The Executive (EX) Committee did not hold a separate meeting in New York but considered its agenda items during the Jt. Mtg. of Executive (EX) Committee and Plenary.

Executive (EX) Committee and Plenary Aug. 6, 2019, Minutes
- Executive (EX) Committee Interim Meeting Report (Attachment One)
- Executive (EX) Committee Task Force Reports (Attachment Two)
- Adopted Amendments to the *Health Maintenance Organization Model Act* (#430) (Attachment Three)
- Adopted the Request for Model Law Development for a Pharmacy Benefit Manager (PBM) Model Law (Attachment Four)
- Adopted the Request for Model Law Development for a Pet Insurance Model Law (Attachment Five)
- NAIC State Ahead Strategic Plan Implementation Report (Attachment Six)
- Report of Model Law Development Requests (Attachment Seven)
- Adopted the Executive (EX) Committee and Plenary June 25, 2019 Minutes (Attachment Eight)
- Adopted Revisions to the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786) to Incorporate the EU and UK Covered Agreements (Attachment Eight-A)
- Adopted Amendments to the *Valuation Manual* (Attachment Nine)
- Adopted Revisions to *Actuarial Guideline XLIII—CARVM for Variable Annuities* (AG 43) (Attachment Ten)
- Adopted the Market Conduct Annual Statement (MCAS) Private Flood Data Call Definitions (Attachment Twelve)
- Adopted the Mental Health Parity Guidance and Data Collection Tool for Mental Health Parity Analysis (Attachment Thirteen)
- Report on States’ Implementation of NAIC-Adopted Model Laws and Regulations (Attachment Fourteen)
The Executive (EX) Committee and Plenary met in joint session in New York, NY, Aug. 6, 2019. The following members participated: Eric A. Cioppa, Chair (ME); Raymond G. Farmer, Vice Chair (SC); David Altmayer, Vice President (FL); Dean L. Cameron, Secretary-Treasurer (ID); James J. Donelon, Most Recent Past President, represented by Nick Lorusso (LA); Lori K. Wing-Heier (AK); Michael Conway (CO); Andrew N. Mais (CT); Stephen C. Taylor (DC); Trinidad Navarro represented by Tanisha Merced (DE); John F. King (GA); Colin M. Hayashida represented by Paul Yuen (HI); Doug Ommen (IA); Robert H. Muriel (IL); Stephen W. Robertson represented by Amy Beard (IN); Vicki Schmidt (KS); Nancy G. Atkins (KY); Gary Anderson (MA); Al Redmer Jr. (MD); Steve Kelley represented by Grace Arnold (MN); Chlora Lindley-Myers (MO); Mike Chaney represented by Mark Haire (MS); Mike Causey represented by Michelle Osborne (NC); Jon Godfread (ND); Bruce R. Ramge (NE); Marlene Caride (NJ); John G. Franchini (NM); Barbara D. Richardson (NV); Linda A. Lacewell represented by Laura Evangelista (NY); Jillian Froment (OH); Glen Mulready (OK); Andrew Stolfi (OR); Jessica Altman (PA); Elizabeth Kelleher Dwyer (RI); Larry Deiter (SD); Carter Lawrence (TN); Kent Sullivan (TX); Todd E. Kiser (UT); Scott A. White (VA); Tregenza A. Roach represented by Dolace McLean (VI); Michael S. Pieciak (VT); Mike Kreidler (WA); Mark Afable (WI); James A. Dodrill (WV); and Jeff Rude (WY).

The Executive (EX) Committee did not hold a separate meeting in New York but considered its agenda items during the Jt. Mtg. of Executive (EX) Committee and Plenary.

During this meeting, the Executive (EX) Committee:

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

Superintendent Cioppa reported the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee met in joint session Aug. 3 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC) of the NAIC Policy Statement on Open Meetings.

During this joint meeting, the Executive (EX) Committee and Internal Administration (EX1) Subcommittee adopted its June 25 and Spring National Meeting minutes.

The Executive (EX) Committee and Internal Administration (EX1) Subcommittee adopted the Aug. 2 Audit Committee report, which included the following action: 1) received an overview of the June 30 financial statements; 2) reconfirmed RSM for the 2019 financial audit; 3) received an update on the 2019 Service Organization Control (SOC) 1 and SOC 2 reviews and reports; 4) received an update on database filing fee payments and approved a charge against the Reserve for Doubtful Accounts; 5) received an update on Zone financials; 6) reaffirmed its 2020 proposed charter; and 7) received an update on the 2020 budget calendar.

The Executive (EX) Committee and Internal Administration (EX1) Subcommittee adopted the Aug. 2 Information Systems (EX1) Task Force report, which included the following action: 1) adopted its 2020 charges, which remain unchanged from 2019; 2) received an operational report for the NAIC’s information technology activities; and 3) received a portfolio update, which includes 22 active projects, and project status reports.

The Executive (EX) Committee and Internal Administration (EX1) Subcommittee also took the following action: 1) approved a recommendation of the Internal Administration (EX1) Subcommittee to invest in a real estate investment trust; 2) approved the SERFF Data Hosting Fiscal for exposure; 3) appointed Commissioner Mais to serve on the International Association of Insurance Supervisors (IAIS) Executive Committee; 4) heard a presentation on the status of the Interstate Insurance Product Regulation Commission (Compact) note payable and directed the joint management team to identify/discuss options; 5) received an overview on Board oversite of corporate culture; 6) received the joint chief executive officer (CEO)/chief operating officer (COO) report; and 7) received an update on the cybersecurity tabletop exercises offered to members.

Commissioner Altmayer made a motion, seconded by Director Farmer, to adopt the report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee. The motion passed.
2. **Adopted its June 25 Interim Meeting Report**

   Commissioner Altmaier made a motion, seconded by Director Cameron, to adopt the Executive (EX) Committee’s June 25 interim meeting report (Attachment One). The motion passed.

3. **Adopted the Reports of its Task Forces**

   The Executive (EX) Committee received reports from: the Financial Stability (EX) Task Force; the Government Relations (EX) Leadership Council; the Innovation and Technology (EX) Task Force; and the Long-Term Care Insurance (EX) Task Force.

   Commissioner Godfread reported that the Innovation and Technology (EX) Task Force referred a charge to the Market Regulation and Consumer Affairs (D) Committee to investigate the states’ privacy protections for insurance transactions and evaluate where there may be gaps or omissions that may require additional work to ensure appropriate protections are in place for data collected. The charge reads: “The Market Regulation and Consumer Affairs (D) Committee will review state insurance privacy protections regarding the collection, use, and disclosure of information gathered in connection with insurance transactions and make recommended changes, as needed, to certain NAIC models, such as the NAIC Insurance Information and Privacy Protection Model Act (#670) and the Privacy of Consumer Financial and Health Information Model Regulation (#672) by the 2020 Summer National Meeting.”

   Commissioner Altmaier made a motion, seconded by Director Farmer, to adopt the reports of the Financial Stability (EX) Task Force, the Government Relations (EX) Leadership Council, the Innovation and Technology (EX) Task Force and the Long-Term Care Insurance (EX) Task Force (Attachment Two). The motion passed.

4. **Adopted Request to Develop Amendments to the Health Maintenance Organization Model Act (#430)**

   Commissioner Altman reported that the request to develop amendments to the Health Maintenance Organization Model Act (#430) would address conflicts and redundancies with provisions in the Life and Health Insurance Guaranty Association Model Act (#520).

   In 2018, the Health Insurance and Managed Care (B) Committee received a referral from the Receivership and Insolvency (E) Task Force to review relevant health maintenance organization (HMO) model laws to determine if conforming changes are needed to provide options for the states that have enacted or are in the process of enacting the recently revised Model #520. The Committee charged the Regulatory Framework (B) Task Force with conducting the review. The Task Force established the HMO Issues (B) Subgroup to perform the review. The Subgroup identified conflicts and redundancies between Model #520 and Model #430, and it recommended revising Model #430 to address these issues.

   The HMO Issues (B) Subgroup unanimously adopted the Request for NAIC Model Law Development on April 29 via conference call. The Regulatory Framework (B) Task Force adopted it on May 15 via conference call, and the Committee adopted the request June 11 via conference call.

   Commissioner Altman made a motion, seconded by Commissioner Altmaier, to adopt the request to amend Model #430 (Attachment Three). The motion passed.

5. **Adopted the Request for Model Law Development for a Pharmacy Benefit Manager (PBM) Model Law**

   Commissioner Altman reported that the Request for Model Law Development for a Pharmacy Benefit Manager (PBM) model law is the result of discussions that began during the Health Insurance and Managed Care (B) Committee’s work to revise the Health Carrier Prescription Drug Benefit Management Model Act (#22). There was discussion on whether the model revisions should include provisions directly regulating PBMs. It was decided that such provisions were beyond the scope of the work.
related to Model #22. Subsequently, the Health Insurance and Managed Care (B) Committee, through the Regulatory Framework (B) Task Force, agreed to discuss whether the NAIC should consider developing a new NAIC model regulating PBMs. The Task Force established the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to carry out these discussions. The Subgroup determined it was appropriate to consider developing a new NAIC model on PBMs.

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adopted the Request for Model Law Development on March 22 via conference call. The Regulatory Framework (B) Task Force and the Health Insurance and Managed Care (B) Committee both adopted the request at the Spring National Meeting.

Commissioner Altman made a motion, seconded by Director Cameron, to adopt the Request for Model Law Development for a PBM model law (Attachment Four). The motion passed.

6. **Adopted the Request for NAIC Model Law Development for a Pet Insurance Model Law**

Superintendent Dwyer reported that the Request for NAIC Model Law Development for a pet insurance model law originated from the Pet Insurance (C) Working Group when the Working Group finalized a white paper earlier this year.

In May, the Pet Insurance (C) Working Group reviewed the white paper and held a comment period concerning whether a model law should be developed. On June 27, the Working Group discussed comments received, and reviewed a Request for NAIC Model Law Development to draft a model that would define a regulatory structure for pet insurance to address issues, such as: producer licensing; policy terms; coverages; claims handling; premium taxes; disclosures; arbitration and preexisting conditions.

The Working Group adopted the Request for Model Law Development on June 27, and the Property and Casualty Insurance (C) Committee adopted it on July 18 via conference call.

Superintendent Dwyer made a motion, seconded by Director Farmer, to adopt the Request for Model Law Development for a new pet insurance model law (Attachment Five). The motion passed.

7. **Received a Status Report on the NAIC State Ahead Strategic Plan Implementation**

Superintendent Cioppa provided an update on the NAIC State Ahead implementation efforts (Attachment Six). There are 94 projects identified for the NAIC’s multi-year strategic plan: 32 have been completed; 41 are underway; and 21 future projects are planned. The number of total projects is expected to change over time. Significant progress has been made in several areas: including tableau reporting; call center improvements; State Based Systems (SBS) implementations and transition to the Cloud.

2019 is the second year for State Ahead and planning for State Ahead 2.0 will begin during the fall of 2019, with additional work in early 2020.

8. **Received a Report of Model Law Development Efforts**

Superintendent Cioppa presented a written report on the progress of ongoing model law development efforts (Attachment Seven).

9. **Heard a Report from the NIPR Board of Directors**

Director Deiter reported the NIPR Board of Directors met Aug. 2 and heard a report from the NIPR Audit Committee regarding NIPR’s financials through June 2019. NIPR’s total revenues are $1,629,301, 7.7% above budget and 11.7% above this time last year. The Audit Committee reported on the SOC 1 and SOC 2 audit of its financial controls from the independent auditor, RubinBrown. Overall, the report was good, with no exceptions.

The Board heard: 1) a report from the NIPR Investment Committee regarding a change in portfolio investments; 2) an update on the NAIC and NIPR’s progress on Cloud migration, which is a strategic priority for NIPR; 3) a report from Angela Middleton, NIPR’s new Chief Technology Officer (CTO), regarding her initial impressions of NIPR’s technical talent and initiatives; and 4) a report on the NAIC and NIPR’s ongoing cybersecurity initiatives.

NIPR has launched new features to its mobile application for licensed insurance producers. The application allows insurance professionals to access their information on a mobile device, making compliance faster and more convenient. The newly
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released License Renewal Reminder will push notifications of an upcoming license expiration, giving producers sufficient time to complete their renewals and meet continuing education (CE) requirements.

The new Appointment Information feature will allow producers to see their company appointments, termination dates and effective dates. Any professional licensed by a state insurance department can use the application to view their basic licensing information—which includes license numbers, expiration dates, and lines of authority—in addition to the new features.

10. **Heard a Report from the Compact**

Superintendent Dwyer reported the Compact held a joint meeting with its Management Committee Aug. 2. The Compact received reports from its Product Standards, Rulemaking and Finance Committees. It adopted amendments to an existing life uniform standard and held a public hearing on two new uniform standards, including the first uniform standard for group annuities.

The Compact discussed the draft Strategic Planning Framework, which was published in June and was the subject of discussion during a Compact breakfast at the mid-year meeting in Maine. The Compact has come to a general agreement on three priorities:

1) Uniform Standards States Support and Companies Willingly Accept; 2) Nationally Recognized Regulatory Review Process; and 3) Resources for Compacting States, Regulated Entities and Consumers.

The Compact received an update on third-party litigation involving questions of whether the Compact is a proper delegation of authority by the Colorado legislature under its Constitution. The District Court of Colorado granted Amica Mutual Insurance summary judgment in the case; which the plaintiff appealed to the 10th Circuit Court of Appeals. The 10th Circuit certified the question posed in this matter to the Colorado Supreme Court to answer, and the Court has accepted it. The NAIC and the Compact will again file a joint amicus brief in the case.

The Compact is having an excellent year in terms of revenue and filing volume associated with life companies having to update or file all new life products to comply with a Jan. 1, 2020 regulatory deadline. This also means the Compact will likely trigger one or both events requiring the Compact to begin payment to the NAIC of the $3.4 million line of credit the Compact used from 2007 to 2012.

The Compact officers have made a request to the NAIC officers and Executive (EX) Committee to consider whether the Compact should and is able to service this repayment on top of continuing to grow and fulfill its purpose to the states, industry and consumers or whether this is the time to put the Compact even or positive in terms of net assets.

**During this meeting, the Executive (EX) Committee and Plenary:**

11. **Adopted its June 25 Minutes**

Commissioner Altmaier made a motion, seconded by Director Farmer, to adopt the Executive (EX) Committee and Plenary’s June 25 minutes (Attachment Eight). The motion passed.

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

Director Farmer made a motion, seconded by Commissioner Altmaier, to adopt by consent the committee, subcommittee and task force minutes of the Spring National Meeting. The motion passed.

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

Commissioner Ommen reported that the Life Insurance and Annuities (A) Committee met Aug. 4. During this meeting, the Committee adopted its July 10 minutes, which included the following action: 1) adopted its Spring National Meeting minutes; 2) adopted 65 *Valuation Manual* amendments; and 3) adopted an amendment to *Actuarial Guideline XLIII—CARVM for Variable Annuities* (AG 43).

The Committee adopted the report of the Annuity Disclosure (A) Working Group, including its June 5 and May 13 minutes and an extension of its Request for NAIC Model Law Development. During its June 5 and May 13 meetings, the Working Group took the following action: 1) reviewed and discussed several comments on multiple iterations of draft revisions to the *Annuity Disclosure Model Regulation* (#245); and 2) approved a resolution of three of five outstanding issues.
The Committee adopted the report of the Annuity Suitability (A) Working Group, which met Aug. 3 and took the following action: 1) adopted its June 20 and Spring National Meeting minutes; 2) continued its discussions of “parking lot” issues; and 3) discussed its next steps, which include forming a technical drafting group to develop an initial draft of proposed revisions to the Suitability in Annuity Transactions Model Regulation (#275).

The Committee adopted the report of the Life Insurance Online Guide (A) Working Group, including its July 8 and June 10 minutes when it took the following action: 1) made progress on its charge to “develop an online resource on life insurance, including the evaluation of existing content on the NAIC website, to be published digitally for the benefit of the public”; 2) heard a presentation from Laura Kane, the NAIC Communications Director, on future plans to streamline and update the NAIC website and coordinate with the Working Group; 3) discussed draft language submitted by state insurance regulators and industry volunteers and reviewed revision suggestions provided by the NAIC-funded consumer representatives; and 4) agreed to continue discussions via conference call following the Summer National Meeting.

The Committee adopted the report of the Life Insurance Illustration Issues (A) Working Group, including its May 15 minutes and an extension of its Request for NAIC Model Law Development. During its May 15 meeting, the Working Group took the following action: 1) continued making progress on the development of a consumer-oriented policy overview document in order to achieve its charge of improving the understandability of the life insurance policy summaries already required in Section 7B of the Life Insurance Illustrations Model Regulation (#582) and Section 5A(2) of the Life Insurance Disclosure Model Regulation (#580); 2) continued to discuss how to revise Model #580 to include a policy overview document to accompany all life insurance policies along with the Life Insurance Buyer’s Guide (Buyer’s Guide), as well as sample policy overview documents; 3) discussed and exposed the April 24 draft revisions to Model #580 for a public comment period ending June 21; and 4) planned to meet via conference call Sept. 3 to continue its work on its goals.

The Committee adopted the report of the Life Actuarial (A) Task Force, which met Aug. 1–2.

The Committee voted to appoint the Retirement Security (A) Working Group, chaired by Commissioner Taylor, to implement the Committee’s charge on retirement security.

The Committee voted to appoint the Accelerated Underwriting (A) Working Group to “consider the use of external data and data analytics in accelerated life underwriting, including consideration of the ongoing work of the Life Actuarial (A) Task Force on the issue and, if appropriate, draft guidance for states.”


Superintendent Cioppa reported that under the procedures in place for updating the Valuation Manual, substantive amendments will be presented for an Executive (EX) Committee and Plenary vote at each Summer National Meeting. Under the Standard Valuation Law (#820), changes to the Valuation Manual must be adopted by NAIC members by an affirmative vote representing: 1) at least three-fourths of the members of the NAIC voting; and 2) members of the NAIC representing jurisdictions totaling greater than 75% of the applicable direct premiums written, as reported in the most recent annual statements available prior to the vote.

Commissioner Ommen presented 65 amendments to the Valuation Manual that had previously been adopted by the Life Actuarial (A) Task Force and then adopted by the Life Insurance and Annuities (A) Committee during its July 10 conference call.

Commissioner Ommen reported the amendments provide the reserve details for the Variable Annuities (VA) Framework. Several amendments came from the Valuation Analysis (E) Working Group as a result of their review of principle-based reserving (PBR) reports and are designed to improve the reporting and clarity of PBR requirements in the Valuation Manual. Other amendments help prepare the Valuation Manual for 2020, which is the required start of PBR for all companies.

Commissioner Ommen made a motion, seconded by Director Farmer, to adopt the package of 65 Valuation Manual amendments (Attachment Nine). The motion was adopted by 49 jurisdictions representing 94.92% of the applicable premiums written. Superintendent Cioppa confirmed that the vote satisfied the requirements to amend the Valuation Manual.
15. **Adopted Revisions to *Actuarial Guideline XLIII—CARVM for Variable Annuities* (AG 43)**

Commissioner Ommen reported that the revisions to *Actuarial Guideline XLIII—CARVM for Variable Annuities* (AG 43) apply the Variable Annuities Framework reserve requirements to products issued prior to Jan. 1, 2017. This amendment will synchronize the reserve requirements for the *Valuation Manual* with in-force business.

Commissioner Ommen made a motion, seconded by Commissioner Altmaier, to adopt the revisions to *Actuarial Guideline XLIII—CARVM for Variable Annuities* (AG 43) (Attachment Ten). The motion passed.

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

Commissioner Altman reported that the Health Insurance and Managed Care (B) Committee met Aug. 4. During this meeting, the Committee adopted its June 11 and Spring National Meeting minutes. During its June 11 meeting, the Committee took the following action: 1) adopted the Regulatory Framework (B) Task Force’s revised 2019 amended charges, which added a charge for the HMO Issues (B) Subgroup to revise provisions in the *Health Maintenance Organization Model Act* (#430) to address conflicts and inconsistencies with the *Life and Health Insurance Guaranty Association Model Act* (#520); 2) adopted the Task Force’s Request for Model Law Development for the Subgroup to revise Model #430 consistent with its 2019 charge; and 3) adopted the Consumer Information (B) Subgroup’s consumer alert “What to Ask for When Shopping for Health Insurance.”

The Committee adopted the following subgroup, working group and task force reports: the Consumer Information (B) Subgroup; the Health Innovations (B) Working Group; the Health Actuarial (B) Task Force; the Long-Term Care Insurance (E/B) Task Force; the Regulatory Framework (B) Task Force; and the Senior Issues (B) Task Force.

The Committee also took the following action: 1) heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on its recent regulatory activities and discussed the current individual market landscape; 2) heard a panel presentation from Magellan Health, the American Psychiatric Association (APA) and the National Alliance on Mental Illness (NAMI) on the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) regarding current implementation issues and outstanding mental health parity issues; and 3) received a briefing from the NAIC Center for Insurance Policy and Research (CIPR) on its “Rising Health Care Costs: Drivers, Challenges and Solutions” research study. The CIPR is releasing three more installments of the study prior to the Fall National Meeting, which will include topics on the use of big data to reduce health care costs and value-based reimbursement.

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

Superintendent Dwyer reported the Property and Casualty Insurance (C) Committee met Aug. 5. During this meeting, the Committee adopted its July 18 minutes, which included the following action: 1) adopted its Spring National Meeting minutes; 2) adopted a Request for Model Law Development related to pet insurance; 3) heard an update on the status of the private passenger auto report; 4) discussed private flood data collection and a proposed blanks change; and 5) discussed the upcoming Summer National Meeting.

The Committee adopted the reports of its task forces and working groups: the Casualty Actuarial and Statistical (C) Task Force; the Surplus Lines (C) Task Force; the Title Insurance (C) Task Force; the Workers’ Compensation (C) Task Force; the Cannabis Insurance (C) Working Group; the Catastrophe Insurance (C) Working Group; the Climate Risk and Resilience (C) Working Group; the Lender-Placed Insurance Model Act (C) Working Group; the Pet Insurance (C) Working Group; the Terrorism Insurance Implementation (C) Working Group; and the Transparency and Readability of Consumer Information (C) Working Group.

The Committee also took the following action: 1) adopted a white paper titled “Regulatory Guide: Understanding the Market for Cannabis Insurance” that is meant to provide information about the architecture of the cannabis business supply chain, types of insurance needed by the cannabis industry, the availability of cannabis business insurance in state insurance markets and the extent of insurance gaps, and best practices that state insurance regulators can adopt to encourage insurers to write insurance for the cannabis industry; 2) adopted the “Post-Disaster Claims Guide” that is meant to be a state insurance regulator resource, providing consumers with information about navigating the claims process following a natural disaster; 3) adopted the Alien Insurers Private Flood Data Collection Form to collect additional private flood insurance data from alien surplus lines insurers; 4) adopted an extension for revisions to the proposed Real Property Lender-Placed Insurance Model Act; 5) heard a presentation from Amy Bach (United Policyholders) on the problem of individuals being underinsured for catastrophe risks, including on inadequate policy limits, high deductibles and exclusions; and 6) heard a report from Birny Birnbaum (Center for Economic Justice—CEJ) on the issue of bundling non-insurance products with insurance products.

Superintendent Dwyer reported that a drafting group was formed by the Property and Casualty Insurance (C) Committee to develop a white paper for state insurance regulators regarding pet insurance. Multiple conference calls were held from April to October 2018 with numerous comments received.

The white paper provides an overview of the pet insurance market, industry trends, coverage options, regulatory environment and regulatory concerns. Licensing or other regulatory requirements are to be discussed and decided within the drafting of a model law. The Property and Casualty Insurance (C) Committee adopted the white paper on March 28.

Superintendent Dwyer made a motion, seconded by Mr. Lorusso, to adopt the white paper “A Regulator’s Guide to Pet Insurance” (Attachment Eleven). The motion passed.

19. **Received the Report of the Market Regulation and Consumer Affairs (D) Committee**

Director Lindley-Myers reported the Market Regulation and Consumer Affairs (D) Committee met Aug. 5. During this meeting, the Committee adopted its July 15 minutes, which included the following action: 1) adopted its Spring National Meeting minutes; 2) adopted the insurance data security pre-breach and post-breach checklists; 3) adopted standardized data requests (SDRs) for: private passenger auto in-force policies and claims, homeowners’ in-force policies and claims, and personal lines new business declinations; 4) adopted the short-term limited duration (STLD) data call template; 5) adopted the Market Conduct Annual Statement (MCAS) private flood data call and definitions; and 6) adopted the revised MCAS health data call and definitions.

The Committee adopted the reports of its task forces and working groups: the Antifraud (D) Task Force; the Market Information Systems (D) Task Force; the Producer Licensing (D) Task Force; the Market Conduct Annual Statement Blanks (D) Working Group; the Market Conduct Examination Standards (D) Working Group; the Market Actions (D) Working Group; and the Market Analysis Procedures (D) Working Group.

The Committee also took the following action: 1) discussed updates to the *Best Practices and Guidelines for Consumer Information Disclosures*; 2) discussed a proposed charge for the Advisory Organization Examination Oversight (D) Working Group to “[e]nsure that organizations that engage in advisory organization activities are properly licensed and subject to appropriate regulatory oversight.” This charge was referred to the Big Data (EX) Working Group because it aligns with the Working Group’s current charges; 3) discussed the potential referral from the Innovation and Technology (EX) Task Force to review state insurance privacy protections regarding the collection, use and disclosure of information gathered in connection with insurance transactions and made recommended changes, as needed, to certain NAIC models, such as the *Insurance Information and Privacy Protection Model Act* (#670) and the *Privacy of Consumer Financial and Health Information Model Regulation* (#672), by the 2020 Summer National Meeting.

20. **Adopted the Market Conduct Annual Statement (MCAS) Private Flood Data Call Definitions**

Director Lindley-Myers reported on July 15, the Market Regulation and Consumer Affairs (D) Committee adopted the Private Flood Data Call and Definitions for MCAS on July 15. The creation of the Private Flood MCAS blank was a collaborative effort of state insurance regulators, industry and consumer representatives.

The blank collects private flood insurance information on both stand-alone policies, as well as endorsements to existing homeowner or other property policies. For both the stand-alone policies and endorsements, the blank asks carriers to report separately for first-dollar coverages and excess coverages. As with the other MCAS blanks, MCAS requires information on underwriting, claims, complaints and lawsuit activities. The first filing of the Private Flood MCAS will be due on April 30, 2021, covering the 2020 data year.

Director Lindley-Myers made a motion, seconded by Director Cameron, to adopt the Market Conduct Annual Statement (MCAS) Private Flood Data Call & Definitions (Attachment Twelve). The motion passed.
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21. Adopted the Mental Health Parity Guidance and Data Collection Tool for Mental Health Parity Analysis

Director Lindley-Myers reported that the Market Conduct Examination Standards (D) Working Group adopted new mental health parity guidance for market conduct examiners on Dec. 19, 2018, which includes a mental health parity guidance document and a data collection tool to be used by examiners in an analysis of mental health parity.

The Committee adopted the new mental health parity guidance document and the data collection tool at the Spring National Meeting.

Director Lindley-Myers made a motion, seconded by Commissioner Ridling, to adopt the Mental Health Parity Guidance and Data Collection Tool for Mental Health Parity Analysis (Attachment Thirteen). The motion passed.

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

Commissioner Altmaier reported that the Financial Condition (E) Committee met Aug. 5. During this meeting, the Committee adopted its May 28 and Spring National Meeting minutes. During its May 28 meeting, the Committee adopted revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786), which implement the reinsurance collateral provisions of the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement), which both become operative 60 months after Sept. 22, 2017.

The Committee adopted the following task force and working group reports: the Accounting Practices and Procedures (E) Task Force; the Capital Adequacy (E) Task Force; the Examination Oversight (E) Task Force; the Long-Term Care Insurance (E/B) Task Force; the Receivership and Insolvency (E) Task Force; the Reinsurance (E) Task Force; the Risk Retention Group (E) Task Force; the Valuation of Securities (E) Task Force; the Group Capital Calculation (E) Working Group; the NAIC/AICPA (E) Working Group; the National Treatment and Coordination (E) Working Group; the Restructuring Mechanisms (E) Working Group; and the Group Solvency Issues (E) Working Group.

The Committee also took the following action: 1) discussed preliminary proposed salary updates to the Financial Condition Examiners Handbook; 2) discussed proposed changes to specific charges of the Restructuring Mechanisms (E) Working Group and the Restructuring Mechanisms (E) Subgroup dealing with a needed specific deadline. The proposed changes will be further considered when the Committee adopts its 2020 proposed charges prior to the Fall National Meeting; and 3) adopted a Request for Model Law Development extension from the Mortgage Guaranty Insurance (E) Working Group.

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.

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

Commissioner Kiser reported the Financial Regulation Standards and Accreditation (F) Committee met Aug. 2 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, to: 1) discuss state-specific accreditation issues; and 2) vote to award continued accreditation to the insurance departments of Montana, Pennsylvania and Utah.

The Committee met in open session Aug. 3. During this meeting, the Committee took the following action: 1) adopted its Spring National Meeting minutes; 2) adopted its 2020 proposed charges, which remain unchanged from 2019; 3) adopted revisions to the Part A: Laws and Regulations Preamble of the Financial Regulation Standards and Accreditation Program to include fraternal benefit societies in regard to principle-based reserving (PBR where specifically referenced in the Liabilities and Reserves standard; 4) adopted revisions to Part D: Organization, Licensing and Change of Control of Domestic Insurers. The revisions include updates to reflect current practices and expansion of the standards to include re-domestications, effective Jan. 1, 2020. In addition, Part D will be included in the review team’s report beginning Jan. 1, 2022 which can affect a state’s accreditation status; 5) exposed proposed revisions to the Self-Evaluation Guide/Interim Annual Review to incorporate the revisions to Part D for a 30-day public comment period ending Sept. 6; 6) exposed proposed revisions to the Review Team
Draft for Adoption

Guidelines for procedures for troubled companies for a 30-day public comment period ending Sept. 6. The revisions provide further information on timely and effective communication between the domiciliary and non-domiciliary states about a troubled or potentially troubled company; and 7) discussed the accreditation impact of the 2019 revisions to Model #785 and Model #786. The states are encouraged to begin adoption of provisions that are substantially similar to the 2019 revisions to Model #785 and Model #786. Consideration of a formal accreditation standard will follow the normal process, which includes public discussion and exposure, as well as considerations of any necessary expediting or waiver of procedures.

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

Commissioner Anderson reported that the International Insurance Relations (G) Committee met Aug. 3. During this meeting, the Committee: 1) adopted its Spring National Meeting minutes; 2) reported that it met July 30 and May 30 in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings; and 3) discussed with interested parties key 2019 projects of the International Association of Insurance Supervisors (IAIS), focusing on the holistic framework on systemic risk, the ICS and monitoring period, and the new IAIS strategic plan for 2020–2024. Committee members and interested parties discussed various aspects of these projects, including concerns on design elements, implementation, and potential impacts and views of ongoing development and direction.

The Committee adopted the report of the ComFrame Development and Analysis (G) Working Group, which met Aug. 3 in regulator-to-regulator session pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, and took the following action: 1) discussed and provided input on issues related to the insurance capital standard (ICS) and the monitoring period process; and 2) heard an update on the ICS and aggregation method field testing processes.

25. Received an Update on the States’ Implementation of NAIC-Adopted Model Laws and Regulations

Superintendent Cioppa referred to the written report for updates on the states’ implementation of NAIC-adopted model laws and regulations (Attachment Fourteen).

Having no further business, the Executive (EX) Committee and Plenary adjourned.
The Executive (EX) Committee met June 25, 2019. The meeting was held in regulator-to-regulator session pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee:

1. Appointed Director Lori K. Wing-Heier (AK) to serve on the National Insurance Producer Registry (NIPR) Board of Directors beginning in June 2019.


3. Received an NAIC Audit Committee report on Service Organization Control (SOC) 1 and SOC 2.

4. Heard an update on State Ahead.

5. Approved a recommendation to contribute to the NAIC defined benefit plan by mid-July.

6. Approved Management’s recommendation to extend the residential mortgage-backed securities (RMBS)/commercial mortgage-backed securities (CMBS) modeling contract with BlackRock.

7. Adopted the revised NAIC Consumer Participation Program Plan of Operation.


9. Approved the recommendation to expose the System for Electronic Rate and Form Filing (SERFF) Data Hosting Proposal.

10. Selected the meeting locations for the 2023 spring and summer national meetings: the 2023 Spring National Meeting will be held in Louisville, KY; and the 2023 Summer National Meeting will be held in Seattle, WA.
REPORT OF THE EXECUTIVE (EX) COMMITTEE TASK FORCES

Financial Stability (EX) Task Force—The Financial Stability (EX) Task Force met Aug. 5 and took the following action: 1) adopted its Spring National Meeting minutes; 2) adopted the Liquidity Assessment (EX) Subgroup’s May 10 minutes and noted that the Subgroup met June 14 and July 30 via conference call in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss progress made by the Liquidity Stress Testing Study Group; 3) heard an update on Financial Stability Oversight Council (FSOC) developments; 4) received an update from the Liquidity Assessment (EX) Subgroup on its progress toward achieving its deliverables related to liquidity stress testing; 5) received an update from the Receivership and Insolvency (E) Task Force on its work to address the Financial Stability (EX) Task Force’s referral letter to undertake analysis relevant to the NAIC Macroprudential Initiative; 6) heard an update on leveraged loans; and 7) heard an update on macroprudential surveillance.

Government Relations (EX) Leadership Council—The Government Relations (EX) Leadership Council did not meet at the Summer National Meeting. The Leadership Council meets weekly via conference call in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues relating to federal legislative and regulatory matters or international regulatory matters) of the NAIC Policy Statement on Open Meetings, to discuss federal legislative and regulatory developments affecting insurance regulation.

Innovation and Technology (EX) Task Force—The Innovation and Technology (EX) Task Force met June 4 and took the following action: 1) adopted its Spring National Meeting minutes; 2) heard presentations from various stakeholders, including representatives for producers, insurers, InsurTechs, consumers, and state insurance regulators, regarding anti-rebating. The Task Force also met Aug. 5 and took the following action: 1) adopted its June 4 minutes; 2) adopted its working group reports and heard a report on the activities of the Innovation and Technology State Contact group; 3) discussed options for moving forward on the issue of anti-rebating. During that discussion, the Task Force members received a draft guideline from North Dakota addressing a specific interpretation of its statutory language considering anti-rebating issues and discussed the appropriateness of pursuing model law or regulation language, as well as a guideline. The Task Force members also heard an update on the activities of the National Conference of Insurance Legislators (COIL) regarding anti-rebating and e-commerce; 4) heard an update on cybersecurity activity, including a legislative update and briefing on data privacy from NAIC Legal staff. The decision was made to refer a charge to the Market Regulation and Consumer Affairs (D) Committee to review state insurance privacy protections to determine if additional work is necessary to close potential gaps or omissions; 5) heard a presentation from an innovator, Theta Lake, Inc, on using artificial intelligence (AI) to evaluate unstructured data for regulatory compliance; and 6) decided to form an Artificial Intelligence (EX) Working Group under the Task Force to further evaluate issues related to the use of AI in insurance transactions and AI principles.

The Big Data (EX) Working Group met Aug. 3 and took the following action: 1) adopted its Spring National Meeting minutes; 2) heard presentations from the Insurance Services Office (ISO) and the National Insurance Crime Bureau (NICB) on the use of data to detect fraud and settle property/casualty (P/C) claims; and 3) received an update from the Casualty Actuarial and Statistical (C) Task Force regarding its draft white paper on best practices for the review of predictive models and analytics filed by insurers to justify rates, the development of state guidance (e.g., information and data) for rate filings that are based on complex predictive models, and the development of training for the sharing of expertise through predictive analytics webinars.

The Speed to Market (EX) Working Group did not meet at the Summer National Meeting. The Working Group met via conference call June 26 and June 25. During its June 26 call, the Working Group discussed suggestions for 2019 changes to the Life, Accident/Health, Annuity and Credit Uniform Product Coding Matrix (PCM) effective Jan. 1, 2020. The suggestions involved changes to existing Types of Insurance (TOIs)/sub-TOIs and the addition of new TOIs/sub-TOIs. The Working Group decided that the suggested changes were not needed at this time due to the lack of need by most states. Where needed, the states can utilize state TOIs. By way of an email vote that was finalized on July 16, the following change was adopted: 1) the removal of references to 2010 dates on Medicare Supplement instructions for all TOIs and sub-TOIs. The statement, “Product filings may be submitted prior to 6/1/2010; however, plan is not effective until 6/1/2010,” is to be replaced with, “Product filings may be submitted prior to 01/01/2020; however, filing is not effective until 1/1/2020.”
During its June 25 call, the Working Group discussed suggestions for 2019 changes to the Property and Casualty Uniform PCM effective Jan. 1, 2020. By way of an email vote that was finalized on July 16, the following changes were adopted:

1) update the description for 05.0 Commercial Multi-Peril (CMP) Liability and Non-Liability to state, “various property and/or liability risk exposures” in lieu of “various property and liability risk exposures”; 2) update the description for 05.1 CMP Non-Liability Portion Only to read, “Coverage for non-liability commercial multiple peril contracts”; 3) update the description for 05.2 CMP Liability Portion Only to read, “Coverage for liability commercial multiple peril contracts”; and 4) add a sub-TOI under 16.0 Worker’s Compensation: 16.0005 Occupational Accident Worker’s Compensation.

**Long-Term Care Insurance (EX) Task Force**—The Long-Term Care Insurance (EX) Task Force met Aug. 4 and took the following action: 1) received a progress report on the activities of the Task Force whereby the Task Force has identified six workstreams that should be further explored to accomplish the goals set forth in its charges as follows: a) multistate rate review practices; b) restructuring techniques; c) reduced benefit options and consumer notices; d) valuation of long-term care insurance (LTCI) reserves; e) non-actuarial variance among states; and f) data call design and oversight; and 2) heard from consumer and industry representatives—including California Health Advocates (CHA), the Center for Economic Justice (CEJ) and American Council of Life Insurers (ACLI)—primarily on the topics of reduced benefit options and impacts to consumers.
REQUEST FOR NAIC 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:

HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force

2. NAIC staff support contact information:

Jolie Matthews jmatthews@naic.org

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

The Subgroup has a charge to revise provisions in the Health Maintenance Organization Model Act (#430) to address conflicts and redundancies with provisions in the Life and Health Insurance Guaranty Association Model Act (#520).

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

The revisions would provide guidance to those states that have adopted Model #430 and the revised Model #520, which added HMOs as members of the guaranty association, in addressing conflicts and redundancies in Model #430 with the revised Model #520.

b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?

☐ Yes or ☐ No (Check one)

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

☐ 1 High Likelihood ☐ 2 ☐ 3 ☐ 4 ☐ 5 Low Likelihood (Check one)

Explanation, if necessary: The current subgroup would target completion of a model within one year.
6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☐ 1  ☒ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary: State adoption of the anticipated revisions will depend on whether states have adopted the current Model #430 or its equivalent and adopted the revised Model #520.

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

☐ 1  ☒ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary: State adoption of the anticipated revisions will depend on whether states have adopted the current Model #430 or its equivalent and adopted the revised Model #520.

8. Is this model law referenced in the NAIC 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
REQUEST FOR NAIC 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:
Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force

2. NAIC staff support contact information:
Jolie Matthews imatthews@naic.org

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

The Subgroup has a charge to consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs).

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

The proposed new model would provide a consistent approach among the states for providing a regulatory scheme for these entities to address, for some states, a potential regulatory gap.

b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?
   ☒ Yes or ☐ No (Check one)

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

☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary: The current subgroup would target completion of a model within one year.
6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood       Low Likelihood

Explanation, if necessary: Some states have already implemented laws and/or regulations establishing a regulatory scheme for these entities, which may or may not be consistent with the provisions in the proposed new model. For those states with laws or regulations not consistent with the new model’s provisions, the issue will be whether these states will want to re-open those laws or regulations after adoption the new model.

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

☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood       Low Likelihood

Explanation, if necessary: Some states have already implemented laws and/or regulations establishing a regulatory scheme for these entities, which may or may not be consistent with the provisions in the proposed new model. For those states with laws or regulations not consistent with the new model’s provisions, the issue will be whether these states will want to re-open those laws or regulations after adoption the new model.

8. Is this model law referenced in the NAIC 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. However, the U.S. Department of Health and Human Services (HHS) has proposed rules on rebating safe harbors. In addition, the HHS and/or other federal government agencies currently are considering proposing further federal policy guidance in the areas concerning PBMs and prescription drug pricing transparency and disclosure. In developing the new NAIC model, the Subgroup most likely will be discussing the same or similar issues.
REQUEST FOR NAIC 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:
   Pet Insurance (C) Working Group

2. NAIC staff support contact information:
   Aaron Brandenburg
   abrandenburg@naic.org
   816 783 8271

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

   Pet Insurance Model Law. This model would define a regulatory structure related to pet insurance, including issues such as producer licensing, policy terms, coverages, claims handling, premium taxes, disclosures, arbitration, and preexisting conditions.

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: Interested parties agree that there is ambiguity within regulation of the pet insurance market and having a more defined and consistent regulatory structure will improve the market and benefit consumers. The NAIC Paper, A Regulators’ Guide to Pet Insurance, the Pet Insurance (C) Working Group and the Producer White Licensing (D) Task Force have previously discussed some of these ambiguities in the regulation of the market.

   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law? ☒ Yes or ☐ No (Check one)

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

   ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

   High Likelihood               Low Likelihood

   Explanation, if necessary: The NAIC White Paper, “A Regulator’s Guide to Pet Insurance” has provided the background for the Working Group to understand the issues and begin to draft a model.
6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood

Low Likelihood

Explaination, if necessary:

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

☐ 1 ☐ 2 ☒ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

8. Is this model law referenced in the NAIC 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
State Ahead Status Reporting - July 2019

Projects by Strategic Themes
- Theme I: 22
- Theme II: 28
- Theme III: 44

Projects by Strategic Goals
- Goal 1: 22
- Goal 2: 28
- Goal 3: 29

Projects by Strategic Objectives
- Objective A: 13
- Objective B: 9
- Objective C: 17

Current Status of Active Projects
- On Schedule: 36
- At Risk: 4
- At Significant Risk: 1

Current Project Phase
- Active: 41
- Future: 21
- Closed: 32

Goal 4: 5
Goal 3: 39
Goal 2: 28
Goal 1: 22

Objective H: 5
Objective G: 33
Objective F: 6
Objective E: 6
Objective D: 5
Objective C: 17
Objective B: 9
Objective A: 13

Projects by Strategic Objectives

Projects by Strategic Goals

Projects by Strategic Themes

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Model Law Development Report

Amendments to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)—Amendments to Model #171 are required for consistency with the federal Affordable Care Act (ACA) and, therefore, did not require approval of a Request for NAIC Model Law Development by the Executive (EX) Committee. At the 2015 Fall National Meeting, the Regulatory Framework (B) Task Force discussed the proposed revisions to this model. The Task Force requested additional comments by Jan. 22, 2016. The Task Force met Feb. 11, 2016, and appointed the Accident and Sickness Insurance Minimum Standards (B) Subgroup to work on revisions to this model. The Subgroup has been meeting on a regular basis since the 2016 Spring National Meeting and plans to continue meeting via conference call until it completes its work. During its meetings, the Subgroup has discussed a number of issues, including its approach for revising the model’s disability income insurance coverage provisions, and decided preliminarily to review the Interstate Insurance Product Regulation Commission’s (Compact) approach. After pausing its work due to the ACA’s potential repeal, replacement or modification—and the possible impact on the provisions of this model, as well as the Subgroup’s preliminary proposed revisions to the model—the Subgroup began meeting again via conference call in May 2018. Revisions to Model #170, now known as the Supplementary and Short-Term Health Insurance Minimum Standards Model Act, were adopted by the full NAIC membership at the Spring National Meeting. The Subgroup has begun meeting to consider revisions to Model #171 for consistency with the revised Model #170. The Subgroup hopes to complete its work by the Fall National Meeting.

Amendments to the Annuity Disclosure Model Regulation (#245)—The Executive (EX) Committee met June 19, 2017, and approved a Request for NAIC Model Law Development to amend Model #245. The amendments will revise Section 6—Standards for Illustrations. The purpose of the revision is to address issues identified by the Life Insurance and Annuities (A) Committee’s Annuity Disclosure (A) Working Group related to innovations in annuity products that are not addressed, or not addressed adequately, in the current standards. Revisions addressing participating income annuities were adopted by the Life Insurance and Annuities (A) Committee during its July 19, 2018, conference call and held pending the resolution of the Working Group’s discussions regarding illustrating indexes in existence for less than 10 years. The Working Group continues to discuss additional revisions on the index issue. At the 2019 Spring National Meeting, the Life Insurance and Annuities (A) Committee granted a request for extension of time to the Annuity Disclosure (A) Working Group to continue drafting amendments. The Working Group made progress during discussions via conference call on May 13, June 5, July 15 and July 29, and it received an extension from the Life Insurance and Annuities (A) Committee at the Summer National Meeting to continue its work. The Working Group hopes to complete its work by the Fall National Meeting.

Amendments to the Suitability in Annuity Transactions Model Regulation (#275)—Amendments to Model #275 are being drafted for consistency with federal rules and, therefore, did not require approval of a Request for NAIC Model Law Development by the Executive (EX) Committee. The Life Insurance and Annuities (A) Committee’s Annuity Suitability (A) Working Group is drafting amendments to Model #275 that would raise the standard of conduct requirement for insurers and producers offering annuity products. The Working Group held an in-person meeting in June to consider the comments received on the draft proposed revisions exposed for a public comment period ending Feb. 15. The Working Group continued its discussion July 23 and July 29 via conference call, as well as during its meeting at the Summer National Meeting. Additional calls will be held following the Summer National Meeting.

Amendments to the Life Insurance Disclosure Model Regulation (#580) and Life Insurance Illustrations Model Regulation (#582) Policy Overview Document—The Executive (EX) Committee met June 19, 2017, and approved the Request for NAIC Model Law Development to incorporate a policy overview document requirement into Model #580 and Model #582 in order to improve the understandability of the life insurance policy summary and narrative summary already required by Section 5A(2) of Model #580 and Section 7B of Model #582. The Life Insurance and Annuities (A) Committee’s Life Insurance Illustration Issues (A) Working Group has been meeting via conference call to develop language to add a requirement for a one- to two-page consumer-oriented policy overview. The Working Group has received an extension from the Life Insurance and Annuities (A) Committee until the Summer National Meeting. The Working Group continued to make progress during its discussions May 15 and July 30 via conference call and received an extension from the Life Insurance and Annuities (A) Committee at the Summer National Meeting to continue its work. The Working Group hopes to complete its work by the Fall National Meeting.

Amendments to the Mortgage Guaranty Insurance Model Act (#630)—The Executive (EX) Committee and Plenary approved the Request for NAIC Model Law Development to amend Model #630 on July 26, 2013. The Financial Condition (E) Committee’s Mortgage Guaranty Insurance (E) Working Group developed substantial changes to the model but continues to discuss those changes. The Working Group’s focus has shifted to working with a consultant to produce a capital model that
will serve as the basis for levels of intervention included in Model #630, with significant progress made in this area since the Spring National Meeting. The Working Group is requesting an additional extension from the Financial Condition (E) Committee at this meeting.

**New Model: Real Property Lender-Placed Insurance Model Act**—The Executive (EX) Committee approved the Request for NAIC Model Law Development, submitted by the Property and Casualty Insurance (C) Committee, to draft the new Real Property Lender-Placed Insurance Model Act at the 2017 Summer National Meeting. The Property and Casualty Insurance (C) Committee’s Lender-Placed Insurance Model Act (C) Working Group exposed a draft of this proposed new model focusing on lender-placed insurance related to mortgage loans for a public comment period ending Oct. 31, 2018. At the 2019 Summer National Meeting, the Working Group received an extension of time to continue drafting the new model.
Plenary
Conference Call
June 25, 2019

The Executive (EX) Committee and Plenary met in joint session via conference call June 25, 2019. The following members participated: Eric A. Cioppa, Chair (ME); Raymond G. Farmer, Vice Chair (SC); David Altmaier, Vice President (FL); Dean L. Cameron, Secretary-Treasurer (ID); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Allen W. Kerr represented by Russ Galbraith (AR); Keith Schraad (AZ); Michael Conway (CO); Andrew N. Mais (CT); Stephen C. Taylor (DC); Trinidad Navarro (DE); Jim Beck represented by Josh McKoon (GA); Doug Ommen represented by Mike Yanacheck (IA); Robert H. Muriel (IL); Stephen W. Robertson (IN); Vicki Schmidt (KS); Nancy G. Atkins (KY); Al Redmer Jr. (MD); Anita G. Fox (MI); Steve Kelley (MN); Chlora Lindley-Myers (MO); Mike Chaney (MS); Matthew Rosendale (MT); Mike Causey (NC); Jon Godfread (ND); Bruce R. Range (NE); Marlene Caride (NJ); John G. Franchini (NM); Linda A. Lacewell represented by Laura Evangelista (NY); Jillian Froment (OH); Glen Mulready (OK); Jessica Altman (PA); Elizabeth Kelleher Dwyer (RI); Larry Deiter (SD); Carter Lawrence (TN); Kent Sullivan (TX); Todd E. Kiser (UT); Scott A. White (VA); Tregenza A. Roach (VI); Mike Kreidler (WA); Mark Afable (WI); James A. Dodrill (WV); and Jeff Rude (WY).

1. **Adopted Revisions to Model #785 and Model #786 to Incorporate the EU and UK Covered Agreements**

Commissioner Altmaier reported that on Sept. 22, 2017, the U.S. Department of the Treasury (Treasury Department) and U.S. Trade Representative signed the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement). The EU Covered Agreement requires the states to eliminate reinsurance collateral requirements for EU reinsurers within 60 months (five years) of signing or face potential federal preemption by the Federal Insurance Office (FIO). On Dec. 18, 2018, a separate Covered Agreement was signed between the U.S. and the United Kingdom (UK), the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement), which mirrors the language from the EU Covered Agreement and has the same timing requirements for implementation.

The first order of business was for the NAIC to decide on the right approach for addressing the Covered Agreements. To do this, the NAIC held a Public Hearing on Feb. 20, 2018, and heard comments from state, federal and international insurance regulators, as well as interested parties. There appeared to be almost unanimous consensus on all key points. As a result, the Executive (EX) Committee adopted a Request for Model Law Development to eliminate reinsurance collateral requirements for reinsurers that meet certain capital and solvency requirements.

The Reinsurance (E) Task Force and its drafting group, led by Director Lindley-Myers and John Rehagen (MO), worked very hard to address these issues, and on May 15 they adopted the revisions to Model #785 and Model #786. The Financial Condition (E) Committee then adopted these revisions during a conference call on May 28. The final revisions are consistent with the terms of the Covered Agreements.

Commissioner Altmaier made a motion, seconded by Director Range, to adopt the revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) (Attachment Eight-A). The motion passed unanimously.

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

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CREDIT FOR REINSURANCE MODEL LAW

Preface to Credit for Reinsurace Models

The amendments to the NAIC Credit for Reinsurance Model Law (#785) & Regulation (#786) are part of a larger effort to modernize reinsurance regulation in the United States. The NAIC initially adopted the Reinsurance Regulatory Modernization Framework Proposal during its 2008 Winter National Meeting. The NAIC recommended that this framework be implemented through federal legislation in order to best preserve and improve state-based regulation of reinsurance, ensure timely and uniform implementation throughout all NAIC member jurisdictions, and as a more comprehensive alternative to related federal legislation. In addition to this proposed federal legislation, the framework also provided that changes to state insurance laws should be considered. For example, state laws to establish requirements under which states would regulate qualified reinsurers, and also to consider reinsurance risk diversification and notice requirements for ceding insurers.

On July 21, 2010, Congress passed and the President signed related federal legislation, the Nonadmitted and Reinsurance Reform Act, which became effective July 21, 2011. While this act does not implement the NAIC framework, it does preempt the extraterritorial application of state credit for reinsurance law and permits states of domicile to proceed forward with reinsurance collateral reforms on an individual basis if they are accredited. This federal legislation also does not prohibit the states from acting together, through the NAIC, to achieve the reinsurance modernization framework goals. In addition to the current work on the credit for reinsurance models, the NAIC will continue its efforts to implement other aspects of the framework. These efforts will continue both through work conducted by the Reinsurance Task Force and through referrals to the appropriate groups within the NAIC. In addition, the NAIC will consider a proposal to form a new group to provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage. Such an effort would be supported by NAIC staff with substantial expertise to support the functions of such a group.

Finally, the NAIC will continue to work on requirements for NAIC review and approval of qualified jurisdictions, and will undertake a re-examination of the collateral amounts within two years from the effective date of the revisions to the models.

CREDIT FOR REINSURANCE MODEL LAW

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Section 2. Credit Allowed a Domestic Ceding Insurer

Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of Subsections A, B, C, D, E, or F or G of this section; provided further, that the commissioner may adopt by regulation pursuant to Section 5B specific
additional requirements relating to or setting forth: (1) the valuation of assets or reserve credits; (2) the amount and forms of security supporting reinsurance arrangements described in Section 5B; and/or (3) the circumstances pursuant to which credit will be reduced or eliminated.

**Drafting Note:** This new regulatory authority is being added in response to reinsurance arrangements entered into, directly or indirectly, with life/health insurer-affiliated captives, special purpose vehicles or similar entities that may not have the same statutory accounting requirements or solvency requirements as US-based multi-state life/health insurers. To assist in achieving national uniformity, commissioners are asked to strongly consider adopting regulations that are substantially similar in all material respects to NAIC adopted model regulations in the handling and treatment of such reinsurance arrangements.

Credit shall be allowed under Subsections A, B or C of this section only as respects cessions of those kinds or classes of business which the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a U.S. branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. Credit shall be allowed under Subsections C or D of this section only if the applicable requirements of Subsection GH have been satisfied.

**F. (1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer meeting each of the conditions set forth below.**

(a) The assuming insurer must have its head office or be domiciled in, as applicable, and be licensed in a Reciprocal Jurisdiction. A “Reciprocal Jurisdiction” is a jurisdiction that meets one of the following:

(i) A non-U.S. jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and European Union, is a member state of the European Union. For purposes of this subsection, a “covered agreement” is an agreement entered into pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;

(ii) A U.S. jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or

(iii) A qualified jurisdiction, as determined by the commissioner pursuant to [Subsection 2E(3) of Credit for Reinsurance Model Law], which is not otherwise described in subparagraph (i) or (ii) above and which meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the commissioner in regulation.

(b) The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount to be set forth in regulation. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain on an ongoing basis minimum capital and surplus equivalents (net of liabilities), calculated according to the methodology applicable in its domiciliary jurisdiction, and a central fund containing a balance in amounts to be set forth in regulation.
(c) The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio, as applicable, which will be set forth in regulation. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain on an ongoing basis a minimum solvency or capital ratio in the Reciprocal Jurisdiction where the assuming insurer has its head office or is domiciled, as applicable, and is also licensed.

(d) The assuming insurer must agree and provide adequate assurance to the commissioner, in a form specified by the commissioner pursuant to regulation, as follows:

(i) The assuming insurer must provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in subparagraphs (b) or (c), or if any regulatory action is taken against it for serious noncompliance with applicable law;

(ii) The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process. The commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement. Nothing in this provision shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;

(iii) The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

(iv) Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent (100%) of the assuming insurer’s liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate; and

(v) The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement which involves this state’s ceding insurers, and agrees to notify the ceding insurer and the commissioner and to provide security in an amount equal to one hundred percent (100%) of the assuming insurer’s liabilities to the ceding insurer should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of Section 2E and Section 3 and as specified by the commissioner in regulation.

Drafting Note: Section 9C(4)(c) of the Credit for Reinsurance Model Regulation (#786) sets forth the acceptable forms of security under this subparagraph by specifically referencing Sections 12, 13 and 14 of Model #786.
(e) The assuming insurer or its legal successor must provide, if requested by the commissioner, on behalf of itself and any legal predecessors, certain documentation to the commissioner as specified by the commissioner in regulation.

(f) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria set forth in regulation.

(g) The assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction, that the assuming insurer complies with the requirements set forth in subparagraphs (b) and (c).

(h) Nothing in this provision precludes an assuming insurer from providing the commissioner with information on a voluntary basis.

(2) The commissioner shall timely create and publish a list of Reciprocal Jurisdictions.

(a) A list of Reciprocal Jurisdictions is published through the NAIC Committee Process. The commissioner’s list shall include any Reciprocal Jurisdiction as defined under Section 2F(1)(a)(i) and (ii), and shall consider any other Reciprocal Jurisdiction included on the NAIC list. The commissioner may approve a jurisdiction that does not appear on the NAIC list of Reciprocal Jurisdictions in accordance with criteria to be developed under regulations issued by the commissioner.

(b) The commissioner may remove a jurisdiction from the list of Reciprocal Jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a Reciprocal Jurisdiction in accordance with a process set forth in regulations issued by the commissioner, except that the commissioner shall not remove from the list a Reciprocal Jurisdiction as defined under Section 2F(1)(a)(i) and (ii). Upon removal of a Reciprocal Jurisdiction from this list credit for reinsurance ceded to an assuming insurer which has its home office or is domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to [cite to state law equivalent to Credit for Reinsurance Model Law].

(3) The commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this subsection and to which cessions shall be granted credit in accordance with this subsection. The commissioner may add an assuming insurer to such list if an NAIC accredited jurisdiction has added such assuming insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the commissioner as required under Paragraph (1)(d) of this subsection and complies with any additional requirements that the commissioner may impose by regulation, except to the extent that they conflict with an applicable covered agreement.

(4) If the commissioner determines that an assuming insurer no longer meets one or more of the requirements under this subsection, the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this subsection in accordance with procedures set forth in regulation.

(a) While an assuming insurer’s eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer’s obligations under the contract are secured in accordance with Section 3.
(b) If an assuming insurer’s eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer’s obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of Section 3.

(5) If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

(6) Nothing in this subsection shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this [cite to state law equivalent to Credit for Reinsurance Model Law] or other applicable law or regulation.

(7) Credit may be taken under this subsection only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements pursuant to Section 2F(1) herein, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal.

(a) This paragraph does not alter or impair a ceding insurer’s right to take credit for reinsurance, to the extent that credit is not available under this subsection, as long as the reinsurance qualifies for credit under any other applicable provision of [cite to state law equivalent to Credit for Reinsurance Model Law].

(b) Nothing in this subsection shall authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement.

(c) Nothing in this subsection shall limit or in any way alter the capacity of parties to any reinsurance agreement to renegotiate the agreement.

Section 5. Rules and Regulations

A. The commissioner may adopt rules and regulations implementing the provisions of this law.

Drafting Note: It is recognized that credit for reinsurance also can be affected by other sections of the enacting state’s code, e.g., a statutory insolvency clause or an intermediary clause. It is recommended that states that do not have a statutory insolvency clause or an intermediary clause consider incorporating such clauses in their legislation.

B. The commissioner is further authorized to adopt rules and regulations applicable to reinsurance arrangements described in Paragraph (1) of this Section 5B.

Drafting Note: This new regulatory authority is being added in response to reinsurance arrangements entered into, directly or indirectly, with life/health insurer-affiliated captives, special purpose vehicles or similar entities that may not have the same statutory accounting requirements or solvency requirements as US-based multi-state life/health insurers. To assist in achieving national uniformity, commissioners are asked to strongly consider adopting regulations that are substantially similar in all material respects to NAIC adopted model regulations in the handling and treatment of such policies and reinsurance arrangements.

(1) A regulation adopted pursuant to this Section 5B, may apply only to reinsurance relating to:
(a) Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;

(b) Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

(c) Variable annuities with guaranteed death or living benefits;

(d) Long-term care insurance policies; or

(e) Such other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance.

(2) A regulation adopted pursuant to Paragraph 1(a) or 1(b) of this Section 5B, may apply to any treaty containing (i) policies issued on or after January 1, 2015, and/or (ii) policies issued prior to January 1, 2015, if risk pertaining to such pre-2015 policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

Drafting Note: The NAIC’s Actuarial Guideline XLVIII (AG 48) became effective January 1, 2015, and covers policies ceded on or after this date unless they were ceded as part of a reserve financing arrangement as of December 31, 2014. One regulation contemplated by this revision to the NAIC Credit for Reinsurance Model Law is intended to substantially replicate the requirements for the amounts and forms of security held under the rules provided in AG 48. AG 48 was written to sunset upon a state’s adoption (pursuant to the enabling authority of the preceding paragraph) of a regulation with terms substantially similar to AG 48. The preceding paragraph is intended to provide continuity of rules applicable to those policies and reinsurance arrangements, including continuity as to the policies covered by such rules. The preceding paragraph is not intended to change the scope of, or collateral requirements for policies and treaties covered under AG 48.

(3) A regulation adopted pursuant to this Section 5B may require the ceding insurer, in calculating the amounts or forms of security required to be held under regulations promulgated under this authority, to use the Valuation Manual adopted by the NAIC under Section 11B(1) of the NAIC Standard Valuation Law, including all amendments adopted by the NAIC and in effect on the date as of which the calculation is made, to the extent applicable.

(4) A regulation adopted pursuant to this Section 5B shall not apply to cessions to an assuming insurer that:

(a) Meets the conditions set forth in Section 2F of the Credit for Reinsurance Model Law in this state or, if this state has not adopted provisions substantially equivalent to Section 2F of the Credit for Reinsurance Model Law, the assuming insurer is operating in accordance with provisions substantially equivalent to Section 2F of the Credit for Reinsurance Model Law in a minimum of five (5) other states; or

(b)(c) Is certified in this state or, if this state has not adopted provisions substantially equivalent to Section 2E of the Credit for Reinsurance Model Law, certified in a minimum of five (5) other states; or

(bc) Maintains at least $250 million in capital and surplus when determined in accordance with the NAIC Accounting Practices and Procedures Manual, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices; and is

(i) licensed in at least 26 states; or
(ii) licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.

(5) The authority to adopt regulations pursuant to this Section 5B does not limit the commissioner’s general authority to adopt regulations pursuant to Section 5A of this law.
Preface to Credit for Reinsurance Models

The amendments to the NAIC Credit for Reinsurance Model Law (#785) & Regulation (#786) are part of a larger effort to modernize reinsurance regulation in the United States. The NAIC initially adopted the Reinsurance Regulatory Modernization Framework Proposal during its 2008 Winter National Meeting. The NAIC recommended that this framework be implemented through federal legislation in order to best preserve and improve state-based regulation of reinsurance, ensure timely and uniform implementation throughout all NAIC member jurisdictions, and as a more comprehensive alternative to related federal legislation. In addition to this proposed federal legislation, the framework also provided that changes to state insurance laws should be considered. For example, state laws to establish requirements under which states would regulate qualified reinsurers, and also to consider reinsurance risk diversification and notice requirements for ceding insurers.

On July 21, 2010, Congress passed and the President signed related federal legislation, the Nonadmitted and Reinsurance Reform Act, which became effective July 21, 2011. While this act does not implement the NAIC framework, it does preempt the extraterritorial application of state credit for reinsurance law and permits states of domicile to proceed forward with reinsurance collateral reforms on an individual basis if they are accredited. This federal legislation also does not prohibit the states from acting together, through the NAIC, to achieve the reinsurance modernization framework goals. In addition to the current work on the credit for reinsurance models, the NAIC will continue its efforts to implement other aspects of the framework. These efforts will continue both through work conducted by the Reinsurance Task Force and through referrals to the appropriate groups within the NAIC. In addition, the NAIC will consider a proposal to form a new group to provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage. Such an effort would be supported by NAIC staff with substantial expertise to support the functions of such a group.

Finally, the NAIC will continue to work on requirements for NAIC review and approval of qualified jurisdictions, and will undertake a re-examination of the collateral amounts within two years from the effective date of the revisions to the models.

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<tr>
<td>CR-1</td>
<td>Certificate of Certified Reinsurer</td>
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Section 8. Credit for Reinsurance—Certified Reinsurers

A. Pursuant to [cite state law equivalent of Section 2E of the Credit for Reinsurance Model Law], the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that has been certified as a reinsurer in this state at all times for which statutory financial statement credit for reinsurance is claimed under this section. The credit allowed shall be based upon the security held by or on behalf of the ceding insurer in accordance with a rating assigned to the certified reinsurer by the commissioner. The security shall be in a form consistent with the provisions of [cite state law equivalent of Section 2E and Section 3 of the Credit for Reinsurance Model Law] and 41, 12 or 13, 12, 13 or 14 of this Regulation. The amount of security required in order for full credit to be allowed shall correspond with the following requirements:

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<th>Ratings</th>
<th>Security Required</th>
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<tbody>
<tr>
<td>Secure – 1</td>
<td>0%</td>
</tr>
<tr>
<td>Secure – 2</td>
<td>10%</td>
</tr>
<tr>
<td>Secure – 3</td>
<td>20%</td>
</tr>
<tr>
<td>Secure – 4</td>
<td>50%</td>
</tr>
<tr>
<td>Secure – 5</td>
<td>75%</td>
</tr>
<tr>
<td>Vulnerable – 6</td>
<td>100%</td>
</tr>
</tbody>
</table>

(2) Affiliated reinsurance transactions shall receive the same opportunity for reduced security requirements as all other reinsurance transactions.

(3) The commissioner shall require the certified reinsurer to post one hundred percent (100%), for the benefit of the ceding insurer or its estate, security upon the entry of an order of rehabilitation, liquidation or conservation against the ceding insurer.

(4) In order to facilitate the prompt payment of claims, a certified reinsurer shall not be required to post security for catastrophe recoverables for a period of one year from the date of the first instance of a liability reserve entry by the ceding company as a result of a loss from a catastrophic occurrence as recognized by the commissioner. The one year deferral period is contingent upon the certified reinsurer continuing to pay claims in a timely manner. Reinsurance recoverables for only the following lines of business as reported on the NAIC annual financial statement related specifically to the catastrophic occurrence will be included in the deferral:

(a) Line 1: Fire
(b) Line 2: Allied Lines
(c) Line 3: Farmowners multiple peril
(d) Line 4: Homeowners multiple peril
(e) Line 5: Commercial multiple peril
(f) Line 9: Inland Marine
(g) Line 12: Earthquake
(h) Line 21: Auto physical damage

(5) Credit for reinsurance under this section shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer. Any reinsurance contract entered into prior to the effective date of the certification of the assuming insurer that is subsequently amended after the effective date of the certification of the assuming insurer, or a new reinsurance contract, covering any risk for which
collateral was provided previously, shall only be subject to this section with respect to losses incurred and reserves reported from and after the effective date of the amendment or new contract.

(6) Nothing in this section shall prohibit the parties to a reinsurance agreement from agreeing to provisions establishing security requirements that exceed the minimum security requirements established for certified reinsurers under this section.

B. Certification Procedure.

(1) The commissioner shall post notice on the insurance department’s website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The commissioner may not take final action on the application until at least thirty (30) days after posting the notice required by this paragraph.

**Drafting Note:** States that do not wish to make the internet the required mechanism for providing public notice should modify this provision accordingly. This provision was intended to provide a less formal notice requirement than is typically called for under state Administrative Procedure Acts.

(2) The commissioner shall issue written notice to an assuming insurer that has made application and been approved as a certified reinsurer. Included in such notice shall be the rating assigned the certified reinsurer in accordance with Subsection A of this section. The commissioner shall publish a list of all certified reinsurers and their ratings.

(3) In order to be eligible for certification, the assuming insurer shall meet the following requirements:

(a) The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction, as determined by the commissioner pursuant to Subsection C of this section.

(b) The assuming insurer must maintain capital and surplus, or its equivalent, of no less than $250,000,000 calculated in accordance with Subparagraph (4)(h) of this subsection. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least $250,000,000 and a central fund containing a balance of at least $250,000,000.

(c) The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. These financial strength ratings will be one factor used by the commissioner in determining the rating that is assigned to the assuming insurer. Acceptable rating agencies include the following:

(i) Standard & Poor’s;
(ii) Moody’s Investors Service;
(iii) Fitch Ratings;
(iv) A.M. Best Company; or
(v) Any other Nationally Recognized Statistical Rating Organization.

(d) The certified reinsurer must comply with any other requirements reasonably imposed by the commissioner.
Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate, except that an association including incorporated and individual unincorporated underwriters that has been approved to do business as a single certified reinsurer may be evaluated on the basis of its group rating. Factors that may be considered as part of the evaluation process include, but are not limited to, the following:

(a) The certified reinsurer’s financial strength rating from an acceptable rating agency. The maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as outlined in the table below. The commissioner shall use the lowest financial strength rating received from an approved rating agency in establishing the maximum rating of a certified reinsurer. A failure to obtain or maintain at least two financial strength ratings from acceptable rating agencies will result in loss of eligibility for certification:

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<thead>
<tr>
<th>Ratings</th>
<th>Best</th>
<th>S&amp;P</th>
<th>Moody’s</th>
<th>Fitch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure – 1</td>
<td>A++</td>
<td>AAA</td>
<td>Aaa</td>
<td>AAA</td>
</tr>
<tr>
<td>Secure – 2</td>
<td>A+</td>
<td>AA+, AA, AA-</td>
<td>Aa1, Aa2, Aa3</td>
<td>AA+, AA, AA-</td>
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<tr>
<td>Secure – 3</td>
<td>A</td>
<td>A+, A</td>
<td>A1, A2</td>
<td>A+, A</td>
</tr>
<tr>
<td>Secure – 4</td>
<td>A-</td>
<td>A-</td>
<td>A3</td>
<td>A-</td>
</tr>
<tr>
<td>Secure – 5</td>
<td>B++, B+</td>
<td>BBB+, BBB, BBB-</td>
<td>Baa1, Baa2, Baa3</td>
<td>BBB+, BBB, BBB-</td>
</tr>
<tr>
<td>Vulnerable – 6</td>
<td>B, B-C++, B+, B-, CCC, CC, C, D, E, F</td>
<td>BB+, BB, BB-, B1, B2, B3, Caa, Ca, C</td>
<td>Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C</td>
<td>BB+, BB, BB-, B+, B-, CCC+, CC, CCC+, DD</td>
</tr>
</tbody>
</table>

(b) The business practices of the certified reinsurer in dealing with its ceding insurers, including its record of compliance with reinsurance contractual terms and obligations;

(c) For certified reinsurers domiciled in the U.S., a review of the most recent applicable NAIC Annual Statement Blank, either Schedule F (for property/casualty reinsurers) or Schedule S (for life and health reinsurers);

(d) For certified reinsurers not domiciled in the U.S., a review annually of Form CR-F (for property/casualty reinsurers) or Form CR-S (for life and health reinsurers) (attached as exhibits to this regulation);

(e) The reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurers’ Schedule F reporting of overdue reinsurance recoverables, including the proportion of obligations that are more than ninety (90) days past due or are in dispute, with
specific attention given to obligations payable to companies that are in administrative supervision or receivership;

(f) Regulatory actions against the certified reinsurer;

(g) The report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in paragraph (h) below;

(h) For certified reinsurers not domiciled in the U.S., audited financial statements (audited U.S. GAAP basis if available, audited IFRS basis statements are allowed but must include an audited footnote reconciling equity and net income to a U.S. GAAP basis, or, with the permission of the state insurance commissioner, audited IFRS statements with reconciliation to U.S. GAAP certified by an officer of the company), regulatory filings, and actuarial opinion (as filed with the non-U.S. jurisdiction supervisor, with a translation into English). Upon the initial application for certification, the commissioner will consider audited financial statements for the last three (3) two (2) years filed with its non-U.S. jurisdiction supervisor;

(i) The liquidation priority of obligations to a ceding insurer in the certified reinsurer’s domiciliary jurisdiction in the context of an insolvency proceeding;

(j) A certified reinsurer’s participation in any solvent scheme of arrangement, or similar procedure, which involves U.S. ceding insurers. The commissioner shall receive prior notice from a certified reinsurer that proposes participation by the certified reinsurer in a solvent scheme of arrangement; and

(k) Any other information deemed relevant by the commissioner.

(5) Based on the analysis conducted under Subparagraph (4)(e) of a certified reinsurer’s reputation for prompt payment of claims, the commissioner may make appropriate adjustments in the security the certified reinsurer is required to post to protect its liabilities to U.S. ceding insurers, provided that the commissioner shall, at a minimum, increase the security the certified reinsurer is required to post by one rating level under Subparagraph (4)(a) if the commissioner finds that:

(a) More than fifteen percent (15%) of the certified reinsurer’s ceding insurance clients have overdue reinsurance recoverables on paid losses of ninety (90) days or more which are not in dispute and which exceed $100,000 for each cedent; or

(b) The aggregate amount of reinsurance recoverables on paid losses which are not in dispute that are overdue by ninety (90) days or more exceeds $50,000,000.

(6) The assuming insurer must submit a properly executed Form CR-1 (attached as an exhibit to this regulation) as evidence of its submission to the jurisdiction of this state, appointment of the commissioner as an agent for service of process in this state, and agreement to provide security for one hundred percent (100%) of the assuming insurer’s liabilities attributable to reinsurance ceded by U.S. ceding insurers if it resists enforcement of a final U.S. judgment. The commissioner shall not certify any assuming insurer that is domiciled in a jurisdiction that the commissioner has determined does not adequately and promptly enforce final U.S. judgments or arbitration awards.

(7) The certified reinsurer must agree to meet applicable information filing requirements as determined by the commissioner, both with respect to an initial application for certification and on an ongoing basis. All information submitted by certified reinsurers which are not
otherwise public information subject to disclosure shall be exempted from disclosure under [cite state law equivalent of Freedom of Information Act] and shall be withheld from public disclosure. The applicable information filing requirements are, as follows:

(a) Notification within ten (10) days of any regulatory actions taken against the certified reinsurer, any change in the provisions of its domiciliary license or any change in rating by an approved rating agency, including a statement describing such changes and the reasons therefore;

(b) Annually, Form CR-F or CR-S, as applicable [per the instructions to be developed as an exhibit to this model];

(c) Annually, the report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in Subsection (d) below;

(d) Annually, the most recent audited financial statements (audited U.S. GAAP basis if available, audited IFRS basis statements are allowed but must include an audited footnote reconciling equity and net income to a U.S. GAAP basis, or, with the permission of the state insurance commissioner, audited IFRS statements with reconciliation to U.S. GAAP certified by an officer of the company), regulatory filings, and actuarial opinion (as filed with the certified reinsurer’s supervisor, with a translation into English). Upon the initial certification, audited financial statements for the last three (3) two (2) years filed with the certified reinsurer’s supervisor;

(e) At least annually, an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers;

(f) A certification from the certified reinsurer’s domestic regulator that the certified reinsurer is in good standing and maintains capital in excess of the jurisdiction’s highest regulatory action level; and

(g) Any other information that the commissioner may reasonably require.

(8) Change in Rating or Revocation of Certification.

(a) In the case of a downgrade by a rating agency or other disqualifying circumstance, the commissioner shall upon written notice assign a new rating to the certified reinsurer in accordance with the requirements of Subparagraph (4)(a).

(b) The commissioner shall have the authority to suspend, revoke, or otherwise modify a certified reinsurer’s certification at any time if the certified reinsurer fails to meet its obligations or security requirements under this section, or if other financial or operating results of the certified reinsurer, or documented significant delays in payment by the certified reinsurer, lead the commissioner to reconsider the certified reinsurer’s ability or willingness to meet its contractual obligations.

(c) If the rating of a certified reinsurer is upgraded by the commissioner, the certified reinsurer may meet the security requirements applicable to its new rating on a prospective basis, but the commissioner shall require the certified reinsurer to post security under the previously applicable security requirements as to all contracts in force on or before the effective date of the upgraded rating. If the rating of a certified reinsurer is downgraded by the commissioner, the commissioner shall require the certified reinsurer to meet the security requirements applicable to its new rating for all business it has assumed as a certified reinsurer.
(d) Upon revocation of the certification of a certified reinsurer by the commissioner, the assuming insurer shall be required to post security in accordance with Section 11 in order for the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer. If funds continue to be held in trust in accordance with Section 7, the commissioner may allow additional credit equal to the ceding insurer’s pro rata share of such funds, discounted to reflect the risk of uncollectibility and anticipated expenses of trust administration. Notwithstanding the change of a certified reinsurer’s rating or revocation of its certification, a domestic insurer that has ceded reinsurance to that certified reinsurer may not be denied credit for reinsurance for a period of three (3) months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the commissioner to be at high risk of uncollectibility.

C. Qualified Jurisdictions.

(1) If, upon conducting an evaluation under this section with respect to the reinsurance supervisory system of any non-U.S. assuming insurer, the commissioner determines that the jurisdiction qualifies to be recognized as a qualified jurisdiction, the commissioner shall publish notice and evidence of such recognition in an appropriate manner. The commissioner may establish a procedure to withdraw recognition of those jurisdictions that are no longer qualified.

(2) In order to determine whether the domiciliary jurisdiction of a non-U.S. assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner shall evaluate the reinsurance supervisory system of the non-U.S. jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-U.S. jurisdiction to reinsurers licensed and domiciled in the U.S. The commissioner shall determine the appropriate approach for evaluating the qualifications of such jurisdictions, and create and publish a list of jurisdictions whose reinsurers may be approved by the commissioner as eligible for certification. A qualified jurisdiction must agree to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction. Additional factors to be considered in determining whether to recognize a qualified jurisdiction, in the discretion of the commissioner, include but are not limited to the following:

(a) The framework under which the assuming insurer is regulated.
(b) The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and financial surveillance.
(c) The substance of financial and operating standards for assuming insurers in the domiciliary jurisdiction.
(d) The form and substance of financial reports required to be filed or made publicly available by reinsurers in the domiciliary jurisdiction and the accounting principles used.
(e) The domiciliary regulator’s willingness to cooperate with U.S. regulators in general and the commissioner in particular.
(f) The history of performance by assuming insurers in the domiciliary jurisdiction.
(g) Any documented evidence of substantial problems with the enforcement of final U.S. judgments in the domiciliary jurisdiction. A jurisdiction will not be
considered to be a qualified jurisdiction if the commissioner has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.

(h) Any relevant international standards or guidance with respect to mutual recognition of reinsurance supervision adopted by the International Association of Insurance Supervisors or successor organization.

(i) Any other matters deemed relevant by the commissioner.

(3) A list of qualified jurisdictions shall be published through the NAIC Committee Process. The commissioner shall consider this list in determining qualified jurisdictions. If the commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the commissioner shall provide thoroughly documented justification with respect to the criteria provided under Subsections 8.C(2)(a) to (i).

(4) U.S. jurisdictions that meet the requirements for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.

D. Recognition of Certification Issued by an NAIC Accredited Jurisdiction.

(1) If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the commissioner has the discretion to defer to that jurisdiction’s certification, and to defer to the rating assigned by that jurisdiction, if the assuming insurer submits a properly executed Form CR-1 and such additional information as the commissioner requires. The assuming insurer shall be considered to be a certified reinsurer in this state.

(2) Any change in the certified reinsurer’s status or rating in the other jurisdiction shall apply automatically in this state as of the date it takes effect in the other jurisdiction. The certified reinsurer shall notify the commissioner of any change in its status or rating within 10 days after receiving notice of the change.

(3) The commissioner may withdraw recognition of the other jurisdiction’s rating at any time and assign a new rating in accordance with Subsection B(8) of this section.

(4) The commissioner may withdraw recognition of the other jurisdiction’s certification at any time, with written notice to the certified reinsurer. Unless the commissioner suspends or revokes the certified reinsurer’s certification in accordance with Subsection B(8) of this section, the certified reinsurer’s certification shall remain in good standing in this state for a period of three (3) months, which shall be extended if additional time is necessary to consider the assuming insurer’s application for certification in this state.

E. Mandatory Funding Clause. In addition to the clauses required under Section 4415, reinsurance contracts entered into or renewed under this section shall include a proper funding clause, which requires the certified reinsurer to provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer under this section for reinsurance ceded to the certified reinsurer.

F. The commissioner shall comply with all reporting and notification requirements that may be established by the NAIC with respect to certified reinsurers and qualified jurisdictions.
Section 9. Credit for Reinsurance—Reciprocal Jurisdictions

A. Pursuant to [cite state law equivalent of Section 2F of the Credit for Reinsurance Model Law], the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that is licensed to write reinsurance by and has its head office or is domiciled in a Reciprocal Jurisdiction, and which meets the other requirements of this regulation.

B. A “Reciprocal Jurisdiction” is a jurisdiction, as designated by the commissioner pursuant to Subsection D, that meets one of the following:

(1) A non-U.S. jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, is a member state of the European Union. For purposes of this subsection, a “covered agreement” is an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;

(2) A U.S. jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or

(3) A qualified jurisdiction, as determined by the commissioner pursuant to [cite state law equivalent of Section 2E(3) of the Credit for Reinsurance Model Law and Section 8C of the Credit for Reinsurance Model Regulation], which is not otherwise described in paragraph (1) or (2) above and which the commissioner determines meets all of the following additional requirements:

(a) Provides that an insurer which has its head office or is domiciled in such qualified jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance is received for reinsurance assumed by insurers domiciled in such qualified jurisdiction;

(b) Does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by the non-U.S. jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

(c) Recognizes the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by a competent regulatory authority, in such qualified jurisdiction, that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the commissioner or the commissioner of the domiciliary state and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the qualified jurisdiction; and

Drafting Note: Nothing in this subparagraph is intended to enhance or limit the authority of U.S. state insurance regulation with respect to the group-wide supervision of insurance holding company systems pursuant to the state law equivalent of the NAIC Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation (#450), or other applicable state law.
(d) Provides written confirmation by a competent regulatory authority, in such qualified jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the commissioner in accordance with a memorandum of understanding or similar document between the commissioner and such qualified jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.

C. Credit shall be allowed when the reinsurance is ceded from an insurer domiciled in this state to an assuming insurer meeting each of the conditions set forth below.

(1) The assuming insurer must be licensed to transact reinsurance by, and have its head office or be domiciled in, a Reciprocal Jurisdiction.

(2) The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction, and confirmed as set forth in Subsection C(7) according to the methodology of its domiciliary jurisdiction, in the following amounts:

(a) No less than $250,000,000; or

(b) If the assuming insurer is an association, including incorporated and individual unincorporated underwriters:

(i) Minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least $250,000,000; and

(ii) A central fund containing a balance of the equivalent of at least $250,000,000.

(3) The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio, as applicable, as follows:

(a) If the assuming insurer has its head office or is domiciled in a Reciprocal Jurisdiction as defined in Section 9B(1), the ratio specified in the applicable covered agreement;

(b) If the assuming insurer is domiciled in a Reciprocal Jurisdiction as defined in Section 9B(2), a risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, calculated in accordance with the formula developed by the NAIC; or

(c) If the assuming insurer is domiciled in a Reciprocal Jurisdiction as defined in Section 9B(3), after consultation with the Reciprocal Jurisdiction and considering any recommendations published through the NAIC Committee Process, such solvency or capital ratio as the commissioner determines to be an effective measure of solvency.

Drafting Note: The United States has entered into bilateral agreements with both the European Union and United Kingdom, signed on September 22, 2017, and December 18, 2018, respectively, which specify a solvency ratio of one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union with respect to assuming insurers which have their head office or are domiciled in those jurisdictions.
The assuming insurer must agree to and provide adequate assurance, in the form of a properly executed Form RJ-1 (attached as an exhibit to this regulation), of its agreement to the following:

(a) The assuming insurer must agree to provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in paragraphs (2) or (3) of this subsection, or if any regulatory action is taken against it for serious noncompliance with applicable law.

(b) The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process.
   
   (i) The commissioner may also require that such consent be provided and included in each reinsurance agreement under the commissioner’s jurisdiction.
   
   (ii) Nothing in this provision shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws.

(c) The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained.

(d) Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent (100%) of the assuming insurer’s liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its estate, if applicable.

(e) The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement, which involves this state’s ceding insurers, and agrees to notify the ceding insurer and the commissioner and to provide one hundred percent (100%) security to the ceding insurer consistent with the terms of the scheme should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of [cite state law equivalent of Section 2E and Section 3 of the Credit for Reinsurance Model Law] and Section 12, 13 or 14 of this Regulation. For purposes of this Regulation, the term “solvent scheme of arrangement” means a foreign or alien statutory or regulatory compromise procedure subject to requisite majority creditor approval and judicial sanction in the assuming insurer’s home jurisdiction either to finally commute liabilities of duly noticed classed members or creditors of a solvent debtor, or to reorganize or restructure the debts and obligations of a solvent debtor on a final basis, and which may be subject to judicial recognition and enforcement of the arrangement by a governing authority outside the ceding insurer’s home jurisdiction.

(f) The assuming insurer must agree in writing to meet the applicable information filing requirements as set forth in Paragraph (5) of this subsection.
(5) The assuming insurer or its legal successor must provide, if requested by the commissioner, on behalf of itself and any legal predecessors, the following documentation to the commissioner:

(a) For the two years preceding entry into the reinsurance agreement and on an annual basis thereafter, the assuming insurer’s annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report;

(b) For the two years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion, if filed with the assuming insurer’s supervisor;

(c) Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, an updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States; and

(d) Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, information regarding the assuming insurer’s assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer to allow for the evaluation of the criteria set forth in Paragraph (6) of this subsection.

Drafting Note: In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting” under which the commissioner has the discretion to defer to another state’s determination with respect to compliance with this Section. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings. It is anticipated that “lead” states will uniformly require assuming insurers to provide the documentation described in Section 9C(5) of this regulation, so that other states may rely upon the lead state’s determination.

(6) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met:

(a) More than fifteen percent (15%) of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the commissioner;

(b) More than fifteen percent (15%) of the assuming insurer’s ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer $100,000, or as otherwise specified in a covered agreement; or

(c) The aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds $50,000,000, or as otherwise specified in a covered agreement.

(7) The assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with the requirements set forth in Paragraphs (2) and (3) of this subsection.

(8) Nothing in this provision precludes an assuming insurer from providing the commissioner with information on a voluntary basis.
D. The commissioner shall timely create and publish a list of Reciprocal Jurisdictions.

(1) A list of Reciprocal Jurisdictions is published through the NAIC Committee Process. The commissioner’s list shall include any Reciprocal Jurisdiction as defined under Section 9B(1) and (2), and shall consider any other Reciprocal Jurisdiction included on the NAIC list. The commissioner may approve a jurisdiction that does not appear on the NAIC list of Reciprocal Jurisdictions as provided by applicable law, regulation, or in accordance with criteria published through the NAIC Committee Process.

(2) The commissioner may remove a jurisdiction from the list of Reciprocal Jurisdictions upon a determination that the jurisdiction no longer meets one or more of the requirements of a Reciprocal Jurisdiction, as provided by applicable law, regulation, or in accordance with a process published through the NAIC Committee Process, except that the commissioner shall not remove from the list a Reciprocal Jurisdiction as defined under Section 9B(1) and (2). Upon removal of a Reciprocal Jurisdiction from this list credit for reinsurance ceded to an assuming insurer domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to [cite to state law equivalent of Credit for Reinsurance Model Law or Credit for Reinsurance Model Regulation].

Drafting Note: It is anticipated that the NAIC will develop criteria and a process with respect to Reciprocal Jurisdictions that is similar to the NAIC Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions. Included will be processes for revocation or suspension of the status as a Reciprocal Jurisdiction, provided that such process would not conflict with the terms of an in-force covered agreement. The NAIC and the states intend to communicate and coordinate with the U.S. Department of Treasury and United States Trade Representative and other relevant federal authorities with respect to the evaluation of Reciprocal Jurisdictions, as appropriate.

E. The commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this section and to which cessions shall be granted credit in accordance with this section.

(1) If an NAIC accredited jurisdiction has determined that the conditions set forth in Subsection C have been met, the commissioner has the discretion to defer to that jurisdiction’s determination, and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit in accordance with this subsection. The commissioner may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC in satisfaction of the requirements of Subsection C.

(2) When requesting that the commissioner defer to another NAIC accredited jurisdiction’s determination, an assuming insurer must submit a properly executed Form RJ-1 and additional information as the commissioner may require. A state that has received such a request will notify other states through the NAIC Committee Process and provide relevant information with respect to the determination of eligibility.

F. If the commissioner determines that an assuming insurer no longer meets one or more of the requirements under this section, the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this section.

(1) While an assuming insurer’s eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer’s obligations under the contract are secured in accordance with Section 11.
(2) If an assuming insurer’s eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer’s obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of Section 11.

G. Before denying statement credit or imposing a requirement to post security with respect to Section 9F of this regulation or adopting any similar requirement that will have substantially the same regulatory impact as security, the commissioner shall:

(1) Communicate with the ceding insurer, the assuming insurer, and the assuming insurer’s supervisory authority that the assuming insurer no longer satisfies one of the conditions listed in Subsection C of this section;

(2) Provide the assuming insurer with 30 days from the initial communication to submit a plan to remedy the defect, and 90 days from the initial communication to remedy the defect, except in exceptional circumstances in which a shorter period is necessary for policyholder and other consumer protection;

(3) After the expiration of 90 days or less, as set out in (2), if the commissioner determines that no or insufficient action was taken by the assuming insurer, the commissioner may impose any of the requirements as set out in this Subsection; and

(4) Provide a written explanation to the assuming insurer of any of the requirements set out in this Subsection.

H. If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding liabilities.
FORM RJ-1  
CERTIFICATE OF REINSURER DOMICILED IN RECIPROCAL JURISDICTION  

I, _____________________________________________, _______________________________________________________
(name of officer)       (title of officer)  
of ___________________________________________________________________________________, the assuming insurer
(name of assuming insurer)  
under a reinsurance agreement with one or more insurers domiciled in _____________________________________, in order to
(name of state)  
be considered for approval in this state, hereby certify that _____________________________________ (“Assuming Insurer”):
(name of assuming insurer)  

1. Submits to the jurisdiction of any court of competent jurisdiction in [Name of State] for the adjudication of any issues
arising out of the reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction,
and will abide by the final decision of such court or any appellate court in the event of an appeal. The assuming insurer
agrees that it will include such consent in each reinsurance agreement, if requested by the commissioner. Nothing in this
paragraph constitutes or should be understood to constitute a waiver of assuming insurer’s rights to commence an action
in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to
seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States.
This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to
arbitrate their disputes if such an obligation is created in the agreement, except to the extent such agreements are
unenforceable under applicable insolvency or delinquency laws.

2. Designates the Insurance Commissioner of [Name of State] as its lawful attorney in and for the [Name of State] upon
whom may be served any lawful process in any action, suit or proceeding in this state arising out of the reinsurance
agreement instituted by or on behalf of the ceding insurer.

3. Agrees to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared
enforceable in the territory where the judgment was obtained.

4. Agrees to provide prompt written notice and explanation if it falls below the minimum capital and surplus or capital or
surplus ratio, or if any regulatory action is taken against it for serious noncompliance with applicable law.

5. Confirms that it is not presently participating in any solvent scheme of arrangement, which involves insurers domiciled
in [Name of State]. If the assuming insurer enters into such an arrangement, the assuming insurer agrees to notify the
ceding insurer and the commissioner, and to provide 100% security to the ceding insurer consistent with the terms of the
scheme.

6. Agrees that in each reinsurance agreement it will provide security in an amount equal to 100% of the assuming insurer’s
liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a
final U.S. judgment, that is enforceable under the law of the territory in which it was obtained, or a properly enforceable
arbitration award whether obtained by the ceding insurer or by its resolution estate, if applicable.

7. Agrees to provide the documentation in accordance with [cite relevant provision of the state equivalent of Section 9C(5)
of the Credit for Reinsurance Model Regulation], if requested by the commissioner.

Dated: ___________________________  __________________________________________________
(name of assuming insurer)  
BY: ______________________________________________ 
(name of officer)  
________________________________________________
(title of officer)  

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

On Sept. 22, 2017, the U.S. Department of the Treasury (Treasury Department) and the Office of the U.S. Trade Representative (USTR) signed the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement). The EU Covered Agreement includes requirements on group capital, group supervision and reinsurance collateral. The EU Covered Agreement would eliminate reinsurance collateral requirements for European Union (EU) reinsurers that maintain a minimum amount of own funds equivalent to $250 million and a solvency capital requirement (SCR) of 100% under Solvency II. Conversely, U.S. reinsurers that maintain capital and surplus equivalent to 226 million euros with a risk-based capital (RBC) of 300% of authorized control level would not be required to maintain a local presence in order to do business in the EU or post collateral in any EU jurisdiction.

On Dec. 11, 2018, the Treasury Department and the USTR announced that the U.S. and the United Kingdom (UK) had reached a final agreement on reinsurance collateral and other insurance regulatory measures outlined in the “Bilateral Agreement Between the United States Of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement). A separate Covered Agreement for the UK was necessary due to plans by the UK to exit the EU. The UK Covered Agreement mirrors the language in the prior Covered Agreement between the U.S. and the EU, and, for the purposes of this project history, they will be referred to collectively as the “Covered Agreement.”

While the group capital and group supervision provisions of the Covered Agreement are not expected to require changes to state laws, the Covered Agreement will require the states to take action with respect to the reinsurance collateral provisions within 60 months (five years) of signing or face potential federal preemption by the Federal Insurance Office (FIO) under the federal Dodd-Frank Wall Street Reform and Consumer Protection Act. Specifically, in 2011, the NAIC membership adopted revisions to Section 2E of the Credit for Reinsurance Model Law (#785) and Section 8 of the Credit for Reinsurance Model Regulation (#786) which will be affected by the Covered Agreement. These revisions served to reduce reinsurance collateral requirements for certified non-U.S. licensed reinsurers that are licensed and domiciled in qualified jurisdictions. Prior to these amendments, in order for domestic U.S. ceding companies to receive reinsurance credit, the reinsurance must either have been ceded to U.S. licensed reinsurers or secured by collateral representing 100% of liabilities for which the credit was recorded.

On Feb. 20, 2018, the NAIC and the Reinsurance (E) Task Force held a Public Hearing in New York to address the reinsurance collateral provisions of the Covered Agreement. On April 17, 2018, based on public comments and testimony received at the Public Hearing, the Executive (EX) Committee agreed to the following actions with respect to the Covered Agreement:

- Adopted a Request for NAIC Model Law Development with respect to Model #785 and Model #786. The motion adopted was that these models be revised to: 1) conform to the requirements in the covered agreement with respect to EU reinsurers; and 2) provide reinsurers domiciled in NAIC-qualified jurisdictions other than within the EU (currently, Bermuda, Japan, Switzerland and, after Brexit, the United Kingdom) with similar reinsurance collateral reductions as those to be implemented to comply with the covered agreement, with provisions regarding group supervision, group capital, information-sharing and enforcement.
On May 15, 2019, the Task Force adopted revisions to Model #785 and Model #786 consistent with these charges during a public conference call, which were then approved by the Financial Condition (E) Committee on May 28, 2019. The revisions would eliminate reinsurance collateral requirements for “reciprocal” reinsurers that have their head office or are domiciled in any of the following:

1. An EU-member country (or any other non-U.S. jurisdiction) that is subject to an in-force covered agreement addressing the elimination of reinsurance collateral requirements with U.S. ceding insurers (Covered Agreement Reciprocal Jurisdictions).

2. A U.S. jurisdiction that meets the requirements for accreditation under the NAIC Financial Regulation Standards and Accreditation Program (Accredited State Reciprocal Jurisdictions).

3. A non-U.S. jurisdiction recognized as a qualified jurisdiction that meets certain additional requirements consistent with the terms of a covered agreement (Qualified Jurisdiction Reciprocal Jurisdictions).

The requirements for reciprocal reinsurers under the revisions to Model #785 and Model #786 mirror the requirements for reinsurers under the Covered Agreement, and they would place the following additional requirements with respect to reciprocal reinsurers:

- Maintain minimum capital and surplus of no less than $250 million.
- Maintain a minimum solvency or capital ratio, as applicable, of 100% of the SCR or a risk-based capital (RBC) ratio of 300% of the authorized control level, or such other solvency or capital ratio that the commissioner determines is an effective measure of solvency.
- Provide certain assurances to the state insurance commissioner on a new form (Form RJ-1), which includes providing prompt notice to the state insurance commissioner in the event of noncompliance with the minimum capital and surplus and minimum solvency requirements; or serious noncompliance with applicable law, consent to service of process, consent to payment of final judgments, nonparticipation in solvent schemes; and other assurances.
- Provide annual audited financial statements and other specified financial information for the two years preceding entry into the reinsurance agreement, and file annual audited financial statements and other specified financial information on a semi-annual basis.
- Maintain a practice of prompt payment of claims under reinsurance agreements.

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

The Reinsurance (E) Task Force of the Financial Condition (E) Committee was responsible for drafting the revisions to the Model #785 and Model #786:

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<tr>
<th>State</th>
<th>Chair</th>
<th>Vice Chair</th>
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<tr>
<td>Missouri</td>
<td>Chlora Lindley-Myers</td>
<td>Raymond G. Farmer</td>
<td>Eric A. Cioppa</td>
<td>Maine</td>
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<td>Alabama</td>
<td>Jim L. Ridling</td>
<td>Lori K. Wing-Heier</td>
<td>Gary Anderson</td>
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<td>Allen W. Kerr</td>
<td>Matthew Rosendale</td>
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<td>Ricardo Lara</td>
<td>Michael Conway</td>
<td>Bruce R. Ramge</td>
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<td>Andrew N. Mais</td>
<td>Trinidad Navarro</td>
<td>Barbara D. Richardson</td>
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<td>Stephen C. Taylor</td>
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<td>John Elias</td>
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<td>Tiffany</td>
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<td>Georgia</td>
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<td>Dean L. Cameron</td>
<td>Linda A. Lacewell</td>
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<td>Mike Causey</td>
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<td>Jon Godfread</td>
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<td>Jillian Froment</td>
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<td>Ricard C. Taylor</td>
<td>Glen Mulready</td>
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<td>Kentucky</td>
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<td>Julie Mix McPeak</td>
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<td>Nancy G. Atkins</td>
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<td>Mike Causey</td>
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3. Project Authorized by What Charge and Date First Given to the Group

On April 17, 2018, the Executive (EX) Committee adopted the following charges to the Reinsurance (E) Task Force and a Request for NAIC Model Law Development with respect to these charges, which were reapproved by the Committee for 2019:

- The Task Force is directed to develop revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) to conform to the terms of the Covered Agreement.

- The Task Force is directed to develop revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) to allow reinsurers domiciled in NAIC qualified jurisdictions other than within the EU to realize reinsurance collateral requirements similar to those provided under the Covered Agreement under specified circumstances. In order for an insurer domiciled in a qualified jurisdiction outside of the EU to receive the same collateral requirement treatment as provided to EU-domiciled reinsurers, that non-EU qualified jurisdiction must agree to adhere to all other standards imposed upon the EU in the Covered Agreement, including the requirement that the qualified jurisdiction must agree to recognize the states’ approach to group supervision, including group capital. As part of its deliberations, the Task Force should consult with international regulators, in addition to all other interested parties.

- The Task Force is directed to develop revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) to address the effect of a breach of the Covered Agreement (as determined pursuant to its terms) on a reinsurer’s collateral obligations and the effect of a failure of a non-EU qualified jurisdiction to meet the standards imposed by its agreement or acknowledgment to adhere to the terms of the Covered Agreement and/or the model law and regulation.

- In conjunction with any revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786), the Qualified Jurisdiction (E) Working Group is directed to consider changes to the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions to require that qualified jurisdictions recognize key NAIC solvency initiatives, including group supervision, group capital standards, and as well as require strengthening of the information-sharing requirements between the states and qualified jurisdictions, in order for reinsurers domiciled in qualified jurisdictions to receive similar treatment to EU reinsurers under the Covered Agreement, and processes of removal of qualified jurisdiction status in the event of a breach.

- The Reinsurance Financial Analysis (E) Working Group is directed to consider changes in its current methods of monitoring certified reinsurers domiciled in Qualified Jurisdictions to incorporate changes to state reinsurance collateral requirements caused by the EU Covered Agreement and any changes to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) to provide similar treatment to reinsurers domiciled in Qualified Jurisdictions.

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

At the 2017 Fall National Meeting, the NAIC membership tasked a leadership group of commissioners to develop a strategy for proceeding forward with revisions to Model #785 and Model #786. This included the 2018 NAIC officers: President Julie Mix McPeak (TN); President-Elect Eric A. Cioppa (ME); Vice President Raymond G. Farmer (SC); and Secretary-Treasurer Gordon I. Ito (HI). It also included Commissioner David Altmaier (FL), chair of the Financial Condition (E) Committee; then-Superintendent Maria T. Vullo (NY), then-chair of the Reinsurance (E) Task Force; and then-Director Peter L. Hartt (NJ), the state insurance commissioner representative on the Financial Stability Oversight Council (FSOC).

On Feb. 20, 2018, the NAIC and Reinsurance (E) Task Force held a public hearing in New York City to address the reinsurance collateral provisions of the Covered Agreement. The public hearing was presided over by Commissioner Mix McPeak, Commissioner Altmaier and then-Superintendent Vullo. Also in attendance at the public hearing were: then-Commissioner Katharine L. Wade (CT); Superintendent Cioppa; Director Chlora Lindley-Myers represented by John Rehagen (MO); then-Acting Commissioner Marlene Caride and then-Director Hartt (NJ); Superintendent Elizabeth Kelleher Dwyer (RI); Director Farmer; then-Commissioner Ted Nickel (WI); and Commissioner Tom Glause (WY). During the public hearing, the NAIC and the Task Force heard from 18 speakers, including a representative of the Treasury Department, as well as U.S.
domestic insurers, U.S. trade associations, international reinsurers and international trade associations. The NAIC also received 20 comment letters from a wide variety of stakeholders and interested parties. There were approximately 160 people in attendance at the public hearing, with another 181 participating via conference call.

On March 14, 2018, a memorandum titled, “Covered Agreement: Proposed Next Steps,” was sent to the Financial Condition (E) Committee by Commissioner Mix McPeak; Commissioner Altmaier, chair of the Committee; and then-Superintendent Vullo, then-chair of the Reinsurance (E) Task Force. This memorandum recommended that the Committee take the following actions with respect to the Covered Agreement, based on public comments and testimony received at the public hearing:

- Adopt a Request for NAIC Model Law Development with respect to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786). Specifically, these models should be revised to (a) conform to the requirements in the Covered Agreement with respect to EU reinsurers, and (b) provide reinsurers domiciled in NAIC qualified jurisdictions other than within the EU (currently, Bermuda, Japan, Switzerland and, after Brexit, the United Kingdom) with similar reinsurance collateral reductions as those to be implemented to comply with the Covered Agreement, with provisions regarding group supervision, group capital, information sharing and enforcement.

- Adopt charges to the Reinsurance (E) Task Force, and its Qualified Jurisdiction (E) Working Group and Reinsurance Financial Analysis (E) Working Group to make certain revisions to Model #785 and Model #786, and to develop processes to implement the changes to the models.

- Adopt charges to the Capital Adequacy (E) Task Force and the Statutory Accounting Principles (E) Working Group to address related reinsurance collateral issues raised at the Public Hearing.

The Financial Condition (E) Committee adopted the Request for NAIC Model Law Development at the 2018 Spring National Meeting. The Executive (EX) Committee adopted the Request for NAIC Model Law Development for amendments to Model #785 and Model #786, as well as the proposed related charges for various Financial Condition (E) Committee groups, during its April 17, 2018, conference call. These charges were renewed for the 2019 calendar year.

The Reinsurance (E) Task Force adopted draft revisions to Model #785 and Model #786 at the 2018 Fall National Meeting. The Financial Condition (E) Committee adopted the revised models as adopted by the Task Force, but with direction to NAIC staff and the drafting group to consider if any further technical changes were needed that were consistent with the issues raised at the Task Force meeting. The Executive (EX) Committee and Plenary were prepared to consider the draft revisions for adoption during its Dec. 19, 2018, conference call; however, the vote was delayed due to feedback received from the Treasury Department and the USTR. In a memorandum to the Financial Condition (E) Committee dated Feb. 11, 2019, the NAIC leadership group on reinsurance made a recommendation that the Task Force and its drafting group consider making additional revisions to resolve the following issues:

- **Recognition of Reciprocal Jurisdictions.** Whether any additional revisions are necessary with respect to a state insurance commissioner’s discretion to make a determination as to whether an EU jurisdiction should be recognized as a Reciprocal Jurisdiction.

- **Determination of Compliance with the Covered Agreement.** Whether any additional revisions are necessary with respect to a state insurance commissioner’s discretion to determine whether each EU member state is in compliance with the Covered Agreement.

- **Commissioner Discretion to Impose Additional Requirements.** Whether any additional revisions are necessary with respect to any additional requirements being imposed on EU reinsurers.

- **Effective Date.** Whether any additional revisions are necessary with respect to the effective date provision in the model revisions regarding which reinsurance agreements and policies are covered.

- **Service of Process.** Whether any additional revisions are necessary with respect to requiring assuming reinsurers to submit the confirmation of consent to service of process to each state in which the reinsurer intends to operate.
• **Other Covered Agreement Issues.** Whether any additional technical revisions are necessary to make the draft models more consistent with the Covered Agreement.

• **Additional Requirements for Qualified Jurisdictions.** Whether any additional revisions are necessary and appropriate with respect to requirements that are applicable to Qualified Jurisdictions but are not applicable to EU jurisdictions.

• **Recognition of U.S. State Regulatory System by Qualified Jurisdictions.** Whether any additional revisions are necessary with respect to the requirement for Qualified Jurisdictions to recognize aspects of the U.S. state regulatory system in order to be considered a Reciprocal Jurisdiction.

• **Recognition of NAIC Accredited Jurisdictions as Reciprocal Jurisdictions.** Whether U.S. jurisdictions that meet the requirements for accreditation under the NAIC Financial Standards and Accreditation Program should be recognized as Reciprocal Jurisdictions.

The Financial Condition (E) Committee adopted these recommendations during its Feb. 19, 2019, conference call. At the direction of Director Lindley-Myers, current chair of the Reinsurance (E) Task Force, draft revisions to Model #785 and Model #786 were released May 1, 2019, which were then approved by the Task Force during its May 15, 2019, conference call. The Financial Condition (E) Committee adopted the draft revisions to Model #785 and Model #786 during its May 28, 2019, conference call, with the following revision to Section 2F(7) of Model #785:

Credit may be taken under this subsection only for reinsurance agreements entered into, amended, or renewed on or after the date on which the assuming insurer has satisfied the requirements to assume reinsurance under this subsection on or after the effective date of the statute adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements pursuant to Section 2F(1) herein, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal.

**Drafting Group.** At the 2018 Summer National Meeting, then-Superintendent Vullo (NY), then-chair of the Reinsurance (E) Task Force, directed NAIC staff to create an informal drafting group composed of members of the Task Force tasked with developing the initial draft revisions to Model #785 and Model #786 incorporating the provisions of the Covered Agreement for discussion and consideration by the Task Force. The members of the drafting group were composed of state insurance regulators from the following states: California, Colorado, Connecticut, Florida, Maine, Missouri, Nebraska, New Jersey, New York and Texas. The drafting group met Aug. 16, Aug. 23, Sept. 5, Sept. 7, Oct. 22, Nov. 2 and Nov. 29, 2018, via conference call in regulator-to-regulator session. The drafting group also met Feb. 20, Feb. 22, Feb. 27, April 16 and April 30, 2019, via conference call in regulator-to-regulator session. The drafting group discussed and drafted multiple proposed revisions to Model #785 and Model #786, which were presented to the Task Force for consideration of adoption.

**Federal and International Regulators.** NAIC staff met via conference call with representatives of the European Commission on Oct. 29, 2018 and May 13, 2019, and received comment letters from the European Commission—dated Oct. 16, Nov. 16 and Dec. 18, 2018; and March 28 and May 13, 2019—in which the European Commission expressed concerns about the consistency of the draft revisions with the EU Covered Agreement. State insurance regulators and NAIC staff also met via conference call with representatives of the Treasury Department and the USTR on Nov. 16, Nov. 30 and Dec. 4, 2018, and on March 8, April 25 and May 23, 2019, to discuss their concerns regarding the consistency of the draft revisions with the Covered Agreement. During these conference calls, Director Steven Seitz (FIO) advised that any past or future discussion of Model #785 and Model #786 would be without prejudice to any future preemption analysis of state law the FIO may conduct. The Task Force and its drafting group took into account the concerns expressed by both the European Commission and the U.S. federal regulators, and the Task Force and its drafting group are of the opinion that the final revisions to Model #785 and Model #786 are entirely consistent with the provisions of the Covered Agreement.

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)**

**Feb. 20, 2018, Public Hearing.** On Feb. 20, 2018, the NAIC held a public hearing in New York City to address the reinsurance collateral provisions of the Covered Agreement. A detailed discussion of the public hearing and the actions taken by the Financial Condition (E) Committee and Executive (EX) Committee with respect to the results of the public hearing can be found under Section 4—General Description of the Drafting Process of this project history.
June 21, 2018, Exposure. On June 13, 2018, the Reinsurance (E) Task Force met in regulator-to-regulator session pursuant to paragraph 6 (consultations with NAIC staff) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings. During the conference call, the Task Force agreed to expose proposed revisions to Model #785 and Model #786 dated June 21, 2018, for a public comment period ending July 23, 2018. The Task Force received 18 comment letters, which included 16 from international and domestic insurance companies and industry groups, as well as two from state insurance regulators. The Task Force discussed the comment letters at the 2018 Summer National Meeting and directed a newly formed drafting group to work with NAIC staff to consider the comments and determine whether to incorporate them into the models and create updated drafts.

Sept. 25, 2018, Exposure. The drafting group considered the comment letters received at the 2018 Summer National Meeting and prepared draft revisions for the consideration of the Reinsurance (E) Task Force, which met Sept. 25, 2018, in regulator-to-regulator session pursuant to paragraph 6 (consultations with NAIC staff) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, and agreed to release proposed revisions to Model #785 and Model #786 for a 21-day public comment period ending Oct. 16, 2018. The Task Force received 14 comment letters, which were discussed during its Nov. 17, 2018, meeting. At that meeting, the Task Force adopted the draft revisions to Model #785 and Model #786, and the Financial Condition (E) Committee adopted the revised models as adopted by the Task Force, but with direction to NAIC staff and the drafting group to consider if any further technical changes were needed consistent with the issues raised by the Task Force. A detailed discussion of the action taken by the Executive (EX) Committee and Plenary and the Financial Condition (E) Committee with respect to these draft revisions can be found under Section 4—General Description of the Drafting Process of this project history.

Nov. 9, 2018, Exposure. The drafting group considered the comment letters received on the Sept. 25, 2018, exposure and again prepared draft revisions for the consideration of the Reinsurance (E) Task Force. The Task Force met Nov. 9, 2018, in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, and agreed to release proposed revisions to Model #785 and Model #786 for discussion by the Task Force at the 2018 Fall National Meeting. The Task Force received 16 comment letters, which were discussed during its Nov. 17, 2018, meeting. At that meeting, the Task Force adopted the draft revisions to Model #785 and Model #786, and the Financial Condition (E) Committee adopted the revised models as adopted by the Task Force, but with direction to NAIC staff and the drafting group to consider if any further technical changes were needed consistent with the issues raised by the Task Force. A detailed discussion of the action taken by the Executive (EX) Committee and Plenary and the Financial Condition (E) Committee with respect to these draft revisions can be found under Section 4—General Description of the Drafting Process of this project history.

March 7, 2019, Exposure. The drafting group again considered the comment letters and public discussion, as well as recommendations made by the Financial Condition (E) Committee in its memorandum dated Feb. 11, 2019. The drafting group again prepared draft revisions to Model #785 and Model #786 for discussion by the Task Force. The Task Force met March 7, 2019, in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff) of the NAIC Policy Statement on Open Meetings, and agreed to release proposed revisions to Model #785 and Model #786 on March 7, 2019, for a 25-day public comment period ending April 1, 2019. The Task Force received 10 comment letters on the March 7, 2019, exposure, which were discussed by the Task Force at the 2019 Spring National Meeting. The Task Force did not take a vote on the proposed revisions at this meeting, but it directed the drafting group to consider the comments heard and the comment letters received to update the draft revisions, which will not require a separate formal exposure period.

May 1, 2019, Exposure. The drafting group again considered the comment letters and public discussion, and it prepared draft revisions to Model #785 and Model #786 dated May 1, 2019, for discussion by the Reinsurance (E) Task Force during its May 15, 2019, conference call. During this conference call, the Task Force adopted the revisions and agreed to refer the proposed revisions to the Financial Condition (E) Committee for consideration of adoption.

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

The following significant issues were discussed extensively with state insurance regulators and interested parties during the drafting process:

- **NAIC Compliance with the Covered Agreement.** The NAIC initially opposed the EU Covered Agreement, primarily for failing to provide for formal recognition of the U.S. by the EU as a fully “equivalent” regulatory jurisdiction for Solvency II purposes. Following the signing of the EU Covered Agreement, the NAIC released a statement that it was pleased that the Treasury Department and the USTR clarified its interpretation in key areas and appreciated their affirmation of the primacy of state-based insurance regulation. On April 17, 2018, the Executive
The Executive (EX) Committee adopted a charge to the Reinsurance (E) Task Force to develop revisions to Model #785 and Model #786 to conform to the terms of the Covered Agreement.

- **Similar Treatment for Qualified Jurisdictions.** In the NAIC “Notice of Public Hearing and Request for Comments,” the Reinsurance (E) Task Force requested specific comments on providing reinsurers domiciled in NAIC qualified jurisdictions with similar reinsurance collateral requirements as those provided under the Covered Agreement. On April 17, 2018, the Executive (EX) Committee adopted a charge to the Task Force to develop revisions to Model #785 and Model #786 to allow reinsurers domiciled in NAIC qualified jurisdictions other than within the EU to realize reinsurance collateral requirements similar to those provided under the Covered Agreement under specified circumstances. In order for an insurer domiciled in a qualified jurisdiction outside of the EU to receive the same collateral requirement treatment as provided to EU-domiciled reinsurers, the non-EU qualified jurisdiction must agree to adhere to all other standards imposed under the Covered Agreement, including the requirement that the qualified jurisdiction must agree to recognize the states’ approach to group supervision, including group capital.

- **Breach of the Covered Agreement.** On April 17, 2018, the Executive (EX) Committee adopted a charge to the Reinsurance (E) Task Force to develop revisions to Model #785 and Model #786 to address the effect of a breach of the Covered Agreement on a reinsurer’s collateral obligations and the effect of a failure of a non-EU qualified jurisdiction to meet the standards imposed by its agreement or acknowledgment to adhere to the terms of the Covered Agreement and/or Model #785 and Model #786. The Sept. 25, 2018, exposure draft of Model #785 contained a requirement that the reciprocal jurisdiction “is a member state of the European Union, and has been determined by the Commissioner to be in compliance with all material terms of the agreement.” In its comment letters, the European Commission argued that this section provides the commissioner with the power to determine if each individual EU member state complies with the terms of the Covered Agreement, which appears to be inconsistent with the terms of the Covered Agreement. The drafting group deleted this provision from the May 1, 2019, draft of Model #785, and substituted “is subject to an in-force covered agreement.”

- **Recognition of Qualified Jurisdictions.** On April 17, 2018, the Executive (EX) Committee adopted a charge to the Qualified Jurisdiction (E) Working Group to consider changes to the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions to require that qualified jurisdictions recognize key NAIC solvency initiatives, including group supervision and group capital standards, as well as require the strengthening of the information-sharing requirements between the states and qualified jurisdictions, in order for reinsurers domiciled in qualified jurisdictions to receive similar treatment to EU reinsurers under the Covered Agreement, and processes of removal of qualified jurisdiction status in the event of a breach. The Nov. 9, 2018, exposure draft of Model #786 contained a provision that it “[r]ecognizes the U.S. state regulatory system, including its approach to group supervision and group capital, by providing through statute, regulation or the equivalent, including but not limited to confirmation by a competent regulatory authority, in such qualified jurisdiction…” Interested parties requested clarification on the process of recognition, and Section 9B(3)(c) of the March 7, 2019, exposure draft of Model #786 was revised to provide, as follows: “Recognizes the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by a competent regulatory authority, in such qualified jurisdiction….”

- **Recognition of Group-wide Supervision.** Due to concerns expressed by interested parties that Section 9B(3)(c) of Model #786 might act to change the group supervisor of a U.S.-domiciled affiliate, the drafting group clarified in a drafting note in the March 7, 2019, exposure that nothing in this provision is intended to enhance or limit the authority of U.S. state insurance regulation with respect to the group-wide supervision of insurance holding company systems pursuant to state law.

- **Recognition of NAIC-Accredited Jurisdictions as Reciprocal Jurisdictions.** The initial June 21, 2018, exposure drafts did not include U.S. jurisdictions that meet the requirements for accreditation under the NAIC Financial Regulation Standards and Accreditation Program as reciprocal jurisdictions. Interested parties commented that this was not consistent with the current qualified jurisdiction provisions of Model #785 and Model #786, noting that U.S. reinsurers domiciled in accredited states should receive similar treatment to EU reinsurers and other reinsurers domiciled in qualified jurisdictions. The Reinsurance (E) Task Force added U.S. jurisdictions that meet the requirements for accreditation under the NAIC Financial Regulation Standards and Accreditation Program as reciprocal jurisdictions in the March 7, 2019, exposure drafts.
• **Memorandum of Understanding.** At the suggestion of interested parties, the memorandum of understanding required for qualified jurisdictions and reciprocal jurisdictions under Section 9B of Model #786 was clarified to include the International Association of Insurance Supervisors’ (IAIS) Multilateral Memorandum of Understanding (MMoU) or other multilateral memoranda of understanding coordinated by the NAIC in the Sept. 25, 2018, exposure.

• **Annual Reduction in Collateral by 20%**. Article 9(3)(a) of the Covered Agreement provides that “the United States shall encourage each U.S. State to promptly adopt the following measures: (a) the reduction, in each year following the date of entry into force or provisional application of this Agreement, of the amount of collateral required by each State to allow full credit for reinsurance by 20 percent of the collateral that the U.S. State required as of the January 1 before signature of this Agreement.” The Task Force determined that it was not consistent with the current Model #785 and Model #786 to meet this requirement. Instead, the Task Force determined that the best course of action was to work in an expeditious manner to amend Model #785 and Model #786 for enactment by the states to eliminate collateral for assuming insurers domiciled in Covered Agreement jurisdictions.

• **Commissioner Discretion: EU Jurisdictions.** The European Commission’s comment letters argued that the draft revisions to Model #785 and Model #786 contained additional requirements on EU reinsurers that were not provided in the Covered Agreement. For example, the European Commission argued that a state insurance commissioner does not have the discretion to determine whether an individual EU jurisdiction is in compliance with the Covered Agreement, and Section 9C(8) of Model #786 provided in its initial drafts that “the assuming insurer must satisfy any other requirements deemed relevant by the commissioner.” The May 1, 2019, exposure drafts removed all elements of commissioner discretion with respect to reinsurers domiciled in Covered Agreement reciprocal jurisdictions.

• **Commissioner Discretion: Qualified Jurisdictions.** The original draft revisions to Model #785 and Model #786 contained additional requirements that were applicable to assuming insurers domiciled in qualified jurisdictions, but they were not applicable to those reinsurers domiciled in jurisdictions subject to a Covered Agreement. For example, Section 2F(1)(h) of Model #785 required the assuming insurer to “satisfy any other requirement deemed relevant by the commissioner” for its cedant to receive the benefit of the credit for reinsurance provisions. In addition, the definition of “reciprocal jurisdiction” in Model #786 included “[s]uch additional factors as may be considered in the discretion of the commissioner.” Interested parties representing qualified jurisdictions argued that the NAIC should work toward a framework that treats EU and non-EU jurisdictions equivalently and provide additional clarity regarding the standards imposed on non-EU jurisdictions. The May 1, 2019, exposure drafts have removed the remaining distinctions between EU and non-EU jurisdictions, and they treat qualified jurisdictions similarly to EU jurisdictions.

• **Effective Date.** The original June 21, 2018, draft of Section 2F(7) of Model #785 contains the following provision: “This subsection shall not apply to reinsurance agreements entered into before the subsection’s application, or to losses incurred or to reserves posted before the subsection’s application.” This was to clarify that these revisions would not eliminate reinsurance collateral that is currently in place, similar to the current certified reinsurer provisions of Model #785 and Model #786. This provision was included in the **Statement of the United States on the Covered Agreement with the European Union** issued Sept. 22, 2017. There were concerns expressed by interested parties, including the European Commission, that this sentence was not consistent with Article 3(8) of the Covered Agreement. The Task Force removed this provision in the March 7, 2019, exposure draft.

In its comment letter dated March 28, 2019, the European Commission also stated that Section 2F(7) was not consistent with Article 3(8) of the Covered Agreement, which provides that the Covered Agreement takes effect “only to reinsurance agreements entered into, amended, or renewed on or after the date on which a measure that reduces collateral pursuant to this Article takes effect…” The Task Force disagreed with this interpretation, noting that there are additional requirements contained in Article 3 of the Covered Agreement that also must be met before an EU reinsurer is permitted to eliminate reinsurance collateral, including meeting minimum capital and surplus requirements of $250 million, 100% SCR, consent to the jurisdiction of the courts, service of process requirements, filing of audited financial statements, actuarial opinions, list of all disputed and overdue claims, information on prompt payment of claims, etc. Therefore, the Task Force made the determination that Section 2F(7) should remain, as follows: “Credit may be taken under this subsection only for reinsurance agreements entered into, amended, or renewed on or after the date on which the assuming insurer has satisfied the requirements to assume reinsurance under this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming
insurer has met all eligibility requirements pursuant to Section 2F(1) herein [emphasis added], and (ii) the effective date of the new reinsurance agreement, amendment, or renewal.”

- **Foreign Currency Exchange.** Section 9C(2)(c), Section 9C(6)(b) and Section 9C(6)(c) of Model #786 in the initial June 21, 2018, exposure draft contained a reference to foreign currency exchange rates to calculate the $250 million capital and surplus requirement for EU reinsurers under Article 3(4)(a) of the Covered Agreement. The European Commission commented that a reference to foreign currency exchange rates was not necessary with respect to EU reinsurers, because the Covered Agreement made 226 million euros equivalent to $250 million for these purposes. The drafting group disagreed with this interpretation, but it removed the reference in the May 1, 2019, exposure draft of Model #786, because commissioners are already utilizing foreign currency exchange rates in the calculation of minimum capital and surplus with respect to certified reinsurers licensed and domiciled in qualified jurisdictions.

- **Service of Process.** Section 2F(1)(d)(ii) of the Sept. 25, 2018, draft to Model #785 provided: “The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process. Either by law, regulation or request of the commissioner, such consent shall be included in each reinsurance agreement.” The European Commission commented that Article 3(4)(e) of the Covered Agreement provides that “where applicable for ‘service of process’ purposes, the assuming reinsurer provides written confirmation to the Host supervisory authority of consent to the appointment of that supervisory authority as agent for service of process. The Host supervisory authority may require that such consent be provided to it and included in each reinsurance agreement under its jurisdiction.” This section was amended in the March 7, 2019, exposure draft to be consistent with the Covered Agreement: “The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process. The commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement.”

- **Insolvency of U.S. Ceding Insurer.** The June 21, 2018, exposure of Model #785 contained the following provision: “The commissioner shall require [emphasis added] an assuming insurer under this subsection to post one hundred percent (100%) security, for the benefit of the ceding insurer or its estate, upon the entry of an order of rehabilitation, liquidation or conservation against the ceding insurer.” Interested parties noted that Article 3(4)(k) of the Covered Agreement instead provides: “if subject to a legal process of resolution, receivership, or winding-up proceedings as applicable, the ceding insurer, or its representative, [emphasis added] may seek and, if determined appropriate by the court in which the resolution, receivership, or winding-up proceedings is pending, may obtain an order [emphasis added] requiring that the assuming reinsurer post collateral for all outstanding ceded liabilities.” The Task Force agreed that the Covered Agreement required the ceding insurer or its representative to seek such an order from the court, not the insurance commissioner, and amended Section 9H of Model #786 in the March 7, 2019, exposure draft accordingly.

- **Audited Financial Statements for Certified Reinsurers.** At the request of the European Commission, the drafting group and Reinsurance (E) Task Force amended Section 8B(4)(h) and Section 8B(7)(d) of Model #786 to require the filing of annual financial statements for certified reinsurers consistent with the requirements of Article 3(4)(h) of the Covered Agreement; i.e., two years of audited financial statements filed with the assuming insurer’s supervisor. This makes the certified reinsurer provisions consistent with Article 3(4)(h)(i) of the Covered Agreement.

- **Passporting Process.** Section 9C(5) of the June 21, 2018, draft of Model #786 provided that the assuming insurer “must provide the following documentation to the commissioner.” The European Commission noted that Article 3(4)(h) of the Covered Agreement provides that this information must only be provided “if requested by that supervisory authority.” The Task Force amended Section 9C(5) in the March 7, 2019, exposure draft to be consistent with the language of the Covered Agreement, but it added a drafting note encouraging the states to utilize the “passporting” process under which the commissioner has the discretion to defer to another state’s determination with respect to compliance. In order to facilitate the passporting process, the states will uniformly require assuming insurers to provide the documentation described in Section 9C(5) so that other states may rely on the lead state’s determination.

- **Serious Noncompliance.** Section 9C(4)(a) of the Sept. 25, 2018, draft of Model #786 provided a definition for “serious noncompliance with applicable law” in order to promote uniformity among the states and provide guidance to reciprocal jurisdiction reinsurers. Interested parties noted that Article 3(4)(c)(ii) of the Covered Agreement does not contain a definition of “serious noncompliance,” and, as such, the drafting group and the Reinsurance (E) Task
For deleted this definition in the March 7, 2019, exposure draft due to perceived inconsistency with the Covered Agreement.

- **Solvent Schemes of Arrangement.** The Nov. 9, 2018, exposure draft of Model #785 deleted the definition of “solvent scheme of arrangement” from Section 2F(1(d)(v), but it retained it in Section 9C(4)(e) of Model #786. Interested parties recommended that the Reinsurance (E) Task Force should clarify that the requirements with respect to solvent schemes also apply to Part VII-like transfers under UK law, and U.S. state insurance regulators should treat Part VII transfers the same as solvent schemes of arrangement. Interested parties argued that Part VII transfers should not be treated differently than a solvent scheme for the purposes of triggering the posting of 100% collateral because a Part VII transfer typically produces the same result to ceding insurers as a commutation in that a Part VII transfer typically involves a transfer of assumed business by an assuming reinsurer to another reinsurer that: 1) does not write new business; 2) does not have access to additional capital; and 3) does not have the intent or ability to raise additional capital, if necessary, to satisfy all remaining assumed obligations. The drafting group and the Task Force determined not to make this clarification, and Part VII-like transfers are not intended to be solvent schemes of arrangement for the purposes of this provision.

- **Reciprocal Jurisdiction Process.** The Reinsurance (E) Task Force added a drafting note after Section 9D of Model #786 at the request of interested parties to address the process with respect to the revocation or suspension of the status of a reciprocal jurisdiction. Interested parties requested that the process specifically be included in either Model #785 or Model #786, but the drafting group determined that this process should be developed after adoption of the revisions to the models. The drafting group also added a provision to the drafting note in the March 7, 2019, exposure draft that “such process would not conflict with the terms of an in-force covered agreement” to clarify that such jurisdictions are automatically included on the NAIC List of Reciprocal Jurisdictions.

- **Other Inconsistencies with the Covered Agreement.** Throughout the exposure process, interested parties made numerous comments about perceived inconsistencies between the language of the Covered Agreement and the exposure drafts of Model #785 and Model #786. The drafting group and the Reinsurance (E) Task Force have made every attempt to conform the language of Model #785 and Model #786 to the specific language utilized by the Covered Agreement.

- **Material Adverse Development Coverage.** Interested parties commented that Section 2F(7) of Model #785 (Effective Date) does not account for certain agreements entered into in contemplation of some long-tail losses, such as adverse development covers that are signed after losses occur, but before the reserves have developed to be within the limits of the adverse development cover. This could have the unintended consequence of excluding adverse development coverage contracts from application of the reciprocal jurisdiction provisions. Tying the application of reciprocal status requirements to only those “losses incurred” after reciprocal status may negatively impact loss portfolio transfers and adverse development covers. The drafting group recognized the value of such reinsurance as a useful regulatory and commercial tool to facilitate the transfer of blocks of business and rehabilitate financially distressed companies, and discussed various options in addressing this issue, but ultimately it was unable to agree upon specific language satisfactory to everyone. In addition, there were some concerns expressed with providing the commissioner additional discretion in this area. Therefore, the Task Force does not take a position on whether material adverse development coverage agreements are or should be subject to reduced collateral authorized by the changes to the model law.

- **Kroll Bond Rating Agency.** On Dec. 3, 2017, the Reinsurance (E) Task Force adopted the recommendation that the states may consider Kroll Bond Rating Agency as an acceptable rating agency for certified reinsurer purposes, and the Task Force adopted the Uniform Application Checklist for Certified Reinsurers with the additional language, stating that it be “recognized by the SEC to provide financial strength ratings on insurance companies” and included the proposed matrix of ratings and collateral levels for use with Kroll Bond Rating Agency. However, the Task Force could not agree on language to amend the ratings matrix found in Section 8B of Model #786 to include Kroll Bond Rating Agency.

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

The Reinsurance (E) Task Force has not had formal discussions with respect to whether the current Reinsurance Ceded accreditation standard under the NAIC Financial Regulation Standards and Accreditation Program should be amended to
include the current revisions to Model #785 and/or Model #786. However, these revisions would have the effect of eliminating reinsurance collateral with respect to reinsurers domiciled in reciprocal jurisdictions, so, at a minimum, it will be necessary to amend the accreditation standards to reflect these revisions with respect to Reinsurance Ceded to Certified Reinsurers, which reduce but do not completely eliminate reinsurance collateral. In addition, it is further the recommendation of the Task Force that it is necessary to expeditiously modify these standards in accordance with the Procedure for the Adoption of Additional Model Laws, Regulations or Standards for Accreditation. This waiver in procedure is necessary because the states are expected to immediately begin considering these revisions for enactment into state law and regulation due to the 60-month (five-year) period in which the states are required to enact the revisions to in order to be consistent with the Covered Agreement or face potential federal preemption.

The Task Force has not determined whether these revisions should result in an “optional” accreditation standard or a “uniform” accreditation standard. The NAIC originally adopted the significant elements of the 2011 revisions to Model #785 and Model #786 as an “optional” accreditation standard. Specifically, under this optional standard, a state was not required to enact the certified reinsurer revisions to the models, but if it chose to reduce its reinsurance collateral requirements, the state’s laws and regulations must be substantially similar to the key elements of the revisions. Upon further review and consultation with state insurance regulators and interested parties, the Financial Regulation Standards and Accreditation (F) Committee determined that the certified reinsurer provisions result in increased financial solvency regulation and increased consumer protection to policyholders, and they should be adopted as a “uniform” standard applicable to all NAIC-accredited jurisdictions under the “substantially similar” definition. The 2019 revisions to Model #785 and Model #786 could be considered under either an “optional” or a “uniform” accreditation standard.

Finally, the Task Force should consider whether to make the “passporting” process subject to the Part B: Regulatory Practices and Procedures accreditation standards. Generally, models are incorporated into the Part A: Laws and Regulations accreditation standards, but the NAIC’s passporting process is not specifically required in Model #785 and/or Model #786. Model #786 does contain the following drafting note found after Section 9C(5):

Drafting Note: In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting” under which the commissioner has the discretion to defer to another state’s determination with respect to compliance with this Section. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings. It is anticipated that “lead” states will uniformly require assuming insurers to provide the documentation described in Section 9C(5) of this regulation, so that other states may rely upon the lead state’s determination.

The Task Force should consider whether the passporting process should become part of the Part B accreditation requirements and require states to participate in passporting consistent with the guidance provided in the drafting note.
ATTACHMENT A: REQUEST FOR NAIC 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:
   Reinsurance (E) Task Force

2. NAIC staff support contact information:
   Daniel Schelp
dschelp@naic.org
   (816) 783-8027

   Jake Stultz
   jstultz@naic.org
   (816) 783-8481

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

   • Credit for Reinsurance Model Law (#785)
   • Credit for Reinsurance Model Regulation (#786)

On Sept. 22, 2017, the U.S. Department of the Treasury and the Office of the U.S. Trade Representative signed the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement). The Covered Agreement includes requirements on group capital, group supervision and reinsurance collateral. The Covered Agreement would eliminate reinsurance collateral requirements for European Union (EU) reinsurers that maintain a minimum amount of own funds equivalent to $250 million and a solvency capital ratio (SCR) of 100% under Solvency II. Conversely, U.S. reinsurers that maintain capital and surplus equivalent to €226 million with a risk-based capital (RBC) of 300% of authorized control level would not be required to maintain a local presence in order to do business in the EU.

On Nov. 6, 2011, the NAIC membership adopted revisions to Section 2E of Model #785 and Section 8 of Model #786, which will be impacted by the Covered Agreement. These revisions served to reduce reinsurance collateral requirements for certified non-U.S. licensed reinsurers that are licensed and domiciled in qualified jurisdictions. Prior to these amendments, for states that adopted the models or a substantially similar law and/or regulation, in order for their domestic U.S. ceding companies to receive reinsurance credit, the reinsurance must either have been ceded to U.S. licensed reinsurers or secured by collateral representing 100% of U.S. liabilities for which the credit was recorded.

While the group capital and group supervision provisions of the Covered Agreement are not expected to require changes to the states’ laws, the states will need to take action with respect to reinsurance collateral provisions within 60 months (five years) or face potential federal preemption by the Federal Insurance Office (FIO). Specifically, it is recommended that Model #785 and Model #786 be revised to conform to the requirements of the Covered Agreement, and to provide reinsurers domiciled in other NAIC qualified jurisdictions other than within the EU with similar reinsurance collateral requirements as those provided to EU reinsurers under the Covered Agreement. In addition, any revisions to Model #785 and Model #786 should incorporate other standards included in the Covered Agreement, the most noteworthy among such
standards being the requirement that the qualified jurisdiction must agree to recognize the states’ approach to group supervision, including group capital, as well as provisions for enforcement of these requirements.

4. Does the model law meet the Model Law Criteria?  ☒ Yes  or  ☐ No  (Check one)

(If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states?  ☒ Yes  or  ☐ No  (Check one)

   If yes, please explain why:

   The federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) provides that a state insurance law or regulation may be subject to preemption upon a determination by the FIO director, in accordance with notice and other procedural requirements set forth in the Dodd-Frank Act, that the state insurance measure is inconsistent with a covered agreement and results in less favorable treatment of non-U.S. insurers subject to the covered agreement than a U.S. insurer domiciled, licensed or otherwise admitted in the state. Under the Covered Agreement, the states have 60 months (five years) from signature of the agreement to enact reinsurance reforms removing collateral requirements for EU reinsurers that meet the prescribed conditions in the Covered Agreement.

   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?  ☒ Yes  or  ☐ No  (Check one)

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

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

   High Likelihood  Low Likelihood

   Explanation, if necessary:

   As previously noted, the states have 60 months (five years) from signature of the Covered Agreement (Sept. 22, 2017) to conform their reinsurance collateral requirements for applicable EU reinsurers to the terms of the Covered Agreement, or face potential federal preemption through determinations by the FIO director. Under the Covered Agreement, the process for considering potential preemption determinations of state laws that are inconsistent with the Covered Agreement begins 42 months following signature of the agreement, with any preemption determination required to be completed by the end of the 60-month period. In order to meet this rigid time frame, it will be important for the NAIC membership to complete the proposed revisions to Model #785 and Model #786 as soon as is reasonably possible, in order to provide the states with the maximum time to implement the revisions.

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

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

   High Likelihood  Low Likelihood

   Explanation, if necessary: See previous discussion.
7. What is the likelihood that state legislatures will adopt the model law in a uniform manner within three years of adoption by the NAIC?

☐ 1 High Likelihood ☐ 2 Low Likelihood ☐ 3 ☐ 4 ☐ 5 (Check one)

Explanation, if necessary: See previous discussion.

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

On April 9, 2013, the NAIC adopted the significant elements of the 2011 revisions to Model #785 and Model #786 as an “optional” accreditation standard. Specifically, under this optional standard, a state is not required to adopt the certified reinsurer revisions to the models, but if it chooses to reduce its reinsurance collateral requirements, the state’s laws and regulations must be substantially similar to the key elements of the revisions. Effective Jan. 1, 2019, the NAIC membership made the current Reinsurance Ceded to Certified Reinsurers provisions of Part A: Laws & Regulations—Traditional Insurers a required and uniform accreditation standard applicable to all NAIC-accredited jurisdictions. This new uniform standard continues to require that accredited jurisdictions adopt the provisions of the models in a substantially similar manner.

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

Yes. Under Title V of the Dodd-Frank Act, the U.S. Department of the Treasury and the Office of the U.S. Trade Representative are authorized to jointly negotiate covered agreements, defined under the Dodd-Frank Act as written bilateral or multilateral agreements between the United States and one or more foreign governments, authorities or regulators regarding prudential measures with respect to insurance or reinsurance, on the condition that the prudential measures subject to a covered agreement achieve a level of protection for insurance or reinsurance consumers that is “substantially equivalent” to the level of protection achieved under U.S. state insurance laws. The Covered Agreement was negotiated pursuant to authority included within the Dodd-Frank Act and has been represented to be an agreement consistent with such authority. The Covered Agreement requires the states to eliminate reinsurance collateral requirements for EU reinsurers that maintain a minimum amount of own funds equivalent to $250 million and a solvency capital ratio (SCR) of 100% under Solvency II. The states will need to take action with respect to reinsurance collateral reforms within 60 months (five years) or face potential federal preemption determinations by the FIO director.
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<td>VM-31 Section 3.C.3.j</td>
<td>Recommendation #11 from VAWG’s memo regarding PBR Recommendations and Referrals to LATF. The new post-level term language relates to VAWG recommendation #17.</td>
<td>5/9/2019</td>
</tr>
<tr>
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<td>2019-08</td>
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<td>4/4/2019</td>
</tr>
<tr>
<td>34</td>
<td>105</td>
<td>2019-09</td>
<td>VM-31 Section 3.C.6.i</td>
<td>Recommendation #22 from VAWG’s 10/24/18 memo regarding PBR Recommendations and Referrals to LATF.</td>
<td>4/4/2019</td>
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<tr>
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<td>119</td>
<td>2019-14</td>
<td>VM-31 Section 3.B.3 and VM-G Section 1.E</td>
<td>Additional governance documentation</td>
<td>5/21/2019</td>
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<td>121</td>
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<td>VM-31 Section 3.C.11</td>
<td>Recommendations #18, #29, #30 and third consideration in recommendation #5 from VAWG memo</td>
<td>4/4/2019</td>
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<td>42</td>
<td>134</td>
<td>2019-18</td>
<td>VM-20 Section 9.G.8.b</td>
<td>Make VM-20 consistent with VM-21 as to revenue-sharing rules.</td>
<td>5/2/2019</td>
</tr>
<tr>
<td>Attachment Number</td>
<td>Page Number</td>
<td>LATF VM Amendment</td>
<td>Valuation Manual Reference</td>
<td>Valuation Manual Amendment Proposal Descriptions</td>
<td>LATF Adoption Date</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------</td>
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<td>5/9/2019</td>
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<td>2019-22</td>
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<td>142</td>
<td>2019-23</td>
<td>VM-31 Sec. 3.C.1, 3.C.3, VM-20 9.B.1/9.C.2.e</td>
<td>Recommendation #6, #7 and part of #4 of VAWG memo</td>
<td>5/21/2019</td>
</tr>
<tr>
<td>47</td>
<td>147</td>
<td>2019-25</td>
<td>VM-31 Sec. 3.C.3.h</td>
<td>Recommendation #12 and part of #34 of VAWG memo</td>
<td>5/2/2019</td>
</tr>
<tr>
<td>48</td>
<td>149</td>
<td>2019-26</td>
<td>VM-01</td>
<td>Revisions to VM-01</td>
<td>6/20/2019</td>
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<tr>
<td>49</td>
<td>160</td>
<td>2019-27</td>
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<tr>
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<td>291</td>
<td>2019-28</td>
<td>VM-31</td>
<td>Revisions to VM-31</td>
<td>6/20/2019</td>
</tr>
<tr>
<td>52</td>
<td>334</td>
<td>2019-31</td>
<td>Section 2.D</td>
<td>Revision to the Life PBR Exemption</td>
<td>6/25/2019</td>
</tr>
<tr>
<td>54</td>
<td>337</td>
<td>2019-35</td>
<td>VM-31 Section 3.C.8.a</td>
<td>Clarification of whether a reinsurance agreement involves a captive</td>
<td>5/9/2019</td>
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<td>55</td>
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<td>2019-36</td>
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<td>56</td>
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<td>-------------------</td>
</tr>
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<td>2019-38</td>
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</tr>
<tr>
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<td>2019-46</td>
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<td>6/20/2019</td>
</tr>
<tr>
<td>62</td>
<td>365</td>
<td>2019-52</td>
<td>Intro, VM-01, VM-20, VM-31</td>
<td>Addresses VAWG Recommendation #5</td>
<td>5/30/2019</td>
</tr>
<tr>
<td>65</td>
<td>376</td>
<td>2019-55</td>
<td>VM-20 Sec 7.L</td>
<td>Delete a CHDS criterion that was moved to VM-01</td>
<td>6/20/2019</td>
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</tbody>
</table>
Adopted by Life Insurance and Annuities (A) Committee, July 10, 2019

Actuarial Guideline XLIII

CARVM FOR VARIABLE ANNUITIES

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Section I Background
Section II Scope
Section III Reserve Requirements
Section IV Effective Date and Transition

Section I) Background

This Actuarial Guideline (Guideline) interprets the standards for the valuation of reserves for variable annuity and other contracts involving certain guaranteed benefits similar to those offered with variable annuities. The Guideline codifies the basic interpretation of the Commissioners Annuity Reserve Valuation Method (CARVM) by clarifying the assumptions and methodologies that will comply with the intent of the Standard Valuation Law. It also applies similar assumptions and methodologies to contracts that contain characteristics similar to those described in the scope, but that are not directly subject to CARVM.

In developing the Guideline, two regulatory sources provided guidance. First, the Standard Valuation Law defines CARVM as the greatest present value of future guaranteed benefits. Second, the NAIC Model Variable Annuity Regulation (VAR) states that the “reserve liability for variable annuities shall be established pursuant to the requirements of the Standard Valuation Law in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.”

During 2019 this Guideline was amended to follow the reserve requirements provided in VM-21 of the Valuation Manual. This was done for uniformity for all coverages within scope regardless of whether they were issued prior to or on and after the operative date of the Valuation Manual. This was also done to reflect the extensive analysis carried out by the NAIC, Oliver Wyman consulting for the NAIC, and industry participants for improvements to the variable annuity framework.

Section II) Scope

A) The Guideline applies to contracts, and product features on contracts, issued on or after January 1, 1981 and prior to the date that the Valuation Manual becomes effective in the applicable jurisdiction, whether directly written or assumed through reinsurance, falling into any of the following categories:

1) Variable deferred annuity contracts subject to the Commissioner’s Annuity Reserve Valuation Method (CARVM), whether or not such contracts contain Guaranteed Minimum Death Benefits (GMDBs), or Variable Annuity Guaranteed Living Benefits (VAGLBs);

2) Variable immediate annuity contracts, whether or not such contracts contain GMDBs or VAGLBs;

3) Group annuity contracts that are not subject to CARVM, but contain guarantees similar in nature1 to GMDBs, VAGLBs, or any combination thereof; and

---

1 The term “similar in nature,” as used in sections II)A)3) and II)A)4) is intended to capture both current products and benefits as well as product and benefit designs that may emerge in the future. Examples of the currently known designs are listed in footnote #2 below. Any product or benefit design that does not clearly fit the Scope should be evaluated on a case-by-case basis taking into consideration factors that include, but are not limited to, the nature of the guarantees, the definitions of GMDB and VAGLB in VM-01and whether the contractual amounts paid in the absence of the guarantee are based on the investment performance of a market-value fund or market-value index (whether or not part of the company’s separate account).
4) All other products that contain guarantees similar in nature to GMDBs or VAGLBs, even if the insurer does not offer the mutual funds or variable funds to which these guarantees relate, where there is no other explicit reserve requirement.\(^1\)

If such a benefit is offered as part of a contract that has an explicit reserve requirement and that benefit does not currently have an explicit reserve requirement:

a) The Guideline shall be applied to the benefit on a standalone basis (i.e., for purposes of the reserve calculation, the benefit shall be treated as a separate contract);

b) The reserve for the underlying contract is determined according to the explicit reserve requirement; and

c) The reserve held for the contract shall be the sum of a) and b).

B) The company may elect to apply these requirements to contracts and product features on contracts, whether directly written or assumed through reinsurance, falling into any of the categories defined in Section II.A. and issued prior to January 1, 1981.

C) The Guideline does not apply to contracts falling under the scope of the NAIC Model Modified Guaranteed Annuity Regulation (Model #255); however, it does apply to contracts listed above that include one or more subaccounts containing features similar in nature to those contained in Modified Guaranteed Annuities (e.g., market value adjustments).

D) Separate account annuity contracts that guarantee an index and do not offer GMDBs or VAGLBs are excluded from the scope of the Guideline.

Section III) Reserve Requirements

A) Reserves shall be determined by following the requirements in VM-21 from the version of the NAIC Valuation Manual applicable for that valuation date. For purposes of determining reserves, at the election of the company, the contracts subject to this Guideline may be aggregated with the contracts subject to VM-21 of the Valuation Manual. Alternatively, the company may elect to not aggregate the contracts subject to this Guideline with those subject to VM-21 of the Valuation Manual, and value these as a separate group of contracts.

B) The development of the reserves shall be documented following the requirements in VM31 of the NAIC Valuation Manual applicable for that valuation date.

Section IV) Effective Date and Transition

A) This Actuarial Guideline applies for valuations on or after January 1, 2020. The phase-in provisions of VM-21 also apply for the contracts and product features subject to the Guideline.

B) A company may elect to apply these requirements for the valuation on December 31, 2019 in lieu of the requirements of the prior version of this Guideline. If so elected, the reserves will be established by following the requirements of VM-21 from the 2020 NAIC Valuation Manual and the documentation requirements of VM-31 from the 2020 NAIC Valuation Manual.

\(^1\) For example, a group life contract that wraps a GMDB around a mutual fund would generally fall under the scope of the Guideline since there is not an explicit reserve requirement for this type of group life contract. However, for an individual variable life contract with a GMDB and a benefit similar in nature to a VAGLB, the Guideline would generally apply only to the VAGLB-type benefit, since there is an explicit reserve requirement that applies to the variable life contract and the GMDB.
A REGULATOR’S GUIDE TO PET INSURANCE
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INTRODUCTION

In December 2016, an insurer in the pet health insurance (pet insurance) industry voiced concerns to the Producer Licensing (D) Task Force regarding the use of limited lines licensing for pet insurance. The insurer recommended that pet insurance be removed from the State Licensing Handbook (Handbook) Uniform Licensing Standard (ULS) No. 37 – Surplus Line Exam as a limited line. It was the insurer’s opinion that a full property/casualty (P/C) line should be required to sell, solicit or negotiate pet insurance. Reasons cited include: 1) tremendous growth in the pet insurance market; 2) policy premiums that far exceed the cost of the covered item; i.e., the pet; and 3) complex policies with multiple coverage options and exclusions. Traditionally, limited lines products are designed to be incidental to the sale of another product, which, according to the insurer, is not the case with pet insurance. The Task Force decided it needed to better understand the complexities of pet insurance before offering guidance regarding the type of producer license required to sell the product. As a result, the Task Force made a referral to the Property and Casualty Insurance (C) Committee to draft a comprehensive white paper providing information on coverage options, product approval, marketing, ratemaking, claims practices and regulatory concerns.

As discussed during the Property and Casualty Insurance (C) Committee’s meeting at the 2018 Spring National Meeting, the Committee formed a drafting group to develop a white paper to provide an overview of the pet insurance industry. This white paper represents the Committee’s findings. Please note that all websites and companies discussed in this paper are included for research only and are not endorsements by the NAIC.

Pet insurance provides accident and illness coverage for family-owned pets, primarily dogs and cats. Although pet insurance is classified and regulated as P/C insurance, it bears many similarities to human health insurance with annual coverage offered at an actuarially determined rate subject to various conditions and exclusions. This coverage was started in the U.S. in 1980 and has grown significantly since that time.

The North American Pet Health Insurance Association (NAPHIA) represents more than 99% of the U.S. and Canada pet insurance industry as an advocacy group. As shown in Figure 1, the total premium volume for NAPHIA members in 2017 was approximately $1.03 billion in the U.S.,
representing 23.2% growth over the prior year. The growth of the P/C insurance industry as a whole was only 4.7% from 2016 to 2017. The direct written premium in the U.S. (including the territories) was approximately $640 billion in 2017, so while the pet insurance market is growing faster than the total P/C market, pet insurance still represents a small percentage of the total.

FIGURE 1. PET INSURANCE PREMIUM VOLUME

According to a survey conducted by the American Pet Products Association (APPA),\(^1\) in 2017, approximately 68% of U.S. households, or 84.65 million families, owned at least one pet (dog, cat or other). 60 million of these households owned at least one dog, and 47 million of the households owned at least one cat. There are significant opportunities for growth in the pet insurance market, with approximately 90 million household dogs and 95 million household cats in the U.S. According to the NAPHIA, as shown in Figure 2 below, approximately 1.5 million dogs and 300,000 cats were insured in 2017, meaning fewer than 2% of dogs and less than 0.5% of cats owned in the U.S. were insured in 2017. As shown in Figure 2, the number of insured dogs and cats increased by 17.5% from 2016 to 2017.

\(^1\) https://americanpetproducts.org/Uploads/MemServices/GPE2017_NPOS_Seminar.pdf
FIGURE 2. TOTAL INSURED PETS

TOTAL INSURED PETS

USA

Note: Most companies have a "one pet per policy" system; a few have multiple pets per policy.

<table>
<thead>
<tr>
<th>Year</th>
<th>Dogs</th>
<th>Cats</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>937,526</td>
<td>180,031</td>
</tr>
<tr>
<td>2014</td>
<td>1,048,530</td>
<td>201,403</td>
</tr>
<tr>
<td>2015</td>
<td>1,177,008</td>
<td>222,297</td>
</tr>
<tr>
<td>2016</td>
<td>1,310,408</td>
<td>244,816</td>
</tr>
<tr>
<td>2017</td>
<td>1,537,573</td>
<td>290,553</td>
</tr>
</tbody>
</table>

TOTAL INSURED PETS

+17.5% FROM 2016
+11.1% FROM 2015
+12.0% FROM 2014
+11.8% FROM 2013
+11.8% FROM 2013

HISTORY

The first “pet insurance”\(^2\) policy was issued in 1890 in Sweden and focused on horses and livestock. In 1924, the first policy covering a dog was issued in Sweden. In 1947, the first pet insurance policy was issued in the United Kingdom (UK). In Sweden and the UK, modern pet insurance policies are designed with the ability to cover pet medical costs and liability to third parties for the action of pets. Sweden has a requirement that dog owners must maintain liability coverage and, as a result, 60–70% of pet owners retain pet insurance. In the UK, 25–30% of dog and/or cat owners maintain pet insurance.

The first pet policy in the U.S. was issued in 1982 by Veterinary Pet Insurance (VPI). VPI was founded by a veterinarian from Orange County, CA. For the majority of the 1980s and 90s, VPI had a near monopoly over the U.S. market. In the early 2000s, additional companies joined the market. At the time, VPI had approximately 80% of the market. As shown in Figure 3 below, VPI, which was purchased by Nationwide and operating under that name, maintained more than 35% of the market for pet insurance in 2017. The market has grown significantly from the 1980s. Figure 1 above shows the remarkable growth over the past five years alone.

Figure 3 shows the 2017 U.S. premiums written by the top five insurers and branding entities with their 2017 premiums written established for the sale of pet insurance. Branding entities are programs that can be underwritten and sold by multiple insurers and are subject to change. Additionally, insurers may underwrite a variety of pet insurance programs. Branding entities may have programs underwritten by multiple insurers, and insurers may underwrite for multiple brands. The use of brand names is common in the industry which, without proper disclosure can cause confusion for state insurance regulators and consumers in determining the entity with a duty to indemnify.

\(^2\) The use of the term “pet insurance” in this paper does not refer to insurance policies that cover horses and livestock, commonly referred to as “blood stock,” which provide indemnity for animal mortality. The term “pet insurance” in this paper refers to the products commonly covering dogs and cats and providing indemnity for the cost of dogs’ and cats’ medical treatment. All of the participants in the market cover cats and dogs. A few participants also cover horses and exotic animals kept as pets.
FIGURE 3. TOP SELLERS

<table>
<thead>
<tr>
<th>COMPANY/BRANDING ENTITY</th>
<th>USD (IN MILLIONS)</th>
<th>MARKET SHARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationwide</td>
<td>$374.60</td>
<td>36.33%</td>
</tr>
<tr>
<td>Trupanion</td>
<td>$191.60</td>
<td>18.58%</td>
</tr>
<tr>
<td>Healthy Paws Pet Insurance and Foundation</td>
<td>$123.20</td>
<td>11.95%</td>
</tr>
<tr>
<td>Petplan Pet Insurance</td>
<td>$83.60</td>
<td>8.11%</td>
</tr>
<tr>
<td>Crum &amp; Forster Pet Insurance Group</td>
<td>$69.20</td>
<td>6.71%</td>
</tr>
<tr>
<td>Other</td>
<td>$188.80</td>
<td>18.32%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$1,031.00</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>


Although the U.S. market has been growing by 15% or 20% a year for the last five years, it still only covers approximately 1% of the estimated 1.1 million dogs and cats kept as pets in the U.S. As noted in Figure 4, pet insurance coverage is concentrated in larger urban areas, with California and New York being the largest markets. However, over the last two decades, product offerings have expanded as additional insurers have entered the market. Caution should be used when contemplating data contained in Figures 1–4. Data for these figures was provided by the industry association NAPHIA, not the states or the NAIC. Data contained in Figures 1–4 include NAPHIA members only and, therefore, are not exhaustive of the entire market for pet insurance. As discussed later in the paper, premiums and losses for pet insurance policies are contained in the inland marine line of business on the NAIC annual financial statement; therefore, data for pet insurance, specifically, is indeterminate at this time.

A few states have initiated data calls or market conduct examinations concerning pet insurance. Massachusetts’ data call was designed to identify pet insurance writers and their premium volume in the state. New Hampshire published a report of its data call, revealing that 20 companies filed forms in the System for Electronic Rate and Form Filing (SERFF) in 2017, but only nine reported premiums from 2015 through 2017. The two largest companies accounted for 59% of the market in New Hampshire in 2017.
FIGURE 4. POLICIES AND PREMIUMS BY STATE

<table>
<thead>
<tr>
<th>2017</th>
<th>Number of Policies</th>
<th>Number of Policies (%)</th>
<th>Gross Written Premium ($)</th>
<th>Gross Written Premium (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>1,832,592</td>
<td>100%</td>
<td>$1.03 B</td>
<td>100%</td>
</tr>
<tr>
<td>Alabama</td>
<td>7,254</td>
<td>0.4%</td>
<td>$3.79 M</td>
<td>0.4%</td>
</tr>
<tr>
<td>Alaska</td>
<td>5,720</td>
<td>0.3%</td>
<td>$2.62 M</td>
<td>0.3%</td>
</tr>
<tr>
<td>Arizona</td>
<td>34,485</td>
<td>1.9%</td>
<td>$19.21 M</td>
<td>1.9%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>2,862</td>
<td>0.2%</td>
<td>$1.35 M</td>
<td>0.1%</td>
</tr>
<tr>
<td>California</td>
<td>362,727</td>
<td>19.8%</td>
<td>$219.54 M</td>
<td>21.4%</td>
</tr>
<tr>
<td>Colorado</td>
<td>53,986</td>
<td>2.9%</td>
<td>$30.81 M</td>
<td>3.0%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>39,215</td>
<td>2.1%</td>
<td>$22.65 M</td>
<td>2.2%</td>
</tr>
<tr>
<td>Delaware</td>
<td>6,497</td>
<td>0.4%</td>
<td>$4.24 M</td>
<td>0.4%</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>8,444</td>
<td>0.5%</td>
<td>$3.87 M</td>
<td>0.4%</td>
</tr>
<tr>
<td>Florida</td>
<td>116,855</td>
<td>6.4%</td>
<td>$64.94 M</td>
<td>6.3%</td>
</tr>
<tr>
<td>Georgia</td>
<td>31,757</td>
<td>1.7%</td>
<td>$16.11 M</td>
<td>1.6%</td>
</tr>
<tr>
<td>Hawaii</td>
<td>9,073</td>
<td>0.5%</td>
<td>$5.19 M</td>
<td>0.5%</td>
</tr>
<tr>
<td>Idaho</td>
<td>5,003</td>
<td>0.3%</td>
<td>$2.51 M</td>
<td>0.2%</td>
</tr>
<tr>
<td>Illinois</td>
<td>62,149</td>
<td>3.4%</td>
<td>$34.53 M</td>
<td>3.4%</td>
</tr>
<tr>
<td>Indiana</td>
<td>15,336</td>
<td>0.8%</td>
<td>$7.40 M</td>
<td>0.7%</td>
</tr>
<tr>
<td>Iowa</td>
<td>6,522</td>
<td>0.4%</td>
<td>$3.01 M</td>
<td>0.3%</td>
</tr>
<tr>
<td>Kansas</td>
<td>6,981</td>
<td>0.4%</td>
<td>$3.28 M</td>
<td>0.3%</td>
</tr>
<tr>
<td>Kentucky</td>
<td>8,848</td>
<td>0.5%</td>
<td>$4.21 M</td>
<td>0.4%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>9,724</td>
<td>0.5%</td>
<td>$4.76 M</td>
<td>0.5%</td>
</tr>
<tr>
<td>Maine</td>
<td>8,371</td>
<td>0.5%</td>
<td>$4.35 M</td>
<td>0.4%</td>
</tr>
<tr>
<td>Maryland</td>
<td>45,449</td>
<td>2.5%</td>
<td>$25.70 M</td>
<td>2.5%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>86,703</td>
<td>4.7%</td>
<td>$48.83 M</td>
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<td>$1.28 M</td>
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<td>0.9%</td>
<td>$8.63 M</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

naphia.org/industry/research-and-reports/terms-conditions-use-state-industry-report
A study of the more developed markets in other countries may help identify points of concern and direct the governing of pet insurance products in the U.S. There are no filing or producer licensing requirements in the UK or Sweden, so no instructive elements can be gleaned from their experience on these two issues. The Canadian market is similar to the U.S. market in both products and market penetration, having developed over a similar time period. Pet insurers report that 70% of sales are initiated online, and 30% of sales are initiated through call centers.

California is the only state with a law specifically governing pet insurance. California Insurance Codes 12880–12880.4 were created in 2014 and can be found in Appendix 2. The laws require pet insurers to disclose baseline information regarding reimbursement benefits; preexisting condition limitations; and a clear explanation of limitations of coverage including coinsurance, waiting periods, deductibles, and annual or lifetime policy limits. The California laws also provide consumers with a 30-day “free look” period in which a pet insurance policy can be returned for a full refund. An earlier version of this bill attempted to prevent exclusions for preexisting conditions but was vetoed by the Governor of California. A pet insurance bill was introduced, but not enacted, in New York.

None of the failed bills or the California statute address producer or adjuster licensing. Most states require a full P/C license to sell, solicit or negotiate pet insurance, while a few states—Idaho, New Jersey, Rhode Island and Virginia—allow for use of a limited lines license.

**CARRIERS**

As noted above, insurance companies commonly advertise pet insurance products using the insurers’ brand name (a practice referred to as “branding”) rather than the insurance company name. Branding is common practice in many lines of business, not limited to pet insurance, and with proper disclosure it should not present any legal or regulatory concerns. Additionally, it is commonplace in the pet insurance market for branded entities to change underwriters for their pet insurance program with some frequency. This makes it difficult for examiners to identify licensed entities associated with the sale of pet insurance products and track compliance with regulatory

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3 California has a pending bill, CA AB 1535, that would require pet insurers to provide additional disclosures to consumers.
requirements. When insurers use a brand name, the insured must read the fine print at the bottom of the advertisement, application or website to find the identity of the underwriting company. In addition to use of brand names, one to three agencies may sell the pet insurance products for an insurer under a specified brand name. The agency communicates with the consumer and receives applications. In most cases, the agency is also responsible, as a third-party administrator (TPA), for claims processing and answering consumer inquiries. This practice can cause confusion for consumers in determining the entity responsible for paying claims and who should be named if they need to file a complaint with the state insurance department.

**COVERAGE OPTIONS**

Two coverage types are available through a majority of carriers selling pet insurance: 1) accident only; and 2) accident and illness. According to the NAPHIA, 98% of policies written in 2017 were for accident and illness insurance, which may include embedded wellness, while 2% were accident only. The average premium for accident and illness plans was approximately $516, while the average premium for accident only plans was approximately $181 per pet in the U.S. in 2017.

Some veterinary clinics offer agreements for preventive care. If the agreement is a two-party contract between the veterinarian and consumer where no risk is transferred or assumed and no third party is involved, these plans are not insurance. However, these may cause confusion for consumers as they may be construed as insurance. State insurance regulators should be aware that these exist, as they may be called upon to review the structure of the agreement.

Coverage options vary by carrier. Most companies write coverage for dogs and cats only. One carrier also has policies for exotic pets, such as reptiles and birds. Consistent with human or non-pet coverage, plans have varying deductibles, copayments and limits. In most cases, pet owners must pay the vet directly and wait to be reimbursed by the insurance carrier or account administrator. Reimbursement methods differ. Some include a benefit schedule based on illness or injury and coverage level. There are waiting periods and pre-coverage exams required in many cases. Pets must be above the minimum and below the maximum age limits to begin coverage. Many carriers exclude coverage for pets less than eight weeks old or older than 12 years. Exclusions exist for preexisting conditions, and there may be limitations on coverage for hereditary
or congenital conditions as well. Definitions of conditions are inconsistent across policies and, therefore, may have varying impacts on the consumer’s ability to receive reimbursement for claims. Appendix 1 contains a glossary of terms as defined in California Assembly Bill No. 2056, Chapter 896, requiring use of the specified terms for all policies that are marketed, issued, amended, renewed or delivered to a California resident, on or after July 1, 2015. While there are many different policies on the market today with various coverage options, most policies include:

- **Two primary coverage types: accident only, or accident and illness plans.** Comprehensive policies may cover reasonable and necessary veterinary expenses that occur during the policy period for medical management, diagnosis or treatment of a pet’s condition. Veterinary expenses or services include medical advice, diagnosis, care or treatment provided by a veterinarian. Other services and medical expenses that may be covered include the costs of the visit, prescription drugs, food, supplements and medical equipment, surgical procedures, physical therapy, and dental procedures.

- **Optional wellness and preventive coverage.** Such coverage may be available, which covers veterinary expenses during the policy period for preventive treatment or treatment provided to preserve or improve general nutrition or health when there are no underlying symptoms of an associated diagnosed medical condition. This typically includes vaccinations, flea and heartworm medication, wellness exams, blood tests, radiographs, heartworm tests, screens, urinalysis, deworming, pet identification (microchip), spaying or neutering, dental cleaning, genetic certification, etc.

- **Different plan options.** Pet health insurers may offer different plan options or tiers with varying policy limits.

- **Description of the veterinarians and clinics that may be used under the plan.**

- **Limits, which may be annual, lifetime, per procedure, per incident or a combination.** Optional coverages may have special limits.

- **Copayments applicable to the cost of each procedure, an overall limit or other basis.** Generally, there is a coinsurance percentage and/or deductible.

- **Waiting periods for injury, illness and orthopedic care.** Pet health waiting periods are usually broken up into two separate periods for illness and injury, but other pet health insurers may add longer waiting periods for specific coverages such as orthopedics or cruciate ligament events, etc. Although most of the definitions in pet
health policies for waiting periods include the language “these waiting periods are waived for continuous renewal,” the waiting periods may apply again if there are policy changes.

- **Policy exclusions, which often include exclusions for preexisting conditions.** Some may even exclude coverage in renewal policies for conditions diagnosed or treated in prior coverage periods. Many policies also exclude coverage for congenital and heredity conditions, such as hip dysplasia, heart defects, cataracts and diabetes. Other typical exclusions may include: preventive treatment or wellness care; dental care; vaccinations; flea prevention; spaying or castration; behavioral training/therapy or treatment; procedures, services or supplements for a condition not covered by the policy; service or procedures not performed or prescribed by a licensed veterinarian; over-the-counter food or supplies; boarding or accommodation; transportation; grooming; membership fees; experimental and/or investigative treatment that is not within the standard of care; diagnosis, treatment, tests or procedures associated with breeding etc.

- **A schedule or plan for recovery of benefits.** Most plans include a reimbursement model, meaning the insured must pay out of pocket to the veterinarian and be reimbursed by the insurer. Only one carrier in the market today pays the veterinarian directly.

- **Nondiscretionary arbitration provisions.** Many contracts contain nondiscretionary arbitration provisions. Alternatively, some pet insurance policies contain language that set forth an arbitration process that requires peer review of the treatment provided by a veterinarian as opposed to engaging in an arbitration process conducted through the American Arbitration Association (AAA).

The coverage options and policy details associated with pet insurance are like those found in human health insurance. However, pet insurance is regulated and reported as P/C coverage because pets are considered property under the law. Provisions for in-network providers, co-insurance or co-payment, exclusions for preexisting conditions, age limits, and waiting periods are more like health insurance than P/C coverage.
Consumers may want to research policy provisions on their own prior to purchase. There are several consumer websites that provide guidance on pet insurance products. Consumers should also be aware that the price of insurance may increase substantially as the animal gets older. These websites also provide additional information on some of the policy provisions identified in the prior paragraphs.

**POLICY FORMS**

State law governs the requirements for policy review in a given line of business. State law may govern that the state is use and file, file and use, or prior approval. File and use means the form must be filed with the state insurance regulator but can be used before approval is obtained. Use and file means the form can be used before it is filed with the state insurance regulator. Prior approval requires that all insurance policy forms, riders and endorsements be approved by the state insurance commissioner/superintendent/director prior to being issued and sold to the public. While prior approval provides the highest level of oversight because policy forms cannot be used until approved, use and file, and file and use still provide states with the oversight to review filings for compliance with state-specific requirements.

A basic insurance policy form is an insurance contract delineating the terms, provisions and conditions of an insurance product. It includes endorsements and applications of which written application is required and is to be attached to the policy or be part of the contract.

Although state regulation of insurance was initially designed to prevent insurer insolvency, regulatory jurisdiction has evolved over the decades to protect consumers. Policy form review is an integral part of market regulation. Policy forms are reviewed to ensure statutory compliance and that products are fair and not harmful to consumers. Regulatory review also helps insurance companies, as examiners may catch errors, inconsistencies, ambiguous or misleading language, and omission before products are offered to the public. This helps improve the quality of products offered and promotes consumer confidence.

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Policy form filings may be submitted through SERFF in most states. Currently, six states and the territories are not using SERFF for policy filing review. Policy form filings are generally submitted separately for each program. Insurers must be properly licensed for the appropriate line of business prior to submission of a form filing. Regulatory analysts review the policy forms submitted in the SERFF form filing to check for compliance issues relative to federal and state law, regulation, legislation or mandated language, and any state-specific advisory letters or bulletins issued by the state insurance commissioner/superintendent/director.

**MARKETING STRATEGIES**

Pet insurance may be sold via online marketing, veterinary clinics, pet stores, shelters and animal support and rescue organizations, or word of mouth referrals. Pet insurance may also be sold as part of an employee benefit package or through licensed insurance producers. The most common distribution methods are web-based marketing and referrals from veterinary clinics or friends and family. Veterinary offices, clinics or hospitals may promote pet insurance products to their customers or allow placement of printed materials throughout their office. Printed marketing materials may refer consumers to a website to obtain further information about a product. Materials sometimes include an application or phone number for the insurance company, a licensed insurance producer, or TPA. The veterinarian may partner with one brand exclusively or provide customers with brochures or pamphlets on several different brands. In addition, kennels and breeding clubs may promote coverage for pets or even have preferred carriers for specific breeds. Also, some organizations include information on pet insurance on their website to educate consumers about pet insurance and assist consumers in making comparisons among coverage options. However, as of this writing, none of that information has been vetted by the NAIC.

The fastest growing form of distribution is through an employee benefit package. Coverage may be sponsored in part by the employer or entirely employee paid. Special employee pricing is sometimes offered with group discounts. According to Nationwide, 50% of Fortune 500 companies offered pet insurance as an employee benefit in 2017.
To encourage uniformity, the Producer Licensing Uniformity (D) Working Group developed the ULS within the Handbook. Adopted originally in 2002, the ULS is a guide for state insurance regulators to use in their producer licensing process. In the November 2011 update, ULS No. 37 was added to address non-core limited lines licensure. Pet insurance was mentioned as an example, and a definition of “limited lines pet insurance” was included to mean an insurer designee, such as a managing general underwriter, managing general agent (MGA), or limited lines producer of pet insurance. As of September 2018, four states—Idaho, New Jersey, Rhode Island and Virginia—offer pet insurance as a non-core limited line.

Several market conduct enforcement actions on pet insurers were reported from 2015 to 2016. The issues identified in these actions included unlicensed sales, illegal inducements and rebating, improper use of rates, and unlawful claims practices.

The Producer Licensing (D) Task Force has held several meetings to discuss the type of license states should require of producers who are to sell, solicit or negotiate pet insurance policies.5 “Negotiate” is defined in the Producer Licensing Model Act (#218) as “the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.” State insurance regulators agree that pet insurance should not be sold by unlicensed individuals, but they agree that what level of licensure and what steps should require licensure are open topics of discussion.

There is an open debate as to whether insurance producers and claims adjusters (in states where claims adjusters are licensed) should be required to have a full P/C license or a limited lines license to sell pet insurance. According to Model #218,6 in order to obtain a resident license for the P/C line of authority, one must pass a written examination. According to the Handbook, states that require pre-licensing shall require 20 credit hours of pre-licensing education per major line of

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5 2017 Summer and Fall National Meeting Proceedings.
authority. The six major lines of authority identified in the Handbook are: 1) life; 2) accident and health (A&H) or sickness; 3) property; 4) casualty; 5) variable life and variable annuity; and 6) personal lines. Limited lines are considered alternatives to the major lines of authority. The products offered and the licensing requirements for limited lines tend to be more limited in scope. Except for crop and surety, pre-licensing examinations are not required for limited lines. Under both reciprocity standards set forth in Model #218 and the ULS, pre-licensing education is not required for nonresident applicants or nonresident producers who change their state of residency. Additionally, 24 credits of continuing education (CE) are required for each biennial compliance period only if the producer holds a license in one of the six major lines of authority. The Handbook also states that a person licensed as a limited lines producer in his or her home state shall receive a nonresident limited lines producer license, granting the same scope of authority as granted under the license issued by the provider’s home state. This may be problematic if the type of license is inconsistent across states for a specified line of authority. A benefit of having the full licensing requirements is that education and testing requirements for licensure ensures that producers are competent and qualified to sell insurance to consumers, ultimately resulting in consumer protection. Alternatively, some take the position that the individuals most able to provide information on pets and pet insurance are those outside of the traditional insurance distribution channels. They may also argue that, under ULS No. 37, the traditional pre-licensing, testing and continuing legal education (CLE) do not include topics specific to pets or pet insurance; as such, the limited lines license model is more appropriate. As noted in the excerpt below, individuals offering insurance on a limited lines basis must receive a program of instruction or training subject to review by the insurance department.

In June 2015, the New Jersey Department of Banking and Insurance, Division of Insurance adopted N.J.A.C. 11:17-2.4 adding pet insurance to the list of limited lines coverage. The proposed rule cited the following reasons: 1) pet insurance products are offered by pet stores, veterinarian offices, pet training facilities, and other similar establishments, and are incidental to the services offered by such businesses; and 2) the knowledge and training needed to offer the product is unrelated to typical property and casualty insurance products and, as such, qualifies pet insurance as a limited line.
In November 2015, the former Producer Licensing Uniformity (D) Working Group adopted the following addition to ULS No. 37 in the Handbook:

“A state is not required to implement any non-core limited line of authority for which a state does not already require a license or which is already encompassed within a major line of authority; however, the states should consider products where the nature of the insurance offered is incidental to the product being sold to be limited line insurance products. If a state offers non-core limited lines (such as pet insurance or legal expense insurance), it shall do so in accordance with the following licensing requirements. Individuals who sell, solicit or negotiate insurance, or who receive commission or compensation that is dependent on the placement of the insurance product, must obtain a limited line insurance producer license. The individual applicant must: 1) obtain the limited lines insurance producer license by submitting the appropriate application form and paying all applicable fees as set forth in applicable state law; and 2) receive a program of instruction or training subject to review by the insurance department.”

The Working Group defined pet insurance as “health insurance coverage including, but not limited to, coverage for injury, illness and wellness for pets such as birds, cats, dogs and rabbits.”

Another issue to consider regarding producer licensing is claims handling. One approach could be to require the business to hold or maintain a license and designate one person to be licensed within the organization. This is similar to the license required for portable electronics insurance which is sold to cover the cost of repair or replacement of the electronic device being sold. Employees assisting in claims handling would not be required to be licensed under certain circumstances if their claim-related activity was limited to pet insurance. Due to the complex coverage options offered by pet insurance policies, it may not be in the best interest of the consumer to allow unlicensed individuals to adjust pet insurance claims. Alternatively, adjusters must review veterinary records, including non-standard pet health codes, which may require technical knowledge and expertise in animal science. This is not dissimilar to other lines of business in which subject matter experts (SMEs) work in conjunction with licensed adjusters or adjusters need specialized training to effectively handle claims where a high level of technical knowledge is
required. A combination of adjuster training and access to SMEs is needed to properly adjust pet insurance claims. Other lines of business may have separate licensing requirements for producers and adjusters requiring a full property casualty license for producers and a limited lines license for adjusters.

**RATES**

Pet insurance is regulated as a P/C insurance line of business included in the annual statement under inland marine. There is no specific financial reporting line for pet insurance, which makes it difficult to track the premiums attributable to pet insurance. Like most P/C lines, the rates and rating rules are regulated by the department of insurance (DOI) of the state in which the policies are written. SERFF contains a specific sub-type of insurance for pet insurance plans (9.0004). However, its use is not consistent in all states. For instance, in Rhode Island, pet insurance policies are filed under inland marine, a personal insurance code, rather than under the pet sub-type of insurance. Florida and, until recently, Virginia require pet insurance to be filed under livestock. Proposed rates and rating rules are frequently scrutinized by insurance professionals working within or under contract for the DOI to ensure that the rates are not inadequate, excessive or unfairly discriminatory.

When an insurer initiates a pet insurance program in a given state, and each time it wishes to change the rates and/or rating rules, the insurer files its proposal, with supporting documentation and various state-specific information, with the DOI. The DOI reviews the filing and either approves or disapproves the insurer’s plan. State-specific filing guidance can be found at each state DOI’s website. (See [https://www.serff.com/serff_filing_access.htm](https://www.serff.com/serff_filing_access.htm).)

Like in other lines of insurance, for pet policies, the rate or premium charged is intended to cover the three basic costs of the insurer: 1) claim costs (also known as losses); 2) the insurer’s expenses; and 3) a profit provision. The claim costs represent the largest portion of the insurance premium dollar (60%–70% for most P/C lines) and include loss adjustment expenses (LAEs). The expenses of the insurer include commissions paid to agents, general operating expenses, premium taxes, and other fees paid to the states. The profit provision (also known as profit and contingencies) affords a reasonable return on the insurer’s invested capital. A significant amount of capital must be
available to guard against poor claim experience and catastrophes. Figure 5 shows the typical components of each premium dollar charged for pet insurance.

FIGURE 5. MAKEUP OF THE PREMIUM DOLLAR

As discussed in detail under the coverage options section above, many pet insurance carriers offer more than one health plan. By far the most common is an “accident and illness” plan covering both fortuitous injuries, as well as health issues of the pet (subject to various limitations and exclusions). A less expensive alternative is an accident-only plan, which may cost around 60% less than an accident and illness plan. Most policies are written on an annual basis.

For an additional charge, typical plan options can include (on a bundled or unbundled basis):

- Preventive/wellness care
- Dental care
- Spay/neuter
- Cancer treatment
- Diabetes coverage
- Inherited/congenital conditions
- Behavioral therapy
- Prescription coverage
• Alternative medicine
• Lost pet recovery
• Ambulance care
• Euthanasia/cremation/funeral coverage
• Accidental death benefit
• Travel/vacation coverage
• Boarding/kenneling (unforeseen circumstances)

Few insurers offer preventive or wellness as a stand-alone coverage. It is typically offered as an add-on to an accident and illness policy.

RATING

To understand pet insurance rates, one can think of an overall rate level and a rate structure. The overall rate level is usually represented by a base rate. A base rate is the starting point before various rate structure modifications are made. The rate structure can be viewed as a set of tables of multiplicative factors that modify the base rate according to various risk characteristics.

Given a rate structure, the base rate can be viewed as a scaling factor that adjusts the overall rate level to an appropriate magnitude. Consider a highly simplified example in which the rate structure recognizes two species (dog and cat) and two geographic classifications (rural and urban). Let us say the rate structure has the following rating factors:

<table>
<thead>
<tr>
<th>Species</th>
<th>Geographic Class</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
</tr>
<tr>
<td>Dog</td>
<td>1.00</td>
</tr>
<tr>
<td>Cat</td>
<td>0.60</td>
</tr>
</tbody>
</table>

In this rate structure, all else equal, the cat necessitates 40% less cost than the dog, and urban areas entail 100% more cost than rural areas. Of course, the insurer must select an overall dollar rate level to apply to the four rating factors as appropriate. Let us say the insurer selects an annual base rate of $300. Then, a table of annual rates can be laid out as the above table of rating factors, multiplied by $300, which represents the dollar-denominated scaling factor for the rating system:
Building the rates upon an overall rate level and rate structure allows the insurer to easily analyze and adjust rates over time. Inflation in veterinary costs will cause the base rate to increase over time. The rate structure will often stay stable for years at a time. Modest adjustments may be needed due to changes in cost drivers. Insurers typically monitor known cost drivers for increases over time.

Pet insurance rate structures are relatively similar across insurers, but they will have some variances in the risk characteristics, the rating factors for those risk characteristics, or both. Insurers generally use the same rate structure in all the states where they operate, but there may be exceptions based on a company initiative or state regulatory requirement.

Policy premium is the amount charged to the insured for coverage. An installment fee may be applied if the insured elects to pay for the insurance in installments rather than paying in full at the beginning of the policy term. Installment fees typically vary from $1 to $6 per pay period, depending on the insurer and the mode of payment (electronic funds transfer [EFT], credit card, etc.). An insurer may charge other fees such as non-sufficient fund fees, late fees, and reinstatement fees. These ancillary fees generally vary from $10 to $30 each. All fees, including ancillary fees, must be properly disclosed in rate filings along with supporting documentation.

**RATING VARIABLES**

A rating variable is a characteristic of a rating plan. Typical rating variables for pet insurance include geographic area, deductible, copay, limit, species, pet age, breed, etc. These rating variables are discussed in more detail below.
**Geographic Area**

Pet insurance rates generally vary by state and often by territory within the state. These territories are usually drawn along the boundaries of counties or ZIP code groupings. Generally, the rates will be higher in urban areas due to higher costs of veterinary services and other socioeconomic factors. For pet insurance, geographic rating factors may range from 1.000 on the low end to 2.000 for the highest cost areas in the U.S.

**Deductible**

A deductible is the amount of money an insured has agreed to pay for pet treatment before the insurer begins paying out on provided coverage. The deductible is intended to ensure that the insured seeks only necessary pet health treatment and pays for much or all of the smaller claims, with the insurer paying out only for larger claims. Discounts are provided for higher deductibles, resulting in lower annual premiums. Typical deductibles range from $50 to $250, although higher deductible plans can be purchased at a substantial premium savings.

Deductibles are typically provided by insurers on a per incident or annual basis. Some insurers allow the insured to select either annual or per incident options, while others only have one reimbursement method. Coverage typically costs more with an annual deductible because it tends to result in a higher cost for the insurer and lower cost for the insured. Coverage with an annual deductible routinely costs 4–6% more than a per incident deductible plan.

**Co-Insurance or Copay**

The co-insurance percentage (sometimes referred to as copay) is the percentage of loss the insured has agreed to pay after the deductible is satisfied. Much like the deductible, the co-pay is intended to encourage the insured to use the insurance judiciously, with some “skin in the game” in partnering with the insurer to keep costs at a necessary and reasonable level. Copays are usually provided as multiples of 10; i.e., 10%, 20%, 30% and possibly higher. As compared with a 10% co-pay, a 20% co-pay can save between 5% and 25% of the insurance cost, depending on the insurer. Premium discounts are provided for out-of-pocket costs in the form of the copayments for the insured. Plans with 0% copay may be available for a higher premium amount.
Limit

Insurance policy limits are the maximum dollar amount an insurer will pay for claims. Policy limits are normally expressed on a per incident basis, as well as an aggregate policy term basis. Many insurers have both per incident and aggregate limits for one policy. Few insurers also use maximum lifetime limits; i.e., for the life of the pet. Higher limits are more expensive because they could ultimately result in higher claim payments for the insurer. An illustration follows:

- **Deductible**: $100
- **Deductible Type**: Per Incident
- **Copay**: 20%
- **Per Incident Limit**: $1,000
- **Annual Limit**: $10,000

(1) Amount Charged for Pet Treatment: $75, $150, $1,500
(2) Amount Paid by Insurer: $0, $40, $1,000
(3) Amount Paid by Insured: $75, $110, $500

NOTES:
$75 treatment: $0 = $75 – $100, subject to a minimum of $0
$150 treatment: $40 = ($150 – $100) x (100% – 20%)
$1,500 treatment: $1,000 = ($1,500 – $100) x (100% – 20%), subject to a maximum of $1,000; i.e., the per incident limit

(3) = (1) – (2)

Also: If there had been 12 $1,500 treatments in the course of an annual policy term, the insurer would have paid the first 10 only at $1,000 each, since the insurer’s annual limit (maximum liability) of $10,000 would have been reached at that point.
Species

Most pet insurance carriers offer insurance for dogs and cats. Only one insurer offers coverage for other types of animals, such as birds and reptiles, under its exotics policy.

Pet Age

Most insurers will not cover pets less than eight weeks old or more than 12 years old. Health risks tend to be greater for these age ranges. For both dogs and cats, older pets can cost two to four times as much, depending on the insurer.

A few insurers use the age at which the pet was initially enrolled for health insurance, either in addition to or in lieu of the pet’s current age. Use of initial enrollment age allows an insurer to guard against adverse selection (e.g., an older pet in failing health being insured for the first time). If the exact age of a pet is not known, the insurer may ask the insured to obtain an estimate from the pet’s veterinarian. At least one insurer uses four different age curves for dogs depending on their weight. Typically, the heavier the dog, the steeper the age curve.

Breed

There are more than 100 dog breeds and around 50 cat breeds. Some of the most common dog breeds in the U.S. are Mixed Breed, Labrador Retriever, Golden Retriever, German Shepherd, Rottweiler, Bulldog, Poodle, Terrier and Boxer. Common cat breeds are the American Shorthair, Maine Coon, Oriental, Persian, Ragdoll, Siamese, Sphynx, Birman and Abyssinian. Most insurers group the breeds into 10 or 12 rating categories, with each category assigned a rating factor. Smaller dogs and mixed breeds are frequently in the lower rating categories, while larger pure bred dogs are assigned to the higher rating categories. Dogs in the highest rated category can cost 50–75% more than the lowest rated group. Cost variances for cats tend to be less. The cat breed factor curve will usually be significantly flatter, with the highest rated costing 0–50% more versus the lowest rated breed. This reflects the fact that breeds are significantly more homogeneous for cats than dogs in terms of size, build and other characteristics.
Multi-Pet

Many insurers offer a multi-pet discount because of the reduced administrative expenses per pet for a multi-pet policy. Multi-pet discounts are often in the 5–10% range.

Group Marketing

Many insurers offer a group marketing discount, also known as an association or affiliation discount. Marketing discounts recognize the cost efficiencies of partnering with different types of organizations in promoting the insurer’s product and offering seminars, pamphlets and other services that strive to lower pet health costs. Typical partners include designated corporate groups—i.e., group benefit plans—affinity groups, strategic partners and veterinary clinics, for which the employees and/or members may receive the discount. Group marketing discounts are often in the 5–10% range.

Miscellaneous

Other rating variables used by some insurers include:

- Policy term; i.e., pro rata factor if other than one year.
- Waiting period length (discount for longer periods).
- Renewal discount.
- Claim-free discount.
- Pet gender; i.e., females rated about 5% less than males.
- Spay/neuter discount.
- Wellness plan discount.
- Predictive test discount.
- Exam fee coverage (discount for exclusion).
- Microchip/identification tattoo discount.
- Service or therapy dog discount (or surcharge).
- Military discount.
- Animal health employee discount.
- Shelter adoptee discount.
- Automated clearing house (ACH) payment discount.
- Premium paid-in-full discount; i.e., no installment plan used.
Online enrollment/paperless policy administration discount.

RATING EXAMPLE

For a typical accident and illness plan, an illustrative and hypothetical example of the workup of a rate follows:

Overall Rate Level:
Annual Base Rate* $300

*Reflects:
Geographic Area #1
Deductible $100
Deductible Type Per Incident
Co-Pay 10%
Per Incident Limit $1,000
Annual Limit $10,000
Species Dog
Pet Age Less than 1 year
Breed Group 1
Multi-Pet No
Group Marketing Member No

Rate Structure Adjustments:
Geographic Area (#3) 1.160
Deductible ($150) 0.955
Deductible Type (Annual) 1.060
Co-Pay (20%) 0.925
Per Incident Limit ($2,000) 1.280
Annual Limit ($10,000) 1.000
Species (Dog) 1.000
Pet Age (5) 1.240
Breed Group (4) 1.050
Multi-Pet (No) 1.000
Group Marketing Member (Yes) 0.950

Final Rate $516; i.e., $300 x 1.160 x … x 0.950

RATEMAKING

Ratemaking represents the estimation of a set of rates needed to manage an insurance program. Rating uses a set of rates to determine which rate is appropriate for a particular risk given its risk characteristics. Generally, ratemaking is performed by an actuary; rating is performed by an underwriter. An overview of actuarial science is provided in Appendix 3.

Actuarial Standards of Practice (ASOPs) set forth principles and considerations for an actuary estimating costs associated with the transfer of risk. Principle 1, Principle 2 and Principle 3 from the Casualty Actuarial Society’s (CAS) Statement of Principles Regarding Property and Casualty Insurance Ratemaking are particularly relevant:

- Principle 1: A rate is an estimate of the expected value of future costs.
- Principle 2: A rate provides for all costs associated with the transfer of risk.
- Principle 3: A rate provides for the costs associated with an individual risk transfer.

Adherence to these principles should lead to P/C rates that are reasonable, not excessive, and not unfairly discriminatory.

Some of the most important ASOPs published by the Actuarial Standards Board (ASB) that pertain to pet insurance ratemaking include:

- ASOP 12 – Risk Classification
- ASOP 13 – Trending Procedures in Property/Casualty Insurance
- ASOP 23 – Data Quality
- ASOP 25 – Credibility Procedures
- ASOP 29 – Expense Provisions in Property/Casualty Insurance Ratemaking
- ASOP 30 – Treatment of Profit and Contingency Provisions and the Cost of Capital in Property/Casualty Insurance Ratemaking
- ASOP 41 – Actuarial Communications
RATEMAKING EXAMPLE

If the actuary can estimate the expected losses for a given policy and knows the expense structure, he/she can estimate the needed rate as a grossing up of the expected losses. This approach is often used at the onset of an insurance program.

As the insurance program grows and develops a significant amount of premium, the actuary will normally analyze the performance annually to determine the indicated rate change. The goal is to estimate how much the premiums would need to be adjusted to bring the relationship between losses and premiums (loss ratio) in line with the targeted loss ratio as implied by the expense structure. An example is provided below.
Overall Rate Indication

A simple example

Assume all expenses are variable with premium and add to 33.3% of premium. Earned premium and incurred losses have been “adjusted to current levels.”

<table>
<thead>
<tr>
<th>Accident Year</th>
<th>Earned Premium</th>
<th>Incurred Losses</th>
<th>Loss Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>125,000</td>
<td>50,000</td>
<td>40.0%</td>
</tr>
<tr>
<td>2014</td>
<td>370,000</td>
<td>209,000</td>
<td>56.5%</td>
</tr>
<tr>
<td>2015</td>
<td>490,000</td>
<td>220,000</td>
<td>44.9%</td>
</tr>
<tr>
<td>2016</td>
<td>600,000</td>
<td>355,000</td>
<td>59.2%</td>
</tr>
<tr>
<td>2017</td>
<td>720,000</td>
<td>395,000</td>
<td>54.9%</td>
</tr>
<tr>
<td>Total/Average</td>
<td>$2,305,000</td>
<td>$1,229,000</td>
<td>53.3%</td>
</tr>
</tbody>
</table>

Expected and Projected Loss Ratio: 53.3%
Permissible Loss Ratio (= 100.0% - 33.3%) = 66.7%
Indicated Rate Change = -20.1%

Notes: Loss Ratio = (Incurred Losses)/(Earned Premium); -20.1% indication = 53.3%/66.7% - 1

Example of Rate Structure Change:

Assuming the book of business is equally weighted among rural dogs, rural cats, urban dogs and urban cats, the rating factors are as follows:

<table>
<thead>
<tr>
<th>Geographic Class</th>
<th>Species</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dog</td>
<td>1.000</td>
<td>2.000</td>
<td></td>
</tr>
<tr>
<td>Cat</td>
<td>0.600</td>
<td>1.200</td>
<td></td>
</tr>
</tbody>
</table>

Average rating factor = 1.200 = (25% x 1.000) + (25% x 0.600) + (25% x 2.000) + (25% x 1.200)
Average rate = $360 = ($300 base rate) x (1.200 average rating factor)
If the loss experience in the rural category is 10% better than expected and the urban experience is 25% better than expected (overall experience 20% better than expected), then the indicated rating factors would be:

<table>
<thead>
<tr>
<th>Geographic Class</th>
<th>Species</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dog</td>
<td>0.900</td>
<td>1.500</td>
<td></td>
</tr>
<tr>
<td>Cat</td>
<td>0.540</td>
<td>0.900</td>
<td></td>
</tr>
</tbody>
</table>

Average rating factor = 0.960 = (25% x 0.900) + (25% x 0.540) + (25% x 1.500) + (25% x 0.900)

The rural dog is intended to be the starting point in the rating system with a factor of 1.000, so all four factors need to be multiplied by 1.111 to rebase the starting point.

<table>
<thead>
<tr>
<th>Geographic Class</th>
<th>Species</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dog</td>
<td>1.000</td>
<td>1.667</td>
<td></td>
</tr>
<tr>
<td>Cat</td>
<td>0.600</td>
<td>1.000</td>
<td></td>
</tr>
</tbody>
</table>

Average rating factor = 1.067 = (25% x 1.000) + (25% x 0.600) + (25% x 1.667) + (25% x 1.000)

The average rate started at $360 and the experience came in 20% better than expected, so the new system should have an average rate of $288 ($360 x [100% – 20%]). Because the new rate structure has an average rating factor of 1.067, the new base rate should be $270 ($288 / 1.067).

**ANNUAL STATEMENT DATA**

Pet insurance is a health insurance policy for a pet. This is a relatively new product to the insurance market and is regulated as P/C. Pet insurance is filed within the NAIC *Financial Annual Statement on the Exhibit of Premiums and Losses* (state page) for inland marine (line 09). This is unique to P/C because the policy is not purchased to insure an animal for purely monetary reasons. Pet owners purchase this type of insurance to protect their pet’s health and help manage the cost of
veterinary bills. Coverage includes veterinary care plan insurance policies. Veterinary care plan policies provide coverage for the insured’s pet in the event of illness or accident. Insurance companies report total premium for pet insurance under inland marine insurance, which may include other coverages such as travel insurance, jewelry, and other scheduled personal property. As a result, determining the exact premium volume for a product within the inland marine line is challenging. The NAPHIA provides premiums by state in its annual *State of the Market Report* for a fee. However, the information does not provide a breakdown by company, and such information would likely require a separate data call or modification to the NAIC *Financial Annual Statement*. Modification could include a separate line item on the state page specifically for pet insurance.

Although inland marine (line 09) of the state page will account for most pet insurance data, additional data may be found under farmowners multiple peril (line 03), commercial multiple-peril (line 05), and aggregate write-ins for other lines of business (line 34). Also, depending on the type of animal insured, there could be additional categories in other inland marine areas, such as livestock (line 9.0001). Finally, homeowners policies (line 04 on the state page) may include insurance coverage if a pet causes someone injury, as in a dog bite. However, homeowners insurance covers the owner’s liability only and does not provide medical coverage for the insured’s pet. Several exclusions, including specified dog breeds, apply.

**CLAIMS PRACTICES**

According to the NAPHIA’s 2018 *State of the Industry Report*, approximately 1.83 million pets in the U.S. were covered by pet insurance, with 98% of those being accident and illness policies, earning insurers more than $1 billion in premiums. In a high frequency, low severity product line, how claims are handled has a significant impact on an insurer’s profit, as well as its ability to attract and maintain customers.

State insurance regulators have historically identified claim practice concerns through the tracking of consumer complaints. However, this information is not readily available for pet insurance for a couple of reasons. The first reason is pet insurance is not separately identified in most state complaint databases. To remedy this lack of information, states using State Based Systems (SBS) could include a separate item in the complaints section for pet insurance. The second reason for
the lack of information regarding consumer complaints tied to pet insurance could be because consumers do not know how to file claims or which entity they should report due to the use of brand names.

The NAPHIA provided complaints data representing the number of complaints reported to the state DOI for each of its member companies. The total represents the minimum number of complaints reported, as it does not include information for all companies, nor does it consider complaints filed directly with the insurer or via any method other than those filed directly with the state DOI. According to the NAPHIA, in 2017, a total of 320 complaints were filed with a DOI. This represents a 0.0174% complaint ratio (320 complaints/1.8 million policies). Without a measurable system to track all complaints specific to pet insurance, it is difficult to determine if the low complaint volume is attributable to consumer satisfaction with the products available in the market.

To supplement the data obtained from the NAPHIA, independent research into pet insurance claim practices was conducted using available online consumer review resources such as https://www.consumeradvocate.org, https://www.consumeraffairs.com, https://www.consumerreports.org and the Better Business Bureau.

Online consumer reviews found on these pages suggest that complaints against pet insurers fall into categories similar to those of other P/C lines of business: claim delay, claim denial, and partial or insufficient claim payments.

Some complaints may be attributed to the consumer’s misunderstanding of coverage and the policy terms and conditions. Restrictions, waiting periods, fee schedules, excluded preexisting, and congenital and hereditary conditions are often not obvious to the consumer until after they have a loss. Companies can serve their policyholders better by providing clear and understandable information regarding:

- Whether congenital and hereditary conditions (such as hip dysplasia, heart defects, cataracts or diabetes) are covered.
• How reimbursement is calculated (cased on the actual vet bill, a benefit schedule, or usual and customary rates).
• Whether the deductible is on a per-incident or annual basis.
• Whether there are limits or caps applied (per incident, per year, age, or over the pet’s lifetime).
• Whether there is an annual contract that determines if anything diagnosed in the prior year of coverage would be considered a preexisting condition and excluded from coverage in subsequent policy terms.
• What conditions may be considered preexisting.
• How to appeal claim denials.
• Whether the vet is paid directly by the insurance carrier or the insured must pay the vet and be reimbursed by the carrier.

A Feb. 13, 2018, NAIC Consumer Alert\(^7\) lists other critical details that a consumer should know, including, but not limited to:

• Can I choose any veterinarian?
• Does the policy cover annual wellness exams?
• Are prescriptions covered?
• Are spaying and neutering covered?
• How long does it take to pay a claim?
• Does the plan have end of life benefits?

California recognized the need for coverage disclosure. Assembly Bill No. 2056, which can be found in Appendix 2, requires insurers to disclose the basis or formula on which the insurer determines claim payments, the benefit schedule used, and the usual and customary fee limitation. Disclosures must be made within the policy and through a link on the main page of the insurer’s website.

According to the *Los Angeles Times*, a 2016 report found that 37% of all pet insurance claims were denied in California. No commensurate figure for the U.S. could be found, but one could extrapolate similar numbers. The subject of the article was a nearly $13,000 claim that was denied, appealed and denied again. It was not until the *Los Angeles Times* stepped in to do an exposé that the claim was paid.

In most cases, especially in emergency situations, the expense is incurred before the insured has an opportunity to check with the insurer regarding coverage. This is another point of contrast, with most other types of property coverage where an adjuster may conduct an appraisal before most expenses are incurred.

**REGULATORY CONCERNS**

Although pet insurance products have been around for many years, the demand for insurers willing to offer the coverage have increased. The regulatory framework and reporting requirements may be less familiar to the more recent entrants to the market. Development of a model to place all carriers on a level playing field may benefit insurers and consumers. State insurance regulators have identified several concerns that might be served by the development of a model act. Insurance regulation is in place to ensure consumer protection and includes requirements for licensure, reporting, policy procedures, marketing and sales. Market conduct activity is a concern for all insurance products, and the issues presented are not representative of the entire pet insurance industry.

In 2013, the Washington State Office of the Insurance Commissioner (OIC) began monitoring a pet insurer due to suspected use of non-licensed producers to market and sell its pet insurance products. The Washington OIC launched a targeted market conduct examination on July 15, 2014. The examination was conducted to address concerns regarding: failure to disclose the legal company name in operations; use of non-licensed producers to market and sell pet insurance; use of the brand name, implying that it is an insurance company; use of non-filed or approved policy

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forms; and offering discounts not included in approved filings.⁹ These issues are exacerbated by the use of brand names and the changing landscape of insurer to branding entity relationships.

**Market Conduct Concerns**

**Conducting Business in Legal Insurer Name**

Marketing by brand name causes confusion not only for consumers, but also for employees of the agencies, TPAs, and partners such as veterinary clinics and hospitals.

According to the *Unfair Trade Practices Act*¹⁰ (#880), “making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any insurer in the conduct of its insurance business, which is untrue, deceptive or misleading” is considered an unfair trade practice.

If consumers have difficulty identifying the underwriter, they may not know how to file a complaint with the state DOI. Branding entities may change underwriters or use multiple underwriters, making it difficult even for state insurance regulators to track the insurer with a duty to indemnify claims. Additionally, consumers may file complaints instead with the branding entity, agency or insurer directly. Review of various social media sites reveals a growing number of consumer complaints regarding claims handling and marketing practices. Due to confusion as to the direct underwriter, these complaints may never be effectively reported. Often, consumers have complaints regarding conditions or what is actually covered in the policy. The California bill addressed these issues by requiring insurers to provide certain disclosures, including the policy exclusions and claim reimbursement methods to policyholders, as well as post them on the

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insurer’s website. Without proper reporting, these issues do not get addressed with the underwriting carrier. Failure to maintain a complete record of all the complaints insurers receive since the date of its last examination is considered an unfair trade practice according to Model #880.

If a model act is drafted, it should address the disclosure of the statutory insurance company to the consumer.

**Use of Non-licensed Producers to Market and Sell Pet Insurance**

During the Washington OIC’s targeted market conduct exam, it was determined that a pet insurer used appointed agencies to market and sell its pet insurance policies. Both entities were licensed producers; although, they employed unlicensed, non-appointed call center representatives to solicit and sell policies to consumers.

Additional insurance departments have found that some pet insurance products are being marketed through unlicensed producers, including veterinarians. In some instances, veterinarians and their staff are incentivized to market specific products with potential for rewards like gift cards, products or even paid vacations. Use of non-licensed personnel for the marketing of insurance products creates a need for additional regulatory investigations and may result in insurer examination.

**Form and Filing Review and Oversight**

Pet insurance products are subject to Model #880 and filed with the state. Unfortunately, it has been found that some branding entities have marketed policy language and rates not filed with the state DOI. There are also concerns regarding premium waivers, unfiled discounts, and satisfaction guarantees made when products are sold. Some pet insurance branding entities offer discounts and/or coupons through online retail sites or flyers and business cards left in veterinarian offices, animal shelters and retail stores. Any discounts or coupons should be reported by the pet insurance carrier and filed with the state DOI.
Additionally, it has been found that pre-dispute arbitration clauses are being used in some pet insurance products. States may want to determine if that is appropriate for this personal line product.

As with many insurance products, consumers may not fully understand the products offered for sale to them. These policies can contain exclusions for coverage due to preexisting or congenital conditions. Treatment of preexisting conditions and how they are applied to the policy are of concern to state insurance regulators. Preexisting conditions should be thoroughly defined, including whether a condition found in one policy term would be excluded in future terms and if a relative condition could be excluded because it may have resulted from a preexisting condition. Coverage options may be added back through additional riders in some, but not all, instances. Plans may also have annual or lifetime limits for payment. The billing process varies by carrier and brand/agency/TPA. Consumers either must pay out of pocket and be reimbursed or billing software may be set up for the insurer to pay the veterinarian directly.

**Lack of Pet Specific Product Data**

**Premium Data**

States may have difficulty measuring growth in their individual markets without a known resource such as the NAIC annual statement because pet insurance does not have its own line. Pet insurance products are to be reported under inland marine, which incorporates several miscellaneous coverages. This makes it difficult to measure the pet insurance market specifically. Therefore, state insurance regulators may want to explore the determination of market share in a coordinated manner through the NAIC. As discussed above, this could be through a specific data call or modification to the NAIC annual financial statement.

**Complaint Data**

Complaint data may be difficult to identify for pet insurance, specifically as it is not always labeled as such in the NAIC state-based system complaint tracking database, the NAIC consumer
information source, or individual state complaint tracking resources. The lack of data regarding
complaint data, specifically for pet insurance products, could be partially remedied by the
modification to allow pet products to be easily identified in complaint databases. Additional
concerns regarding complaints due to the use of brand names are outlined above.

**Reciprocal Producer Licensing**

Some states may grant a limited lines pet insurance producer license. If these producers apply to
another state that does not have a limited lines pet insurance license, depending on the state
reciprocity rules, the producer may be granted a full lines P/C producer license, limiting the
producer to the authority provided by the resident state. For example, Idaho issues a resident
limited lines producer license for pet insurance; however, Washington does not offer this limited
line. In a reciprocal licensing approach, Washington would issue a non-resident producer P/C
license to the Idaho resident, restricting this producer to the authority granted in Idaho. It should
be noted that there is no way to reflect that this license is restricted to pet insurance, and the national
licensing database as well as the Washington website will reflect the non-resident license issued
as a P/C line of authority.

States should address with clarity the licensing obligations for the sale, solicitation and negotiation
of this product and, if applicable in the individual state, the licensing obligations for claims
adjustment. For states that permit limited line producer licenses, products will need to be filed that
align with the authority permitted by the limited license. Producers will also require monitoring to
make sure they are not selling homeowners or other products that exceed the limited line authority.

**RESOURCES**

www.naic.org/cipr_topics/topic_pet_insurance.htm

www.naic.org/documents/cmte_ex_pltf Producer Licensing_exposure_pet_insurance_
presentation.pdf

https://www.aspcapetinsurance.com/research-and-compare/pet-insurance-basics/pet-insurance-
basics/
APPENDICES

Appendix 1: Glossary of Terms

**Chronic condition** means a condition that can be treated or managed, but not cured.

**Congenital anomaly or disorder** means a condition that is present from birth, whether inherited or caused by the environment, which may cause or otherwise contribute to illness or disease.

**Hereditary disorder** means an abnormality that is genetically transmitted from parent to offspring and may cause illness or disease.

**Pet insurance** means an individual or group insurance policy that provides coverage for veterinary expenses.

**Preexisting condition** means any condition for which a veterinarian provided medical advice, the pet received treatment for, or the pet displayed signs or symptoms consistent with the stated condition prior to the effective date of a pet insurance policy or during any waiting period.

**Veterinarian** means an individual who holds a valid license to practice veterinary medicine from the Veterinary Medical Board pursuant to Chapter 11 of Division 2 of the Business and Professions Code or other appropriate licensing entity in the jurisdiction in which he or she practices.

**Veterinary expenses** means the costs associated with medical advice, diagnosis, care or treatment provided by a veterinarian, including, but not limited to, the cost of drugs prescribed by a veterinarian.

**Waiting or affiliation period** means the period of time specified in a pet insurance policy that is required to transpire before some or all of the coverage in the policy can begin.

Source: California Assembly Bill No. 2056, Chapter 896.
Appendix 2: California Assembly Bill No. 2056, Chapter 896

An act to add Part 9 (commencing with Section 12880) to Division 2 of, the Insurance Code, relating to insurance.

[Approved by Governor September 30, 2014. Filed with Secretary of State September 30, 2014.]

legislative counsel’s digest
AB 2056, Dababneh. Insurance: pet insurance.

Existing law governs the business of insurance and authorizes the Insurance Commissioner to provide oversight over the insurance industry including, life and disability insurance, health insurance, workers’ compensation, and liability insurance. The commissioner is authorized to, among other things, conduct investigations and bring enforcement actions against insurers for violations of the laws governing the business of insurance.

This bill would regulate pet insurance policies that are marketed, issued, amended, renewed, or delivered, whether in California, to a California resident, on or after July 1, 2015, regardless of the situs of the contract or master group policyholder, or the jurisdiction in which the contract was issued or delivered. The bill would define certain terms and specify certain disclosures a pet insurer is required to make to consumers. The bill would also require an insurer transacting pet insurance in this state to disclose, among other things, whether the policy excludes coverage because of a preexisting condition, a hereditary disorder, a congenital anomaly, or a chronic condition, and would require that pet insurance policies have a free look cancellation period of not less than 30 days, as provided.

This bill would authorize the commissioner to hold a hearing to determine if an insurer is in violation of the provisions governing pet insurance and to assess a civil penalty, which is to be determined by the commissioner but not to exceed $5,000 for each violation, or $10,000 for a willful violation. The hearing would be required to be conducted pursuant to the Administrative Procedure Act, except as specified, and a person found to be in violation may have the proceedings reviewed by means of any remedy pursuant to a specified statute or the Administrative Procedure Act. The bill would authorize the commissioner to adopt reasonable rules and regulations, as necessary, in accordance with the Administrative Procedure Act in order to implement these requirements.
The people of the State of California do enact as follows:

SECTION 1. Part 9 (commencing with Section 12880) is added to Division 2 of the Insurance Code, to read:

PART 9. PET INSURANCE

12880. For purposes of this part, the following definitions shall apply:

(a) “Chronic condition” means a condition that can be treated or managed, but not cured.
(b) “Congenital anomaly or disorder” means a condition that is present from birth, whether inherited or caused by the environment, which may cause or otherwise contribute to illness or disease.
(c) “Hereditary disorder” means an abnormality that is genetically transmitted from parent to offspring and may cause illness or disease.
(d) “Pet insurance” means an individual or group insurance policy that provides coverage for veterinary expenses.
(e) “Preexisting condition” means any condition for which a veterinarian provided medical advice, the pet received treatment for, or the pet displayed signs or symptoms consistent with the stated condition prior to the effective date of a pet insurance policy or during any waiting period.
(f) “Veterinarian” means an individual who holds a valid license to practice veterinary medicine from the Veterinary Medical Board pursuant to Chapter 11 (commencing with Section 4800) of Division 2 of the Business and Professions Code or other appropriate licensing entity in the jurisdiction in which he or she practices.
(g) “Veterinary expenses” means the costs associated with medical advice, diagnosis, care, or treatment provided by a veterinarian, including, but not limited to, the cost of drugs prescribed by a veterinarian.
(h) “Waiting or affiliation period” means the period of time specified in a pet insurance policy that is required to transpire before some or all of the coverage in the policy can begin.

12880.1. A policy of pet insurance that is marketed, issued, amended, renewed, or delivered, whether or not in California, to a California resident, on or after July 1, 2015, regardless of the situs of the contract or master group policyholder, or the jurisdiction in which the contract was issued or delivered, is subject to this part.

12880.2. (a) An insurer transacting pet insurance in California shall disclose all of the following to consumers:

(1) If the policy excludes coverage due to any of the following:

(A) A preexisting condition.
(B) A hereditary disorder.
(C) A congenital anomaly or disorder.
(D) A chronic condition.
(2) If the policy includes any other exclusion, the following statement: “Other exclusions may apply. Please refer to the exclusions section of the policy for more information.”

(3) Any policy provision that limits coverage through a waiting or affiliation period, a deductible, coinsurance, or an annual or lifetime policy limit.

(4) Whether the insurer reduces coverage or increases premiums based on the insured’s claim history.

(b) (1) If a pet insurer uses any of the terms in paragraph (1) of subdivision (a) in a policy of pet insurance, the insurer shall use the definition of those terms as set forth in Section 12880 and include the definition of the term in the policy. The pet insurer shall also make that definition available through a link on the main page of the insurer’s Internet Web site.

(2) Nothing in this subdivision or Section 12880 in any way prohibits or limits the types of exclusions pet insurers may use in their policies, nor does it require pet insurers to have any of the limitations or exclusions defined in Section 12880.

(c) A pet insurer shall clearly disclose a summary description of the basis or formula on which the insurer determines claim payments under a pet insurance policy within the policy and through a link on the main page of the insurer’s Internet Web site.

(d) A pet insurer that uses a benefit schedule to determine claim payment under a pet insurance policy shall do both of the following:

   (1) Clearly disclose the applicable benefit schedule in the policy.

   (2) Disclose all benefit schedules used by the insurer under its pet insurance policies through a link on the main page of the insurer’s Internet Web site.

(e) A pet insurer that determines claim payments under a pet insurance policy based on usual and customary fees, or any other reimbursement limitation based on prevailing veterinary service provider charges, shall do both of the following:

   (1) Include a usual and customary fee limitation provision in the policy that clearly describes the insurer’s basis for determining usual and customary fees and how that basis is applied in calculating claim payments.

   (2) Disclose the insurer’s basis for determining usual and customary fees through a link on the main page of the insurer’s Internet Web site.

(f) The insurer shall create a summary of all policy provisions required in subdivisions (a) through (e), inclusive, into a separate document titled “Insurer Disclosure of Important Policy Provisions.”

(g) The insurer shall post the “Insurer Disclosure of Important Policy Provisions” document required in subdivision (f) through a link on the main page of the insurer’s Internet Web site.
(h) (1) In connection with the issuance of a new pet insurance policy, the insurer shall provide the consumer with a copy of the “Insurer Disclosure of Important Policy Provisions” document required pursuant to subdivision (f) in at least 12-point type when it delivers the policy.

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(2) In addition, the pet insurance policy shall have clearly printed thereon or attached thereto a notice stating that, after receipt of the policy by the owner, the policy may be returned by the insured for cancellation by delivering it or mailing it to the insurer or to the agent through whom it was purchased.

(A) The period of time set forth by the insurer for return of the policy shall be clearly stated on the notice, and this free look period shall be not less than 30 days. The insured may return the policy to the insurer or the agent through whom the policy was purchased at any time during the free look period specified in the notice.

(B) The delivery or mailing of the policy by the insured pursuant to this paragraph shall void the policy from the beginning, and the parties shall be in the same position as if a policy or contract had not been issued.

(C) All premiums paid and any policy fee paid for the policy shall be refunded to the insured within 30 days from the date that the insurer is notified of the cancellation. However, if the insurer has paid any claim, or has advised the insured in writing that a claim will be paid, the 30-day free look right pursuant to this paragraph is inapplicable and instead the policy provisions relating to cancellation apply to any refund.

(i) The disclosures required in this section shall be in addition to any other disclosure requirements required by law or regulation.

12880.3. (a) A person who violates a provision of this part is liable to the state for a civil penalty to be determined by the commissioner, not to exceed five thousand dollars ($5,000) for each violation, or, if the violation was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each violation. The commissioner may establish the acts that constitute a distinct violation for purposes of this section. However, when the issuance, amendment, or servicing of a policy or endorsement is inadvertent, all of those acts constitute a single violation for purposes of this section.

(b) The penalty imposed by this section shall be imposed by and determined by the commissioner pursuant to Section 12880.4. The penalty imposed by this section is appealable by means of any remedy provided by Section 12940 or by Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

12880.4. (a) Whenever the commissioner shall have reason to believe that a person has engaged or is engaging in this state in a violation of this article, and that a proceeding by the commissioner in respect thereto would be to the interest of the public, he or she shall issue and serve upon that person an order to show cause containing a statement of the charges in that respect, a statement of that person’s potential liability under this part, and a notice of a hearing thereon to be held at a time and place fixed therein, which shall not be less than 30 days after the service thereof, for the purpose of determining whether the commissioner should issue an order to that person to pay the penalty imposed by Section 12880.3 and to cease and desist those methods, acts, or practices, or any of them, that violate this article.
(b) If the charges or any of them are found to be justified, the commissioner shall issue and cause to be served upon that person an order requiring that person to pay the penalty imposed by Section 12880.3 and to cease and desist from engaging in those methods, acts, or practices found to be in violation of this part.

(c) The hearing shall be conducted in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), except that the hearings may be conducted by an administrative law judge in the administrative law bureau when the proceedings involve a common question of law or fact with another proceeding arising under other Insurance Code sections that may be conducted by administrative law bureau administrative law judges. The commissioner and the appointed administrative law judge shall have all the powers granted under the Administrative Procedure Act.

(d) The person shall be entitled to have the proceedings and the order reviewed by means of any remedy provided by Section 12940 or by the Administrative Procedure Act.

12880.5. The commissioner may adopt reasonable rules and regulations, as are necessary to administer this part, in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

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Appendix 3: Overview of Actuarial Science

Considering the ratemaking discussion in this paper, a few words about actuarial science may be helpful.

Actuarial science is the discipline that applies mathematical and statistical methods to evaluate risk in insurance and other business endeavors. Actuaries are professionals who become experts in their field based upon years of education and experience.

Many universities have undergraduate and graduate degree programs in actuarial science. The actuarial profession is well-known for its rigorous professional examinations which must be passed to be recognized as a Fellow of the Society of Actuaries (FSA) or Fellow of the Casualty Actuarial Society (FCAS).

Actuarial science represents several interesting fields, including mathematics, probability theory, statistics, accounting, finance, economics, information technology, law and insurance. In the U.S., there are several actuarial societies serving various functions:

- The Society of Actuaries (SOA)
- The CAS
- The American Academy of Actuaries (Academy)
- The ASB (part of the AAA)

In the P/C insurance company arena, the most common functions that an actuary serves are ratemaking (also known as pricing) and loss reserving. Ratemaking represents the estimation of future costs, and thereby needed premium, for future policies; loss reserving represents the estimation of future claims payments for policies already written by the insurance entity. Such future claims payments represent an important liability for the insurer and also play an important role in the ratemaking process because future costs are estimated based on past costs along with inflation and other adjustments.
Most P/C actuaries work for an insurance company or reinsurance company; some work for a consulting or brokerage firm; and others work for a state DOI, a college or university, a rating bureau, a modeling firm, or other type of entity.
PROJECT HISTORY

A REGULATOR’S GUIDE TO PET INSURANCE

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

In December 2016, an insurer in the pet health insurance (pet insurance) industry voiced concerns to the Producer Licensing (D) Task Force regarding the use of limited lines licensing for pet insurance. The insurer recommended that pet insurance be removed from the State Licensing Handbook Uniform Licensing Standard (ULS) #37 as a limited line. It was the insurer’s opinion that a full property/casualty (P/C) line should be required to sell, solicit or negotiate pet insurance. Reasons cited include: 1) tremendous growth in the pet insurance market; 2) policy premiums that far exceed the cost of the covered item—i.e., the pet; and 3) complex policies with multiple coverage options and exclusions. Traditionally, limited lines products are designed to be incidental to the sale of another product which, according to the insurer, is not the case with pet insurance. The Task Force decided that it needed to better understand the complexities of pet insurance before offering guidance regarding the type of producer license required to sell the product. As a result, the Task Force made a referral to the Property and Casualty Insurance (C) Committee to draft a comprehensive white paper providing information on coverage options, product approval, marketing, ratemaking, claims practices and regulatory concerns.

During the 2018 Spring National Meeting, the Property and Casualty Insurance (C) Committee formed a drafting group to develop a white paper to provide an overview of the pet insurance industry. Pursuant to the charge “to consider the development of a white paper reviewing the coverage options, product approval, marketing, rating, and claims practices related to pet insurance,” the white paper provides context regarding the origination of pet insurance and identifies recent market growth, industry practices, coverage options, the current regulatory environment, claims history and regulatory concerns.

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

A drafting group, formed under the Property and Casualty Insurance (C) Committee, made up of the following state insurance regulators worked on the draft A Regulator’s Guide to Pet Insurance: California, Colorado, Kansas, Louisiana, Maryland, Massachusetts, New Hampshire, Ohio, Rhode Island and Washington.

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

During a conference call held on Nov. 9, 2017, the Property and Casualty Insurance (C) Committee adopted a charge based on a referral from the Producer Licensing (D) Task Force, “to consider the development of a white paper reviewing the coverage options, product approval, marketing, rating and claims practices related to pet insurance.” During the 2018 Spring National Meeting, the Property and Casualty Insurance (C) Committee formed a drafting group to develop the white paper.

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.

Drafting group conference calls were open to all state insurance regulators and interested parties opting to participate. Drafting commenced April 25, 2018, with monthly calls through September and bi-weekly calls through October. The drafting states were California, Colorado, Kansas, Louisiana, Maryland, Massachusetts, New Hampshire, Ohio, Rhode Island and Washington. The following interested parties were also involved throughout the drafting process: North American Pet Health Insurance Association (NAPHIA), American Insurance Association (AIA), Crum & Forster, Chubb, Allianz, State National, Nationwide, Locke Lord, Trupanion, Fairfax, INS Companies, Westmont Associates, Polsinelli, and NAIC funded consumer representatives Birny Birnbaum (Center for Economic Justice—CEJ) and Brenda J. Cude (University of Georgia).

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)

Several drafts of the white paper were exposed to the drafting group between April and October 2018. Interested parties and interested state insurance regulators provided content and comments on the white paper throughout that time. The Property and Casualty Insurance (C) Committee exposed the white paper for comment at the 2018 Fall National Meeting. Comments were collected through Dec. 21, 2018. Four comment letters were received. The white paper was revised based on the comments received and adopted by the Property and Casualty Insurance (C) Committee during its March 28, 2019, conference call.

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

Through the development of the white paper, the drafting group identified deficiencies in credible, un-biased data sources relative to premiums, losses and claims specific to pet insurance. Massachusetts, along with other states, suggested that the NAIC add pet insurance as a separate line of business in the annual financial statement. As noted in the white paper, pet insurance is currently included under inland marine (line 09). Alternatively, data specific to pet insurance could be collected through a separate property supplement, as was done with the cybersecurity insurance coverage supplement. Either change to the NAIC annual financial statement would require a proposal to the Blanks (E) Working Group.

Claims information specific to pet insurance is included in the white paper; however, no data sources were found that could be verified by state insurance regulators. Several state insurance regulators suggested that NAIC systems be modified to collect claims specific to pet insurance.

As noted above, comments were collected throughout the drafting process. As appropriate, comments received were integrated into the white paper. Several interested parties offered suggestions for the licensing of pet insurance producers and/or adjusters. While these comments were helpful to facilitate the discussion, they were not integrated into the white paper as it was determined that a final recommendation was outside the scope of the charge. One carrier recommended the ULS be revised to eliminate pet insurance as an example of a non-core limited line for producers. Another carrier expressed support for pet insurance to be licensed as a non-core limited line for producers. A third carrier voiced concern regarding the licensure of adjusters and the need for animal health science knowledge and technical training not customary for a traditional P/C adjuster. The arguments for each perspective were included in the white paper for state insurance regulator’s consideration, but no final recommendation was made, as that was determined to be outside of the scope of the white paper.

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

During the March 28, 2019, conference call of the Property and Casualty Insurance (C) Committee, the Committee’s chair, Superintendent Elizabeth Kelleher Dwyer (RI), appointed a Pet Insurance (C) Working Group to review the white paper and consider drafting a model law in order to address regulatory issues related to pet insurance.

W:\National Meetings\2019\Summer\Plenary\Att 11 PetInsWP_PH.pdf
# Property & Casualty Market Conduct Annual Statement

## Private Flood Data Call & Definitions

*Adopted by the Market Conduct Annual Statement Blanks (D) Working Group – May 2, 2019*

*Adopted by the Market Regulation and Consumer Affairs (D) Committee – July 9, 2019*

**Line of Business:** Private Flood  
**Reporting Period:** January 1, 20XX through December 31, 20XX  
**Filing Deadline:** April 30, 20XX

## Contact Information

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
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<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

Provide an answer for each of the six product types, unless otherwise instructed.

<table>
<thead>
<tr>
<th>Question</th>
<th>Stand-alone policies</th>
<th>Endorsement to a Homeowners Policy</th>
<th>Endorsement to a Property Policy Other Than Homeowners</th>
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<tbody>
<tr>
<td></td>
<td>First Dollar Coverage</td>
<td>Excess Coverage</td>
<td>First Dollar Coverage</td>
</tr>
<tr>
<td>1. Does the reporting company write private flood policies or endorsements? (Y/N)</td>
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<tr>
<td>2. Were private flood policies or endorsements in force during the reporting period? (Y/N)</td>
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<td>3. In which annual statement lines of business on the state page of the statutory annual statement does the company report private flood experience?</td>
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<td>4.</td>
<td>Were there private flood policies or endorsements in-force during the reporting period that provided Personal Property coverage? (Y/N)</td>
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<tr>
<td>5.</td>
<td>Were there private flood policies or endorsements in-force during the reporting period that provided Loss of Use coverage? (Y/N)</td>
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<tr>
<td>6.</td>
<td>Was the Company still actively writing private flood coverage in the state at year end? (Y/N)</td>
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<tr>
<td>7.</td>
<td>Has the company had a significant event/business strategy that would affect data for this reporting period? Y/N (If yes, please explain in the appropriate column of interrogatory 7A)</td>
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<tr>
<td>7A</td>
<td>Explanation for Interrogatory 7</td>
<td></td>
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<tr>
<td>8.</td>
<td>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, please explain in the appropriate column of interrogatory 8A)</td>
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<tr>
<td>8A.</td>
<td>Explanation for Interrogatory 8</td>
<td></td>
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<tr>
<td>9.</td>
<td>How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original claim/open new claim. If re-open original claim, report 1. If open new claim, report 2. If other, report 3.</td>
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</tbody>
</table>
Property & Casualty Market Conduct Annual Statement
Private Flood Data Call & Definitions

10. Does the number of policies or endorsements in force at the beginning of the reporting period in this report match the number of policies or endorsements in force at the end of the reporting period for the first prior year report? (Y/N) If you answered No in one or more of the product types, please answer interrogatories 10a, 10b and 10c for the relevant product type.

10(a) Number of policies or endorsements in force at end of reporting period in the first prior year report.

10(b) The value of the number of policies or endorsements in force at the beginning of the reporting period in this report minus the number of policies or endorsements in force at the end of the reporting period for the first prior year report.

10(c) The reason for the difference.

11. Claims Comments

12. Underwriting Comments

Private Flood Claims Activity

<table>
<thead>
<tr>
<th>Description</th>
<th>Stand-alone policies</th>
<th>Endorsement to a Homeowners Policy</th>
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<td>Excess Coverage</td>
<td>First Dollar Coverage</td>
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<td>State Indicator (State for which data is being submitted)</td>
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<td>NAIC Company Code</td>
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<tr>
<td>Description</td>
<td>First Dollar Coverage</td>
<td>Excess Coverage</td>
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<td>Endorsement to a Property Policy Other Than Homeowners</td>
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<tr>
<td>Stand-alone policies</td>
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<tr>
<td>NAIC Group Code Automatically loaded</td>
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<td>Coverage Identifier Automatically loaded</td>
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<tr>
<td>1. Number of claims open at the beginning of the period</td>
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<td>2. Number of claims opened during the period with payment</td>
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<td>3. Number of claims closed during the period, without payment</td>
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<td>4. Number of claims closed at the end of the period</td>
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<td>5. Median days to final payment</td>
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<td>6. Number of claims closed with payment within 0-30 days</td>
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<td>7. Number of claims closed with payment within 31-60 days</td>
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<td>8. Number of claims closed with payment within 61-90 days</td>
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<td>9. Number of claims closed with payment within 91-180 days</td>
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<tr>
<td>10. Number of claims closed with payment within 181-365 days</td>
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## Property & Casualty Market Conduct Annual Statement
### Private Flood Data Call & Definitions

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<td>First Dollar Coverage</td>
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<td>First Dollar Coverage</td>
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<tr>
<td>12. Number of claims closed with payment beyond 365 days</td>
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<td>13. Number of claims closed without payment within 0-30 days</td>
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<td>14. Number of claims closed without payment within 31-60 days</td>
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<td>15. Number of claims closed without payment within 61-90 days</td>
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<td>16. Number of claims closed without payment within 91-180 days</td>
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<td>17. Number of claims closed without payment within 181-365 days</td>
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<td>18. Number of claims closed without payment beyond 365 days</td>
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## Property & Casualty Market Conduct Annual Statement

### Private Flood Data Call & Definitions

#### Private Flood Underwriting

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<td>Automatically loaded</td>
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<tr>
<td>NAIC Group Code</td>
<td>Automatically loaded</td>
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</table>

1. Number of private flood policies or endorsements in force at the beginning of the reporting period?

2. Number of private flood policies or endorsements written during the reporting period?

3. Number of private flood policies or endorsements in force at the end of the reporting period?

4. Dollar amount of direct premium written during the reporting period for private flood policies or endorsements.

5. Number of Company-Initiated non-renewals during the period for private flood policies.

6. Number of cancellations for non-pay or insufficient funds for private flood policies or endorsements.

7. Number of cancellations at the insured’s request for private flood policies or endorsements.
## Property & Casualty Market Conduct Annual Statement
### Private Flood Data Call & Definitions

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<tr>
<td>8.</td>
<td><strong>Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company for private flood policies or endorsements.</strong></td>
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<td>9.</td>
<td><strong>Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company for private flood policies or endorsements.</strong></td>
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<tr>
<td>10.</td>
<td><strong>Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company for flood policies or endorsements.</strong></td>
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### Private Flood Lawsuits and Complaints

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<tbody>
<tr>
<td><strong>Number of lawsuits open at beginning of the period</strong></td>
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<td><strong>Number of lawsuits opened during the period</strong></td>
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<tr>
<td><strong>Number of lawsuits closed during the period</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of lawsuits closed during the period with consideration for the consumer</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of lawsuits open at end of period</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number Of Complaints Received Directly From Any Person or Entity Other than the DOI</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Definitions:

Private Flood Insurance – Coverage that insures residential property against the peril of flood.

Include:
- Mobile/manufactured homes intended for use as a dwelling.
- Individual unit condo coverage
- Stand-alone policies
- Endorsements or riders to residential property insurance policies
- First dollar and excess policies

Exclude:
- NFIP policies
- Commercial policies
- Condo master policies
- Lender-placed or creditor-placed policies.
- Private flood written on a surplus lines basis

Report experience for Private Flood regardless of whether the coverage is provided as a stand-alone policy or endorsement or rider to another residential property insurance policy and regardless of the line of business in the statutory annual statement in which the experience is reported and regardless of whether the coverage is first dollar or excess.

Cancellations – Includes all cancellations of the policies where the cancellation effective date is during the reporting year. The number of cancellations should be reported on a policy basis regardless of the number of dwellings insured under the policy.

Report cancellations separately for:
- Policies cancelled for non-payment of premium or non-sufficient funds.
  - These should be reported every time a policy cancels for the above reasons. (i.e., if a policy cancels for non-pay three times in a policy period, and is reinstated each time; each cancellation should be counted.)
- Policies cancelled at the insured’s request.
- Policies cancelled for underwriting reasons.

Exclude:
- Policies cancelled for ‘re-write’ purposes where there is no lapse in coverage.

Cancellations within the first 59 days – Company-initiated cancellations for new business where the notice of cancellation was issued within the first 59 days after the original effective date of the policy.
- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ‘underwriting’ period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Cancellations from 60 to 90 days – Company-initiated cancellations where the notice of cancellation was issued 60 to 90 days after the original effective date of the policy.
- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ‘underwriting’ period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.
Cancellations greater than 90 days – Company-initiated cancellations where the notice of cancellation was issued more than 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ‘underwriting’ period for new business.

The notice of cancellation is the date the cancellation notice was mailed to the insured.

Claim - A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy or endorsement. Each insured reporting a loss is counted separately. Each reserve opened is counted separately; a single event may result in multiple private flood claims if there are multiple coverages provided in the policy or endorsement.

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”.

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.

Clarification:
- 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 closed 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 that supplemental payment from the time the request for supplemental payment was received to the date of the final payment was made.

Claims Closed Without Payment – Claims closed with no payment made to an insured. 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 even though payment was made for company loss adjustment expenses.
- A demand for payment for which it was determined that no relevant policy 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.

Calculation Clarification:
• For each coverage identifier, the sum of the claims closed without payment across each closing time interval should equal the total number of claims closed without payment during the reporting period.

Complaint – 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.

Include:
• Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
• Complaints received from third parties.

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 date was made during the reporting period regardless of the date of loss or when the claims 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 loss to either the company or insurance agent.

Direct Written Premium - The total amount of direct written premium for all polices covered by the market conduct annual statement (new and renewal) written during the reporting period.

Calculation Clarification:
• Premium amounts should be determined in the same manner as used for the financial annual statement state page exhibit.
• If premium is refunded or additional premium is written during the reporting period (regardless of the applicable policy effective date), the net effect should be reported.
• If there is a difference of 20% or more between the Direct Written Premium for stand-alone private flood reported for market conduct annual statement and the Direct Written Premium reported on the financial annual statement state page exhibit line 2.5, provide an explanation for the difference when filing the market conduct annual statement in order to avoid inquiries from the regulator receiving the market conduct annual statement filing.
• Reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor, shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

Endorsement to a Homeowners Policy - means the offer of private flood through an addition to a homeowners policy through endorsement, rider, amendment or any other means.
Endorsement to a Property Insurance Policy Other Than Homeowners - means the offer of private flood through an addition to a property insurance policy other than a homeowners policy through endorsement, rider, amendment or any other means.

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 lawsuit 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 members reside. 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.

Median Days to Final Payment – The median value for all claims closed with payment during the period.

Calculation for losses with one final payment date during the reporting period:
- Date the loss was reported to the company to the date of final payment.

Calculation for losses with multiple final payment dates during the reporting period:
- Date the request for supplemental payment 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 loss 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>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>Days to Settle</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</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>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>Days to Settle</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

Median Days to Final Payment = \( \frac{5 + 6}{2} = 5.5 \)

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>Time Interval</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.

**New Business Policy Written** – A newly written agreement that puts insurance coverage into effect during the reporting period.

Exclude:
- ‘Re-written’ policies unless there was a lapse in coverage.

**Non-Renewals** – A policy for which the insurer elected not to renew the coverage for circumstances allowed under the “non-renewal” clause of the policy.

Include:
- All company-initiated non-renewals of the policies where the non-renewal effective date is during the reporting period.
Exclude:
- Policies where a renewal offer was made and the policyholder did not accept the offer.
- Instances where the policyholder requested that the policy not be renewed.

Calculation Clarification:
- The number of nonrenewals should be reported on a policy basis regardless of the number of dwellings insured under the policy.

Policies or Endorsements In-Force - Coverage, through the relevant policy or endorsement, was in effect at some point in time during the specified time frame. Time frames used in this MCAS include at the end of the prior reporting period, at the beginning of the current reporting period, at any point during the current reporting period and at the end of the current reporting period.

Stand-alone private flood: Private flood insurance provided through a policy providing only coverage for the peril of flood.
Introduction

The intent of (Section in Chapter 24 of the Market Regulation Handbook TBD)—Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination in the Market Regulation Handbook is primarily to provide guidance when reviewing insurers whose business includes major medical policies offering mental health and/or substance use disorder coverage.

The examination standards in Chapter 24—Conducting the Health Examination of the Market Regulation Handbook provide guidance specific to all health insurers, but large group coverage may or may not include mental health and/or substance use disorder coverage. (Section in Chapter 24 of the Market Regulation Handbook TBD) strictly applies to examinations to determine compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) found at 42 U.S.C 300gg-26 and its implementing regulations found at 45 CFR §146.136 and 45 CFR §147.160, and is to be used for plans that offer mental health and/or substance use disorder benefits.

Generally, MHPAEA regulations require that any financial requirement (FR) (e.g. copayments, deductibles, coinsurance, or out-of-pocket maximums) or quantitative treatment limitation (QTL) (e.g., day or visit limits) imposed on mental health and substance use disorder (MH/SUD) benefits not be more restrictive than the predominant financial requirement or treatment limitation of that type that applies to substantially all medical and surgical benefits, on a classification-by-classification basis, as discussed below. With regard to any nonquantitative treatment limitation (NQTL) (e.g., preauthorization requirements, fail-first requirements), MHPAEA regulations prohibit imposing an NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical (M/S) benefits in the same classification.

MHPAEA applies to major medical group and individual health insurance. Mental health and substance use disorder treatment are essential health benefits under the Patient Protection and Affordable Care Act, so examination of individual and small group ACA-compliant plans will include parity analysis. In the large group market, an insurer’s plan is not required to cover mental health and/or substance use disorder services. If the insurer’s large group plan does cover mental health and/or substance use disorder services, parity requirements apply. MHPAEA does not apply to excepted benefit plans, nor to short-term limited duration insurance. Some states may have mental health parity requirements that are stricter than federal requirements.

Federal law relies on state insurance regulators as the first-line enforcers of health reform provisions in the individual, small group, and large group insurance markets.

Examination Standards

Each examination standard includes a citation to MHPAEA or its implementing regulations, but additional information can be found in federal guidance documents and state law or state interpretation of federal law. Please note that the federal government periodically updates its guidance documents related to MHPAEA. Examiners should refer to the U.S. Departments of Labor, Health and Human Services, and the Treasury for any updates or new MHPAEA guidance. MHPAEA allows states to enact statutes or regulations that are stricter than federal requirements. Examiners should contact their state’s legal division for assistance and interpretation of federal guidance, as well as any additional state requirements. Where there is a reasonable interpretation of MHPAEA, that reasonable interpretation should be given due consideration.

Collaboration Methodology

The development of state market conduct compliance tools for MHPAEA will result in enhanced state collaboration, to provide more consistent interpretation and review of parity standards.
LIST OF QUESTIONS

Question 1.
Is this insurance coverage exempt from MHPAEA (45 CFR §146.136(f))? If so, please indicate the reason (e.g., retiree-only plan, excepted benefits (45 CFR §146.145(b)), short term, limited duration insurance,* small employer exemption (45 CFR §146.136(f)), increased cost exemption (45 CFR §146.136(g)).

*Under the Public Health Services Act (as added by HIPAA), short term limited duration insurance is excluded from the definition of individual health insurance coverage (45 CFR §144.103).

Question 2.
If not exempt, does the insurance coverage provide MH and/or SUD benefits in addition to providing M/S benefits?

Unless the insurance coverage is exempt or does not provide MH/SUD benefits (note that MH/SUD is one of the EHBs for non-grandfathered coverage in the individual and small group markets), continue to the following sections to examine compliance with requirements under MHPAEA.

Question 3.
Are all conditions that are defined as being or as not being a mental health condition, a substance use disorder or a medical condition defined in a manner that is consistent with generally recognized independent standards of current medical practice?

See 45 CFR §146.136(a). This section provides definition of “mental health benefits” and “substance use disorder benefits”.

Question 4.
Does the insurance coverage provide MH/SUD benefits in every classification in which M/S benefits are provided?

Under the MHPAEA regulations, the six classifications of benefits are:
1) inpatient, in-network;
2) inpatient, out-of-network;
3) outpatient, in-network;
4) outpatient, out-of-network;
5) emergency care; and
6) prescription drugs.

See 45 CFR §146.136(c)(2)(ii).

Because parity analysis for this standard is at the classification level, data must be collected for each classification. An example data collection tool is provided, which collects information needed to answer this question.

Question 5.
If the plan includes multiple tiers in its prescription drug formulary, are the tier classifications based on reasonable factors (such as cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up) determined in accordance with the rules for NQTLs at 45 CFR §146.136(c)(4)(i), and without regard to whether the drug is generally prescribed for MH/SUD or M/S benefits? Explain how the plan’s tiering methodology for MH/SUD prescription drugs is comparable to and are applied no more stringently than the tiering methodology for M/S prescription drugs.

See 45 CFR §146.136(c)(3)(iii)(A).

Question 6.
If the plan includes multiple network tiers of in-network providers, is the tiering based on reasonable factors (such as quality, performance, and market standards) determined in accordance with the rules for NQTLs at 45 CFR §146.136(c)(4)(i), and without regard to whether a provider provides services with respect to MH/SUD benefits or M/S benefits? Explain how the plan’s tiering methodology for MH/SUD network tiers are comparable to and are applied no more stringently than the tiering methodology for M/S network tiers.

See 45 CFR §146.136(c)(3)(iii)(B).
Question 7.
Does the plan comply with the parity requirements for aggregate lifetime and annual dollar limits, including the prohibition on lifetime dollar limits or annual dollar limits for MH/SUD benefits that are lower than the lifetime or annual dollar limits imposed on M/S benefits? List the services subject to lifetime or annual limits, separated into MH/SUD and M/S benefits.

See 45 CFR §146.136(b). This prohibition applies only to dollar limits on what the plan would pay, and not to dollar limits on what an individual may be charged. If a plan or issuer does not include an aggregate lifetime or annual dollar limit on any M/S benefits, or it includes one that applies to less than one-third of all M/S benefits, it may not impose an aggregate lifetime or annual dollar limit on MH/SUD benefits. 45 CFR §146.136(b)(2). Also note that the parity requirements regarding lifetime and annual dollar limits only apply to the provision of MH/SUD benefits that are not EHBs because lifetime limits and annual dollar limits are prohibited for EHBs, including MH/SUD services.

Question 8.
Does the plan impose any financial requirements (e.g., deductibles, copayments, coinsurance, and out-of-pocket maximums) or quantitative treatment limitations (e.g., annual, episode, and lifetime day and visit limits) on MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type that applies to substantially all M/S benefits in the same classification? Demonstrate compliance with this standard by completing the attached data collection tool.

See 45 CFR §146.136(c)(2). Because parity analysis is at the classification level and analysis is based on the dollar amount for expected benefits paid, data must be collected per classification. An example data collection tool is provided, which collects information needed to answer this question.

Financial Requirements (FRs) include deductibles, copayments, coinsurance, and out-of-pocket maximums. 45 CFR §146.136(c)(1)(ii). Quantitative Treatment Limitations (QTLs) include annual, episode, and lifetime day and visit limits, such as number of treatments, visits, or days of coverage. 45 CFR §146.136(c)(1)(ii).

If a plan includes a FR (copayment or coinsurance) or QTL (session or day limit) for MH/SUD benefits, the first step is to identify the comparison point by looking at M/S benefits for that classification. Determine whether the FR or QTL applies to at least two-thirds (“substantially all”) of the M/S benefits in that classification. For purposes of determining whether a type of FR or QTL applies to at least two-thirds of all M/S benefits in a classification, the FR or QTL is considered to apply regardless of the magnitude or level of that type of FR or QTL. For example, a copayment, coinsurance, session or day limit is considered to apply to the benefits regardless of the dollar amount, coinsurance percentage, or number of sessions or days for that type of FR or QTL. The portion of M/S benefits subject to the FR or QTL is based on the dollar amount of expected payments for M/S benefits in a year. If the type of FR or QTL applies to less than two-thirds of the M/S benefits in a classification, then that type of FR or QTL cannot be applied to MH/SUD benefits in that classification. If the type of FR or QTL applies to two-thirds or more of the M/S benefits in the classification, as determined under 45 CFR §146.136(c)(3)(i)(A), the examiner will go to the next step to look at the level of the FR or QTL, for example the specific copayment dollar amount, coinsurance percentage, or limitation on number of sessions or days.

If the type of FR or QTL is imposed on at least two-thirds of the M/S benefits in a classification, then the “level” (e.g., copayment dollar amount, coinsurance percentage, or limitation on number of days or sessions) is analyzed to determine the “predominant” level. In this second step, the examiner will look at the M/S benefits to which the FR or QTL applies and find the “predominant” level of the limitation—this means the specific dollar amount, coinsurance percentage, or limitation on number of sessions or days that applies to more than 50% of the M/S benefits in that classification subject to the FR or QTL. The FR or QTL imposed on MH/SUD benefits cannot be more restrictive than the predominant level.

If less than 50% of the M/S benefits that are subject to the FR or QTL in a classification are subject to a certain “level” of FR or QTL, levels of the FR or QTL can be combined to reach 50% of the M/S benefits in the classification, with the least restrictive level within the combination being the level that can be applied to MH/SUD benefits in the classification.
Question 9.
Does the plan apply any cumulative financial requirement or cumulative QTL for MH/SUD benefits in a classification that accumulates separately from any cumulative financial requirement or QTL established for M/S benefits in the same classification? Demonstrate compliance with this standard by completing the attached data collection tool.

See 45 CFR §146.136(c)(3)(v). For example, a plan may not impose an annual $250 deductible on M/S benefits in a classification and a separate $250 deductible on MH/SUD benefits in the same classification. Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums (but do not include aggregate lifetime or annual dollar limits because those two terms are excluded from the meaning of financial requirements). 45 CFR §146.136(a).

Cumulative financial requirements and treatment limitations are also subject to the predominant and substantially all tests in Question 7.

Question 10.
Does the plan impose Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD benefits in any classification? If so, demonstrate compliance with parity requirements by completing the attached data collection tool.

Examples of NQTLs (not exclusive):
   a) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
   b) Prior authorization and ongoing authorization requirements;
   c) Concurrent review standards;
   d) Formulary design for prescription drugs;
   e) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
   f) Standards for provider admission to participate in a network, including reimbursement rates;
   g) Plan or insurer’s methods for determining usual, customary and reasonable charges;
   h) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as “fail-first” policies or “step therapy” protocols);
   i) Restrictions on applicable provider billing codes;
   j) Standards for providing access to out-of-network providers;
   k) Exclusions based on failure to complete a course of treatment;
   l) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan; and
   m) Any other non-numerical limitation on MH/SUD benefits.

Note that not every NQTL needs an evidentiary standard. There is flexibility under MHPAEA for plans to use NQTLs. The focus is on finding out what processes and standards the plan actually uses.

Question 11.

Does the insurer comply with MHPAEA disclosure requirements including (1) criteria for medical necessity determinations for MH/SUD benefits, and (2) the reasons for any denial?

See 45 CFR §146.136(d)(1) and (2).

Note that the state’s grievance procedure and external review statutes may contain additional disclosure requirements.
DATA COLLECTION TOOL FOR MENTAL HEALTH PARITY ANALYSIS

Most parity analysis examines benefits by comparing MH/SUD to M/S within a classification. 45 CFR §146.136(c)(2)(i). The exception is aggregate lifetime or annual dollar limits (to the extent the plan is not prohibited from imposing such limits under Federal or State law), which are examined for the plan as a whole. 45 CFR §146.136(b). The following is intended to simplify data collection for parity analysis at the classification level. Examiners may find it helpful to identify a person with MHPAEA experience, from the state’s legal or health policy division, to interpret results after data is received from the insurer.

GUIDANCE FOR PLACING BENEFITS INTO CLASSIFICATIONS:

MH/SUD and M/S benefits must be mapped to one of six classifications of benefits: (1) inpatient in-network, (2) inpatient out-of-network, (3) outpatient in-network, (4) outpatient out-of-network, (5) prescription drugs, and (6) emergency care. 45 CFR §146.136(c)(2)(ii).

- The “inpatient” classification typically refers to services or items provided to a beneficiary when a physician has written an order for admission to a facility, while the “outpatient” classification refers to services or items provided in a setting that does not require a physician’s order for admission and does not meet the definition of emergency care.

- “Office visits” are a permissible sub-classification separate from other outpatient services.

- The term “emergency care” typically refers to services or items delivered in an emergency department setting or to stabilize an emergency or crisis, other than in an inpatient setting.

- Some benefits, for example lab and radiology, may fit into multiple classifications depending on whether they are provided during an inpatient stay, on an outpatient basis, or in the emergency department.

- Insurers should use the same decision-making standards to classify all benefits, so that the same standard applies to M/S and MH/SUD benefits. For example, if a plan classifies care in skilled nursing facilities and rehabilitation hospitals for M/S benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits.

FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS:

Types of Financial Requirements (FRs) include deductibles, copayments, coinsurance, and out-of-pocket maximums. 45 CFR §146.136(c)(1)(ii). Types of Quantitative Treatment Limitations (QTLs) include annual, episode, and lifetime day and visit limits, for example number of treatments, visits, or days of coverage. 45 CFR §146.136(c)(1)(ii). A two-part analysis applies to financial requirements (FRs) and quantitative treatment limitations (QTLs). In general, MHPAEA regulations require that any FR or QTL imposed on MH/SUD benefits not be more restrictive than the predominant level of financial requirement or treatment limitation of that type that applies to substantially all medical/surgical benefits in a classification.

If the plan applies a cumulative FR or QTL (a FR or QTL that determine whether or to what extent benefits are provided based on accumulated amounts), the FR or QTL must not accumulate separately from any established for M/S benefits in a classification.
<table>
<thead>
<tr>
<th>Does the plan provide MH/SUD benefits?</th>
<th>Does the plan provide M/S benefits?</th>
<th>Total dollar amount of all plan payments for M/S benefits expected to be paid for the relevant plan year</th>
<th>List each financial requirement that applies to the classification for MH/SUD benefits:</th>
<th>For each type of financial requirement that applies to MH/SUD benefits, list the expected percentage of plan payments for M/S benefits in each classification that are subject to that same type of financial requirement:</th>
<th>For each level of each type of financial requirement that applies to at least 2/3rds of all M/S benefits in the classification, list the expected percentage of plan payments for M/S benefits subject to that financial requirement, that are subject to that level:</th>
<th>Emergency Care</th>
<th>Prescription Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient In-Network (if network tiers, may separate into tiers in accordance with 45 CFR §146.136(c)(3)(iii)(B))</td>
<td>Inpatient Out-of-Network</td>
<td>Outpatient In-Network (Issuer can choose to have subclassifications for Outpatient Office Visits, and Other Outpatient Services) (if network tiers, may separate into tiers in accordance with 45 CFR §146.136(c)(3)(ii)(B))</td>
<td>Outpatient Out-of-Network (Issuer can choose to have subclassifications for Outpatient Office Visits, and Other Outpatient Services)</td>
<td>Emergency Care</td>
<td>Prescription Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Requirements and Quantitative Treatment Limitations, Cont’d</td>
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<td><strong>Emergency Care</strong></td>
<td><strong>Prescription Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the plan impose a separate cumulative financial requirement or QTL for MH/SUD benefits that accumulates separately from any cumulative financial requirement or QTL for M/S benefits?</td>
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<tr>
<td>List each QTL that applies to the classification for MH/SUD benefits:</td>
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<tr>
<td>For each type of QTL that applies to MH/SUD benefits, list the expected percentage of plan payments for M/S benefits in each classification that are subject to that same type of QTL:</td>
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<tr>
<td>For each level of each type of QTL that applies to at least 2/3rds of all M/S benefits in the classification, list the expected percentage of plan payments for M/S benefits subject to that QTL, that are subject to that level:</td>
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</tbody>
</table>
**NON-QUANTITATIVE TREATMENT LIMITATIONS:**

Non-Quantitative Treatment Limitations include but are not limited to medical management techniques such as step therapy and pre-authorization requirements. Coverage cannot impose a NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to M/S benefits in the classification. Note that not every NQTL needs an evidentiary standard. There is flexibility under MHPAEA for plans to use NQTLs. The focus is on finding out what processes and standards the plan actually uses.

All plan standards that are not FRs or QTLs and that limit the scope or duration of benefits for services are subject to the NQTL parity requirements. This includes restrictions such as geographic limits, facility-type limits, and network adequacy.

The following data collection chart is modeled after a tool used in federal MHPAEA examinations. Insurers who have completed “Table 5” for NQTLs may substitute those documents for completion of this chart.

<table>
<thead>
<tr>
<th>Area</th>
<th>Medical/Surgical Benefits</th>
<th>Mental Health/Substance Use Disorder Benefits</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Definition of Medical Necessity</td>
<td>Summarize the plan’s applicable NQTLs, including any variations by benefit</td>
<td>Summarize the plan’s applicable NQTLs, including any variations by benefit</td>
<td>Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR §146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described and list this documentation in the space provided below. Please include in this column an explanation of how the MH/SUD benefits compare to M/S benefits</td>
</tr>
<tr>
<td></td>
<td>What is the definition of medical necessity?</td>
<td></td>
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</tr>
</tbody>
</table>
## NON-QUANTITATIVE TREATMENT LIMITATIONS, CONT’D

<table>
<thead>
<tr>
<th>Area</th>
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</tr>
</tbody>
</table>

### B. Prior Authorization Review Process

Include all services for which prior authorization is required. Describe any step therapy or “fail first” requirements and requirements for submission of treatment request forms or treatment plans.

**Inpatient, In-Network:**

**Outpatient, In-Network: Office Visits:**

**Outpatient, In-Network: Other Outpatient Items and Services:**

**Inpatient, Out-of-Network:**

**Outpatient, Out-of-Network: Office Visits:**

**Outpatient, Out-of-Network: Other Items and Services:**
### NON-QUANTITATIVE TREATMENT LIMITATIONS, CONT’D

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</table>

**C. Concurrent Review Process,** including frequency and penalties for all services. Describe any step therapy or “fail first” requirements and requirements for submission of treatment required forms or treatment plans.

*Inpatient, In-Network:*

*Outpatient, In-Network: Office Visits:*

*Outpatient, In-Network: Other*

*Outpatient Items and Services:*

*Inpatient, Out-of-Network:*

*Outpatient, Out-of-Network: Office Visits:*

*Outpatient, Out-of-Network: Other Items and Services:*

**D. Retrospective Review Process,** including timeline and penalties.

*Inpatient, In-Network:*

*Outpatient, In-Network: Office Visits:*

*Outpatient, In-Network: Other*

*Outpatient Items and Services:*

*Inpatient, Out-of-Network:*

*Outpatient, Out-of-Network: Office Visits:*

*Outpatient, Out-of-Network: Other Items and Services:*

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Executive (EX) Committee and Plenary 8/6/19

Attachment Thirteen
<table>
<thead>
<tr>
<th>Area</th>
<th>Medical/Surgical Benefits</th>
<th>Mental Health/Substance Use Disorder Benefits</th>
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<tbody>
<tr>
<td>E. Emergency Services</td>
<td>Summarize the plan’s applicable NQTLs, including any variations by benefit</td>
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<td>F. Pharmacy Services</td>
<td>Include all services for which prior authorization is required, any step therapy or “fail first” requirements, any other NQTLs. Tier 1: Tier 2: Tier 3: Tier 4:</td>
<td></td>
<td></td>
</tr>
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</tr>
</tbody>
</table>

**G. Prescription Drug Formulary Design**  
How are formulary decisions made for the diagnosis and medically necessary treatment of medical, mental health and substance use disorder conditions?  
Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy:  
What disciplines, such as primary care physicians (internists and pediatricians) and specialty physicians (including psychiatrists) and pharmacologists, are involved in development of the formulary for medications to treat medical, mental health and substance use disorder conditions?  

**H. Case Management**  
What case management services are available?  
What case management services are required?  
What are the eligibility criteria for case management services?
### NON-QUANTITATIVE TREATMENT LIMITATIONS, CONT’D

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#### I. Process for Assessment of New Technologies

- Definition of experimental/investigational:
- Qualifications of individuals evaluating new technologies:
- Evidence consulted in evaluating new technologies:

#### J. Standards for Provider Credentialing and Contracting

- Is the provider network open or closed?
- What are the credentialing standards for physicians?
- What are the credentialing standards for licensed non-physician providers? Specify type of provider and standards; e.g., nurse practitioners, physician assistants, psychologists, clinical social workers?
- What are the credentialing/contracting standards for unlicensed personnel; e.g., home health aides, qualified autism service professionals and paraprofessionals?

#### K. Exclusions for Failure to Complete a Course of Treatment

- Does the plan exclude benefits for failure to complete treatment?
### NON-QUANTITATIVE TREATMENT LIMITATIONS, CONT’D

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</tr>
<tr>
<td>L. Restrictions that Limit Duration or Scope of Benefits for Services</td>
<td>Does the plan restrict the geographic location in which services can be received; e.g., service area, within the state, within the United States?</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Does the plan restrict the type(s) of facilities in which enrollees can receive services?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M. Restrictions for Provider Specialty</td>
<td>Does the plan restrict the types of provider specialties that can provide certain M/S and/or MH/SUD benefits?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>List of Documents Referenced Above</td>
<td>List each document referenced above, including reference to exhibit number, file name, or other identifying information for examiners.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

Executive (EX) Committee

- Adoption of the new Insurance Data Security Model Law (#668)—This model was adopted by the Executive (EX) Committee and Plenary at the 2017 Fall National Meeting. Six states have enacted this model.

Life Insurance and Annuities (A) Committee

- Amendments to the Separate Accounts Funding Guaranteed Minimum Benefits Under Group Contracts Model Regulation (#200)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2016 Fall National Meeting. One state has enacted these revisions to the model.

- Amendments to the Standard Nonforfeiture Law for Individual Deferred Annuities (#805)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2017 Summer National Meeting. Two states have enacted these revisions to the model.

Health Insurance and Managed Care (B) Committee

- Amendments to the Health Insurance Reserves Model Regulation (#10) (Cancer Expense Table)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2017 Spring National Meeting. Four states have enacted these revisions to the model.

- Amendments to the Health Carrier Prescription Drug Benefit Management Model Act (#22)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2018 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Accident and Sickness Insurance Minimum Standards Model Act (#170)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2019 Spring National Meeting. 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. NAIC staff are not aware of any state activity regarding 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. Three states have enacted these revisions to the model.

- Adoption of the Limited Long-Term Care Insurance Model Act (#642)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Adoption of the Limited Long-Term Care Insurance Model Regulation (#643)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)—These revisions were for consistency with the federal Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and were adopted by the Executive (EX) Committee and Plenary at the 2016 Summer National Meeting. Twenty-three states have enacted these revisions to the model.
Property and Casualty Insurance (C) Committee

- Adoption of the Travel Insurance Model Act (#632)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. Six states have enacted this model.

Market Regulation and Consumer Affairs (D) Committee

- 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. Nine states have enacted these revisions to the model.

Financial Condition (E) Committee

- 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. Twenty-five states have enacted elements of this model.

- Amendments to the Credit for Reinsurance Model Law (#785)—These revisions were adopted by the Executive (EX) Committee and Plenary during the June 26, 2019 conference call. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the Credit for Reinsurance Model Regulation (#786)—These revisions were adopted by the Executive (EX) Committee and Plenary during the June 26, 2019 conference call. NAIC staff are not aware of any state activity regarding this model.

- 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. Four states have enacted this model.