate amount of real estate then held by the insurer under Subsection C of this section would exceed ten percent (10%) of its admitted assets. With the permission of the commissioner, additional amounts of real estate may be acquired under Subsection C of this section.
Section 16. Securities Lending, Repurchase, Reverse Repurchase and Dollar Roll Transactions

An insurer may enter into securities lending, repurchase, reverse repurchase and dollar roll transactions with business entities, subject to the following requirements:

A. The insurer's board of directors shall adopt a written plan that is consistent with the requirements of the written plan in Section 4A that specifies guidelines and objectives to be followed, such as:

   (1) A description of how cash received will be invested or used for general corporate purposes of the insurer;

   (2) Operational procedures to manage interest rate risk, counterparty default risk, the conditions under which proceeds from \textit{reverse}-repurchase transactions may be used in the ordinary course of business and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction; and

   (3) The extent to which the insurer may engage in these transactions.

B. The insurer shall enter into a written agreement for all transactions authorized in this section other than dollar roll transactions. The written agreement shall require that each transaction terminate no more than one year from its inception or upon the earlier demand of the insurer. The agreement shall be with the business entity counterparty, but for securities lending transactions, the agreement may be with an agent acting on behalf of the insurer, if the agent is a qualified business entity, and if the agreement:

   (1) Requires the agent to enter into separate agreements with each counterparty that are consistent with the requirements of this section; and

   (2) Prohibits securities lending transactions under the agreement with the agent or its affiliates.

C. Cash received in a transaction under this section shall be invested in accordance with this Act and in a manner that recognizes the liquidity needs of the transaction or used by the insurer for its general corporate purposes. For so long as the transaction remains outstanding, the insurer, its agent or custodian shall maintain, as to acceptable collateral received in a transaction under this section, either physically or through the book entry systems of the Federal Reserve, Depository Trust Company, Participants Trust Company or other securities depositories approved by the commissioner:

   (1) Possession of the acceptable collateral;

   (2) A perfected security interest in the acceptable collateral; or

   (3) In the case of a jurisdiction outside of the United States, title to, or rights of a secured creditor to, the acceptable collateral.

D. The limitations of Sections 10 and 17 shall not apply to the business entity
counterparty exposure created by transactions under this section. For purposes of calculations made to determine compliance with this subsection, no effect will be given to the insurer’s future obligation to resell securities, in the case of a reverse repurchase transaction, or to repurchase securities, in the case of a reverse repurchase transaction. An insurer shall not enter into a transaction under this section if, as a result of and after giving effect to the transaction:

(1) The aggregate amount of securities then loaned, sold to or purchased from any one business entity counterparty under this section would exceed five percent (5%) of its admitted assets. In calculating the amount sold to or purchased from a business entity counterparty under repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement; or

(2) The aggregate amount of all securities then loaned, sold to or purchased from all business entities under this section would exceed forty percent (40%) of its admitted assets.

E. In a securities lending transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to 102 percent of the market value of the securities loaned by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than the market value of the loaned securities, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals 102 percent of the market value of the loaned securities.

F. In a reverse repurchase transaction, other than a dollar roll transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to ninety-five percent (95%) of the market value of the securities transferred by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than ninety-five percent (95%) of the market value of the securities so transferred, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals ninety-five percent (95%) of the market value of the transferred securities.

G. In a dollar roll transaction, the insurer shall receive cash in an amount at least equal to the market value of the securities transferred by the insurer in the transaction as of the transaction date.

H. In a reverse repurchase transaction, the insurer shall receive as acceptable collateral transferred securities having a market value at least equal to 102 percent of the purchase price paid by the insurer for the securities. If at any time the market value of the acceptable collateral is less than 100 percent of the purchase price paid by the insurer, the business entity counterparty shall be obligated to provide additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals 102 percent of the purchase price. Securities acquired by an insurer in a reverse repurchase transaction shall not be sold in a reverse repurchase transaction, loaned in a securities lending transaction or otherwise pledged.

Drafting Note 8: Subsections E, F, and H of this section contain requirements that at the time of drafting this model act
were contained in the *Purposes and Procedures of the Securities Valuation Office*. However, concomitant with the drafting of this model act, a separate task force was considering a revised publication which did not contain these requirements inasmuch as the SVO considered these requirements as accounting-type rules which were deemed not suitable to such a publication. Moreover, another working group was developing a draft of a revised accounting manual but had not considered proposing separate accounting guidance regarding these requirements. Instead, the accounting manual implicitly referred to the requirements stipulated in this model act. Pending the results of consideration of these requirements by the three groups, in concert, these requirements have been included in this model act. If after due consideration, these requirements are included in the revised accounting manual as representative of statutory accounting principles or, in the alternative, are inserted in the revised *Purposes and Procedures of the Securities Valuation Office*, then States may opt not to codify these requirements within their insurer investment code.

Section 17. Foreign Investments and Foreign Currency Exposure

A. Subject to the limitations of Section 10, an insurer may acquire foreign investments, or engage in investment practices with persons of or in foreign jurisdictions, of substantially the same types as those that an insurer is permitted to acquire under this Act, other than of the type permitted under Section 12, if, as a result and after giving effect to the investment:

(1) The aggregate amount of foreign investments then held by the insurer under this subsection does not exceed twenty percent (20%) of its admitted assets; and

(2) The aggregate amount of foreign investments then held by the insurer under this subsection in a single foreign jurisdiction does not exceed ten percent (10%) of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or three percent (3%) of its admitted assets as to any other foreign jurisdiction.

B. Subject to the limitations of Section 10, an insurer may acquire investments, or engage in investment practices denominated in foreign currencies, whether or not they are foreign investments acquired under Subsection A of this section, or additional foreign currency exposure as a result of the termination or expiration of a hedging transaction with respect to investments denominated in a foreign currency, if:

(1) The aggregate amount of investments then held by the insurer under this subsection denominated in foreign currencies does not exceed ten percent (10%) of its admitted assets; and

(2) The aggregate amount of investments then held by the insurer under this subsection denominated in the foreign currency of a single foreign jurisdiction does not exceed ten percent (10%) of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or three percent (3%) of its admitted assets as to any other foreign jurisdiction.

(3) However, an investment shall not be considered denominated in a foreign currency if the acquiring insurer enters into one or more contracts in transactions permitted under Section 18 and the business entity counterparty agrees under the contract or contracts to exchange all payments made on the foreign currency denominated investment for United States currency at a rate which effectively insulates the investment cash flows against future changes in currency exchange rates during the period the contract or contracts are in effect.
C. In addition to investments permitted under Subsections A and B of this section, an insurer that is authorized to do business in a foreign jurisdiction, and that has outstanding insurance, annuity or reinsurance contracts on lives or risks resident or located in that foreign jurisdiction and denominated in foreign currency of that jurisdiction, may acquire foreign investments respecting that foreign jurisdiction, and may acquire investments denominated in the currency of that jurisdiction, subject to the limitations of Section 10. However, investments made under this subsection in obligations of foreign governments, their political subdivisions and government sponsored enterprises shall not be subject to the limitations of Section 10 if those investments carry an SVO rating of 1 or 2. The aggregate amount of investments acquired by the insurer under this subsection shall not exceed the greater of:

1. The amount the insurer is required by the law of the foreign jurisdiction to invest in the foreign jurisdiction; or
2. One hundred fifteen percent (115%) of the amount of its reserves, net of reinsurance, and other obligations under the contracts on lives or risks resident or located in the foreign jurisdiction.

D. In addition to investments permitted under Subsections A and B of this section, an insurer that is not authorized to do business in a foreign jurisdiction, but which has outstanding insurance, annuity or reinsurance contracts on lives or risks resident or located in that foreign jurisdiction and denominated in foreign currency of that jurisdiction, may acquire foreign investments respecting that foreign jurisdiction, and may acquire investments denominated in the currency of that jurisdiction subject to the limitations of Section 10. However, investments made under this subsection in obligations of foreign governments, their political subdivisions and government sponsored enterprises shall not be subject to the limitations of Section 10 if those investments carry an SVO rating of 1 or 2. The aggregate amount of investments acquired by the insurer under this subsection shall not exceed 105 percent of the amount of its reserves, net of reinsurance, and other obligations under the contracts on lives or risks resident or located in the foreign jurisdiction.

E. Investments acquired under this section shall be aggregated with investments of the same types made under all other sections of this Act, and in a similar manner, for purposes of determining compliance with the limitations, if any, contained in the other sections. Investments in obligations of foreign governments, their political subdivisions and government sponsored enterprises of these persons, except for those exempted under Subsections C and D of this section, shall be subject to the limitations of Section 10.
Section 18. Derivative Transactions

An insurer may, directly or indirectly through an investment subsidiary, engage in derivative transactions under this section under the following conditions:

A. General Conditions

(1) An insurer may use derivative instruments under this section to engage in hedging transactions and certain income generation transactions, as these terms may be further defined in regulations promulgated by the commissioner.

(2) An insurer shall be able to demonstrate to the commissioner the intended hedging characteristics and the ongoing effectiveness of the derivative transaction or combination of the transactions through cash flow testing or other appropriate analyses.

B. Limitations on Hedging Transactions

An insurer may enter into hedging transactions under this section if, as a result of and after giving effect to the transaction:

(1) The aggregate statement value of options, caps, floors and warrants not attached to another financial instrument purchased and used in hedging transactions does not exceed seven and one half percent (7.5%) of its admitted assets;

(2) The aggregate statement value of options, caps and floors written in hedging transactions does not exceed three percent (3%) of its admitted assets; and

(3) The aggregate potential exposure of collars, swaps, forwards and futures used in hedging transactions does not exceed six and one-half percent (6.5%) of its admitted assets.

C. Limitations on Income Generation Transactions

An insurer may only enter into the following types of income generation transactions if, as a result of and after giving effect to the transactions, the aggregate statement value of the fixed income assets that are subject to call or that generate the cash flows for payments under the caps or floors, plus the face value of fixed income securities underlying a derivative instrument subject to call, plus the amount of the purchase obligations under the puts, does not exceed ten percent (10%) of its admitted assets:

(1) Sales of covered call options on non-callable fixed income securities, callable fixed income securities if the option expires by its terms prior to the end of the noncallable period or derivative instruments based on fixed income securities;

(2) Sales of covered call options on equity securities, if the insurer holds in its portfolio, or can immediately acquire through the exercise of options, warrants or conversion rights already owned, the equity securities subject to call during the complete term of the call option sold;
Investments of Insurers Model Act

(3) Sales of covered puts on investments that the insurer is permitted to acquire under this Act, if the insurer has escrowed, or entered into a custodian agreement segregating, cash or cash equivalents with a market value equal to the amount of its purchase obligations under the put during the complete term of the put option sold; or

(4) Sales of covered caps or floors, if the insurer holds in its portfolio the investments generating the cash flow to make the required payments under the caps or floors during the complete term that the cap or floor is outstanding.

D. Counterparty Exposure

An insurer shall include all counterparty exposure amounts in determining compliance with the limitations of Section 10.

E. Additional Transactions

Pursuant to regulations promulgated under Section 8, the commissioner may approve additional transactions involving the use of derivative instruments in excess of the limits of Subsection B of this section or for other risk management purposes under regulations promulgated by the commissioner, but replication transactions shall not be permitted for other than risk management purposes.

Section 19. Policy Loans

A life insurer may lend to a policyholder on the security of the cash surrender value of the policyholder’s policy a sum not exceeding the legal reserve that the insurer is required to maintain on the policy.

Section 20. Additional Investment Authority

A. Solely for the purpose of acquiring investments that exceed the quantitative limitations of Sections 10 through 17, an insurer may acquire under this subsection an investment, or engage in investment practices described in Section 16, but an insurer shall not acquire an investment, or engage in investment practices described in Section 16, under this subsection if, as a result of and after giving effect to the transaction:

(1) The aggregate amount of investments then held by an insurer under this subsection would exceed three percent (3%) of its admitted assets; or

(2) The aggregate amount of investments as to one limitation in Sections 10 through 17 then held by the insurer under this subsection would exceed one percent (1%) of its admitted assets.

B. In addition to the authority provided under Subsection A of this section, an insurer may acquire under this subsection an investment of any kind, or engage in investment practices described in Section 16, that are not specifically prohibited by this Act, without regard to the categories, conditions, standards or other limitations of Sections 10 through 17 if, as a result of and after giving effect to the transaction, the aggregate amount of investments then held under this subsection would not exceed the lesser of:
(a) Ten percent (10%) of its admitted assets; or
(b) Seventy-five percent (75%) of its capital and surplus.

(2) However, an insurer shall not acquire any investment or engage in any investment practice under this subsection if, as a result of and after giving effect to the transaction, the aggregate amount of all investments in any one person then held by the insurer under this subsection would exceed three percent (3%) of its admitted assets.

C. In addition to the investments acquired under Subsections A and B of this section, an insurer may acquire under this subsection an investment of any kind, or engage in investment practices described in Section 16, that are not specifically prohibited by this Act without regard to any limitations of Sections 10 through 17 if:

1. The commissioner grants prior approval;
2. The insurer demonstrates that its investments are being made in a prudent manner and that the additional amounts will be invested in a prudent manner; and
3. As a result of and after giving effect to the transaction the aggregate amount of investments then held by the insurer under this subsection does not exceed the greater of:

   (a) Twenty-five percent (25%) of its capital and surplus; or
   (b) One hundred percent (100%) of capital and surplus less ten percent (10%) of its admitted assets.

D. An investment prohibited under Section 5, not permitted under Section 18 or additional derivative instruments acquired under Section 18 shall not be acquired under this section.

ARTICLE III. PROPERTY AND CASUALTY, FINANCIAL GUARANTY AND MORTGAGE GUARANTY INSURERS

Section 21. Applicability

This Article shall apply to the investments and investment practices of property and casualty, financial guaranty and mortgage guaranty insurers, subject to the provisions of Section 1B.

Section 22. Reserve Requirements

A. Reserve Requirements

1. Subject to all other limitations and requirements of this Act, a property and casualty, financial guaranty, mortgage guaranty or accident and health insurer shall maintain an amount at least equal to one hundred percent (100%) of adjusted loss reserves and loss adjustment expense reserves, one hundred percent (100%) of adjusted unearned premium reserves and one hundred percent (100%) of statutorily required policy and contract reserves in:
Investments of Insurers Model Act

(a) Cash and cash equivalents;

(b) High and medium grade investments that qualify under Sections 24 or 25;

(c) Equity interests that qualify under Section 26 and that are traded on a qualified exchange;

(d) Investments of the type set forth in Section 30 if the investments are rated in the highest generic rating category by a nationally recognized statistical rating organization recognized by the SVO for rating foreign jurisdictions and if any foreign currency exposure is effectively hedged through the maturity date of the investments;

(e) Qualifying investments of the type set forth in Subparagraphs (b), (c) or (d) of this paragraph that are acquired under Section 32;

(f) Interest and dividends receivable on qualifying investments of the type set forth in Subparagraphs (a) through (e) of this subsection; or

(g) Reinsurance recoverable on paid losses.

(2) Reserve Requirement Amount

(a) For purposes of determining the amount of assets to be maintained under this subsection, the calculation of adjusted loss reserves and loss adjustment expense reserves, adjusted unearned premium reserves and statutorily required policy and contract reserves shall be based on the amounts reported as of the most recent annual or quarterly statement date.

(b) Adjusted loss reserves and loss adjustment expense reserves shall be equal to the sum of the amounts derived from the following calculations:

(i) The result of each amount reported by the insurer as losses and loss adjustment expenses unpaid for each accident year for each individual line of business; multiplied by

(ii) The discount factor that is applicable to the line of business and accident year published by the Internal Revenue Service under Internal Revenue Code Section 846 (26 U.S.C. § 846), as amended, for the calendar year that corresponds to the most recent annual statement of the insurer; minus

(iii) Accrued retrospective premiums discounted by an average discount factor. The discount factor shall be calculated by dividing the losses and loss adjustment expenses unpaid after discounting (the product of Items (i) and (ii) in this subparagraph) by loss and loss adjustment expense reserves before discounting Item (i) of this subparagraph.

(iv) For purposes of these calculations, the losses and loss
adjustment expenses unpaid shall be determined net of anticipated salvage and subrogation, and gross of any discount for the time value of money or tabular discount.

(c) Adjusted unearned premium reserves shall be equal to the result of the following calculation:

(i) The amount reported by the insurer as unearned premium reserves; minus

(ii) The admitted asset amounts reported by the insurer as:

   (I) Premiums in and agents’ balances in the course of collection, accident and health premiums due and unpaid and uncollected premiums for accident and health premiums;

   (II) Premiums, agents’ balances and installments booked but deferred and not yet due; and

   (III) Bills receivable, taken for premium.

Drafting Note 9: The amounts to be subtracted are the amounts allowed to be reported as admitted assets on lines 9.1, 9.2 and 11 of page 2 of the Property and Casualty Annual Statement, line 15 of page 2 of the Life and Accident and Health Annual Statement, or line 9 of the Hospital Medical and Dental Service or Indemnity Corporations Annual Statement in accordance with the applicable Annual Statement Instructions and the applicable Accounting Practices and Procedures Manual of the NAIC and like amounts reported in quarterly statements.

(d) Statutorily required policy and contract reserves also shall include, in the case of a financial guaranty insurer, the amounts required by [cite sections of the code that require contingency reserves and any other reserves that are not covered by the terms “loss reserves,” “loss adjustment expense reserves” and “unearned premium reserves” for financial guaranty insurers] and, in the case of a mortgage guaranty insurer, the amounts required by [cite sections of the code that require contingency reserves and any other reserves that are not covered by the terms “loss reserves,” “loss adjustment expense reserves” and “unearned premium reserves” for mortgage guaranty insurers] and, in the case of an accident and health insurer, the amounts required by [cite sections of the code that require additional or contingency reserves and any other reserves that are not covered by the terms “loss reserves,” “loss adjustment expense reserves” and “unearned premium reserves” for accident and health insurers].

B. Monitoring and Reporting

A property and casualty, financial guaranty, mortgage guaranty or accident and health insurer shall supplement its annual statement with a reconciliation and summary of its assets and reserve requirements as required in Subsection A of this section. A reconciliation and summary showing that an insurer’s assets as required in Subsection A of this section are greater than or equal to its undiscounted reserves referred to in Subsection A of this section shall be sufficient to satisfy this requirement. Upon prior notification, the commissioner may require an insurer to submit such a reconciliation and summary with any quarterly statement filed during
the calendar year.

**Drafting Note 10:** The supplement to the annual statement is not intended to be a new exhibit to the NAIC Annual Statement blank. This filing is a state specific filing required by those states adopting this Model Act. Upon adoption by a significant number of states, a change to the NAIC Annual Statement blank to incorporate this exhibit may be considered.

C. Notification Requirements and Mandatory Safeguards

If a property and casualty, financial guaranty, mortgage guaranty or accident and health insurer's assets and reserves do not comply with Subsection A of this section, the insurer shall notify the commissioner immediately of the amount by which the reserve requirements exceed the annual statement value of the qualifying assets, explain why the deficiency exists and within thirty (30) days of the date of the notice propose a plan of action to remedy the deficiency.

D. Authority of the Commissioner

(1) If the commissioner determines that an insurer is not in compliance with Subsection A of this section, the commissioner shall require the insurer to eliminate the condition causing the noncompliance within a specified time from the date the notice of the commissioner's requirement is mailed or delivered to the insurer.

(2) If an insurer fails to comply with the commissioner's requirement under Paragraph (1) of this subsection, the insurer is deemed to be in hazardous financial condition, and the commissioner shall take one or more of the actions authorized by law as to insurers in hazardous financial condition.

Section 23. General Five Percent Diversification, Medium and Lower Grade Investments and Canadian Investments

A. General Five Percent Diversification

(1) Except as otherwise specified in this Act, an insurer shall not acquire directly or indirectly through an investment subsidiary an investment under this Act if, as a result of and after giving effect to the investment, the insurer would hold more than five percent (5%) of its admitted assets in investments of all kinds issued, assumed, accepted, insured or guaranteed by a single person.

(2) This five percent (5%) limitation shall not apply to the aggregate amounts insured by a single financial guaranty insurer with the highest generic rating issued by a nationally recognized statistical rating organization.

(3) Asset-backed securities shall not be subject to the limitations of paragraph (1) of this subsection, however an insurer shall not acquire an asset-backed security if, as a result of and after giving effect to the investment, the aggregate amount of asset-backed securities secured by or evidencing an interest in a single asset or single pool of assets held by a trust or other business entity, then held by the insurer would exceed five percent (5%) of its admitted assets.

B. Medium and Lower Grade Investments

(1) An insurer shall not acquire, directly or indirectly through an investment
subsidiary, an investment under Sections 24, 27, 30 or counterparty exposure under Section 31D if, as a result of and after giving effect to the investment:

(a) The aggregate amount of all medium and lower grade investments then held by the insurer would exceed twenty percent (20%) of its admitted assets;

(b) The aggregate amount of lower grade investments then held by the insurer would exceed ten percent (10%) of its admitted assets;

(c) The aggregate amount of investments rated 5 or 6 by the SVO then held by the insurer would exceed five percent (5%) of its admitted assets;

(d) The aggregate amount of investments rated 6 by the SVO then held by the insurer would exceed one percent (1%) of its admitted assets; or

(e) The aggregate amount of medium and lower grade investments then held by the insurer that receive as cash income less than the equivalent yield for Treasury issues with a comparative average life, would exceed one percent (1%) of its admitted assets.

(2) An insurer shall not acquire, directly or indirectly through an investment subsidiary, an investment under Sections 24, 27, 30 or counterparty exposure under Section 31D if, as a result of and after giving effect to the investment:

(a) The aggregate amount of medium and lower grade investments issued, assumed, guaranteed, accepted or insured by any one person or, as to asset-backed securities secured by or evidencing an interest in a single asset or pool of assets, then held by the insurer would exceed one percent (1%) of its admitted assets; or

(b) The aggregate amount of lower grade investments issued, assumed, guaranteed, accepted or insured by any one person or, as to asset-backed securities secured by or evidencing an interest in a single asset or pool of assets, then held by the insurer would exceed one half of one percent (.5%) of its admitted assets.

(3) If an insurer attains or exceeds the limit of any one rating category referred to in this subsection, the insurer shall not thereby be precluded from acquiring investments in other rating categories subject to the specific and multi-category limits applicable to those investments.

C. Canadian Investments

(1) An insurer shall not acquire, directly or indirectly through an investment subsidiary, any Canadian investments authorized by this Act, if as a result of and after giving effect to the investment, the aggregate amount of these investments then held by the insurer would exceed forty percent (40%) of its admitted assets, or if the aggregate amount of Canadian investments not acquired under Section 24B then held by the insurer would exceed twenty-five percent (25%) of its admitted assets.
(2) However, as to an insurer that is authorized to do business in Canada or that has outstanding insurance, annuity or reinsurance contracts on lives or risks resident or located in Canada and denominated in Canadian currency, the limitations of Paragraph (1) of this subsection shall be increased by the greater of:

(a) The amount the insurer is required by Canadian law to invest in Canada or to be denominated in Canadian currency; or

(b) One hundred twenty-five percent (125%) of the amount of its reserves and other obligations under contracts on risks resident or located in Canada.

Section 24. Rated Credit Instruments

Subject to the limitations of Subsection F of this section, an insurer may acquire rated credit instruments:

A. Subject to the limitations of Section 23B, but not to the limitations of Section 23A, an insurer may acquire rated credit instruments issued, assumed, guaranteed or insured by:

(1) The United States; or

(2) A government sponsored enterprise of the United States, if the instruments of the government sponsored enterprise are assumed, guaranteed or insured by the United States or are otherwise backed or supported by the full faith and credit of the United States.

B. (1) Subject to the limitations of Section 23B, but not to the limitations of Section 23A, an insurer may acquire rated credit instruments issued, assumed, guaranteed or insured by:

(a) Canada; or

(b) A government sponsored enterprise of Canada, if the instruments of the government sponsored enterprise are assumed, guaranteed or insured by Canada or are otherwise backed or supported by the full faith and credit of Canada;

(2) However, an insurer shall not acquire an instrument under this subsection if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this subsection would exceed forty percent (40%) of its admitted assets.

C. (1) Subject to the limitations of Section 23B, but not to the limitations of Section 23A, an insurer may acquire rated credit instruments, excluding asset-backed securities:

(a) Issued by a government money market mutual fund—a class one money market mutual fund or a class one listed bond mutual fund;
(b) Issued, assumed, guaranteed or insured by a government sponsored enterprise of the United States other than those eligible under Subsection A of this section;

(c) Issued, assumed, guaranteed or insured by a state, if the instruments are general obligations of the state; or

(d) Issued by a multilateral development bank.

(2) However, an insurer shall not acquire an instrument of any one fund, any one enterprise or entity, or any one state under this subsection if, as a result of and after giving effect to the investment, the aggregate amount of investments then held in any one fund, enterprise or entity or state under this subsection would exceed ten percent (10%) of its admitted assets.

D. Subject to the limitations of Section 23, an insurer may acquire preferred stocks that are not foreign investments and that meet the requirements of rated credit instruments if, as a result of and after giving effect to the investment:

(1) The aggregate amount of preferred stocks then held by the insurer under this subsection does not exceed twenty percent (20%) of its admitted assets; and

(2) The aggregate amount of preferred stocks then held by the insurer under this subsection which are not sinking fund stocks or rated P1 or P2 by the SVO does not exceed ten percent (10%) of its admitted assets.

E. Subject to the limitations of Section 23 in addition to those investments eligible under Subsections A, B, C and D of this section, an insurer may acquire rated credit instruments that are not foreign investments.

F. An insurer shall not acquire special rated credit instruments under this section if, as a result of and after giving effect to the investment, the aggregate amount of special rated credit instruments then held by the insurer would exceed five percent (5%) of its admitted assets.

Drafting Note 11: In states which have not adopted Secondary Mortgage Market Enhancement Act of 1984, as amended (SMMEA) override legislation, obligations of Federal National Mortgage Association, Federal Home Loan Mortgage Corporation, and other mortgage-backed or mortgage related securities as defined in Section 106 of Title I of SMMEA (15 U.S.C. § 77r-1) may be invested in to the same extent as allowed under Section 24A, whether or not they are rated credit instruments authorized in Section 24A. Appropriate changes to Section 24 or other Sections of this Act may be necessary.

Section 25. Insurer Investment Pools

A. An insurer may acquire investments in investment pools that:

(1) Invest only in:

(a) Obligations that are rated 1 or 2 by the SVO or have an equivalent of an SVO 1 or 2 rating (or, in the absence of a 1 or 2 rating or equivalent rating, the issuer has outstanding obligations with an SVO 1 or 2 or equivalent rating) by a nationally recognized statistical rating organization recognized by the SVO and have:

(i) A remaining maturity of 397 days or less or a put that entitles the holder to receive the principal amount of the obligation
Investments of Insurers Model Act

which put may be exercised through maturity at specified intervals not exceeding 397 days; or

(ii) A remaining maturity of three (3) years or less and a floating interest rate that resets no less frequently than quarterly on the basis of a current short-term index (federal funds, prime rate, treasury bills, London InterBank Offered Rate (LIBOR) or commercial paper) and is subject to no maximum limit, if the obligations do not have an interest rate that varies inversely to market interest rate changes;

(b) Government money market mutual funds or class one money market mutual funds; or

(c) Securities lending, repurchase and reverse repurchase transactions that meet all the requirements of Section 29, except the quantitative limitations of Section 29D; or

(2) Invest only in investments which an insurer may acquire under this Act, if the insurer’s proportionate interest in the amount invested in these investments does not exceed the applicable limits of this Act.

B. For an investment in an investment pool to be qualified under this Act, the investment pool shall not:

(1) Acquire securities issued, assumed, guaranteed or insured by the insurer or an affiliate of the insurer;

(2) Borrow or incur any indebtedness for borrowed money, except for securities lending and reverse repurchase transactions that meet the requirements of Section 29 except the quantitative limitations of Section 29D; or

(3) Permit the aggregate value of securities then loaned or sold to, purchased from or invested in any one business entity under this section to exceed ten percent (10%) of the total assets of the investment pool.

C. The limitations of Section 23A shall not apply to an insurer’s investment in an investment pool, however an insurer shall not acquire an investment in an investment pool under this section if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this section:

(1) In any one investment pool would exceed ten percent (10%) of its admitted assets;

(2) In all investment pools investing in investments permitted under Subsection A(2) of this section would exceed twenty-five percent (25%) of its admitted assets; or

(3) In all investment pools would exceed forty percent (40%) of its admitted assets.

D. For an investment in an investment pool to be qualified under this Act, the manager
of the investment pool shall:

(1) Be organized under the laws of the United States or a state and designated as the pool manager in a pooling agreement;

(2) Be the insurer, an affiliated insurer or a business entity affiliated with the insurer, a qualified bank, a business entity registered under the Investment Advisors Act of 1940 (15 U.S.C. §§ 80a-1 et seq.), as amended or, in the case of a reciprocal insurer or interinsurance exchange, its attorney-in-fact, or in the case of a United States branch of an alien insurer, its United States manager or affiliates or subsidiaries of its United States manager;

(3) Compile and maintain detailed accounting records setting forth:
   (a) The cash receipts and disbursements reflecting each participant’s proportionate investment in the investment pool;
   (b) A complete description of all underlying assets of the investment pool (including amount, interest rate, maturity date (if any) and other appropriate designations); and
   (c) Other records which, on a daily basis, allow third parties to verify each participant’s investment in the investment pool; and

(4) Maintain the assets of the investment pool in one or more accounts, in the name of or on behalf of the investment pool, under a custody agreement with a qualified bank. The custody agreement shall:
   (a) State and recognize the claims and rights of each participant;
   (b) Acknowledge that the underlying assets of the investment pool are held solely for the benefit of each participant in proportion to the aggregate amount of its investments in the investment pool; and
   (c) Contain an agreement that the underlying assets of the investment pool shall not be commingled with the general assets of the custodian qualified bank or any other person.

E. The pooling agreement for each investment pool shall be in writing and shall provide that:

(1) An insurer and its affiliated insurers or, in the case of an investment pool investing solely in investments permitted under Subsection A(1) of this section, the insurer and its subsidiaries, affiliates or any pension or profit sharing plan of the insurer, its subsidiaries and affiliates or, in the case of a United States branch of an alien insurer, affiliates or subsidiaries of its United States manager, shall, at all times, hold one hundred percent (100%) of the interests in the investment pool;

(2) The underlying assets of the investment pool shall not be commingled with the general assets of the pool manager or any other person;

(3) In proportion to the aggregate amount of each pool participant’s interest in
Section 26. Equity Interests

A. Subject to the limitations of Section 23, an insurer may acquire equity interests in business entities organized under the laws any domestic jurisdiction.

B. An insurer shall not acquire an investment under this section if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this section would exceed the greater of twenty-five percent (25%) of its admitted assets or one hundred percent (100%) of its surplus as regards policyholders.

C. An insurer shall not acquire under this section any investments that the insurer may acquire under Section 28.

D. An insurer shall not short sell equity investments unless the insurer covers the short sale by owning the equity investment or an unrestricted right to the equity instrument exercisable within six (6) months of the short sale.

Section 27. Tangible Personal Property Under Lease

A. (1) Subject to the limitations of Section 23, an insurer may acquire tangible personal property or equity interests therein located or used wholly or in part
within a domestic jurisdiction either directly or indirectly through limited partnership interests and general partnership interests not otherwise prohibited by Section 5D, joint ventures, stock of an investment subsidiary or membership interests in a limited liability company, trust certificates or other similar instruments.

(2) Investments acquired under Paragraph (1) of this subsection shall be eligible only if:

(a) The property is subject to a lease or other agreement with a person whose rated credit instruments in the amount of the purchase price of the personal property the insurer could then acquire under Section 24; and

(b) The lease or other agreement provides the insurer the right to receive rental, purchase or other fixed payments for the use or purchase of the property, and the aggregate value of the payments, together with the estimated residual value of the property at the end of its useful life and the estimated tax benefits to the insurer resulting from ownership of the property, shall be adequate to return the cost of the insurer's investment in the property, plus a return deemed adequate by the insurer.

B. The insurer shall compute the amount of each investment under this section on the basis of the out-of-pocket purchase price and applicable related expenses paid by the insurer for the investment, net of each borrowing made to finance the purchase price and expenses, to the extent the borrowing is without recourse to the insurer.

C. An insurer shall not acquire an investment under this section if, as a result of and after giving effect to the investment, the aggregate amount of all investments then held by the insurer under this section would exceed:

(1) Two percent (2%) of its admitted assets; or

(2) One half of one percent (.5%) of its admitted assets as to any single item of tangible personal property.

D. For purposes of determining compliance with the limitations of Section 23, investments acquired by an insurer under this section shall be aggregated with those acquired under Section 24, and each lessee of the property under a lease referred to in this section shall be deemed the issuer of an obligation in the amount of the investment of the insurer in the property determined as provided in Subsection B of this section.

E. Nothing in this section is applicable to tangible personal property lease arrangements between an insurer and its subsidiaries and affiliates under a cost sharing arrangement or agreement permitted under [insert reference to holding company law].

Section 28. Mortgage Loans and Real Estate

A. Mortgage Loans
Subject to the limitations of Section 23, an insurer may acquire, either directly, indirectly through limited partnership interests and general partnership interests not otherwise prohibited by Section 5D, joint ventures, stock of an investment subsidiary or membership interests in a limited liability company, trust certificates, or other similar instruments, obligations secured by mortgages on real estate situated within a domestic jurisdiction, but a mortgage loan which is secured by other than a first lien shall not be acquired unless the insurer is the holder of the first lien. The obligations held by the insurer and any obligations with an equal lien priority, shall not, at the time of acquisition of the obligation, exceed:

(a) Ninety percent (90%) of the fair market value of the real estate, if the mortgage loan is secured by a purchase money mortgage or like security received by the insurer upon disposition of the real estate;

(b) Eighty percent (80%) of the fair market value of the real estate, if the mortgage loan requires immediate scheduled payment in periodic installments of principal and interest, has an amortization period of thirty (30) years or less and periodic payments made no less frequently than annually. Each periodic payment shall be sufficient to assure that at all times the outstanding principal balance of the mortgage loan shall be not greater than the outstanding principal balance which would be outstanding under a mortgage loan with the same original principal balance, with the same interest rate and requiring equal payments of principal and interest with the same frequency over the same amortization period. Mortgage loans permitted under this subsection are permitted notwithstanding the fact that they provide for a payment of the principal balance prior to the end of the period of amortization of the loan. For residential mortgage loans, the eighty percent (80%) limitation may be increased to ninety-seven percent (97%) if acceptable private mortgage insurance has been obtained; or

(c) Seventy-five percent (75%) of the fair market value of the real estate for mortgage loans that do not meet the requirements of Subparagraphs (a) or (b) of this paragraph.

For purposes of Paragraph (1) of this subsection, the amount of an obligation required to be included in the calculation of the loan-to-value ratio may be reduced to the extent the obligation is insured by the Federal Housing Administration or guaranteed by the Administrator of Veterans Affairs, or their successors.

A mortgage loan that is held by an insurer under Section 3F or acquired under this section and is restructured in a manner that meets the requirements of a restructured mortgage loan in accordance with the NAIC Accounting Practices and Procedures Manual or successor publication shall continue to qualify as a mortgage loan under this Act.

Subject to the limitations of Section 23, credit lease transactions that do not qualify for investment under Section 24 with the following characteristics shall be exempt from the provisions of Paragraph (1) of this subsection:
(a) The loan amortizes over the initial fixed lease term at least in an amount sufficient so that the loan balance at the end of the lease term does not exceed the original appraised value of the real estate; 

(b) The lease payments cover or exceed the total debt service over the life of the loan; 

(c) A tenant or its affiliated entity whose rated credit instruments have a SVO 1 or 2 designation or a comparable rating from a nationally recognized statistical rating organization recognized by the SVO has a full faith and credit obligation to make the lease payments; 

(d) The insurer holds or is the beneficial holder of a first lien mortgage on the real estate; 

(e) The expenses of the real estate are passed through to the tenant, excluding exterior, structural, parking and heating, ventilation and air conditioning replacement expenses, unless annual escrow contributions, from cash flows derived from the lease payments, cover the expense shortfall; and 

(f) There is a perfected assignment of the rents due pursuant to the lease, or for the benefit of, the insurer. 

B. Income Producing Real Estate 

(1) An insurer may acquire, manage and dispose of real estate situated in a domestic jurisdiction either directly or indirectly through limited partnership interests and general partnership interests not otherwise prohibited by Section 5D, joint ventures, stock of an investment subsidiary or membership interests in a limited liability company, trust certificates, or other similar instruments. The real estate shall be income producing or intended for improvement or development for investment purposes under an existing program (in which case the real estate shall be deemed to be income producing). 

(2) The real estate may be subject to mortgages, liens or other encumbrances, the amount of which shall, to the extent that the obligations secured by the mortgages, liens or encumbrances are without recourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with Subsections D(2) and D(3) of this section. 

C. Real Estate for the Accommodation of Business 

An insurer may acquire, manage, and dispose of real estate for the convenient accommodation of the insurer’s (which may include its affiliates) business operations, including home office, branch office and field office operations. 

(1) Real estate acquired under this subsection may include excess space for rent to others, if the excess space, valued at its fair market value, would otherwise be a permitted investment under Subsection B of this section and is so qualified by the insurer;
The real estate acquired under this subsection may be subject to one or more mortgages, liens or other encumbrances, the amount of which shall, to the extent that the obligations secured by the mortgages, liens or encumbrances are without recourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with Subsection D(4) of this section; and

For purposes of this subsection, business operations shall not include that portion of real estate used for the direct provision of health care services by an insurer whose insurance premiums and required statutory reserves for accident and health insurance constitute at least ninety-five percent (95%) of total premium considerations or total statutory required reserves, respectively. An insurer may acquire real estate used for these purposes under Subsection B of this section.

**D. Quantitative Limitations**

(1) An insurer shall not acquire an investment under Subsection A of this section if, as a result of and after giving effect to the investment, the aggregate amount of all investments then held by the insurer under Subsection A of this section would exceed:

(a) One percent (1%) of its admitted assets in mortgage loans covering any one secured location;

(b) One quarter of one percent (.25%) of its admitted assets in construction loans covering any one secured location; or

(c) One percent (1%) of its admitted assets in construction loans in the aggregate.

(2) An insurer shall not acquire an investment under Subsection B of this section if, as a result of and after giving effect to the investment and any outstanding guarantees made by the insurer in connection with the investment, the aggregate amount of investments then held by the insurer under Subsection B of this section plus the guarantees then outstanding would exceed:

(a) One percent (1%) of its admitted assets in any one parcel or group of contiguous parcels of real estate, except that this limitation shall not apply to that portion of real estate used for the direct provision of health care services by an insurer whose insurance premiums and required statutory reserves for accident and health insurance constitute at least ninety-five percent (95%) of total premium considerations or total statutory required reserves, respectively, such as hospitals, medical clinics, medical professional buildings or other health facilities used for the purpose of providing health services; or

(b) The lesser of ten percent (10%) of its admitted assets or forty percent (40%) of its surplus as regards policyholders in the aggregate, except for an insurer whose insurance premiums and required statutory reserves for accident and health insurance constitute at least ninety-five percent (95%) of total premium considerations or total statutory reserves.
required reserves, respectively, this limitation shall be increased to fifteen percent (15%) of its admitted assets in the aggregate.

(3) An insurer shall not acquire an investment under Subsection A or B of this section if, as a result of and after giving effect to the investment and any guarantees it has made in connection with the investment, the aggregate amount of all investments then held by the insurer under Subsections A and B of this section plus the guarantees then outstanding would exceed twenty-five percent (25%) of its admitted assets.

(4) The limitations of Section 23 shall not apply to an insurer’s acquisition of real estate under Subsection C of this section. An insurer shall not acquire real estate under Subsection C of this section if, as a result of and after giving effect to the acquisition, the aggregate amount of all real estate then held by the insurer under Subsection C of this section would exceed ten percent (10%) of its admitted assets. With the permission of the commissioner, additional amounts of real estate may be acquired under Subsection C of this section.

Section 29. Securities Lending, Repurchase, Reverse Repurchase and Dollar Roll Transactions

An insurer may enter into securities lending, repurchase, reverse repurchase and dollar roll transactions with business entities, subject to the following requirements:

A. The insurer’s board of directors shall adopt a written plan that is consistent with the requirements of the written plan in Section 4A that specifies guidelines and objectives to be followed, such as:

(1) A description of how cash received will be invested or used for general corporate purposes of the insurer;

(2) Operational procedures to manage interest rate risk, counterparty default risk, the conditions under which proceeds from reverse—repurchase transactions may be used in the ordinary course of business and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction; and

(3) The extent to which the insurer may engage in these transactions.

B. The insurer shall enter into a written agreement for all transactions authorized in this section other than dollar roll transactions. The written agreement shall require that each transaction terminate no more than one year from its inception or upon the earlier demand of the insurer. The agreement shall be with the business entity counterparty, but for securities lending transactions, the agreement may be with an agent acting on behalf of the insurer, if the agent is a qualified business entity, and if the agreement:

(1) Requires the agent to enter into separate agreements with each counterparty that are consistent with the requirements of this section; and

(2) Prohibits securities lending transactions under the agreement with the agent or its affiliates.
C. Cash received in a transaction under this section shall be invested in accordance with this Act and in a manner that recognizes the liquidity needs of the transaction or used by the insurer for its general corporate purposes. For so long as the transaction remains outstanding, the insurer, its agent or custodian shall maintain, as to acceptable collateral received in a transaction under this section, either physically or through the book entry systems of the Federal Reserve, Depository Trust Company, Participants Trust Company or other securities depositories approved by the commissioner:

(1) Possession of the acceptable collateral;

(2) A perfected security interest in the acceptable collateral; or

(3) In the case of a jurisdiction outside of the United States, title to, or rights of a secured creditor to, the acceptable collateral.

D. The limitations of Sections 23 and 30 shall not apply to the business entity counterparty exposure created by transactions under this section. For purposes of calculations made to determine compliance with this subsection, no effect will be given to the insurer’s future obligation to resell securities, in the case of a reverse repurchase transaction, or to repurchase securities, in the case of a reverse repurchase transaction. An insurer shall not enter into a transaction under this section if, as a result of and after giving effect to the transaction:

(1) The aggregate amount of securities then loaned, sold to or purchased from any one business entity counterparty under this section would exceed five percent (5%) of its admitted assets. In calculating the amount sold to or purchased from a business entity counterparty under repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement; or

(2) The aggregate amount of all securities then loaned, sold to or purchased from all business entities under this section would exceed forty percent (40%) of its admitted assets but the limitation of this subsection shall not apply to reverse repurchase transactions for so long as the borrowing is used to meet operational liquidity requirements resulting from an officially declared catastrophe and subject to a plan approved by the commissioner.

E. In a securities lending transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to 102 percent of the market value of the securities loaned by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than the market value of the loaned securities, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals 102 percent of the market value of the loaned securities.

F. In a reverse repurchase transaction, (other than a dollar roll transaction), the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to ninety-five percent (95%) of the market value of the securities transferred by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than ninety-five percent (95%) of the market value of the securities so transferred, the business entity counterparty shall
be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals ninety-five percent (95%) of the market value of the transferred securities.

G. In a dollar roll transaction, the insurer shall receive cash in an amount at least equal to the market value of the securities transferred by the insurer in the transaction as of the transaction date.

H. In a reverse repurchase transaction, the insurer shall receive as acceptable collateral transferred securities having a market value at least equal to 102 percent of the purchase price paid by the insurer for the securities. If at any time the market value of the acceptable collateral is less than 100 percent of the purchase price paid by the insurer, the business entity counterparty shall be obligated to provide additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals 102 percent of the purchase price. Securities acquired by an insurer in a reverse repurchase transaction shall not be sold in a reverse repurchase transaction, loaned in a securities lending transaction or otherwise pledged.

Drafting Note 12: Subsections E, F, and H of this section contain requirements that at the time of drafting this model act were contained in the Purposes and Procedures of the Securities Valuation Office. However, concomitant with the drafting of this model act, a separate task force was considering a revised publication which did not contain these requirements inasmuch as the SVO considered these requirements as accounting-type rules which were deemed not suitable to such a publication. Moreover, another third working group was developing a draft of a revised accounting manual but had not considered proposing separate accounting guidance regarding these requirements. Instead, the accounting manual implicitly referred to the requirements stipulated in this model act. Pending the results of consideration of these requirements by the three groups, in concert, these requirements have been included in this model act. If after due consideration, these requirements are included in the revised Purposes and Procedures of the Securities Valuation Office, then States may opt not to codify these requirements within their insurer investment code.

Section 30. Foreign Investments and Foreign Currency Exposure

A. Subject to the limitations of Section 23, an insurer may acquire foreign investments, or engage in investment practices with persons of or in foreign jurisdictions, of substantially the same types as those that an insurer is permitted to acquire under this Act, other than of the type permitted under Section 25, if, as a result and after giving effect to the investment:

(1) The aggregate amount of foreign investments then held by the insurer under this subsection does not exceed twenty percent (20%) of its admitted assets; and

(2) The aggregate amount of foreign investments then held by the insurer under this subsection in a single foreign jurisdiction does not exceed ten percent (10%) of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or five percent (5%) of its admitted assets as to any other foreign jurisdiction.

B. Subject to the limitations of Section 23, an insurer may acquire investments, or engage in investment practices denominated in foreign currencies, whether or not they are foreign investments acquired under Subsection A of this section, or additional foreign currency exposure as a result of the termination or expiration of a hedging transaction with respect to investments denominated in a foreign currency, if:
(1) The aggregate amount of investments then held by the insurer under this subsection denominated in foreign currencies does not exceed fifteen percent (15%) of its admitted assets; and

(2) The aggregate amount of investments then held by the insurer under this subsection denominated in the foreign currency of a single foreign jurisdiction does not exceed ten percent (10%) of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or five percent (5%) of its admitted assets as to any other foreign jurisdiction.

(3) However, an investment shall not be considered denominated in a foreign currency if the acquiring insurer enters into one or more contracts in transactions permitted under Section 31 and the business entity counterparty agrees under the contract or contracts to exchange all payments made on the foreign currency denominated investment for United States currency at a rate which effectively insulates the investment cash flows against future changes in currency exchange rates during the period the contract or contracts are in effect.

C. In addition to investments permitted under Subsections A and B of this section, an insurer that is authorized to do business in a foreign jurisdiction, and that has outstanding insurance, annuity or reinsurance contracts on lives or risks resident or located in that foreign jurisdiction and denominated in foreign currency of that jurisdiction, may acquire foreign investments respecting that foreign jurisdiction, subject to the limitations of Section 23. However, investments made under this subsection in obligations of foreign governments, their political subdivisions and government sponsored enterprises shall not be subject to the limitations of Section 23 if those investments carry an SVO rating of 1 or 2. The aggregate amount of investments acquired by the insurer under this subsection shall not exceed the greater of:

(1) The amount the insurer is required by law to invest in the foreign jurisdiction; or

(2) One hundred twenty-five percent (125%) of the amount of its reserves, net of reinsurance, and other obligations under the contracts.

D. In addition to investments permitted under Subsections A and B of this section, an insurer that is not authorized to do business in a foreign jurisdiction but which has outstanding insurance, annuity or reinsurance contracts on lives or risks resident or located in a foreign jurisdiction and denominated in foreign currency of that jurisdiction, may acquire foreign investments respecting that foreign jurisdiction, and may acquire investments denominated in the currency of that jurisdiction subject to the limitations set forth in Section 23. However, investments made under this subsection in obligations of foreign governments, their political subdivisions and government sponsored enterprises shall not be subject to the limitations of Section 23 if those investments carry an SVO rating of 1 or 2. The aggregate amount of investments acquired by the insurer under this subsection shall not exceed 105 percent of the amount of its reserves, net of reinsurance, and other obligations under the contracts on risks resident or located in the foreign jurisdiction.

E. Investments acquired under this section shall be aggregated with investments of the
same types made under all other sections of this Act, and in a similar manner, for purposes of determining compliance with the limitations, if any, contained in the other sections. Investments in obligations of foreign governments, their political subdivisions and government sponsored enterprises of these persons, except for those exempted under Subsections C and D of this section, shall be subject to the limitations of Section 23.

Section 31. Derivative Transactions

An insurer may, directly or indirectly through an investment subsidiary, engage in derivative transactions under this section under the following conditions:

A. General Conditions

(1) An insurer may use derivative instruments under this section to engage in hedging transactions and certain income generation transactions, as these terms may be further defined in regulations promulgated by the commissioner.

(2) An insurer shall be able to demonstrate to the commissioner the intended hedging characteristics and the ongoing effectiveness of the derivative transaction or combination of transactions through cash flow testing or other appropriate analyses.

B. Limitations on Hedging Transactions

An insurer may enter into hedging transactions under this section if, as a result of and after giving effect to the transaction:

(1) The aggregate statement value of options, caps, floors and warrants not attached to another financial instrument purchased and used in hedging transactions does not exceed seven and one half percent (7.5%) of its admitted assets;

(2) The aggregate statement value of options, caps and floors written in hedging transactions does not exceed three percent (3%) of its admitted assets; and

(3) The aggregate potential exposure of collars, swaps, forwards and futures used in hedging transactions does not exceed six and one-half percent (6.5%) of its admitted assets.

C. Limitations on Income Generation Transactions

An insurer may only enter into the following types of income generation transactions if as a result of and after giving effect to the transactions, the aggregate statement value of the fixed income assets that are subject to call plus the face value of fixed income securities underlying a derivative instrument subject to call, plus the amount of the purchase obligations under the puts, does not exceed ten percent (10%) of its admitted assets:

(1) Sales of covered call options on non-callable fixed income securities, callable fixed income securities if the option expires by its terms prior to the end of the noncallable period or derivative instruments based on fixed income.
Investments of Insurers Model Act

(2) Sales of covered call options on equity securities, if the insurer holds in its portfolio, or can immediately acquire through the exercise of options, warrants or conversion rights already owned, the equity securities subject to call during the complete term of the call option sold; or

(3) Sales of covered puts on investments that the insurer is permitted to acquire under this Act, if the insurer has escrowed, or entered into a custodian agreement segregating, cash or cash equivalents with a market value equal to the amount of its purchase obligations under the put during the complete term of the put option sold.

D. Counterparty Exposure

An insurer shall include all counterparty exposure amounts in determining compliance with the limitations of Section 23.

E. Additional Transactions

Pursuant to regulations promulgated under Section 8, the commissioner may approve additional transactions involving the use of derivative instruments in excess of the limits of Subsection B of this section or for other risk management purposes under regulations promulgated by the commissioner, but replication transactions shall not be permitted for other than risk management purposes.

Section 32. Additional Investment Authority

A. An insurer may acquire under this section investments, or engage in investment practices, of any kind that are not specifically prohibited by this Act, or engage in investment practices, without regard to any limitation in Sections 23 through 30, but an insurer shall not acquire an investment or engage in an investment practice under this section if, as a result of and after giving effect to the transaction, the aggregate amount of the investments then held by the insurer under this section would exceed the greater of:

(1) Its unrestricted surplus; or

(2) The lesser of:

(a) Ten percent (10%) of its admitted assets; or

(b) Fifty percent (50%) of its surplus as regards policyholders.

B. An insurer shall not acquire any investment or engage in any investment practice under Subsection A(2) of this section if, as a result of and after giving effect to the transaction the aggregate amount of all investments in any one person then held by the insurer under that subsection would exceed five percent (5%) of its admitted assets.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

Model Regulation Service–April 2001

2001 Proc. 1st Quarter 373-374 (amendments adopted later are printed here).
2001 Proc. 2nd Quarter 11, 14, 319, 339 (amended).
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Report of the
Financial Regulation Standards and Accreditation (F) Committee

The Financial Regulation Standards and Accreditation (F) Committee met Aug. 5, 2017. The meeting was held in regulator-to-regulator session pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee discussed state-specific accreditation issues and voted to award continued accreditation to the insurance departments of Colorado, Minnesota, North Dakota and Virginia.

The Financial Regulation Standards and Accreditation (F) Committee met Aug. 6, 2017. During this meeting, the Committee:

1. Adopted its Spring National Meeting minutes.
2. Adopted its 2018 proposed charges, which remain unchanged from its 2017 charges.
3. Discussed the Corporate Governance Annual Disclosure Model Act (#305) and the Corporate Governance Annual Disclosure Model Regulation (#306) as a possible new accreditation standard. Model #305 and Model #306 require an insurer (or group of insurers) to provide a confidential disclosure regarding its corporate governance practices to the lead state and/or domestic regulator annually by June 1. The Committee voted to defer action at this time and will monitor work related to the “Bilateral Agreement between the European Union and the United States of America on Prudential Measures Regarding Insurance and Reinsurance” (covered agreement) as it pertains to Model #305 and Model #306. This will be discussed further at the Fall National Meeting.
5. Discussed the 2014 revisions to the Insurance Holding Company System Regulatory Act (#440) as an update to the Part A: Holding Company Systems accreditation standard. The 2014 revisions to Model #440 are applicable only to a designated state that acts as a group-wide supervisor of an internationally active insurance group. The Committee voted to defer action at this time and will monitor work related to the covered agreement as it pertains to Model #440. This will be discussed further at the Fall National Meeting.
6. Discussed the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) and the 2016 revisions to the Credit for Reinsurance Model Law (#785) for possible inclusion into the Part A: Laws and Regulations accreditation standard. The Reinsurance (E) Task Force is currently discussing the significant elements to be considered by the Committee as accreditation requirements.
7. Voted to expose for a 30-day comment period proposed revisions to the Review Team Guidelines that provide guidance related to Own Risk and Solvency Assessment filings.
8. Voted to expose for a 30-day comment period proposed revisions to the Review Team Guidelines and the Self-Evaluation Guide | Interim Annual Review Form to incorporate the new risk-focused analysis process that becomes effective Jan. 1, 2018.
MEMORANDUM

TO: Financial Regulation Standards and Accreditation (F) Committee
FROM: Life Actuarial (A) Task Force
DATE: November 3, 2016
RE: Recommendation for Part A Accreditation Standards and Guidelines for 2009 Revisions to the Standard Valuation Law (#820)

Executive Summary

On Sept. 23, 2009, the Executive (EX) Committee and Plenary adopted revisions to the Standard Valuation Law (#820). These revisions authorize the use of the Valuation Manual, which contains the minimum reserve standards for all life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit contracts issued on or after the operative date of the Valuation Manual. The revisions also authorize a principle-based reserving (PBR) basis for those policies and contracts specified in the Valuation Manual, and provide requirements for the actuarial opinion of reserves with respect to these policies. The revisions further mandate that companies shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed by the Valuation Manual. Finally, the Valuation Manual does not become operative until 42 states representing at least 75% of direct written premium adopt the 2009 revisions to Model #820.

Currently, only Section 3 (Actuarial Opinion of Reserves) and Section 4 (Computation of Minimum Standard) are significant elements under the accreditation standard for Model #820. On March 25, 2010, the Life and Health Actuarial Task Force submitted a memorandum to the Financial Regulation Standards and Accreditation (F) Committee that recommended that the following additional sections of Model #820 be considered significant elements:

- Section 3A—Actuarial Opinion Prior to the Operative Date of the Valuation Manual
- Section 3B—Actuarial Opinion of Reserves after the Operative Date of the Valuation Manual
- Section 4—Computation of Minimum Standard
- Section 11—Valuation Manual for Policies Issued on or After the Operative Date of the Valuation Manual
- Section 12—Requirements of a Principle-Based Valuation
- Section 14—Confidentiality

The Committee released the recommendation for adoption of the 2009 revisions to Model #820 as an accreditation standard for a preliminary public comment period of 30 days, and for a one-year public comment period from Jan. 1, 2011, to Dec. 31, 2011. On March 3, 2012, the Committee voted to re-expose the recommendation through the end of 2012, in order to permit work to be completed on the Valuation Manual, which the NAIC membership later adopted on Dec. 12, 2012. In both 2013 and 2014, the Committee voted to waive its normal procedures and defer action on the accreditation standard in order to observe developments in the state PBR implementation process. On March 28, 2015, the Committee voted to send a referral to the Principle-Based Reserving Implementation (EX) Task Force to reconsider the appropriateness of the significant
elements originally recommended to the Committee in 2010, which was then referred to the Life Actuarial (A) Task Force for further development.

On June 10, 2016, the Executive (EX) Committee and Plenary adopted the recommendation of the Principle-Based Reserving Implementation (EX) Task Force that: 1) 45 states, representing 79.5% of the appropriate premium volume have adopted Model #820, or legislation including substantially similar terms and provisions; and 2) those states that have enacted the revised Model #820 should take any necessary action to use Jan. 1, 2017, as the operative date for the Valuation Manual.

With the Valuation Manual operative date determined, the Life Actuarial (A) Task Force recommended the attached proposed significant elements to the accreditation standard with respect to the 2009 revisions to Model #820 on Sept. 29, 2016. It is further the recommendation of the Life Actuarial (A) Task Force that this revised accreditation standard for Model #820 become effective as of Jan. 1, 2020, which is the date that PBR generally becomes applicable to all companies after a three-year phase-in under VM-20, Requirements for Principle-Based Reserves for Life Products, of the Valuation Manual.

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:

Currently, insurers use a formula-based static approach to calculate reserves for products. However, insurance products have increasingly grown in complexity, which has led to a need for a new reserve method. The NAIC membership’s adoption of the revisions to Model #820 in 2009 introduced a new method for calculating life insurance policy reserves. This new method, PBR, supplements the current formulaic approach to determining policy reserves with an approach that more closely reflects the risks of highly complex products. The improved calculation is expected to “right size” reserves; i.e., reduce reserves that are too high for some products and increase reserves that are too low for other products.

The Valuation Manual is established by Model #820 and would be used to detail the reserve calculation requirements. The Valuation Manual defines a process to facilitate future changes in valuation requirements on a more uniform, timely and efficient basis. The goals of the NAIC membership in developing the Valuation Manual are:

1. To consolidate into one document the minimum reserve requirements for life insurance, accident and health insurance, and deposit-type contracts pursuant to Model #820, including those products subject to principle-based valuation requirements and those not subject to principle-based valuation requirements.
2. To promote uniformity among the states’ valuation requirements.
3. To provide for an efficient, consistent and timely process to update valuation requirements as the need arises.
4. To mandate and facilitate the specific reporting requirements of experience data.
5. To enhance industry compliance with Model #820 and subsequent revisions, as adopted in various states.

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

The formulaic approach prescribed by current state laws and regulations needs to be frequently updated as new product designs are introduced. PBR alleviates this need to a great degree. State laws would establish principles upon which reserves are to be based—rather than specific formulas—with more detail and constraints included in the Valuation Manual. Current formulas do not always accurately reflect the risks or the true cost of the liability or obligations of the insurer. For some products, this leads to excessive conservatism in reserve calculations and, for others, it results in inadequate reserves. The current system locks in certain assumptions, resulting in reserves that do not change as economic conditions change or as insurers accumulate actual experience. The new system adjusts reserves as economic conditions change and as insurers accumulate credible experience.

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

Model #820 is currently an accreditation standard and the significant elements have been adopted in substantially similar form by all NAIC-accredited jurisdictions. On Nov. 21, 2015, the Principle-Based Reserving Implementation (EX) Task Force adopted the Plan to Evaluate Substantially Similar Terms and Provisions to Determine the Valuation Manual Operative Date, in order to determine whether Model #820, as amended by the NAIC membership in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two (42) of the applicable fifty-five (55) NAIC-member jurisdictions. As part of the plan, on Jan. 29, 2016, the states received a survey to document their current
conformance and deviations in the state’s Standard Valuation Law from Model #820. The NAIC Legal Division and a group of state general counsels completed a legal review of the state survey responses, and determined that the following 46 states (the original 45 states plus Pennsylvania, which adopted PBR after the initial NAIC recommendation) have currently adopted the 2009 revisions to Model #820, or legislation including substantially similar terms and provisions: Alabama; Arizona; Arkansas; California; Colorado; Connecticut; Delaware; Florida; Georgia; Hawaii; Idaho; Illinois; Indiana; Iowa; Kansas; Kentucky; Louisiana; Maine; Maryland; Michigan; Minnesota; Mississippi; Missouri; Montana; Nebraska; Nevada; New Hampshire; New Jersey; New Mexico; North Carolina; North Dakota; Ohio; Oklahoma; Oregon; Pennsylvania; Rhode Island; South Carolina; South Dakota; Tennessee; Texas; Utah; Vermont; Virginia; Washington; West Virginia; and Wisconsin.

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:

The current accreditation standard for Model #820 requires state adoption on a substantially similar basis. In addition, the 2009 revisions to Model #820 requires that, in order for the Valuation Manual to be operative, the 2009 revisions to Model #820, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two (42) of the applicable fifty-five (55) NAIC-member jurisdictions. Therefore, the Life Actuarial (A) Task Force recommends that the attached proposed significant elements for Model #820 be adopted by NAIC-accredited jurisdictions in a “substantially similar” manner, as that term is defined in the Accreditation Interlineations of the NAIC Financial Regulation Standards and Accreditation Program.

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:

The NAIC and the states, as well as the life insurance industry, have recognized that there would be significant costs associated with moving to a principle-based approach to reserving. To this end, the Principle-Based Reserving (PBR) Implementation Plan, dated March 7, 2016, provides a framework for PBR implementation, and contains specific guidance on creating a reporting and regulatory review process, including: 1) conducting a PBR Pilot Program; and 2) coordinating the development of financial analysis, examination and actuarial review procedures, as well as evaluating the actuarial staff resource requirements of the NAIC and the state insurance departments. It also provides guidance on a Company Experience Reporting Framework.

The NAIC and the Society of Actuaries (SOA) have also undertaken to attempt to quantify the costs and impacts from the implementation of PBR. The Report on the Results of the Principle-Based Reserving State Resource Survey by the Principle-Based Reserving Implementation (EX) Task Force, dated April 6, 2013, was issued with the intent of capturing the status of insurance department resources, as they exist today, and given their current understanding of PBR requirements, the jurisdictions expectations of the impact of PBR implementation. In June 2015, the SOA and NAIC jointly issued the Mortality and Other Implications of Principle-Based Reserving (PBR) Survey – Part 1, which provides an overview of the current state of the industry’s preparedness for implementing PBR. In October 2016, the NAIC and SOA also jointly issued the 2016 Mortality & Other Implications of PBR (VM-20) Survey – Part 2, which was designed to provide a more in-depth assessment of the current state of the industry’s preparedness for implementing PBR.

In summary, the estimate for costs for insurance companies to comply with the 2009 revisions to Model #820 adopting PBR, and the impact on state insurance departments to enforce it, is a currently evolving process, and the costs associated with this process are not readily quantifiable at this time. The NAIC continues to work on this issue.

Any Other Matters:

The proposed significant elements would specifically require the states to apply the Valuation Manual to fraternal benefit societies. The current Preamble for Part A provides: “For clarity purposes, the scope of the Part A standards excludes regulation of those insurers licensed as fraternal orders and title insurers.” If the Committee believes it is appropriate for Model #820 to apply to fraternal benefit societies for accreditation purposes, it would be necessary to amend the Part A Preamble in order to include any reference with respect to fraternal benefit societies in the proposed significant elements.
Proposed Significant Elements for 2009 Revisions to Standard Valuation Law (#820)

a. The following definitions under Section 1B apply on or after the operative date of the Valuation Manual: appointed actuary; company; policyholder behavior; principle-based valuation; qualified actuary; and Valuation Manual?

b. Policies and contracts issued prior to the operative date of the Valuation Manual are annually valued in accordance with Section 2A?

c. Policies and contracts issued on or after the operative date of the Valuation Manual are annually valued in accordance with Section 2B?

d. Prior to the operative date of the Valuation Manual, every life insurance company doing business in this state shall annually submit an actuarial opinion on reserves in accordance with Section 3A?

e. After the operative date of the Valuation Manual, every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state shall annually submit the opinion of a qualified actuary in accordance with Section 3B(1)?

f. After the operative date of the Valuation Manual, every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state, except as exempted by the Valuation Manual, shall annually submit an opinion of the qualified actuary with respect to the Actuarial Analysis of Reserves and Assets Supporting Reserves in accordance with Section 3B(2)?

g. After the operative date of the Valuation Manual, a memorandum in form and substance acceptable to the commissioner shall be prepared to support each actuarial opinion in accordance with Section 3B(3)(a)?

h. After the operative date of the Valuation Manual, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner in accordance with Section 3B(3)(b)?

i. Every opinion after the operative date of the Valuation Manual shall be governed by the requirements of the provisions of Section 3B(4)(a) through Section 3B(4)(d)?

j. Prescribe computation of minimum standard for reserves similar to Section 4?

k. With respect to accident and health insurance contracts issued on or after the operative date of the Valuation Manual, the standard prescribed in the Valuation Manual is the minimum standard of valuation required in accordance with Section 10?

l. The Valuation Manual should be adopted by the states uniformly, utilizing the version effective Jan. 1, 2017, and all subsequent revisions adopted by the NAIC membership (including any provisions with respect to fraternal benefit societies). For policies issued on or after the operative date of the Valuation Manual, the standard prescribed in the Valuation Manual is the minimum standard of valuation in accordance with Section 11A?

m. Any changes to the Valuation Manual are made in accordance with Section 11C?

n. The Valuation Manual is required to specify all the requirements described in Section 11D?

o. The commissioner may require a company to change any assumption or method that, in the opinion of the commissioner, is necessary in order to comply with the requirements of the Valuation Manual or Model #820, and the company shall adjust the reserves as required by the commissioner in accordance with Section 11G?
p. Provisions providing that a company must establish reserves using a principle-based valuation that meets conditions similar to those in Section 12A for policies or contracts as specified in the *Valuation Manual*?

q. Provisions providing that a company using a principle-based valuation for one or more policies or contracts specified in the *Valuation Manual* shall establish procedures for corporate governance and oversight of the actuarial valuation function in accordance with Section 12B?

r. With respect to policies in force on or after the operative date of the *Valuation Manual*, provisions providing that a company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the *Valuation Manual* similar to Section 13?

s. Prescribes confidentiality provisions similar to Section 14?

t. Although not required for accreditation, a state’s laws and regulations may allow an exemption from the reserving requirements of the *Valuation Manual* similar to that provided in the *Valuation Manual*. For such cases, the laws and regulations contain provisions that are similar to those provided in the *Valuation Manual*?

- If state law or regulation allows an exemption from the reserving requirements of the *Valuation Manual* based on certain parameters (such as insurer premiums or categories of insurers), please provide the citation. If state law or regulation does not allow for this, please indicate such by including “N/A” in the reference column.
Report of the
International Insurance Relations (G) Committee

The International Insurance Relations (G) Committee met Aug. 6, 2017. During this meeting, the Committee:

1. Adopted its July 27, May 30, and Spring National Meeting minutes, which included the following action:
   b. Discussed the IAIS Consultation Process for ICP 1, ICP 2, ICP 18, ICP 19 and ICP 24.
   c. Approved draft NAIC comments on IAIS revised ICPs and Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) material.
   d. Adopted its March 30 minutes.
   e. Adopted its working group reports.
   g. Heard an update on regional supervisory cooperation activities.
   h. Heard an update on the IAIS.
   i. Heard a presentation on an activities-based approach to systemic risk assessment.

2. Adopted the reports of its working groups. The report from the ComFrame Development and Analysis (G) Working Group addressed an update received from the IAIS Secretariat on the current status of the IAIS development of its global insurance capital standard (ICS), as well as the consultation process on ComFrame material. The report from the International Regulatory Cooperation (G) Working Group included an update on the NAIC International Fellows Program, including a proposal to allow international regulators who are not participating in the full fellows program to attend the one week of training in Kansas City.

3. Heard an update on the OECD, including a summary of the June meeting of the Insurance and Private Pensions Committee (IPPC) in Paris and the IPPC’s plans to hold a roundtable on the institutional structure of insurance regulation and supervision during its December 2017 meeting.

4. Heard an update on work at the IAIS.
   a. With regard to standard-setting, the IAIS recently approved ICS Version 1.0 for extended field testing. Earlier this year, the IAIS released a number of revised ICPs and ComFrame material, and relevant IAIS subcommittees are in the process of reviewing and resolving received comments. The IAIS has a number of other revised ICPs out for public consultation, with comments due to the IAIS Aug. 29 for revised ICP 1, ICP 2, ICP 18 and ICP 19, and Oct. 1 for revised ICP 24. The IAIS recently decided to create a virtual group of subject-matter groups to address innovation and InsurTech issues.
   b. With regard to financial stability, the IAIS launched its fifth globally systemically important insurers (G-SIIs) assessment exercise of insurers in March, and more than 50 participating insurers have submitted their data. The IAIS Systemic Risk Assessment Task Force continues its work and aims to launch an interim public consultation toward the end of 2017 on its findings on cross-sectoral consistency in systemic risk assessment and the development of a conceptual framework for the activities-based approach. A public consultation on a revised entities-based approach and a new activities-based approach, as well as a cross-sectoral risk assessment, is planned for the end of 2018.
   c. With regard to implementation of standards, various workstreams of the IAIS Implementation Committee were discussed, including revisions to the Coordinated Implementation Framework and possible approaches to enhancing the IAIS assessment program. An update on the IAIS Multilateral Memorandum of Understanding (MMoU) was also provided, and there has been a significant increase in the amount of recent applications, including from U.S. states.

5. Heard an update on regional supervisory cooperation activities. For the Asia region, upcoming activities include a seminar for Asian regulators to be jointly hosted by the NAIC, Thailand’s Office of Insurance Commission and the OECD, as well as the fourth annual Asia-Pacific International Forum in Honolulu before the Fall National Meeting. For Europe, in September Commissioner Ted Nickel (WI) and NAIC CEO Michael F. Consedine will participate in the Global Insurance Supervision conference in Frankfurt, Germany. In addition, state insurance regulators continue to maintain good relationships with our European counterparts at the European Insurance and Occupational Pensions Authority (EIOPA) and the European Commission, as well as various European Union (EU) member state jurisdictions, and communicate directly with them on a regular basis. An update on the covered agreement between the U.S. and the
EU also was provided. For the Latin American region, earlier this year the NAIC participated in the annual conference of the Association of Latin American Insurance Supervisors (ASSAL) in Santiago, Chile, and held a bilateral meeting with the ASSAL’s Executive Committee. Also, at the Summer National Meeting, the NAIC signed its 17th memorandum of understanding on regulatory cooperation with Argentina’s National Superintendence of Insurance and participated in a meeting with Superintendent Juan Pazo.

6. Heard a presentation on the insurance market and supervisory reforms in Argentina.
State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

Life Insurance and Annuities (A) Committee

- Amendments to the Separate Accounts Funding Guaranteed Minimum Benefits Under Group Contract Model Regulation (#200)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2016 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Annuity Disclosure Model Regulation (#245)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2015 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Suitability in Annuity Transactions Model Regulation (#275)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2015 Spring National Meeting. Six states have adopted the 2015 amendments.

- Amendments to the Advertisements of Life Insurance and Annuities Model Regulation (#570)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2015 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Life Insurance and Annuities Replacement Model Regulation (#613)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2015 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Synthetic Guaranteed Investment Contracts Model Regulation (#695)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2015 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

Health Insurance and Managed Care (B) Committee

- Amendments to the Health Insurance Reserves Model Regulation (#10)—There have been no updates to state implementations of these amendments.

- Individual Market Health Insurance Coverage Model Act (#26) (falls under the September 2008 federal law exemption to the Executive (EX) Committee approval requirement)—these revisions were adopted by the Executive (EX) Committee and Plenary via conference call in December 2014. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Health Benefit Plan Network Access and Adequacy Model Act (#74) (falls under the September 2008 federal law exemption to the Executive (EX) Committee approval requirement)—these revisions were adopted by the Executive (EX) Committee and Plenary at the 2015 Fall National Meeting. Two states have adopted the model’s provisions, three states have enacted parts of the model and 10 states have adopted provisions equivalent to the revised model’s provisions. Most of the state activity in 2017 relates to so-called “surprise bills,” situations where consumers received a bill from a non-network provider related to health care services received in an in-network facility.

- Small Group Market Health Insurance Coverage Model Regulation (#126) (falls under the September 2008 federal law exemption to the Executive (EX) Committee approval requirement)—These revisions were adopted by the Executive (EX) Committee and Plenary via conference call in December 2014. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Long-Term Care Insurance Model Act (#640)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2016 Fall National Meeting. Due to the recent adoption of the revisions, NAIC staff are not aware of any state activity related to this model.
• Amendments to the *Long-Term Care Insurance Model Regulation* (#641)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2014 Summer National Meeting. It appears that three states have enacted the revisions to this model. NAIC staff are not aware of any additional state activity related to this model.

• Amendments to the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651)—These revisions to Model #651 for consistency with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) were adopted by the Executive (EX) Committee and Plenary at the 2016 Summer National Meeting. NAIC staff are not aware of any state activity regarding this model. In February 2017, the Senior Issues (B) Task Force distributed a frequency asked questions (FAQ) document proving implementation guidance for the MACRA revisions.

**Financial Condition (E) Committee**

• Amendments to the *Annual Financial Reporting Model Regulation* (#205)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2014 Summer National Meeting. It appears 11 states have enacted laws consistent with provisions of the model, and an additional four states are considering enacting the provisions.

• Amendments to the *Corporate Governance Annual Disclosure Model Act* (#305)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2014 Fall National Meeting. It appears 17 states have enacted laws consistent with provisions of the model, and an additional two states are considering enacting the provisions.

• Amendments to the *Corporate Governance Annual Disclosure Model Regulation* (#306)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2014 Fall National Meeting. It appears 11 states have enacted laws consistent with provisions of the model.

• Amendments to the *Insurance Holding Company System Regulatory Act* (#440)—These revisions were adopted by the Executive (EX) Committee and Plenary via conference call in December 2014. It appears 22 states have enacted laws consistent with provisions of the model, and an additional state is considering enacting the provisions.

• Amendments to the *Life and Health Insurance Guaranty Association Model Act* (#520)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2016 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

• Amendments to the *Privacy of Consumer Financial and Health Information Regulation* (#672)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2017 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

• Amendments to the *Credit for Reinsurance Model Law* (#785)—These revisions were adopted by the Executive (EX) Committee and Plenary via conference call in November 2011. It appears that 32 states have enacted laws consistent with provisions of the model. Additional revisions to this model were adopted by the Executive (EX) Committee and Plenary via conference call in January 2016. NAIC staff have been advised that 12 states have enacted these revisions, with an additional two states planning to consider enacting the 2016 revisions.

• Amendments to the *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2016 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.
UPDATE ON THE INTERSTATE INSURANCE COMPACT

MISSION: The Interstate Insurance Product Regulation Compact ("Insurance Compact") and its Commission are significant examples of the ongoing state-based modernization efforts to continually improve the system of insurance regulation for insurance companies doing business in more than one state. The Insurance Compact enhances the efficiency and effectiveness of the way insurance products are filed, reviewed and approved in the United States. The Insurance Compact’s streamlined processes provide uniformity and speed-to-market for the insurance industry, thus affording consumers quicker access to more competitive insurance products. By promoting uniformity through application of national product standards embedded with strong consumer protections, the Insurance Compact is meeting the demands of consumers, industry and regulators in the ever-changing, global financial marketplace.

BACKGROUND: The Insurance Compact has been adopted by 44 States and Puerto Rico to date, representing 75% of the premium volume nationwide. The Insurance Compact established a multi-state public entity, the Commission, which serves as an instrumentality of the Member States. The Insurance Compact is the central point of electronic filing for asset-based insurance products, including individual and group life insurance, annuities, disability income, and long-term care insurance. By leveraging the insurance regulatory expertise of the states, the Insurance Compact is able to employ one set of uniform standards with the highest level of consumer protection on a national level through the Insurance Compact’s collective framework. The Insurance Compact, funded by filing fees, implements its modernization goals without impinging on state budgets.

STATUS: In June 2007, the Insurance Compact became operational and received its first filings within one year of its establishment. The Insurance Compact has defined speed-to-market by providing final disposition in less than 60 days. Companies of all sizes – large, medium, and small – utilize the Insurance Compact’s electronic filing platform to submit product filings using the adopted Uniform Standards. There are 100 Uniform Standards in individual and group life and disability income, and individual annuity and long-term care product lines adopted and available for filing use. The Insurance Compact continues to experience significant growth in the number of registered companies and product filing submissions year over year.

KEY MILESTONES/PLANS:

- **June 2006:** Inaugural Meeting of the IIPRC in Washington, DC
- **December 2006:** First Uniform Life Standards Adopted by Members
- **Summer 2007:** Operations Initiated On-Target/First Insurer Filing Approval
- **January 2008:** Uniform Standards for Individual Annuities in Effect
- **December 2010:** Uniform Standards for Individual Long-Term Care Insurance in Effect
- **January 2012:** Uniform Standards for Individual Disability Income in Effect
- **January 2013:** Uniform Standards for Employer Group Term Life Insurance in Effect
- **December 2014:** IIPRC Office Implements SERFF Filing Access for Web-Based Public Access
- **June 2016:** Group Disability Income Uniform Standards in Effect for Filing Use
- **July 2017:** Connecticut Becomes an Effective Member
- **Summer 2017:** Five-Year Review of Individual Disability Income Uniform Standards
## Insurance Compact Product Filing Statistics

*As of June 30, 2017*

The tables below provide statistics on the product filings submitted to the Insurance Compact since first accepting product filings in June 2007 through June 30, 2017.

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### Historical Filing Data

#### Registrations as of June 2008 to June 2017

*Transactions* refers to the total number of SERFF transactions that have been made through the Insurance Compact.

**The time for product approval is calculated utilizing business days and excludes the company response time to objection letters, as defined in §105 of the “Product Filing Rule”.

***This metric has changed from average to median to reflect 75% of Insurance Compact filings include more than a majority of the states on approval.

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**INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION (IPRC)**

444 North Capitol Street, NW • Hall of the States Suite 700 • Washington, DC 20001
(202) 471-3962 • Fax (816) 460-7476 • comments@insurancecompact.org • www.insurancecompact.org
There are over 22 Types of Insurance (TOIs) available for filing using the 100 adopted Uniform Standards with 130 various sub-TOIs available.

5,800 products have been approved by the Insurance Compact to date since June 2007; which equates to over 178,900 SERFF transactions.

The TOIs for the Product Filings submitted through SERFF for Compact Filings 2017:

**LIFE** (58% of all products received):
- 40% have been TOI – Other (generally application filings)
- 25% have been Whole Life Products
- 16% have been Term Life Products
- 13% have been Flexible Premium Adjustable
- 4% have been Variable Life
- 2% have been Group Life Term

**ANNUITIES** (29% of all products received):
- 58% have been Deferred Non-Variable Annuity
- 20% have been Annuity – Special
- 16% have been Deferred Variable Annuity
- 5% have been Immediate Non-Variable Annuity
- 1% have been TOI – Other (generally application filings)

**LONG-TERM CARE** (9% of all products received)

**DISABILITY INCOME** (4% of all products received)
- 77% have been Individual Disability
- 23% have been Group Disability

Of all of the Registered Companies who have submitted filings since 2007:
- 4% have filed more than 75 times
- 5% have filed 50 or more times
- 21% have filed 20 or more times
- 18% have filed 10 or more times
- 40% have filed more than twice
- 12% have filed once; of the 2017 Registered Companies 3% are first time filers

There have been over 23,000 forms submitted with product filing submissions. The average number of forms per filing is 4. The largest single submission consisted of 103 forms (filed in 2013); and in 2017, the largest single submission consisted of 34 forms.